Decriminalized Abortion in Bogotá, Colombia: Health & Legal Implications

Kalie Richardson¹, Chelsey Brack², Lauren Fink²
¹ Emory University School of Law, ² Emory University Rollins School of Public Health

Background
Each year, an estimated 68,000 women die from unsafe abortions. When women have access to safe and legal abortion services, the vast majority of abortion-related morbidity and mortality is eliminated, while the overall incidence of abortion remains approximately equal (Grimes et al., 2006). Criminalization restricts women’s access to safe services, but after abortion is decriminalized, procedural, economic, informational, and cultural barriers continue to impede access to legal abortion services in many countries (Ashford, Sedgh, & Singh, 2012).

In 2006, the Colombian Constitutional Court issued ruling C-355, which decriminalized abortion in three circumstances:
- to protect life or health of the mother
- when there is a severe fetal malformation
- when pregnancy is the result of rape or incest

Legal Analysis
- Key case law subsequent to C-355
  - T-209/2008: established standards for conscientious objection—a right exclusive to doctors and for religious reasons only
  - T-388/2009: as public functionaries, judges do not have the right to conscientiously object
  - T-585/2010: symbolic effect; abortion is a fundamental right
  - T-841/2011: abortion for mental health upheld

Comparative Legal Analysis with the United States
- Roe v. Wade (1973) ruling based on a woman’s right to privacy, established the trimester framework of gestational limits.
  - Colombian Constitutional Court ruling C-355: right to privacy is less important than the rights to life and health, no gestational limits

- Planned Parenthood v. Casey (1992) reinforced states rights to create barriers to abortion (e.g. parental consent, 24 hour waiting period)
  - Due to structure of government, the departments (Colombian equivalent of states) can legislate to increase access but cannot create barriers.

Methods
Research setting and local support
The study was conducted during June and July of 2014 in Bogotá, Colombia. A graduate student research team from Emory University worked in collaboration with partners at the University of the Andes, and local reproductive health clinics.

Study populations
- Key informants including women’s health advocates and bioethicists (n=11)
- Lawyers working in women’s rights (n=9)
- Women who accessed legal abortion (n=17)
- Self-identified conscientious objectors (n=18)

Data collection
- Semi-structured and in-depth interviews
- Snowball, purposive, and venue-based sampling

Results
Interviews with Women

Barriers to Legal Abortion

Religious
- Internalized stigma
- Pervasive social stigma
- Individuals acting as obstacles

Physical
- Insurance companies (paperwork)
- Distance from clinics
- Clandestine, “false” clinics

Legal
- Gestational Age (14 weeks)
- Different interpretations of C-355/2006
- Noncompliance with T-209/2008

Figure 1. Three “types” of conscientious objectors identified during in-depth interviews. The diversity of reasons for and actions guided by objection could have important implications for policy-making.

Partial objection is not legally regulated

Figure 2. Healthcare Employees as a Barrier to Legal Abortion Access

Discussion
Interviews with our three study populations yielded a variety of opinions and perspectives concerning access to legal abortion in Bogotá. Interpretation of case law by providers can be subjective, and is reflected by experiences reported by women seeking abortion services.

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