"It's a Race Against the Clock": A Qualitative Analysis of Barriers to Legal Abortion in Bogotá, Colombia

CONTEXT: *In 2006, the Colombian Constitutional Court issued a decision largely decriminalizing abortion; however, illegal abortion persists. Understanding the barriers that cause women to resort to unsafe, illegal abortions could help improve access to legal services.*

METHODS: *In-depth interviews were conducted in 2014 with 17 women aged 18 or older who had had legal abortions in the past year in Bogotá, Colombia, to identify barriers to abortion access and elucidate the ways in which these barriers affect women's decision making regarding abortion. Interview transcripts were coded and analyzed using standard techniques to find patterns, parallels and differences; a phenomenological approach guided the thematic analysis.*

RESULTS: *Barriers related to knowledge and information, along with logistic, emotional, financial, cultural and religious barriers culminated in delays in obtaining comprehensive abortion services. Religion influenced social stigma, which manifested most powerfully in the obstructive behavior of health care providers and health insurance companies. Lack of understanding of current laws on abortion and conscientious objection was evident on the part of patients, health care providers and insurers.*

CONCLUSION: *Dissemination of accurate information regarding the availability of clinical and legal abortion is needed. Better training may help physicians, nurses and insurance company personnel understand their roles and legal responsibilities in abortion care and reduce delays in women's access to services.*
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In many parts of the world, unsafe, clandestine abortion is a significant contributor to maternal morbidity and mortality. Complications from unsafe abortions can include hemorrhage, sepsis and trauma, any of which may lead to death.[1] Rates of maternal mortality from abortion range from fewer than one death per 100,000 live births in countries with liberal abortion policies to 34 deaths per 100,000 live births in countries with restrictive abortion laws.[1] In Latin America, unsafe abortions are responsible for 30 maternal deaths per 100,000 live births per year, and 95% of induced abortions in the region are unsafe.[2] Moreover, the proportion of maternal deaths that result from unsafe abortion is higher in Latin America than in any other region.[3,4]

A plethora of studies conducted globally has shown that legal restrictions on abortion access act as barriers to safe abortion.[1,3,5–9] Studies in Mexico,[7] Nepal,[10] Australia,[11] Ghana,[12] India,[13] the United States[14–16] and Colombia[17] have found that educational, physical, financial, emotional, religious and social barriers—acting separately or together—result in delays in obtaining abortion.

In 2006, a landmark decision in the Colombian Constitutional Court, C-355/2006, partially decriminalized abortion. This ruling delineated several situations in which abortion is legally permitted, including those in which the woman's life or health is at risk, there is a fetal deformity that is incompatible with life or the pregnancy is the result of rape or incest.[18,19] The decision is one of few in Latin America that do not limit abortion by gestational age.

Despite this liberalization and abortion's subsequent legal availability, the great majority of abortions in Colombia remained illegal. In 2008, the last date for which data are available, the estimated abortion rate was 39 abortions per 1,000 women aged 15–44, which translates to 400,400 abortions; however, there were only 322 recorded legal abortions.[20] The reason for the high proportion of abortions that were illegal two years following the Court's decision is unclear, and anecdotal data suggest that the situation today remains largely unchanged. La Mesa por la Vida y la Salud de las Mujeres (La Mesa)—a reproductive rights advocacy organization based in Bogotá—published a report on barriers experienced by its clients seeking abortions in 2014 naming legal, financial and religious barriers and a lack of information as the most prominent.[21] Since 2006, implementation of the Court's ruling has been inconsistent, and many women continue to be denied abortion services or experience delays when trying to obtain them.[21–23]

Fundamental disagreements remained about abortion provision in Colombia, despite the guidelines provided by C-355/2006. Key actors—including hospital administrators and physicians—had varying knowledge of law's enactment, and varying understanding of the ethical, legal and medical requirements and obligations

outlined by the ruling.[19,24,25] In an attempt to clarify the legal rights and responsibilities of individual health care providers and hospitals, the Colombian Constitutional Court issued a decision in 2008 that declared that providers have the right of conscientious objection—that is, providers have the right to refuse to perform abortions if their refusal is based on established religious conviction.[26] This national decision, known as T-209/2008, states that facilities such as hospitals do not have the right to adopt conscientious objection as institutional policy, and specifically grants the right only to physicians. Also, T-209/2008 makes clear that objecting physicians at both public and private institutions are obligated to refer patients for abortions elsewhere, and that institutions have a duty to ensure the availability of nonobjecting physicians to whom patients can be referred.[26,27]

Despite the 2008 decision, many health care facilities continue to illegally turn away all patients seeking abortion services.[21] In addition, many Colombian physicians struggle with their comfort level regarding abortion provision. Some illegally and unethically refuse to make referrals to willing providers, try to block patients from obtaining services or engage in case-by-case decision making when patients request an abortion instead of following the standards set by law.[24,25]

In alignment with the Colombian Constitution's guarantee of the right to health, Colombia employs a system of universal health care that covers more than 96% of its residents.[28] Colombian citizens are able to choose their insurance company, known as an *Entidad Promotora de Salud* (EPS). An EPS sells health service packages to the public and contracts with health care institutions to provide those services.[28,29] Government subsidies are available for those who cannot afford the full cost of EPS premiums.

If an EPS refuses to pay for any treatment or service, the patient is entitled to contest the denial in court using a legal mechanism known as a *tutela*. The motion must be ruled on by a judge within 10 days; it is unclear how often the ruling is in favor of the patient.[30] Under the law, every EPS must cover abortion services, but many women in Colombia are unaware of their right to use a tutela to obtain an abortion if they have been denied services.[21]

Globally, greater legal access to abortion is associated with a lower incidence of unsafe abortion; however, when the law is applied and interpreted differently, vulnerable populations (those with fewer financial resources and lack of proximity to health care) will suffer most from lack of access.[5] Despite the availability of legal abortion in Colombia at public hospitals, private university hospitals and some clinics, barriers to access have led to a consistently high incidence of illegal abortion.[20,31] In this study, we sought to identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care.

METHODS

Sample and Data Collection

We conducted 17 in-depth interviews in June–July 2014 with women who had obtained a legal abortion in Bogotá, Colombia. Women were eligible for inclusion if they were aged 18 or older, had obtained an abortion in the past 12 months and exhibited verbal proficiency in Spanish.

Because of the sensitive nature of the research topic, we recruited interviewees via collaboration with La Mesa and with four clinics in Bogotá. Two of the clinics—Centro Amigable Centro Oriente (CAMI CO) and Centro Amigable Suba (CAMI Suba)—were public, and two—Profamilia Clinic–Piloto (Profamilia) and Oriéntame Clinic–Teusaquillo (Oriéntame)—were private. The four sites were selected because they constitute a small network of clinics that usually serve as the first point of contact for women seeking abortion in Bogotá and provide abortion until up to 14 weeks' gestation. Clinic directors, ethics committee representatives and psychologists from the clinic sites and lawyers from La Mesa identified and referred potential participants; women referred by La Mesa had received legal services from the organization and had experienced particularly lengthy delays in obtaining their abortion.

The first author invited the referred women to participate in the study; roughly one out of every 4–5 agreed to do so. A similar number of interviewees (3–4) was recruited from each of the five sources, consistent with purposive sampling. This sampling scheme yielded thematic saturation.

The interviews were conducted in person in Spanish by the first author, who recorded them using a tablet. Interviews were conducted in private consultation rooms provided by the clinics and lasted between 30 minutes and two hours (median, one hour and 10 minutes).

In-Depth Interview Guide

The first two authors created an in-depth interview guide that was informed by the Three Delays model, which outlines three major types of delays that impede pregnancy-related care during obstetric emergencies: delay in the decision to seek care (delay #1), delay in arrival at a health facility (delay #2) and delay in the provision of adequate care (delay #3).[32] The guide prompted participants to answer a series of questions about their experience in obtaining abortion care, their knowledge of available services, barriers they experienced in obtaining abortion care and their attitudes toward abortion. The third author, a native Colombian, reviewed the guide for cultural competency and relevance. The guide consisted of open-ended questions in four conceptual domains: pregnancy recognition, care seeking, arrival at a medical facility and receipt of effective treatment. The inclusion of the last domain was intended to uncover information about treatment type, including the quality, safety and comprehensiveness of the services rendered. Examples of interview questions

include "Can you describe how you found out that you were pregnant?" "Can you talk about any opposition that you faced while deciding to seek an abortion?" "How did you learn about this facility?" and "How would you describe your overall experience of getting an abortion?"

The first author wrote memos after each interview, making note of emergent themes, and incorporated any new themes iteratively into subsequent interview questions and probes.

Data Analysis

A Colombian transcriptionist in Bogotá entered the interviews verbatim. We chose a Colombian for this task to preserve the cultural nuances in participants' narratives. Interview transcripts were then imported into MaxQDA10. All data analysis was performed in Spanish by the first 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. Analyses were done using a phenomenological approach, which centered on in-depth exploration of each participant's experience in obtaining a legal abortion. As the intricacies and nuances of the data emerged, we developed a conceptual framework to illustrate the common patterns surrounding this particular phenomenon,[33] and connected it to a previously published framework. We validated the phenomenological approach using the literature on the topic of abortion decision making and barriers to abortion access.

Ethical approval for this study was provided by the Emory University Institutional Review Board and by the research ethics committees at Universidad de los Andes, Fundación Oriéntame and Profamilia. Before being interviewed, each woman provided written informed consent to be interviewed and recorded. We did not compensate participants for their time.

RESULTS

Study Participants

The 17 participants ranged in age from 18 to 39 (median, 25) and had obtained a legal abortion from two weeks to 11 months before the interview (median, six weeks). Eight of the women had no children, seven had one child (age range, 1–14 years), one had two teenage children and one had three young children (age range, 2–8 years). Gestational age at the time of abortion ranged from four to 22 weeks (median, nine weeks). Sixteen women stated that they had sought abortion services because the pregnancy had threatened their emotional health. One said she had been told by a physician that she needed an abortion because the pregnancy threatened her physical health and she would likely not survive it. None said that their pregnancy had been the result of unwanted intercourse. All 17 resided in Bogotá.

Nine of the participating women were single; the remainder reported being in a relationship (Table 1). Most of the women were Catholic, and one woman reported being an Evangelical Christian. One-third were students, one-third were unemployed and the rest had a regular income. All of the women had at least a secondary education. Twelve women had obtained an abortion during the first trimester, and five during the second trimester.

TABLE 1. Selected characteristics of women who participated in in-depth interviews on barriers to legal abortion, Bogotá, Colombia, 2014

Characteristic	No. of participants
Age	
18–24	7
25–31	8
32–39	2
Marital status	
Single	9
In a relationship	8
Religious affiliation	
Catholic	16
Evangelical Christian	1
Employment status	
Unemployed	5
Employed	6
Full-time student	5
Education level	
Primary	0
Secondary	14
University	3
Timing of abortion	
First trimester	12
Second trimester	5

All 17 participants initially visited one of the four first-stop abortion clinics, but five women ultimately had their abortion at one of five hospitals, two of which were private (Clínica Colombia and Clínica Santa Fe) and three of which were public (Hospital La Victoria, Hospital Maternal e Infantil and Hospital Suba). Participants who obtained their abortion at a hospital did so because the gestational age was beyond 14 weeks; however, those who obtained their abortion at a private hospital did so because their EPS mandated that services be rendered at those locations.

During the interviews, the participants described an array of barriers that served to delay their abortion. These barriers can be categorized as follows: informational, logistic, emotional, cultural and religious, provider-created and financial.

Informational Barriers

• *Knowledge of the law.* Throughout the 17 interviews, lack of information about abortion services and legal rights was the most frequently mentioned barrier to abortion. The most common theme among study participants was a lack of knowledge of their right to an abortion. Only one participant, a lawyer, knew about C-355/2006; in other words, 16 of the women did not know that abortion was legal under broad circumstances in Colombia, and this lack of information was a barrier to timely care. These participants expressed frustration about their lack of

knowledge, and questioned why the legality of abortion seemed to be a secret. One described the misconceptions she had had about the abortion law:

"I had it in perspective that if I wasn't raped, I wouldn't have a right to an abortion.... Because the fact that just because I'm not about to slit my wrists or about to jump off of a bridge doesn't mean that I'm not suffering psychologically.... It manifests in various forms."–*Marta, CAMI Suba**

Several reported having felt powerless before becoming aware of their right to an abortion, and subsequently felt fortunate to have found safe, legal services. None of them knew the law concerning a physician's right to conscientious objection or were aware that physicians were legally obligated to refer them to willing providers. Seven reported discovering during the process of obtaining an abortion that not only was abortion legal, but that health insurance companies were legally obligated to cover its cost. Through self-advocacy and the assistance of La Mesa, these seven were able to obtain full coverage, though they had their abortions later than they had desired. Study participants who had lacked knowledge of the law experienced all three types of delays—in the decision to seek care, in arrival at a health facility and in receipt of adequate care.

• *Knowledge of points of care*. When asked how they had known what to do to obtain an abortion, five participants said that they had confided in friends, or in teachers or psychologists from their academic institutions or community groups, who directed them to one of the four first-stop clinics. Seven said they had searched online for abortion in Bogotá using an Internet search engine, which led them to the first-stop clinics. Of these seven, three said they had used the chat feature on Oriéntame's web page to make their appointment. Three women said they had tried to induce an abortion using home remedies they had found online. One participant, a single mother of two, described her decision making and experience prior to getting to a clinic:

"I looked at my economic situation, my home life, my emotional state. Then I said, 'No, I feel lost, I don't have any help.' So, I looked on the Internet and tried things that could help me get rid of [the pregnancy]; I took some herbs, boiled beer, wrapped a belt around my waist as tight as possible. People said it worked, but I just felt awful. And nothing happened."–*Tana, Hospital La Victoria*

Several women did not have access to accurate information, thus delaying their decision to seek an abortion and their obtaining a safe, legal abortion (delays #1 and #2); their options for an abortion thus were limited by advanced gestational age. Five had gone to a clandestine clinic before seeking legal abortion services. One described her experience with a representative of a clandestine clinic:

"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 [Colombian pesos (COP; US$50)], and they would do it in two minutes."–*Nayely, Hospital Suba*

Study participants described the representatives of clandestine clinics as trying to lure them with prices cheaper than those charged at well-known, legal establishments. These representatives promised that the abortion would be both quick and easy. Also, because clandestine abortion clinics lack public signage, some women—especially those who were unfamiliar with the area—did not realize that the clinic at which they had arrived was not the legal facility at which they had made their appointment. Another participant recounted the deception and coerciveness of clandestine clinics:

"I looked [Oriéntame] up in the yellow pages, the same day I called, [I] 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 then said they would do my abortion for cheaper than Oriéntame, and 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."–*Paola, Oriéntame*

Five knew as soon as they were pregnant that they did not want to carry the pregnancy to term, but did not know where to obtain an abortion. Such lack of knowledge resulted in delays #2 and #3: delays in arrival at a licensed and legitimate health care facility and in receipt of adequate care.

Logistic Barriers

Once study participants had decided to seek care, advanced gestational age was one of the most common logistic barriers that resulted in delays in receiving care. Because the ability of a health care establishment to provide abortion services depends on gestational age, many women found that once they had arrived at the designated facility, they still were unable to have their abortion (delay #3). Five reached one of the four initial points of care after 14 weeks' gestation, so they were unable to obtain an abortion at these sites; the process of getting to one of the hospitals that could provide abortions at later gestational ages caused additional delay in receipt of adequate care. Obtaining an abortion in a timely manner was an issue for women in the first trimester as well. As one participant who obtained 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'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." –*Cristal, Oriéntame*

About half of the study participants had difficulty getting to the facility where they received services (delay #2).

*We do not provide women's personal characteristics after each quotation in this article, but instead provide pseudonyms followed by the site at which each woman obtained her abortion.

Some got lost, and many complained of long waits at the clinic, hospital or EPS office. Although some participants lived within 20 minutes of the clinic or hospital they visited, others spent as long as four hours traveling on public transit.

Women also experienced other logistic barriers. Fifteen of the 17 women had to take time off from work or school to obtain their abortion, and nine had to arrange for child care, all of which delayed the abortion (delay #2). Only five were able to have their abortion at their first appointment; eight had at least two appointments at one or two locations; and four had to work with La Mesa or their EPS for 4–8 weeks, requiring multiple appointments at different locations, before obtaining their abortion (delays #2 and #3). For example, one participant, Adela, reported having three clinic appointments with three different providers, more than 10 phone calls with her EPS, two appointments at La Mesa (with the same lawyer) and two hospital visits (during the second of which she finally obtained her abortion). She was told in every telephone and physical encounter, except those with La Mesa, that she was missing paperwork and authorizations, and was given further instructions. She was at about 12 weeks' gestation at her first appointment, and 20 weeks' gestation on the day of her abortion. The process took her 55 days.

Emotional Barriers

Fifteen of the 17 study participants felt conflicted about having a child at that point in their life and in their situation, and had difficulty in coming to the decision to have an abortion. Three reported feeling unsure about having an abortion after having a sonogram. Ten said they had heard the fetal heartbeat during the sonogram, and had been told their due date by the physician or technician, who in some cases already knew that the woman was having the sonogram to determine the type of abortion for which she was eligible.

Seven reported experiencing taxing and complex emotional situations that made their choice even more difficult, which resulted in several days or weeks of wavering about their decision (delay #1). One participant, a 39-year-old single mother, said that her partner had ended their relationship when she told him she was pregnant. She could not financially support a second child without the help of a partner and was very upset to be ending the unexpected pregnancy. Through tears, she stated:

"Had this been a baby he wanted too, I would have maybe tried to keep it. But to look at a baby every day that looks like him, that I cannot afford, I could not.... I could not decide for weeks. But I had no other option."–*Marisol, Profamilia*

Another participant, Elvia, said she was not emotionally or economically ready for a baby, but because she physically was able to give birth, she struggled with the decision to terminate.

Cultural and Religious Barriers

Fourteen women said that their religious beliefs caused them to feel conflicted about having an abortion. Many expressed concern about the fate of the soul of the embryo or fetus, as well as their own soul. When asked how her religious beliefs affected her feelings about her abortion, Marisol, who had obtained her abortion at Profamilia, responded, "Yes, I killed a person...that is what we say.... And, I am damned to hell. It's complicated.... It's difficult." Pilar, a 19-year-old college student who also had obtained her abortion at Profamilia, said, "I believe in God with all my heart, and I worried. I said to him, 'My God, our souls are in your hands. Forgive me for what I need to do, because maybe it is not to your liking.'" For four of the women, including the two quoted earlier in the paragraph, the stigma associated with abortion led to delays in decision making and in obtaining services (delays #1 and #2).

When asked how she knew what to do about ending her unwanted pregnancy, a single 23-year-old participant said:

"In reality, it was a really agony-inducing situation, due to my religion, my society, my sins. What matters to me the most in my life is my religion, it is of supreme importance.... I want a family, with a husband and kids inside of marriage. And that was not my situation, so it was really difficult. I couldn't eat, I cried, I had an intense depression."–*Ramona, Oriéntame*

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

Participants named religion as the principal driver of Colombian cultural attitudes, beliefs and actions related to abortion. At the time of their interview, eight of the 17 women had not told their partner about their pregnancy or subsequent abortion, and did not have plans to ever tell him. They said they were withholding this information because they feared being judged; feared changing the dynamics of the relationship; or feared hurting, angering or losing their partner. Of the nine who had told their partner about the pregnancy, three had felt pressured by their partner to carry the pregnancy to term and to get married. The partners of these three participants voiced religiously motivated antiabortion attitudes; the women stated that this dynamic resulted in delays in decision making and in obtaining services (delays #1 and #2). One woman described her partner as religious, and his reaction to her pregnancy as extreme:

"He started to have this attitude that we have to get married, and we're going to do this, and he got all authoritative, I think out of fear. We struggled a lot. He could not accept it.... We don't speak now."–*Juana, Profamilia*

Thirteen women had not told their family about their pregnancy or subsequent abortion, and reported difficulty in keeping these events secret. All but one had felt societal pressure to not disclose that they had had an abortion,

specifically referencing Colombian cultural and religious attitudes against abortion. Participants referred to abortion as a topic that is *coco*, or taboo, and spoken about only in secret. More than one-third said that the only people who knew about their abortion were the hospital or clinic staff who had performed or assisted with the abortion and the researcher who was interviewing them.

Three participants described the stigma attached to having a child, in contrast to the stigma of having an abortion, given their current educational endeavors, and romantic and financial situations. They noted that in Colombian society, people pass judgment on single mothers and think poorly of them for having to drop out of school, for having a child out of wedlock and for being unable to afford the child. These participants stated that their families would also judge them for these reasons.

Providers as Barriers

Another common theme was participants' interactions with clinic and hospital staff, including administrators, psychiatrists, physicians and nurses. Six described the ways in which health care providers acted as barriers to obtaining humane, compassionate and comprehensive abortion services (delay #3). One woman, Chana, who obtained her abortion at Clínica Colombia said that while a physician performed her sonogram, he said, "You can already hear the heartbeat, how are you going to kill it?" Lola, who had her abortion at Clínica Santa Fe, reported that a psychiatrist had brought a group of students into her hospital room and described her as a patient with a severely compromised mental state, causing her to break down in tears and nearly check herself out of the hospital.

Five women recounted going to a public hospital first to ask about abortion services; they were met with ignorance and condescension on the part of administrators and providers. One participant, a married mother of one, reported arriving at a hospital two days after finding out that she was pregnant, having missed one period:

"I told them, 'I'm here for a voluntary interruption of pregnancy.' And they said, 'I don't know what that is. What is that?' And I said, 'This is a hospital, I know you know what that is.' And they said, 'Go ask over there, go over there....' In other words, they made me go all over the whole damn hospital, asking about abortion.... Finally, a doctor told me to come back the next day, and when I did, he had me sit in a hallway, waiting the entire day. I thought he forgot about me. But I heard him talking to some nurses.... The whole world was looking at me with shame, and didn't help me."–*Lola, Hospital Maternal e Infantil*

Because of this refusal of care, the woman turned to La Mesa, which eventually helped her receive the abortion to which she was legally entitled, at 16 weeks' gestation.

For women receiving inpatient abortion care, the quality of care provided by nurses sometimes acted as a barrier to comprehensive care (delay #3). Three participants reported that the fetus was presented to them after the abortion, in a plastic bag or wrapped in gauze, and was left at the foot of their bed or in a plastic tub in their hospital room. Another described how a nurse had attempted to talk her out of having an abortion and had threatened to throw the fetus in the trash if the woman terminated the pregnancy. The participant recounted how the nurse fulfilled her threat:

"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, [so] 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."–*Nayely, Hospital Suba*

Not only were some of the women treated badly in their time of need and denied compassionate care, but the abuse they received continued to affect several of them psychologically. Chana, who received services at Clínica Colombia, said she continued to lose sleep thinking about the way a nurse had 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 the bag...it all mortifies me."

The behavior of these nurses–who cannot legally object to participation in abortion services–was described by study participants as being deeply rooted in Catholic beliefs about when life begins and abortion as murder. This treatment of abortion patients on the part of nurses led to a delay in receipt of comprehensive abortion care (delay #3).

Financial Barriers

• *Financial burden.* Ten of the 17 women paid for their abortion out of pocket. The cost varied by abortion method (medical or surgical) and type of anesthesia (general or local). Half of those who paid for abortion services in cash said that they had obtained the money they needed by either selling items they owned (e.g., cell phones, clothing), asking for an advance on their paycheck, or borrowing money from family or friends (all reported being dishonest about their reason for needing money). The time it took to get the money delayed their obtaining services, resulting in their having the abortion later than they had wanted (delay #2). Those who paid out of pocket reported costs as low as COP 40,000 (US$13) and as high as COP 500,000 (US$166). Although cost was generally determined by abortion method type, it was also ultimately determined by individual clinics in an undisclosed manner.

• *Insurance coverage delays and denial.* Some of the seven women whose abortion had been paid for by their EPS said issues with the company had delayed their abortion. EPS representatives abruptly hung up when participants mentioned abortion, did not return their phone calls or told women that abortion was not covered by the EPS. Inconsistent instructions from the companies regarding necessary authorizations further delayed these women from getting approval and

obtaining an abortion in a timely manner. Some women were delayed by as much as two months.

Of the 10 women who paid for their abortion out of pocket, eight had sought financial support from their EPS but were denied. Participants described how EPS representatives had lectured them on morality and told them they were making a bad decision. As one woman stated:

"[La Mesa] referred me to the EPS, which completely denied me. [The EPS representative] 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."–*Adela, Clínica Santa Fe*

In general, insurance companies acted as a barrier to timely access to legal, safe abortion care (delays #2 and #3), even though they are legally obligated to authorize the procedure. Religious sentiments appeared to underlie the behavior of company representatives.

DISCUSSION

The 17 women who participated in the in-depth interviews each had unique interactions with the Colombian health care system. However, their experiences with discrimination and barriers to abortion access were often similar. All study participants reported encountering at least one type of barrier, which led them to experience at least one type of delay; many experienced two or all three types of delay. That this overlap emerged from the data is logical, because the barrier types do not exist in isolation and may occur at different time points.

Analysis of the experiences reported by study participants enabled us to conceptualize six barrier domains with several subdomains, ultimately yielding eight distinct barrier types. With these data, we are able to present the pervasive nature of barriers to legal abortion access in Bogotá, and to demonstrate how the barriers translated into the three types of delays (Figure 1).

A recent study of barriers to legal abortion access in Bogotá sought to identify and estimate the extent of delays women experience.[23] Delays in making the decision to terminate averaged 10.6 days for women in the first trimester and 19.5 days for those in the second trimester. Subsequent delays, primarily caused by financial and logistic barriers, averaged 13.4 days in the first trimester and 24.2 days in the second. As in our study, participants reported that late gestational age, long travel distances to and wait times at the point of care, and difficulty taking time off from school or work were logistic barriers that delayed their access to care.[23]

The present study adds to the growing body of quantitative and qualitative literature examining barriers to abortion worldwide. While other studies have identified and measured barriers to care,[15,16,23] our study sheds light on the personal context surrounding the undue burden that extreme barriers to abortion place on women and gives these women a voice. Their stories underscore the fact that access under the law does not always translate to access in practice.

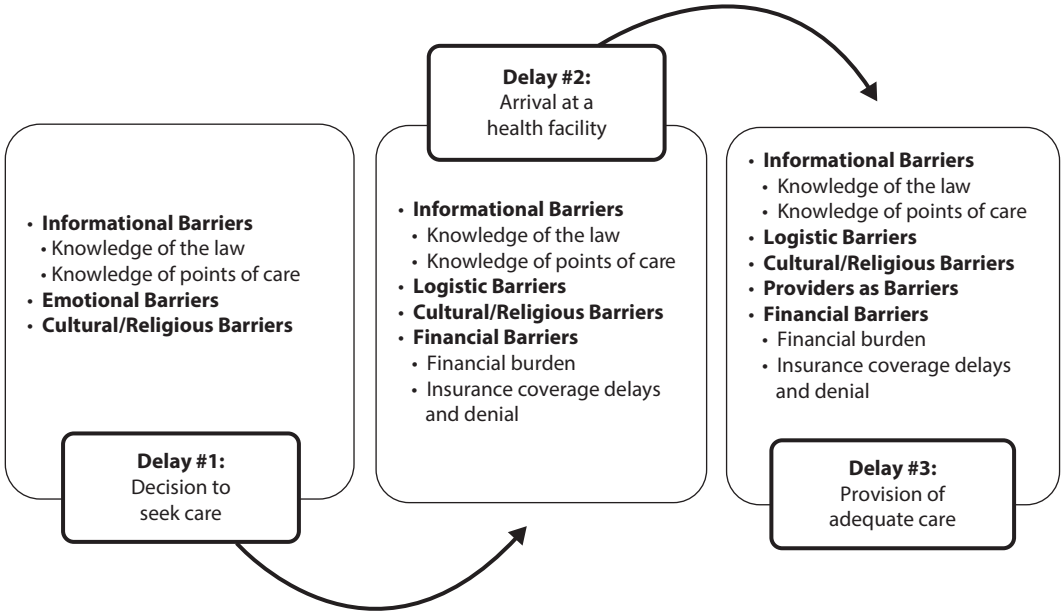
Our findings illustrate the need for more comprehensive dissemination of accurate and complete information about abortion services for women and families in Bogotá. These target audiences could benefit from more broad-reaching campaigns that provide information on where to obtain abortion services, as well as on the legal aid available from La Mesa. Because many study participants reported researching abortion access online, we recommend greater use of social media outreach and other digital methods of promoting abortion services, as well as greater use of the online chat feature that clinics like Oriéntame have used to link women to legal abortion services.

One striking finding of this study was the antiabortion behavior of nurses involved in abortion care. Study participants reported that nurses who disagreed with their choice were vindictive and cruel. The instances in which nurses purposely showed the fetus to study participants after the abortion and used language that shamed patients for having an abortion were unprofessional. The nurses appeared to have difficulty balancing their personal beliefs, level of comfort with abortion provision and their job responsibilities, and may not have possessed knowledge or understanding of current abortion law in Colombia. Ultimately, they failed to act in accordance with the law and caused unnecessary distress to women seeking to exercise their constitutional right to health and choice. This type of behavior on the part of health care providers had not been documented prior to this study. Educational tools, such as Ipas's Values Clarification and Attitudes Toolkit,[34] may help nurses and nursing students identify biases and moral objections to abortion that could prevent them from providing comprehensive, compassionate care.

Study participants frequently reported that insurance companies refused to authorize payment for their abortion, and that some physicians refused to perform an abortion for them. Eight years after the decriminalization of abortion in Colombia, these powerful entities and individuals still lacked clear understanding of laws regarding abortion and conscientious objection, or refused to obey them, or–as other studies have found[24,25]–struggled to resolve contradictory personal beliefs about abortion or increase their comfort level with the procedures. Because of these factors, women may have difficulty obtaining a legal abortion. Research in other countries has similarly found that many physicians are unaware of the legal status of abortion or do not (or are reluctant to) perform abortions because of their personal beliefs.[35]

The obstructive behavior displayed by physicians when women sought abortion care suggests that doctors and medical students could also benefit from education on abortion law and from values clarification. Physicians who claim conscientious objection could also benefit from continuing education seminars that clarify their clinical and legal responsibilities regarding

FIGURE 1. Delays caused by barriers to obtaining abortion services, by type



abortion care. Such educational efforts may lead to improvement in quality of care and legal compliance.

Our study is the first to qualitatively explore and identify the barriers experienced by Colombian women since C-355/2006 established a legal right to safe abortion. It is also the first examination of decision making and experiences with abortion that attempts to draw parallels with delays during obstetric emergencies in low-resource settings. Although there are great differences between the circumstances of women with threatened, wanted pregnancies and those of women with unwanted pregnancies, women have the right to both carry and abort, and therefore investigation of practical access is warranted.

Strengths and Limitations

Strengths of this study include a study population that consisted of women who had successfully obtained legal abortion services, and the achievement of thematic saturation. Moreover, this study provides a previously unexplored understanding of barriers women in Colombia continued to face eight years after decriminalization and examined these barriers using a framework that adapted the Three Delays model of obstetric emergencies.

One researcher conducted the interviews and performed the analysis, which should lead to consistency in data collection and analysis. Also, she was not previously acquainted with any of the participants and advised the participants that their responses would be kept confidential.

We recognized prior to data collection that having both parts of the study performed by one researcher could bring a less-varied analytical approach. However, the first author took several measures aligned with formal qualitative research methods to prevent introduction of bias. She safeguarded against selection bias by use of a purposive, venue-based sampling scheme that yielded thematic saturation; the reliance on gatekeepers (rather than a single individual) to recruit participants further protected against selection bias. She invoked a reflexive approach to each interview, probed tactfully, and allowed participants to speak comfortably and openly in response to each question for as long as they wished. She also consulted frequently with coauthors during data analysis to ensure the use of best approaches.

A weakness of the study is that the sample did not include women who had experienced barriers so great that they were unable to obtain abortion services, or those who had sought or had abortions outside of Bogotá. We also were unable to compare experiences of women within or between study sites.

As in all studies with purposive sampling, the conclusions may be particular to the population studied and not generalizable to all women in Bogotá or Colombia who have had an abortion.

Conclusion

This research uncovered several ways in which Colombian women's legal right to abortion was obstructed. Regardless of their personal characteristics, study participants experienced delays in access to safe, legal abortion care. Women's access to abortion was impeded by lack of accurate information about abortion care and abortion law; by health care providers; and by logistic, emotional, financial, cultural and religious barriers. Typically, the study population experienced several barriers that culminated in one or more of types of delay, making it difficult for them to exercise their right to safe, legal abortion. Our findings suggest that improvements are needed in the dissemination of accurate information, and in medical and nursing

curricula and professional continuing education, to reduce barriers to access to legal abortion services.

REFERENCES

1. Grimes DA et al., Unsafe abortion: the preventable pandemic, *Lancet*, 2006, 368(9550):1908–1919, doi:10.1016/S0140-6736(06)69481-6.

2. Rao KA and Faúndes A, Access to safe abortion within the limits of the law, *Best Practice & Research. Clinical Obstetrics & Gynaecology*, 2006, 20(3):421–432, doi:10.1016/j.bpobgyn.2006.01.020.

3. Yam EA, Dries-Daffner I and García SG, Abortion opinion research in Latin America and the Caribbean: a review of the literature, *Studies in Family Planning*, 2006, 37(4):225–240, doi:10.1111/j.1728-4465.2006.00102.x.

4. Singh S, Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries, *Lancet*, 2006, 368(9550):1887–1892, doi:10.1016/S0140-6736(06)69778-X.

5. Berer M, National laws and unsafe abortion: the parameters of change, *Reproductive Health Matters*, 2004, 12(Suppl. 24):1–8, doi:10.1016/S0968-8080(04)24024-1

6. Levels M, Sluiter R and Need A, A review of abortion laws in Western-European countries: a cross-national comparison of legal developments between 1960 and 2010, *Health Policy*, 2014, 118(1):95–104, doi:10.1016/j.healthpol.2014.06.008

7. Paine J, Noriega RT and Puga AL, Using litigation to defend women prosecuted for abortion in Mexico: challenging state laws and the implications of recent court judgments, *Reproductive Health Matters*, 2014, 22(44):61–69, doi:10.1016/S0968-8080(14)44800-6.

8. Sedgh G et al., Induced abortion: incidence and trends worldwide from 1995 to 2008, *Lancet*, 2012, 379(9816):625–632, doi:10.1016/S0140-6736(11)61786-8.

9. Sedgh G et al., Estimates of the incidence of induced abortion and consequences of unsafe abortion in Senegal, *International Perspectives on Sexual and Reproductive Health*, 2015, 41(1):11–19, doi:10.1363/4101115.

10. Andersen KL et al., Marital status and abortion among young women in Rupandehi, Nepal, *BMC Women's Health*, 2015, Vol. 15(17), doi:10.1186/s12905-015- 0175-4.

11. Doran F and Hornibrook J, Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study, *Australian Journal of Rural Health*, 2014, 22(3):121–126, doi:10.1111/ajr.12096.

12. Rominski SD et al., Female autonomy and reported abortion-seeking in Ghana, West Africa, *International Journal of Gynaecology & Obstetrics*, 2014, 126(3):217–222, doi:10.1016/j.ijgo.2014.03.031.

13. Banerjee SK et al., Woman-centered research on access to safe abortion services and implications for behavioral change communication interventions: a cross-sectional study of women in Bihar and Jharkhand, India, *BMC Public Health*, 2012, 12(175), doi:10.1186/1471-2458-12-175.

14. Peterfy A, Fetal viability as a threshold to personhood: a legal analysis, *Journal of Legal Medicine*, 1995, 16(4):607–636, doi:10.1080/01947649509510995.

15. Drey EA et al., Risk factors associated with presenting for abortion in the second trimester, *Obstetrics & Gynecology*, 2006, 107(1):128–135, doi:10.1097/01.AOG. 0000189095.32382.d0.

16. Finer LB et al., Timing of steps and reasons for delays in obtaining abortions in the United States, *Contraception*, 2006, 74(4):334–344, doi:10.1016/j.contraception.2006.04.010.

17. Prada E, Maddow-Zimet I and Juarez F, The cost of postabortion care and legal abortion in Colombia, *International Perspectives on Sexual and Reproductive Health*, 2013, 39(3):114–123, doi:10.1363/3911413.

18. Corte Constitucional de Colombia, *Sentencia C-355*, 2006, http://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm.

19. Amado ED et al., Obstacles and challenges following the partial decriminalization of abortion in Colombia, *Reproductive Health Matters*, 2010, 18(36):118–126, doi:10.1016/S0968-8080(10)36531-1.

20. Prada E, Biddlecom A and Singh S, Induced abortion in Colombia: new estimates and change between 1989 and 2008, *International Perspectives on Sexual and Reproductive Health*, 2011, 37(3):114–124, doi:10.1363/3711411.

21. La Mesa por la Vida y la Salud de las Mujeres, Barreras para la garantía del derecho a la interrupción voluntaria del embarazo, 2014, http://www.despenalizaciondelaborto.org.co/wp-content/uploads/2016/11/intervencin-debate-control-poltico-septiembre-2014.pdf.

22. Dalén A, *La Implementación de la Despenalización Parcial del Aborto en Colombia*, Bogotá, Colombia: Centro de Estudios de Derecho, Justicia y Sociedad, Dejusticia, 2013, https://www.dejusticia.org/wp-content/uploads/2017/04/fi_name_recurso_362.pdf.

23. Baum S, DePiñeres T and Grossman D, Delays and barriers to care in Colombia among women obtaining legal first- and second-trimester abortion, *International Journal of Gynaecology & Obstetrics*, 2015, 131(3):285–288, doi:10.1016/j.ijgo.2015.06.036.

24. Stanhope K et al., Physician opinions concerning legal abortion in Bogotá, Colombia, *Culture, Health & Sexuality*, 2017, 19(8):873–887, doi:10.1080/13691058.2016.1269365.

25. Fink LR et al., "The fetus is my patient, too": attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia, *International Perspectives on Sexual and Reproductive Health*, 2016, 42(2):71–80, doi:10.1363/42e1016.

26. Corte Constitucional de Colombia, Sentencia T-209, 2008, http://www.corteconstitucional.gov.co/RELATORIA/2008/T-209-08.htm.

27. Cook RJ, Olaya MA and Dickens BM, Healthcare responsibilities and conscientious objection, *International Journal of Gynaecology & Obstetrics*, 2009, 104(3):249–252, doi:10.1016/j.ijgo.2008.10.023.

28. Ministerio de Salud y Proteccion Social, SISPRO: Sistema Integral de Informacion de la Proteccion Social, 2015, http://www.sispro.gov.co/.

29. Giedion U and Uribe MV, Colombia's universal health insurance system, *Health Affairs*, 2009, 28(3):853–863, doi:10.1377/hlthaff.28.3.853.

30. Corte Constitucional de Colombia, Decreto Numero 2591 de 1991, 1991, http://www.corteconstitucional.gov.co/lacorte/DECRETO%202591.php.

31. Ashford L, Sedgh G and Singh S, Making abortion services accessible in the wake of legal reforms, *In Brief*, New York: Guttmacher Institute, 2012.

32. Thaddeus S and Maine D, Too far to walk: maternal mortality in context, *Social Science & Medicine*, 1994, 38(8):1091–1110, doi:10.1016/0277-9536(94)90226-7.

33. Creswell JW et al., Qualitative research designs: selection and implementation, *Counseling Psychologist*, 2007, 35(2):236–264, doi:10.1177/0011000006287390.

34. Turner K and Chapman Page K, *Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women*, 2011, Chapel Hill, NC, USA: Ipas, www.ipas.org/~/media/Files/Ipas%20Publications/VCATYTHE11.ashx.

35. Low WY et al., Access to safe legal abortion in Malaysia: women's insights and health sector response, *Asia-Pacific Journal of Public Health*, 2015, 27(1):33–37, doi:10.1177/1010539514562275.

RESUMEN

Contexto: *En 2006, La Corte Constitucional de la República de Colombia emitió una decisión que en gran medida despenalizó el aborto; sin embargo, el aborto ilegal persiste. Comprender las barreras que conducen a las mujeres a*

acudir a abortos ilegales e inseguros podría ayudar a mejorar el acceso a los servicios legales.

Métodos: *En 2014 se condujeron entrevistas en profundidad con 17 mujeres de 18 años de edad o mayores que habían tenido abortos legales el año anterior en Bogotá, Colombia, con el fin de identificar barreras de acceso al aborto y esclarecer las formas por las cuales estas barreras afectan la toma de decisiones de las mujeres en relación con el aborto. Las transcripciones de las entrevistas se codificaron y analizaron mediante técnicas estándar para identificar patrones, paralelismos y diferencias; un enfoque fenomenológico guio el análisis temático.*

Resultados: *Las barreras relacionadas con conocimientos e información, junto con las barreras logísticas, emocionales, financieras, culturales y religiosas culminaron en retrasos a la hora de obtener servicios integrales de aborto. La religión influyó en el estigma social, el cual se manifestó con mayor fuerza en conductas obstructivas por parte de proveedores de servicios de salud y compañías de seguros de salud. Fue evidente la falta de comprensión en torno a las leyes actuales de aborto y a la objeción de conciencia por parte de pacientes, proveedores de servicios de salud y aseguradoras.*

Conclusiones: *Se necesita difundir información precisa relacionada con la disponibilidad del aborto legal y clínico. Una mejor capacitación puede ayudar a médicos, enfermeras y personal de las compañías de seguros a comprender sus roles y responsabilidades legales en la atención del aborto y reducir los retrasos en el acceso de las mujeres a los servicios.*

RÉSUMÉ

Contexte: *En 2006, la Cour constitutionnelle de Colombie a rendu une décision décriminalisant l'avortement dans une large mesure. L'avortement clandestin persiste cependant. Il pourrait être utile, pour améliorer l'accès aux services légaux, de comprendre les obstacles qui poussent les femmes à recourir à l'avortement clandestin non médicalisé.*

Méthodes: *En 2014, des entretiens en profondeur ont été menés avec 17 femmes âgées de 18 ans ou plus ayant obtenu un avortement légal au cours des 12 derniers mois à Bogota (Colombie), dans le but d'identifier les obstacles à l'accès à l'avortement et d'en élucider les effets sur la décision des femmes concernant l'avortement. Les transcriptions de ces entretiens ont été codées et analysées selon les techniques standard d'établissement des tendances, parallèles et différences. Une approche phénoménologique a guidé l'analyse thématique.*

Résultats: *Les obstacles ayant trait à la connaissance et à l'information, de même que ceux de nature logistique, affective, financière, culturelle et religieuse, aboutissent à des retards d'obtention de services d'avortement complets. La religion influence la stigmatisation sociale, manifestée le plus intensément dans le comportement obstructif des prestataires de soins de santé et des compagnies d'assurance-maladie. Le manque de compréhension des lois actuelles sur l'avortement et l'objection de conscience est évident chez les patientes, les prestataires de santé et les assureurs.*

Conclusion: *La diffusion d'une information exacte concernant la disponibilité de l'avortement clinique légal est nécessaire. Une meilleure formation peut aider les médecins, le personnel infirmier et les compagnies d'assurance à comprendre leurs rôles et responsabilités légales dans les soins d'avortement et réduire les retards d'accès des femmes aux services.*

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