"*Abortar es un acto amoroso y responsable*": Navigating Barriers to Reproductive Justice in Colombia Post-Liberalization

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Thesis submitted to McGill University in partial fulfillment of the requirements of the Master's Degree in Political Science with a Concentration in International Development Studies.

Submission Date: November 2, 2021

ABSTRACT

In Colombia, while access to safe abortion was recognized as a fundamental right under three clauses in 2006 through the Constitutional Court decision C-355, women continue to face unjust barriers. Moreover, these barriers are often varying across socioeconomic, geographic, and educational lines, pointing to legacies of intersecting inequalities. This thesis research sought to analyze the barriers to abortion which emerge in the accounts of women more than a decade since liberalization, and how they choose to navigate them. This adds to existing literature on barriers to abortion through thematic and discursive analysis of a social media source with a feminist critical lens. This thesis situates the analysis in the context of structural violence, echoing Latin American feminist perspectives on reproductive rights.

Ultimately, this thesis research found that financial, informational, and geographic barriers continue to be prevalent. Moreover, that many women hold expectations of low-quality care in the public health system. Women are frequently choosing to navigate this by turning to private health clinics such as Profamilia and Oriéntame or using legal knowledge as a self-advocacy tool. An additional finding emerged in the dataset, which told of provider resistance to sterilization. This points to broader issues regarding reproductive justice in Colombia. These can be situated in the stigma surrounding these reproductive health services, stemming from cultural gender norms surrounding femininity and motherhood.

RESUME

En Colombie, bien que l'accès à l'avortement sans risque ait été reconnu comme un droit fondamental en vertu de trois clauses en 2006 par la décision C-355 de la Cour constitutionnelle, les femmes continuent de se heurter à des obstacles injustes. De plus, ces barrières varient souvent selon des critères socio-économiques et géographiques, ce qui témoigne de l'héritage d'inégalités croisées. Cette thèse de recherche visait à analyser les obstacles à l'avortement qui émergent dans les récits des femmes plus d'une décennie après la libéralisation et comment elles arrivent à les contourner. Cette thèse ajoute à la littérature existante sur les obstacles à l'avortement par le biais d'une analyse thématique et discursive d'une source de médias sociaux avec une lentille critique féministe. Cette thèse fait l'analyse dans le contexte de la violence structurelle, faisant écho aux perspectives féministes latino-américaines sur les droits reproductifs.

Somme toute, cette recherche de thèse a révélé que les obstacles financiers, informationnels et géographiques continuent d'être prédominant. De plus, de nombreuses femmes s'attendent à ce que le système de santé public fournisse des soins de faible qualité. Les femmes choisissent souvent de s'en sortir en se tournant vers des cliniques privées telles que Profamilia et Oriéntame ou en utilisant des connaissances juridiques comme outil de défense de leurs droits. Un autre résultat est apparu dans l'ensemble des données, il s'agit de la résistance des prestataires à la stérilisation. Cela met en évidence des problèmes plus larges concernant la justice reproductive en Colombie. Ces derniers sont ancrés dans la stigmatisation entourant ces services de santé reproductive et proviennent des normes culturelles de genre entourant la féminité et la maternité.

ACKNOWLEDGEMENTS

This thesis was made possible by the combined support and encouragement of supervisors, mentor, and colleagues who guided and supported me throughout my master's education at McGill University. First, I would like to express my gratitude to my primary supervisor, Professor Kelly Gordon, for her critique, insights, and patience as this thesis took shape. As well as for her valuable instruction on interrogating and engaging with feminist ideas. Additionally, to Professor Juan Wang and Professor Manuel Balan for their thorough and constructive advice in the early stages of this thesis. A special thank you also goes out to Professor David Petrasek, whose instruction in international human rights law during my bachelor's degree at the University of Ottawa helped to solidify my passion for sexual and reproductive rights in Latin America and my appreciation for the creative use of legal mechanisms and activism to pursue these rights. Finally, thank you to Julio Masabanda, Hanna Karpenko, and Jean Francois Poisson for their boundless support, love, and faith in my abilities.

Table of Contents

1 Introduction

In March 2005, the Colombian Constitutional Court was approached with a legal case presented by an international women's rights organization, Women's Link Worldwide. This case, led by feminist lawyer, Mónica Roa, was on the behalf of Martha Sulay González, a 37-year-old mother of three who had been diagnosed with uterine cancer. Martha was denied chemotherapy and radiotherapy services due to being six weeks pregnant when diagnosed, as the treatment would result in the termination of her pregnancy. According to abortion law in Colombia at that time, Martha and her doctors would consequently be criminalized for proceeding with medical treatment that could save her life. This situation highlighted a pervasive view in the eyes of the legal system at that point, that the life of the fetus outweighed that of the woman. While the resulting historic court decision C-355, issued the following year, should have been in Martha's favour, it was reached too late as the disease had spread while the case made its way through the court. Martha Sulay González passed away the following year, leaving her children motherless and separated, placed in care among various relatives.

Despite these tragic circumstances, Decision C-355 was widely celebrated as a turning point for reproductive rights in the country. It decriminalized abortion[1] in the cases when: (1) the continuation of pregnancy constitutes a danger for the life or health of the woman, certified by a physician; (2) there is a fetal impairment of the fetus that makes life inviable, certified by a physician; and, (3) pregnancy is the result of a "properly reported" behavior that constitutes abusive, non-consensual carnal abuse or sexual intercourse, or artificial insemination or

[1] The term 'voluntary interruption of pregnancy,' or *interrupcion voluntaria del embarazo* (IVE), is increasingly utilized in Latin America instead of 'abortion.' The major reproductive health provider, Profamilia, has justified this from a standpoint of ethics, freedom and autonomy of women. They claim that behind the word 'abortion' there are hidden "a series of imaginaries related to illegality, fear and crime" (Profamilia). This may make sense for them as a healthcare provider seeking to encourage patients to pursue safe abortion services, however, I believe it may inadvertently contribute to stigmatizing the term 'abortion' further. In line with this view, I will continue to use the term 'abortion' throughout this paper.

transference of fertilized ovum without consent, or incest (Corte Constitucional de Colombia). Moreover, the Constitutional Court deemed that "health" could be interpreted using the World Health Organization definition of a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO). In this sense, anyone facing a pregnancy which is "unsustainable" in terms of social or economic reasons could also technically be eligible for a legal abortion within this criterion (González Vélez, 2012).

This nuanced definition has contributed to mixed interpretations of the legality of abortion in Colombia. Throughout review of literature on the topic, I came across academic texts and news articles which referred to abortion in Colombia as legal (Vivas and Valencia, 2020; Gomez Sarmiento, 2020). Meanwhile, others recognized that this legal shift represented only a partial decriminalization, or liberalization, of abortion. For instance, the Guttmacher Institute, a sexual and reproductive health research and policy institute in the USA, continues to classify Colombia's abortion regime as moderately restrictive (Guttmacher Institute, 2020). It is important to recognize this liberalization as merely partial as this accounts for the fact that, while abortion may have become de facto legal for some womxn[2] in terms of ease of access, abortion simultaneously remains in the Colombian criminal code. Specifically, in Article 122 of the Penal Code. As of 2019, there were 4,834 active cases in some stage of criminal proceedings for abortion in Colombia (González-Vélez and Castro González, 2021). In light of these circumstances, the struggle for legalization of abortion in Colombia is evidently not over.

A gap appears to exist between law and practice when it comes to accessing abortion care in Colombia, more than a decade following this legal shift, which adds to the complicated legal

[2] Following the example of Nandagiri, Coast, and Strong (2020) in their exploration of structural violence in the context of abortion access, I will hereafter utilize the term "womxn" to describe all individuals who may want or need an abortion – including trans-men, nonbinary persons, cis-gender women, among others.

status of abortion. Womxn seeking the procedure continue to face various barriers[3], as documented by qualitative research. For instance, it has been found that healthcare providers[4] continue to impose limits on abortion services in contravention of the law (Fink et al, 2016). The inaccessibility of legal abortion services is further illustrated by the fact that an estimated 400,000 clandestine abortions take place annually in the country, while Colombia's health care providers had only carried out approximately 50,000 legal abortions in the decade following C-355 (Moloney, 2016).

Given that unsafe abortions[5] are estimated to be responsible for 130,000 health complications annually, representing approximately 10 per cent of maternal deaths in Colombia (MSF, 2019), this legal reform has evidently not been the harbinger of reproductive justice in Colombia as previously hoped. Unsafe abortion is one of the five leading causes of maternal mortality globally, along with postpartum haemorrhage, sepsis, birth complications and hypertensive disorders. Notably, out of all these causes, unsafe abortion is the only one that is completely avoidable (Medicos Sin Fronteras, 2019).

The reproductive injustice that takes place in this context is exemplified by the fact that barriers to safe abortion disproportionately burden marginalized groups of womxn. In Colombia, poorer rural womxn are found to have a 70% higher risk of suffering health complications due to unsafe abortions or not receiving timely care, compared to womxn who inhabit urban areas or who have greater wealth (Prada et al, 2011). This illustrates how access to safe abortion echoes

[3] Using the definition of barriers to abortion provided by Ana Cristina González-Vélez, a Colombian reproductive rights advocate and researcher: "any conduct which by action or omission constitutes a limitation or obstacle to women's timely access to legal abortion services" (2020).
[4] I specifically utilize the term 'healthcare provider' (rather than 'healthcare professional,' for instance) to emphasize their professional responsibility to provide quality care and to subsequently highlight when they fail to meet this obligation.
[5] Unsafe abortions are classified by the WHO as a procedure for terminating an unwanted pregnancy carried out either by persons lacking the necessary skills or in an environment that does not confirm to minimal medical standards, or both (WHO, 2019).

existing social and economic inequities. This is a dynamic present across Latin America, wherein abortion services are more difficult to access within public health facilities, one of the few institutional spaces in Latin America where Indigenous and Afro-descendant women are more visible than women from dominant ethnic groups (Castro, 2019).

In addition to impacting the health and wellbeing of womxn, other consequences arise from unsafe abortions such as economic consequences for womxn, their families, and communities. These consequences can include the costs of treating complications and from the inability to perform usual economic and domestic activities for a period of time due to impacted health (Singh, 2016). Moreover, legal and social consequences emerge from possible exposure to the criminal system or stigma manifesting at institutional, community, or individual levels (Ibid.). It can be argued that most womxn with unwanted pregnancies in settings with restrictions to abortion access face limited options which do not perpetuate violence in some form – whether it is in the experience of an unsafe or criminalized abortion, or forced motherhood. With either choice, there is a cost to the womxn which can manifest in social, psychological, physical, and economic harm. Evidently, the implications of barriers to safe abortion access on womxn are profound. In light of this, it is worth exploring which barriers continue to prevail in Colombia.

This paper's objective stems from the perspective that one should not lose sight of the limits of legal liberalization of abortion on actual conditions on the ground. In this sense, it aims to counter the "fetish of legality," described by Amy Krauss (Krauss, 2018), which entails a narrowed public conversation regarding social commitments to womxn's health, obscuring womxn's lived experiences when 'the legal' takes precedence over moral and ethical terms of care. In fact, Martha Sulay González' inability to access a timely legal abortion despite the legal success of her case is emblematic for how the court decision has been applied in the years since

it came into being. While this court decision was widely viewed as a breakthrough for reproductive rights in Colombia, it is increasingly evident that the constitutional right to safe abortion access continues to be merely possible not guaranteed, despite more than a decade having passed.

This critique of how legality is fixated on in womxn's health discourse also links to arguments as to why dialogue surrounding abortion access should shift away from a reproductive rights framework towards one of reproductive justice. Reproductive justice refers to:

> The complete physical, mental, spiritual, political, economic, and social well-being of women and girls [that] will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives (Asian Communities for Reproductive Justice, 2005).[6]

While the reproductive rights framework has largely focused on attaining women's individualistic reproductive freedom through the legal system (Parker, 2019), scholars have questioned how effective legal rights are while other barriers to achieving reproductive freedom continue to exist. For instance, public health scholars exploring the sexual and reproductive health of African American women argue that the reproductive rights movement's focus on pro-choice legal advocacy has contributed to obscuring socio-political and economic inequalities that are disproportionately faced by marginalized women (Ahmed and Gamble, 2017). These are obstacles which will be present regardless of whether the right to reproductive healthcare is codified through law or not (Pacia, 2020), a critique that is also worth considering in the context of Colombia.

[6] This definition comes from one of the founding organizations of the reproductive justice movement in the USA, Asian Communities for Reproductive Justice (now named Forward Together).

1.1 Research Objectives & Questions

This thesis project examines this tension – wherein the legality of abortion has been established in Colombia in various circumstances yet, access to safe, legal abortion remains precarious and difficult to access for some. The law specifying abortion rights in Colombia has been critiqued as "poorly regulated and rarely implemented," (Moloney, 2016) with consistent access to safe abortions in the Colombian health system continuing to be an issue even more than a decade following this seemingly pivotal legal shift. As a context characterized by low rates of social mobility as well as by high levels of political and economic inequality for women (ONU Mujeres, 2017), it is crucial to investigate the ways through which this may manifest as restricted reproductive autonomy in Colombia.

The questions guiding this thesis research were as follows:

1) Which barriers to accessing legal abortion care are womxn in Colombia experiencing post liberalization? And,
2) How do womxn facing unwanted pregnancies navigate these barriers?

I examined these questions through a discourse analysis of posts posted on *ABORTO 🤍 COLOMBIA "SOMOS LA RESISTENCIA"* (Abortion 🤍 Colombia "We are the resistance"),[7] a private Facebook group dedicated to promoting abortion rights for womxn in Colombia. This group has grown to almost 3,000 members since its creation in 2019 and has evolved beyond a group for feminist advocacy and mobilization to also serve as a space where womxn post to solicit advice on matters of reproductive health, provide emotional support, and discuss their personal experiences with seeking abortion, legal or otherwise. In this sense, the page functions as both a discussion forum and an online support group, rendering it a compelling site

[7] Henceforth referred to as *ABORTO 💚 COLOMBIA.*

of analysis for understanding the lived experiences of those seeking safe abortion in Colombia and the barriers which they continue to face more than a decade following reform. This is helped by the almost daily posts, where a variety of womxn present difficult situations, either experienced by themselves or someone they know, seeking support or information from fellow group members. In addition to revealing on a practical level how womxn are dealing with immediate reproductive needs and the challenges they may face; the content in this Facebook group also points to broader themes regarding reproductive justice in Colombia. Namely, to structural factors which infringe upon womxn's reproductive autonomy and wellbeing.

This thesis project approaches the topic of restricted abortion access through the conceptual lens of structural violence, which provides a means of understanding the ways which structures, such as institutional barriers to safe abortion, may indirectly produce experiences of violence (Rylko-Bauer and Farmer, 2017). The concept of structural violence is particularly useful in its ability to help identify how violence of institutions may accumulate and manifest, such as within political, legal, and medical institutions. Additionally, it draws attention to acts of resistance which challenge and confront structural violence and reveal it in action (for instance, collective acts that operate outside of systems of structural violence, such as the Facebook group *ABORTO* 💚 *COLOMBIA*). While analyzing the individual testimonials contained in the Facebook group, this thesis seeks to avoid overlooking structural determinants which may connect these experiences.

The thesis' use of the framework of "structural violence" is supported by the additional inclusion of Latin American feminist perspectives on reproductive rights, most notably the decolonial feminist framework of Rita Segato, an Argentinian feminist anthropologist, which largely situates access to safe abortion as a matter of social justice and its barriers as a form of

violence against women. Including this work further contextualizes this thesis by drawing upon feminist theory produced from the Latin American experience. This is particularly important given these perspectives have informed interlinking activist movements across the region which, in their denunciation of gender-based violence across Latin America, also target restrictive abortion regimes and implicate the state in doing so. *ABORTO* 💚 *COLOMBIA* is arguably a product of this movement.

The remainder of this thesis is divided into seven sections. Following the introduction, section II will outline the context of the case study of Colombia, namely its health system context and the rights established by C-355 as well as institutional backlash. Section III provides a robust review of existing research literature on the barriers to abortion access in Colombia since Decision C-355. Section IV addresses the conceptual lens of structural violence, touching upon its use in the context of abortion. Additionally, feminist perspectives on reproductive rights which were used to guide this thesis research and analysis. Section V describes the methodological approach of thematic and discourse analysis of posts contained within the Facebook group. Subsequently, Section VI presents the paper's main findings, the barriers which recur throughout womxn's shared experiences seeking abortions. Following this, I will outline two themes which appear to characterize the landscape of abortion access post-liberalization. Firstly, the widespread reliance on Profamilia and Oriéntame as abortion providers who provide non-judgemental services and, secondly, legal information-sharing and knowledge as a means of pursuing reproductive justice. Finally, I will develop an unexpected finding from my research which contributes to an understanding of barriers to reproductive justice in Colombia. Specifically, restrictions placed before another reproductive health service that goes against the gendered expectations of motherhood. Ultimately, these findings point to a context wherein

stigmatizing beliefs surrounding abortion within institutions influences womxn's decision-making when facing an unwanted pregnancy and generate expectations of negative care which may act as a deterrent for pursuing legal abortion services. The final section concludes by addressing challenges and limitations of the paper's findings as well as potential pathways for future research.

2 Case Study Context

2.1 The Colombian Healthcare System

This section will briefly address Colombia's healthcare system to provide further context to the gaps between the state's health rights obligations and lived realities of Colombians. Additionally, to describe particular structural features of the Colombian healthcare system which have contributed to successes and obstacles in the implementation of C-355, as critiqued by Stifani et al in their case study on challenges implementing abortion law in Colombia (2018). For instance, the conscientious objection mechanism which has been frequently misused by healthcare providers to prevent womxn from accessing abortions. As will be further explained in Section 3.3, real and perceived financial barriers have been identified as common obstacles for womxn when obtaining abortions from the healthcare system in Colombia. Therefore, it is worth considering this within the context of health insurance and coverage for abortion.

Universal access to healthcare has been a constitutionally enshrined right for Colombians since 1991 and in accordance with this constitutional reform, a national healthcare system was established in 1993, which entailed that all Colombian citizens are entitled to a basic package of healthcare services. In this system, people participate in one of two regimes depending on their income – (1) the contributory regime which covers workers and their families with monthly incomes above a minimum monthly amount, and (2) the subsidized regime which covers those

identified as low-income. The public health plan is referred to as EPS (*Entitades Promotoras de Salud* or Health Promoting Entities). Insurers enter into contracts with specific hospitals and physicians and those who are insured must seek care within the approved network of providers. While everyone in Colombia has the same basic coverage, if they need access to additional services, they must purchase a private policy (Giedion & Villar Uribe, 2009).

Since 2006, surgical and medical abortions have been included in the basic universal insurance plan. EPS and health service provider institutions (IPS), whether of the contributory or subsidized regime, are obliged to comply with C-355 by ensuring access to safe abortion (Stifani et al, 2018). This entails that abortion costs in the public sector are technically covered by health insurance. Notably, in the private sector, the cost of the procedure at some facilities is adjustable according to the client's ability to pay. For instance, Profamilia and Oriéntame are two major private and NGO reproductive healthcare providers in Colombia for whom making abortion services and information accessible for womxn of more disadvantaged backgrounds has long been a priority. Oriéntame's business model relies on subsidizing services for low-income clients with the payments of high-income patients (de Hart et al, 2002). Additionally, following drastically reduced funding for Profamilia due to the re-institution of the 'global gag rule'[8] by former American President Donald Trump, Profamilia chose to continue providing affordable abortion services despite already operating at a loss when this took place in 2017 (Dharssi, 2019). Nevertheless, many womxn, particularly those who are poor or have a low level of

[8] Otherwise known as the Mexico City Policy, it prohibited international organizations from receiving American funding for contraception if they "provide, counsel, refer, or advocate for abortion services." This was regardless of whether the organizations conduct these specific activities with their own non-U.S. funding, and if abortion is legal in their own country. This foreign policy decision resulted in substantial loss of funding for reproductive health services across the world (IPPF).

education, lack information on how to access these options within private facilities and turn to alternative options when facing impediments in public facilities (Ibid.)

The healthcare reform of 1991 involved the decentralization of healthcare service provision, to be delivered instead at the local level, as well as of the health management information system. This has inadvertently contributed to a lack of functional processes and systems to monitor abortion provision across the country, which limits the ability to accurately estimate the number of legal abortions requested or provided (Stifani et al, 2018). Maria Vivas and Salomé Valencia, in their exploration of how role distribution toward non-specialist physicians has been used as a strategy to increase access to abortion provision in Colombia, attribute this lack of accurate data collection partly to the prevalent stigmatization of abortion services throughout the country (2020).

Ultimately, these changes to the healthcare system contributed to a substantial increase in healthcare coverage in the country, from 23% of the population in 1990 to 97% in 2015 (Stifani et al, 2018). This was in addition to improvements in overall health status and reductions of maternal and infant mortality rates. Nevertheless, Colombia healthcare system continues to be characterized by inequalities which interrupt access to basic services and the full exercise of health rights. For instance, there have been found to be a significant amount of people who have fallen through the cracks of this universal system and remain uninsured (5.59% in 2017) – these are largely unemployed, informal workers earning less than minimum wage and poor families who score above the income threshold for government social benefits under the subsidized scheme (Garcia-Ramirez et al., 2020). Despite visions of universal healthcare, deep social inequalities translate into health inequalities. Moreover, geographical health disparities that exist between rural and urban settings have been exacerbated by the fact that, of the considerable

number of Colombians displaced due to lengthy internal armed conflict, most have originated from rural areas (Stifani et al, 2018). Rural areas are typically served primarily by public health providers. Consequently, rural residents may lack choice in accessing service providers, and the public providers they do have access to may not offer the full spectrum of health services they need, such as surgical abortions (Garcia-Ramirez, 2020).

Poor womxn are those who most often experience structural exclusion through their interactions with the health system. The intersectional[9] character of health inequity in Colombia is further underscored by an analysis of maternal mortality according to social determinants of health which found that women living in *departamentos* (or states) with the highest proportion of unmet basic needs in Colombia have a 1.72 times higher risk of death; with the risk increasing in municipalities with predominantly Indigenous and Afro-descendant populations (Republic of Colombia Ministry of Health and Social Protection, 2003). Moreover, access to healthcare is impacted by educational levels. For instance, lack of access to comprehensive sex education and belonging to the lowest level of wealth was found to predict poor access to contraception (Republic of Colombia Ministry of Health and Social Protection, 2015). These profound inequities in sexual and reproductive healthcare, despite the existence of a universal framework, extend to access to abortion, as will be addressed throughout this paper.

2.2 Reproductive Rights Established by Decision C-355

Numerous elements made Decision C-355 a watershed ruling – for instance, Colombia became one of the only countries in Latin America to allow legal abortion without time limits. Moreover, the reasoning behind this ruling rendered it exceptional, as it was one of the first judicial decisions in the world to support abortion rights on the grounds of gender equality, as

[9] Referring to the notion of a co-constitutive relationship between marginalized social identities articulated by legal scholar, Kimberlé Crenshaw (1989).

well as the first by a constitutional court to rule on the constitutionality of abortion within a human rights framework (Ruibal, 2014). Ultimately, Decision C-355 sought to ensure that abortion access in Colombia was in line with women's fundamental rights including the right to life, health, and physical integrity; the right to equality and non-discrimination; and the right to dignity, reproductive autonomy, and development of personality, as demanded by the legal case in the name of Martha Sulay González (Stifani et al, 2018).

The strategic litigation methods employed by the Women's Link Worldwide legal team played a crucial role in this legal victory and will be briefly described to provide context to the abortion rights subsequently established by the Constitutional Court. These methods took advantage of various elements of Colombia's legal landscape which made it more conducive to reform. For instance, Colombia has a broad rights framework which directly incorporates international human rights treaties into the domestic legal framework, enabling judges to directly apply international human rights norms, such as those regarding reproductive rights, within their decisions (Roa and Klugman, 2014). Women's Link Worldwide proposed multiple rights-based claims within one case for the Constitutional Court to consider – the foremost being that the ban on abortion violated a woman's constitutional right to the '*libre desarrollo de la personalidad*,' the free development of their personality and autonomy. The constitutional challenge also claimed that the legislation regarding abortion was disproportional. By criminalizing a medical practice which they understood as required only by women, the total abortion ban violated their right to equality and non-discrimination.

Additionally, the legal team targeted an additional article of the Penal Code which entailed that those who performed abortions on minors under the age of fourteen were subjected to a higher prison sentence. Roa claimed that this violated the constitutional right to autonomy of

minors. The final court challenge within the case argued that initiating criminal proceedings for an abortion in response to sexual violence was a violation of a woman's dignity, freedom, and autonomy. This legal strategy situated the issue of abortion within debate surrounding public health and human rights and successfully distanced the inflammatory subject from the traditional moral and philosophical arguments (Ibid).

The Constitutional Court took these rights-based claims into account when formulating their ruling that all healthcare providers, public and private, are obliged to offer safe abortions. However, only under three specific circumstances. They also established standards for the mechanism of *objeción de conciencia* – conscientious objection. Conscientious objection can be invoked when healthcare providers directly involved in abortion provision are "exempted or exempt themselves from providing or participating in abortion care on religious, moral or philosophical grounds" (Fink et al., 2016). The Constitutional Court emphasized that the right to invoke conscientious objection could only be exercised by individuals, and not by institutions or public bodies such as insurance companies. Additionally, they deemed that healthcare providers must provide unbiased information and refer womxn to other providers willing and able to conduct the procedure. Moreover, that conscientious objection is not applicable when there is an immediate risk to life and when no other providers are available (Ibid.).

In 2008, in response to rampant non-compliance across institutions, the Constitutional Court produced Decisions T-209 and T-388 which imposed sanctions on institutions who invoked conscientious objection collectively and condemned it when invoked by judges ruling in the context of abortion. Notably, the Constitutional Court has been regarded as the "main State institution to stand against attempts to impose fundamentalist religious views through policy-

making process, and to support feminist claims for the full implementation of Decision C-55." (Vivas and Valencia, 2020)

The Ministry of Health introduced additional regulations designed to protect these newly outlined rights, including that medical and surgical abortion would be included in the mandatory health plan and thereby covered without cost to women (Stifani et al, 2018). Additionally, that it must be provided in a timely manner, with no more than 5 days between the woman's request and the abortion service. As explored in literature on barriers to abortion in Colombia (Section 3) and in the findings of data analysis (Sections 6, 7, 8) despite these legally established protections, reproductive justice continues to be undermined and conditions on the ground do not consistently align with these legal provisions.

2.2.1 Institutional Responses to Decision C-355

As has proven to be the case across numerous contexts, such advancement of sexual and reproductive rights could not take place without backlash. According to Natalia Acevedo, a lawyer leading advocacy at the NGO and abortion provider, Profamilia, since Colombia liberalized abortion, conservative lawmakers and Catholic clergy have intensified their efforts in defence of the 'rights of the unborn' (Maldonado, 2008). This echoes a regional pattern. As argued by Mala Htun in her analysis of *Sex and the State in Latin America*, the Catholic Church only began actively organizing against abortion *after* feminist movements came to the fore to collectively claim autonomy for women's bodies and protest the role assigned to women under patriarchy, thereby threatening the social consensus condemning abortion (2003). Intensive religious mobilization against abortion has therefore mostly occurred as a reaction to the advancement of reproductive rights of womxn across Latin America (Cora Fernández Anderson, 2020).

While the Catholic Church is widely recognized as an established social and cultural force in the context of Latin America, the role of the Colombian Catholic Church in particular is noted for being among the most traditional and politically influential (Ruibal, 2014). Remarkably, following the 2006 Court decision, Catholic church officials threatened to excommunicate the medical team who performed Colombia's first legal abortion, for which the patient was an 11-year-old girl who had been raped by her stepfather (Moloney, 2009). This highly visible performance of power on the part of the Church underscored their 'higher' moral authority to law. Moreover, it demonstrates how the Church has remained a bold opponent to reproductive rights in Colombia, regardless of the changing legal landscape. The influence of the Catholic Church in Colombia may be denoted by the fact that, until 1991, when the new Constitution was created, Colombia was governed by a concordat between the state and the Vatican (Conscience, 2001). Although this was revised in 1992, when the right of the Catholic Church to impose moral behaviour on Colombians was formally eliminated, this is still relatively recent in Colombian history and the legacy of Catholic influence on policy, such as those relating to abortion, evidently persists.

Notably, right-wing Catholic clergy have incorporated tactics used in social movements in order to counter the advancement of reproductive rights claims. These mechanisms have included the usage of rights discourse, mobilization based on civil society organizations, legislative lobbying and strategic litigation (Ruibal, 2014). These tactics have also been levelled at issues such as same-sex adoption and marriage (Maldonado, 2018), indicating a far-reaching attempt to exert control on the familial and reproductive roles of Colombian citizens. This countermovement led by the Catholic Church has unfolded in conjunction with efforts by conservative legal actors to dismantle the law and prevent its effective implementation. These

"institutional activists" have purposefully introduced obstacles to the implementation of the law from within political institutions (Ruibal, 2014). An especially effective mechanism has been misinformation campaigns, involving attempts to prevent accurate and widespread knowledge of the abortion law framework which has resulted in many Colombian womxn being unaware of their rights, as well as healthcare insurers and providers not being fully aware of their obligations. This has affected certain groups of womxn disproportionately, according to factors such as geographic location and socioeconomic status. As the adage goes, 'knowledge is power' and obstructing knowledge regarding abortion rights has proven to be an effective tool in limiting womxn's power to hold bodily autonomy and thereby controlling their role in society.

A key instance of interference on the part of institutional actors occurred in 2009, when one of the four entities of the Colombian judicial branch, the Council of State, challenged the Ministry of Health's authority to regulate abortion services. This resulted in the suspension of the use of their official guidelines for the implementation of abortion services, with those being fully annulled in 2013. This action was in response to a lawsuit led by the General Prosecutor at the time, also known as the *Procurador*, Alejandro Ordoñez. This legislative move was significant as, while health facilities were still legally required to provide abortions, there were no longer official government guidelines on the recommended methods of care. This lack of clarity was further exacerbated by directives issued by the Ordoñez which contained misleading claims such as that Decision C-355 had been suspended and that health service providers were not obliged to perform abortions (Ruibal, 2014).

The legal and political role of the *Procurador* in Colombia is significant and involves enforcing the Constitution, general laws, judicial decisions, and administrative acts. Ordoñez, who occupied this position from 2009 to 2016, blatantly used his position of authority to

sabotage the implementation of Decision C-355. For instance, he also targeted the safe abortifacient, misoprostol, and its use for abortion in medical institutions, leading an inquiry based on the unsubstantiated claim that the drug was dangerous in comparison to other methods. He took this a step further by informing public officials, responsible for the implementation of abortion services, that they would be at risk of prosecution for reducing public finances for purchasing the medication. An additional attack seeking to obstruct access to the newly legalized health service involved the investigation and halting of the construction of the *Clinica de la Mujer* (Women's Clinic) which would have provided sexual and reproductive health services in the major city of Medellín (Maldonado, 2018). Ultimately, Ordoñez was removed from his position by the Council of State in 2016, following an inquiry which found significant issues with the election to his position. However, the damage of his efforts, supported by other anti-abortion political actors, to obstruct the effective implementation of C-355 though the spread of disinformation had been accomplished.

It is evident that the legal battle surrounding reproductive rights of Colombian womxn has continued, even more than a decade following the initial watershed ruling. For instance, even on October 17, 2018, a court decision was made to leave Decision C-355 unchanged in response to targeted efforts by a Constitutional Court judge, Cristina Pardo, who sought to establish a 24-week limit for accessing legal abortion services. Through mechanisms such as legislative controls, influential state actors such as Alejandro Ordoñez and Cristina Pardo, have actively sought to exert influence on the reproductive behaviour of womxn in Colombia. In using their political power to prevent womxn from carrying out informed choices regarding their own bodies, they have contributed to undermining reproductive justice. The following statement by Acevedo, further reflects how reproductive rights are continuously under threat within state

institutions in Colombia: “Colombia is progressive in terms of constitutionality, but we have a really conservative congress… we are facing constant challenges and threats coming from the legislative side or even the executive side. The [abortion] ruling is not settled” (Foreign Policy, 2016).

3 Literature Review: Barriers to Accessing Abortion in Colombia

Decision C-355 established that all healthcare service providers in Colombia, public or private, were obliged to make safe abortion services available in specific circumstances, yet qualitative evidence has demonstrated that this is frequently not the case. Numerous studies have been carried out since the ruling which have sought to examine the experiences of womxn seeking legal abortions in Colombia in order to understand why disproportionate rates of illegal abortion persist. These have been produced by academic sources as well as in collaboration with prominent womxn’s health organizations in Colombia, such as the feminist activist network *La Mesa por la Vida y la Salud de las Mujeres* (Network for Women’s Lives and Health, hereafter referred to as La Mesa). These have highlighted various common barriers that are individual, such as lack of knowledge on where to obtain legal services, as well as institutional, including the legal mechanism of conscientious objection (La Mesa, 2014). Notably, these studies collectively portray an institutional environment in Colombia wherein healthcare providers themselves frequently act as barriers to “humane, compassionate and comprehensive” abortion care (Brack et al, 2017). The next section will discuss two key barriers that arise in literature, cultural and religious barriers. Section 3.2 will discuss informational barriers to abortion discussed in literature, mainly revolving around the legal rights and responsibilities surrounding abortion. Following this, Section 3.3 discusses financial barriers to abortion, which are indicative of broader social inequities in Colombia.

3.1 Cultural & Religious Barriers to Abortion Access

Numerous studies described 'cultural' barriers to abortion access, citing conservative cultural attitudes towards abortion in Colombia, which influenced both the actions of patients seeking abortion and of healthcare providers (González Vélez, 2012; Prada et al, 2011; Stanhope et al, 2017). Eduardo Amado et al in *Obstacles and Challenges Following the Partial Decriminalization of Abortion in Colombia* (2010) examined the cases of 36 womxn who approached La Mesa between 2006 and 2008 following difficulties obtaining legal abortion. They found that the various obstacles faced by womxn in healthcare settings stem from "fundamental disagreements about abortion and misunderstandings regarding the ethical, legal and medical requirements arising from the Court's decision" (P.118). In terms of these fundamental disagreements regarding abortion, the authors include those of 'medical autonomy vs. women's autonomy' as well as 'protection of fetal life vs. protection of women's lives' (P.120).

Amado et al are conspicuously one of few authors included in this review to address how these ideological conflicts may be at the root of providers' obstructive behaviour. Provider resistance and stigma are highlighted various times in articles exploring barriers to abortion, but authors such as Baum et al (2015) or DePiñeres et al (2017) do not delve into the ideological beliefs which may inform this behavior. Amado et al explicitly state that these ideological conflicts can manifest in stigmatizing treatment on the part of healthcare providers. This is supported by various powerful anecdotes from patients included in their study. For instance, one participant described how when she was requesting an abortion on the grounds of fetal malformation, a doctor referred to her as a "killer" (P.22), seemingly expressing the 'fundamental disagreement' that the rights of the fetus outweigh that of the womxn. As the

authors point out, this is suggestive of how some healthcare providers may act as "prosecutors" (Ibid), imposing a moral regime[10] when they personally disagree with their patient's decision.

This underscores the delicate balance between the right to conscientious objection and the right to access abortion services, as judgemental interactions such as the above clearly discriminate against womxn pursuing these services. Freedom of conscience does not involve the right to prevent womxn from accessing a healthcare service to which they are entitled to – whether through stigmatizing treatment, misinformation, or delays and refusals to refer patients to healthcare providers willing and able to carry out the abortion. Nevertheless, misuse of conscientious objection continues to serve as a barrier to abortion access in Colombia.

Religious beliefs are tied in with cultural barriers to abortion access. In "*It's a Race Against the Clock": A Qualitative Analysis of Barriers to Legal Abortion in Bogota, Colombia* (2017), Chelsea Brack et al argue that religion contributes to delays accessing abortion services. They attribute this to its influence on social stigma "which manifested most powerfully in the obstructive behaviour of health care providers and health insurance companies" (P.179). Religion was cited as a barrier to abortion access in numerous studies, both for the womxn seeking abortion and for healthcare providers (Amado et al, 2010; Baum et al, 2015; DePiñeres et al, 2017; Keefe-Oates et al. 2019; Prada et al. 2011; Stanhope et al. 2017), due to how it has contributed to stigmatizing perceptions of abortion in Colombia.

These stigmatizing perceptions can stem from the belief that life begins at fertilization, as informed by the Roman Catholic doctrine. For instance, Fink et al found that some physicians involved in their study felt it was part of their medical duty to also protect life from this moment.

[10] 'Moral regimes' refer to the "privileged standards of morality that are used to govern intimate behaviours, ethical judgements, and their public manifestations." As pointed out by medical anthropologists, Lynn M. Morgan and Elizabeth F.S. Roberts, the activities of the biological body, especially the reproductive and sexual body, are often at the centre of moral regimes and are thereby "critical sites of contention" (2012).

This motivated them to prevent womxn from receiving abortions, whether they conducted them or not (2016). It is also worth considering how the predominance of Catholic Church doctrine in Colombia has indirectly contributed as a cultural barrier by informing conservative social norms in terms of familial roles, sexual morality, and gendered expectations.

3.2 Informational Barriers to Abortion Access

Another key theme which emerged among these studies were informational barriers to abortion, revealing an apparent dearth of understanding regarding the rights and responsibilities of abortion care provision. This relates to the cultural and religious barriers previously discussed, as gaps in information and understanding provide space for healthcare providers to impose anti-abortion attitudes. In numerous studies, some participants were initially unaware of the expanded circumstances under which abortion access was legally available when attempting to access abortion services (Brack et al. 2017, Prada et al. 2011, Stanhope et al. 2017, Stifani et al. 2018). Moreover, this lack of clarity surrounding the legal framework of abortion has resulted in confusion among healthcare providers themselves. This can be linked to the suspension of the official guidelines for the implementation of abortion services in 2013, the result of a lawsuit led by the Attorney General at the time, Alejandro Ordoñez. This “dual ignorance” (Stanhope et al., 2017) of both womxn and healthcare providers evidently serve as a major barrier to abortion service provision, even in the circumstances that it should be legally accessible.

Related to inconsistent implementation of the law by providers is an aspect of the 2006 court ruling where, along with the right to abortion in specific circumstances, the Court also outlined guidelines for healthcare providers who wished to invoke ‘conscientious objection.’ In other words, while individuals can object to performing abortion, institutions cannot, therefore objecting physicians would have the responsibility to refer patients to another provider as

conscientious objection "may not involve disregard for the rights of women" (Fink et al., 2016). As previously mentioned, it is apparent that despite the intent of these guidelines, many health providers and legal actors frequently choose to narrowly interpret and improperly exercise this notion of conscientious objection to avoid performing abortions or to prevent womxn from accessing them elsewhere. For instance, research has uncovered that in numerous cases healthcare providers have requested additional judicial or other types of authorizations beyond those actually required by law (Ruibal, 2014). These have included requests such as for parental or partner consent, or authorization from a judge (Amado et al, 2010 and Stanhope et al, 2016). This entails that many Colombian womxn seeking legal abortion must jump through unnecessary bureaucratic hoops to access the medical service that they are constitutionally entitled to.

Medicos Sin Fronteras (MSF), the medical and humanitarian organization, released a report entitled *Aborto no Seguro, mujeres en riesgo* (Unsafe Abortions, Women at Risk) in 2019. The report claimed that a common denominator of medical institutions in the cities of Tumaco and Buenaventura, where the MSF provides safe abortion services,[11] was that a majority of doctors were 'objectors.' Additionally, that many even refused to attend to post-abortion complications or to provide additional information on a womxn's right to safe abortion and where they can go for care. *Aborto no Seguro, mujeres en riesgo* was based on data collected in 2017 and 2018, including testimonies from patients who experienced obstacles seeking safe abortions and eventually turned to the MSF. While the report states that its data cannot be extrapolated directly to the wider context of Colombia, it indicates how withholding or providing misleading information can act as a barrier to abortion. Particularly for womxn already in

[11] It is notable that a humanitarian organization such as MSF chose to establish safe abortion services in these two cities, claiming that the consequences and prevalence of unsafe abortion constitute a medical emergency (Medicos Sin Fronteras, 2019).

vulnerable situations, such as those residing in areas affected by armed conflict like Tumaco and Buenaventura.

Some studies attempting to explain why rates of clandestine abortion continue to remain disproportionate in comparison to rates of legal abortion in Colombia have not only considered the personal experiences of womxn seeking abortion, but also the perspectives of health care professionals responsible for providing this service (Stanhope et al 2016 and Fink et al 2016). For instance, in their 2016 study, Stanhope et al conducted informant interviews with doctors working within the public healthcare system and echoed the point that misunderstanding of their legal obligations was a key barrier, as physicians' misinterpretations of the law led some to act as "gatekeepers" and to "make subjective decisions about a woman's worthiness to receive abortion care, instead of following the legal guidelines for conscientious objection" (2016).

Similarly, Fink et al (2016) sought to understand how physicians invoking this legal mechanism to avoid providing abortion care interpret and practice their 'objection.' After interviewing 15 physicians who self-identified as 'conscientious objectors,' they highlighted the nuances of provider behaviour and intention by concluding that objection falls along a spectrum of three types: extreme objection, moderate objection, and partial objection. Most notably, 'extreme objectors' appeared to be those more likely to perpetuate abortion stigma and to consciously produce barriers to women seeking abortions, such as providing misleading legal and medical information and refusing to refer their patients.[12] These two studies underscore how institutional actors such as healthcare providers frequently interfere to place "unwarranted

[12] Interestingly, this study provoked a response from the organization, Grupo Medico por el Derecho a Decidir (Doctors for Choice), who criticized the framing of these pervasive practices as legitimate forms of conscientious objection rather than unjustified barriers to services. Fink et al are criticized for inadvertently legitimizing these arbitrary practices as forms of conscientious objection in their research even though they diverge from the legal mechanism, deriving from the imposition of beliefs rather than an exercise of conscience (Grupo Médico por el Derecho a Decidir, 2016).

burden" on women seeking legal abortion, acting as an obstacle to both access and quality of care (Amado et al, 2010, P.123).

3.3 Financial Barriers to Abortion

The literature on barriers to abortion also underscores how abortion access is often a reflection of larger health inequity in Colombia. It is apparent that when abortion law is applied and interpreted inconsistently as in Colombia, vulnerable populations – namely those with less financial resources and proximity to health care – are typically the most impacted by lack of access to abortion services. Indeed, in a study set based in Bogota on "Delays and Barriers to Care in Colombia Among Women Obtaining Legal First- and Second- Trimester Abortion," it was found that difficulty accessing abortion care was twice as likely to be reported among women with low socioeconomic status than among those of higher socioeconomic status (Baum et al, 2015).

These 'real or perceived' (Baum et al, 2015) financial barriers were found among women in various qualitative studies (Baum et al. 2015; Depiñeres et al. 2017; Prada et al. 2011; Ruibal, 2014; Stanhope et al, 2017), which is significant given the context of universal insurance coverage in Colombia. Despite the fact that both surgical and medical abortion are included in the basic universal health plan as a result of C-355, many Colombian womxn, especially those of lower socioeconomic status or education levels, do not appear to be adequately informed on how to access this plan, which links to the theme of lack of information as a barrier to abortion access. This reflects a finding by Amado et al (2010) that, of the women in their small-scale study who had encountered refusals, the majority were single and belonged to a poorer social stratum. They make a compelling point that these "failures of the health care system can become a kind of

violence against women" (2010, 122), as they contribute to a structure which repeatedly violates and neglects their reproductive autonomy.

While available research literature exploring barriers to abortion range from the 2006 court ruling to approximately a decade later, the same barriers seem to resurface in the shared experiences of womxn throughout this time. Even when these obstacles may not seem to be directly linked to structural violence against womxn, such as logistical barriers of travelling to request or receive an abortion, they reflect a system in which the odds are stacked against womxn in fulfilling their reproductive rights, and various segments of womxn in particular.

3.4 Gaps in Existing Literature on Abortion in Colombia

This brings us to a significant research gap in literature. While these existing studies highlight crucial perspectives of womxn seeking abortion and healthcare providers in Colombia, these primarily involve data collected in major urban centres such as the capital city, Bogotá (DePiñeres et al, 2013; Brack et al, 2014; Fink et al, 2014; Stanhope et al, 2014; Botero et al, 2016). Barriers faced by womxn living in settings such as rural areas, informal settlements, or conflict zones are exacerbated, yet there is a lack of academic research addressing their experiences. Other sources may be useful for increasing awareness of womxn's experiences in varying contexts across Colombia. For instance, the previously referenced Medicos Sin Fronteras report on barriers faced by women and girls seeking reproductive health services in conflict areas (Medicos Sin Fronteras, 2019).

This thesis deepens and extends these existing analyses of abortion access in Colombia by addressing three gaps in the literature. First, by drawing upon social media as a site of discourse, as opposed to interviews and focus groups, to highlight the barriers that continue to be faced by womxn and how they decide to navigate them. Social media sources have not yet been

utilized as a means of understanding the landscape of abortion access in academic research, despite serving as dominant platforms where personal, social, and political issues are represented and debated (Bouvier and Machin, 2018). Given how this particular Facebook group functions as a support group and a discussion forum on a range of sexual and reproductive health topics, it provides candid and relevant insight into this topic, especially because these womxn's shared perspectives and experiences are not prompted by researcher's interview questions, but by their own need for answers and information.

Second, as an online source, *ABORTO 🤍 COLOMBIA* expands the geographic scope of womxn's perspectives included for analysis beyond the capital city of Colombia, Bogotá. Although the extent of geographic reach cannot be measured in a systematic way due to group members' locations not being consistently available, a range of sites surface in posts. For instance, some womxn state that they are located in small towns or places far from major cities where they can access desired clinics. Or, that they are located in smaller cities such as Cúcuta, Bucaramanga, Cali, Ibaqué, Barranquilla, and Pasto. This allows a sense of perspectives more broadly spread out across Colombia and from those who have not necessarily been able to reach Bogotá to receive an abortion, which data sourced in previous studies is largely comprised of.

Lastly, this paper differs in its exploration of this topic by drawing upon the conceptual lens of structural violence in addition to the contextually relevant perspectives of contemporary Latin American feminism. As I will discuss in the following section, structural violence provides a lens to perceive how widespread barriers to abortion experienced by womxn cumulate to indirectly perpetuate violence against their bodies and their lives by constraining their autonomy. This is relevant to contemporary Latin American feminisms as they target systematic

discrimination against womxn sustained by social and political structures, and give emphasis to the idea that barriers to abortion are symptomatic of a patriarchal society.

4 Theoretical Approach

4.1 Structural Violence

This paper understands the topic of restricted abortion access through the conceptual lens of structural violence. Johan Galtung, a Norwegian sociologist credited with founding the discipline of peace and conflict studies, introduced the term in his 1969 essay "Violence, Peace and Peace Research." Galtung used the term "structural violence" to refer to violence not necessarily as direct force carried out by one or more individual actors as traditionally understood; but rather as violence made possible by a set of specific structures, such as laws or policies, which indirectly produce experiences of violence. These experiences of violence may manifest in avoidable deaths, illness, injury, and deprivation of people and community's agency and dignity (Rylko-Bauer and Farmer, 2017).

According to Galtung, "violence is built into the structure and shows up as unequal power and consequently as unequal life chances" (1969). Structural violence, rather than directly causing physical or mental harm to an individual, produces the specific context in which violence may occur. These are largely contexts of inequity. As Galtung explains, in both personal and structural violence "individuals may be killed or mutilated, hit or hurt… and manipulated by means of stick or carrot strategies but whereas in the first case these consequences can be traced back to concrete persons or actors, in the second case this is no longer meaningful" (1969). In this sense, accountability for structural violence is difficult to achieve. While an individual who enacts violence on another individual may be held legally accountable for their actions, violence which is indirectly caused by discriminatory legal

structures or social stigma, for instance, may not be immediately recognized for harm caused due to the lack of an identifiable perpetrator.

In the context of health equity, structural violence can be understood as the cause of the causes of poor health (De Maio and Ansel, 2018). In this thesis' application of structural violence, I employ the WHO definition of health which informs the health exception of Decision C-355 – specifically, health as encompassing mental health and social well-being. This takes into account the psychological and social impact of facing an unwanted pregnancy, obstructions to accessing a safe abortion, and forced maternity. The concept of structural violence has rarely been utilized in abortion research, as highlighted by Rishita Nandagiri, Ernestina Coast, and Joe Strong (2020). In their paper, they argue that the relevance of structural violence to this issue stems from how it reveals institutionalized and "everyday" forms of violence imposed on womxn which restrict and impact abortion access, quality, and care. In this sense, the entrenched inequities that manifest in unequal ability to fulfil sexual and reproductive health can be interpreted as manifestations of structural violence. As described Nandagiri et al, these inequities are sustained and reproduced by underlying historical, social, political, and cultural contexts which shape access to sexual and reproductive health, and health in general (2020).

Fernando De Maio and David Ansell, both community health researchers, have also drawn on the concept of structural violence in their health research. They emphasize that structural violence is evocative in its framing of health inequities as violent, which merits its use in health equity literature. However, they suggest that using the conceptual lens in conjunction with broader theoretical frameworks would help to strengthen the level of theoretical precision needed to clarify what aspects of "structure" are most relevant in one's analysis (2018). In line with this suggested approach, I incorporated feminist perspectives on reproductive rights from

Latin American theorists. These perspectives focus on the role of the State in contributing to and sustaining historical inequalities and violence against womxn and marginalized bodies in a myriad of forms.

Another practical purpose of drawing upon Latin American feminist frameworks is that these also contextualize the Facebook group and the content within it. These critical feminist perspectives helped to generate the movement for safe, free, and legal abortion out of which *ABORTO 💚 COLOMBIA* emerged. Drawing upon contemporary Latin American feminist perspectives and discourses on reproductive rights enabled a critical interpretation of the data informed by the Latin American experience.

4.2 Latin American Feminist Perspectives on Reproductive Rights: "Este país nos odia por ser mujeres, es una realidad de todos los días."[13]

The belief that hatred of women is an everyday reality in Colombia, expressed in a post in *ABORTO 💚 COLOMBIA*, is not unfounded given the prevalence of violence against womxn in the country and the region it is situated in. Violence can, of course, be understood in the context of literal conflict, such as sexual violence as a tool of war and colonization. For instance, Colombia has endured five decades of armed civil conflict, ongoing since 1984, despite a peace agreement in 2016. The government military, various paramilitary forces, and rebel groups have all been accused of perpetrating sexual violence against civilians throughout this conflict.[14] Nevertheless, as warned by critical feminist scholars, framing sexual violence during conflict as primarily a 'weapon of war' decontextualizes it from structural factors of inequality which

[13] "This country hates us for being women, it is an everyday reality." CS, 2020, Research Dataset.
[14] Notably, during peace negotiations women had to struggle to be included in the peace process, let alone for this element of the conflict to be officially recognized (Céspedes-Báez et al, 2018).

enable its perpetration, such as patriarchal relations (Kreft, 2020).[15] Violence against womxn in Colombia extends beyond the armed conflict to 'everyday life,' with stereotypes, discrimination and socioeconomic conditions underpinning forms of violence against womxn (OECD, 2020). Thus, naming, understanding, and resisting violence against womxn has been an urgent priority for feminist movements in Colombia, and across Latin America. This encompasses the struggle for reproductive justice.

Galtung proposed that we understand structural violence as synonymous with social injustice. This is because structural violence enables a social order which generates unnecessary and avoidable suffering (De Maio and Ansell, 2018). Social injustice informs collective action and activist discourse, as can be observed in contemporary feminist movements in Latin America. The concept of structural violence complements contemporary Latin American feminist perspectives on reproductive rights in several compelling ways. First, Latin American feminist movements recognize engrained, unequal power relationships and how they manifest in violence enacted on bodies, specifically marginalized bodies. Second, various feminist movements seek to hold the state and structures, as opposed to solely individuals, accountable for the cumulative violence enacted against womxn's bodies. This section will map ways which various feminist perspectives and movements across Latin America intersect to influence one another and produce understandings of how structural barriers to safe abortion function as violence against womxn.

This section will primarily refer to the decolonial feminist framework of Rita Segato, an Argentinian feminist anthropologist, whose works have served as reference points for

[15] Interviews with activists from women's organizations involved in supporting victims of the conflict found that they largely did not view sexual violence during the conflict as a standalone issue, but as grounded in patriarchal structures that are deeply embedded in Colombian society (Kreft, 2020).

contemporary feminist movements and theories on gender violence across Latin America (Il Manifesto, 2018). It will also draw upon the relevant notion of 'women's autonomy' as interpreted by the Mexican feminist anthropologist, Marcela Lagarde.[16]

4.2.1 Structural Violence Against the Female Body: New Forms of War

Contemporary feminist activism across Latin America recognizes the entanglement of unequal power relationships based on gender, sexuality, class, and race, and the systematic entrenchment of these dynamics stemming from shared colonial histories. Moreover, that these manifest in violence enacted on bodies, disproportionately female bodies. This is an argument contained in a decolonial feminist framework of Rita Segato, who frames this violence as the "new forms of war" (2010).

Mexican feminist theorist, Marcela Lagarde, adds to this debate regarding the subjectivity of women's bodies, claiming that "*la doble moral machista y misógina"* (the macho and misogynist double standard) surrounding abortion is a main cause of what drives women to expose their health and their lives to clandestine abortions (2013). This double standard, she argues, is perpetuated by predominantly male figures of authority, who hold power over the democratic right to self-determination of women's bodies in economic, political, and social life.

According to Lagarde, the fight for women's autonomy must include increasing the visibility of gender oppression in the forms of impoverishment and violence against women, limited rights, and subordination. Thus, the feminist struggle for the construction of women's economic, political, and social rights have been aligned with discourses of autonomy (2012). This rhetoric was reflected in arguments contained in the case challenging the total abortion ban

[16] Lagarde is also credited for her conceptualization of feminicide, developed in the context of Mexico, which recognizes the role of the State in gender-based violence through its inaction and impunity serving as an enabling mechanism for the perpetration of femicides (Terrorizing Women: Feminicide in the Americas).

in Colombia, brought to the Constitutional Court by the feminist network, Women's Link Worldwide. As previously described, the legal argument claimed that a ban on abortion violates a woman's constitutional right to '*libre desarollo de la personalidad*,'the free development of her personality and autonomy. Additionally, that criminalizing abortion in response to sexual violence was an additional violation of woman's dignity, freedom, and autonomy (Roa & Klugman, 2014).

4.2.2 Holding Structures Accountable through Collective Action

The idea of women's bodies as objects of machismo aggression have been present in the struggles of Latin American feminist movements, which have sought to resist this by reaffirming the autonomy of their bodies. The popular protest slogans "*Mi cuerpo, mi decision*" (My body, my decision) or "*Es mi cuerpo, yo decido y tu te callas*"(This is my body, I decide and you shut up)[17] can be understood as expressions of the feminist movement's reappropriation and resignification of womxn's bodies as a core part of its agenda. Feminist movements across Latin America continue to target these aforementioned wars on womxn's bodily autonomy in their numerous manifestations – from sexual abuse to restricted access to safe abortion to exploitative labour practices. In this sense, Latin American feminisms can be characterized by their concerted efforts to shift understanding of violence against womxn and minoritized bodies from the private into public sphere and subsequently, accountability into the public sphere.

In her anthropological study of the 'feminine condition' (2005), Lagarde uses "captivity" to describe the cultural forms of women's oppression in patriarchal society, which also defines women politically. Feminist movements across Latin America recognize and seek to subvert these conditions, efforts which have involved mobilizing for the legalization of abortion. Natalia

[17] Observed in demonstrations such as the Women's Strike of March 8th (8M), 2017.

de Souza (2019) incorporates Segato's frameworks in exploring how feminist movements, emerging in the context of contemporary Latin American political struggles, actively unite various social justice movements in their efforts to redefine the political subject. As she argues, movements such as the influential *#NiUnaMenos* (Not One [Woman] Less) of 2015 attempted to bring attention to the materiality of women's bodies and the need to reclaim their rights over their bodies – in the sense of retrieving female sexuality and desire from state control but also of keeping women's bodies *alive* in the face of biopolitical regimes (Souza, 2019).

The *Ni Una Menos*[18] movement provides a notable example of contemporary Latin American feminism which seek to resist intersecting forms of violence and cruelties against women and minoritized bodies. Moreover, one which targets barriers to safe abortion access and identifies its outcomes on women as a form of violence. While collective action emerged from frustrations with ceaseless violence committed against women with seeming impunity, the mandate of this movement also encompassed a diversity of interlinking political, economic, and social claims. This is evident in the following statement, posted to the *Ni Una Menos* Facebook page:

> We strike because we are missing the victims of femicide, voices that are violently extinguished to the chilling rhythm of one per day only in Argentina. We are missing the murdered lesbians and transvestites. We are missing the political prisoners, the persecuted, the murdered in our Latin American territory for defending the land and its resources. We are missing women imprisoned for minor crimes that criminalise forms of survival, while the crimes of corporations and drug trafficking go unpunished because they benefit capital. We are missing *the dead and those imprisoned for unsafe abortions.* We are missing those disappeared by trafficking networks; the victims of sexual exploitation. In the face of homes that have become hell, we organise to defend ourselves and *take care of each other*. In the face of sexist crime and its pedagogy of cruelty, in the face of the media's attempt to victimise and terrorise us, we turn individual

[18] The movement sprung into being in 2015 in Argentina, Colombia's neighbouring country, in response to the murder of a pregnant 14-year-old girl, Chiara Paez, at the hands of her boyfriend. It rapidly spread to numerous other countries in the region protesting gender-based violence within their own borders, including Colombia.

> mourning into collective consolation, and rage into a shared struggle. *Faced with cruelty, more feminism*[19] (Ni Una Menos, 2017).

The demands of this movement also reflect Segato's argument that violence against women cannot be understood without considering the logic of capitalism, which necessitates the exploitation of mostly female bodies. Linked to this, that gendered violence in Latin America, in its numerous manifestations, is intertwined with markers of class and race (Segato, 2012). This speaks to the issue of inequitable access to abortion, given that barriers are well-documented as disproportionately faced by women of low socioeconomic status, for whom the consequences would also cause disproportionate hardship.

4.2.3 Violent Implications of Restrictions to Abortion

Restricted abortion access and forced maternity is framed within Latin American feminisms as a violation of women's bodies. Moreover, as representative of the structural violence implicit in normative ideals of female sexuality and motherhood (Ellison, 2003). Notably, these are norms which theorists on abortion stigma[20] also identify as rooted in gender-specific archetypes including "female sexuality solely for procreation, the inevitability of motherhood, and the instinctual nurturance of the vulnerable" (Cockrill and Nack, 2013). Subsequently, stigma surrounding abortion stems from the perception of the choice to abort a pregnancy as an assertion of women's "moral autonomy" that violates social norms (Kumar et al., 2009). When stigma manifests as unjust barriers to abortion services, and thus, to reproductive freedom, it perpetuates structural violence as it presents limited options to womxn facing unwanted pregnancies.

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[19] Emphasis added, see Appendix A for original Spanish text.
[20] Defined by Kumar et al as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (2008).

In the regional context of Latin America, legalization of abortion would directly threaten the patriarchal order as it grants women the right to decide over their own bodies and to challenge the "maternal mandate" (Ariza and Saldivia, 2015). The criminalization and regulations surrounding abortion, and the stigma that these perpetuate, serve as a means of governing women's reproductive lives and thereby, roles in society. Thus, controlling the bodily autonomy of women maintains the patriarchal state's authority. As Segato explains in an interview: "Abortion is an important practice. The prohibition and criminalization of abortion is 'state rape,' because you have in your body a piece of flesh that is not yours and you do not want. This is rape. Forcing you to keep it is a 'state rape'" (Il Manifesto, 2018). By situating forced maternity, imposed by restrictive abortion law, as a violation of a women's body, Segato invokes how the state binds women and robs them of their bodily autonomy.

Additionally, pillars of the patriarchal state, including the police and courts, act as violators of women's bodies. An example of feminist resistance which has acted upon this argument was *Un Violador en Tu Camino* (A Rapist in Your Path) which emerged in Chile in 2019 in response to sexual violence experienced at the hands of police by women protesting the government's neoliberal policies. These were policies which themselves had perpetuated injustice against women, such as entrenching gendered socioeconomic inequalities, so the irony and symbolism of this state response to protesters was especially provoking. The responding demonstrations, in the form of street performance, were initiated by a feminist collective (*Las Tesis*) who had drawn inspiration from Segato's analysis of sexual violence as a political phenomenon (Martin & Shaw, 2021). The protest performance, which targeted rape culture and implicated the state and society for women's oppression, went on to be re-staged in other Latin American countries including Colombia. This movement is an additional expression of feminist

resistance in Latin America which, in targeting violence against women's bodies, also takes aim at other political and social institutions perpetuating structural violence and oppression. These include the social institution of the family and with that, gendered expectations of motherhood. As described in an analysis of *Un Violador* in the context of contemporary Latin American social movements:

> Feminist movements in Latin America have called into question the sanctity of the family and the conservative patriarchal state as its self-proclaimed protector by highlighting the abuses and violence against women that take place within the family and by the state and agents of its institutions: judges, state security forces, police, politicians – all groups explicitly named and denounced by Un Violador." (Martin & Shaw, 2021)

By portraying and implicating the patriarchal state as "A Rapist" through the bodily violations and loss of autonomy it perpetrates, feminist movements like *Un Violador* express frustration and defiance against structural forms of violence including restrictive abortion regimes.

As contained in Galtung's (1969) framework, structural inequalities are at the core of structural violence, manifesting as unequal power and unequal life chances. Structures are violent when they result in avoidable deaths, illness and injury, and deprive people and communities of agency and dignity (Rylko-Bauer and Farmer, 2017). The demands and protests contained in these mobilizations indict barriers to safe and legal abortion enforced by political, judicial, and healthcare institutions as contributing to the unnecessary loss of lives (*Ni Una Menos*), health, and dignity of those facing an unwanted pregnancy. Moreover, the punishment associated with abortion, whether legal or social, contributes to further marginalization of womxn, especially poor womxn. Thus, drawing upon contemporary Latin American perspectives, which approach restricted abortion within a structural violence framework, enables us to comprehend how barriers to abortion may be instituted and reinforced by institutions which place limits on autonomy.

5 Methodology/Research Design

The research objectives of this paper are first, to identify which barriers to accessing abortion womxn are facing and, second, to identify how they are navigating these barriers. The chosen methodology and source of data stems from the intention of elevating womxn's narratives and prioritizing their shared experiences as the main source of information in answering these questions. *ABORTO 💝 COLOMBIA* provides a means of accessing this diverse set of shared experiences, rather than a formal method of data collection such as interviews and focus groups. Moreover, as an online source it provides access to a broader geographic reach than a study using data gathered in a specific location. For instance, there are posts made by womxn seeking abortion who specifically state that they are in small towns or locations where abortion services are not accessible, in contrast to previous research largely conducted in the capital city of Bogotá.

The data gained from previous studies on barriers to abortion in Colombia are highly valuable in understanding the challenges faced by womxn in seeking abortion. While *ABORTO 💝 COLOMBIA* is a site of discourse that might lack a degree of intimacy present in an interview or focus group, this thesis was still able to observe and draw upon candid and detailed disclosures of experiences and perspectives due to its status as a 'private' group. This research engaged in passive analysis of this social media source, involving the study of information patterns observed in the interactions between users in this Facebook group (Franz, 2019). Specifically, I examined what qualitative scholars refer to as computer-mediated discourse – communication produced when humans interact with one another by transmitted messages via networked or mobile computers (Tannen et al, 2015). Analyzing not only posts, but also

responding comments as chains of communication allowed for a more expansive and dynamic dataset for analysis.

My research design made use of thematic analysis and feminist critical discourse analysis techniques. Thematic analysis is described as a qualitative descriptive method for "identifying, analyzing, organizing, describing, and reporting themes found within a data set" (Braun & Clarke, 2006). Thematic analysis differs from content analysis in its consideration of both latent content as theme and manifest content as category in data analysis, while content analysis draws upon one of these (Vaismoradi et al, 2015). This approach enables the identification of emerging patterns from the dataset in comparison to a focus on determining the extent or quantitative occurrence of patterns or events. This research was not aiming to measure or assess the extent of certain barriers, due to the limitations of the source of data, but rather, to observe which were emerging as most prevalent. Therefore, the method of thematic analysis was fitting for this purpose.

Discourse analysis is defined as "a qualitative approach that focuses on the meanings reflected in, and created by, discourses [defined as] sets of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (Burr, 1995: 48, cited in Trimble & Treiberg, 2015: 228). Approaching this method from a feminist critical perspective, in particular, enabled an analysis of content contained within the Facebook group with dynamics of power and gendered constructions in mind, crucial to the topic of reproductive justice. In particular, feminist critical discourse analysis methods aim to reveal the "complex, subtle, and sometimes not so subtle, ways in which frequently taken-for-granted gendered assumptions and hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities" (Lazar, 2007). This analytical

methodology echoes various insights of Latin American feminisms in its recognition that "operations of gender ideology and institutionalized power asymmetries between (and among) groups of women and men are complexly intertwined with other social identities" (Lazar, 2007). Additionally, the social emancipatory goals of critical discourse analysis reflect the intentions of this research project. In investigating barriers to reproductive rights and the means through which womxn resort to, this paper engages with feminist arguments which situate restricted abortion access as a form of structural violence. Through analysis of these experiences and how women understand their right to abortion, in contrast to their actual experiences accessing abortion services, this research project sheds light on the limits of liberalization.

5.1 Source of Data: Facebook Group

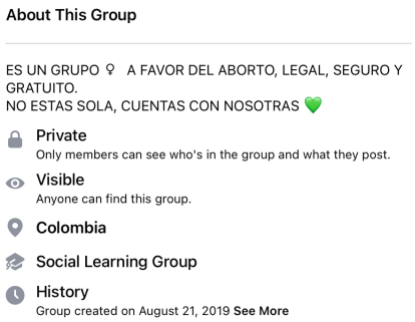

Figure 1. Facebook Group Description: "A group in favour of legal, safe, and free abortion. You are not alone, you can count on us." The 'feminine' sign can be interpreted as signifying a feminist group, and the green heart as a symbol of the campaign for free, safe, and legal abortion across Latin America.

ABORTO 💚 COLOMBIA self-identifies as a pro-choice and feminist group. Its Facebook page contains symbols and discourses which clearly signify it as part of *Ola Verde*, or the Green Wave movement[21] – for instance, the cover picture of the group depicts a black and

[21] The term associated with the feminist campaign for free, safe and legal abortion across Latin America, and the green bandanas worn by its activists. This symbolic movement emerged with the Argentinian feminist alliance, *Campaña Nacional por el Derecho al Aborto legal, Seguro y Gratuito* (National Campaign for the Right to Legal, Safe, and Free Abortion) in 2005.

white cartoon of a woman's face with furrowed brows, expressing anger. The only colour featured is her green eyes and the green bandana wrapped around the lower half of her face, the defining motif of the Green Wave. The bandana reads: "*Educación – Prevención – Libertad de Decisión,*" meaning "Education – Prevention[22] – Freedom of Choice."

The administrators of *ABORTO 💚 COLOMBIA* take care to maintain the group as a supportive and non-judgemental space. For instance, there are numerous rules listed by the group administrators regarding conduct in the group, including: "*Asegúrate de que todos se sientan seguros. No se permite el bullying ni los comentarios degradantes sobre las mujeres que han abortado, la raza, la religión, la cultura, o la orientación sexual".* (Make sure everyone feels safe. No bullying or demeaning comments about women who have had abortions, race, religion, culture, or sexual orientation.) This speaks to the feminist concept of *sororidad* (sorority). *Sororidad* is defined by Mexican feminist theorist, Marcela Lagarde, as "the practice of contemporary feminism," whereby alliances created by women in resistance to patriarchal oppression also "heals and cares" for one another (Moretti & Rosa, 2018). This particular Facebook group functions as a site of resistance in its efforts to position access to free, safe, and legal abortion as a human right while providing emotional and practical support in pursuing this right. This renders it a compelling site of analysis for this topic.

While this Facebook group cannot be taken as representative of the population of womxn seeking abortion in Colombia, it is a relevant source due to the size, level of activity, and the compassionate environment it has fostered which is conducive to less restrained self-disclosure. The representativity of the source may be limited by the fact that it is evidently a feminist, pro-choice group and thus, it likely attracts members who already hold these views. However, it can

[22] Likely referring to prevention of unsafe abortion.

also be construed that regardless of stance on feminism and abortion, many womxn were attracted to this group as a tolerant space where they could disclose their problems on topics widely held as taboo in Colombian society. Regardless of these limitations, the posts in the group highlight the complexities of accessing safe abortion that exist even when abortion has been made more legally accessible. This provides insight as to whether liberalization has been effective in removing unjust barriers to abortion, thereby ensuring reproductive justice.

5.2 Research Design

Best practice guidelines to assist researchers interested in conducting qualitative studies using data derived from Facebook are lacking, as pointed out in a 2020 literature review on the use of Facebook in qualitative research (Franz et al., 2020). I am conscious that the use of data contained in a private Facebook group potentially raises questions of ethics. For instance, literature on the use of Facebook in qualitative research highlights how the boundary between private and public Facebook data is sometimes unclear. The ethics of social media research are still being established as approaches to conducting research in this realm continue to be refined and developed (Franz et al, 2019). Regardless of this lack of clear guidelines, in order to maintain an ethical boundary, I chose to not include personal data of the profiles of those whose posts I included in the dataset. This was aside from characteristics which provide context – for instance, if they mention their age or geographic location. However, names or information are not recorded aside from initials, to maintain anonymity of individuals.

I began my analytical process by familiarizing myself with the data, and actively reading through the Facebook group's activity to understand the context. This involved reading posts and comments over the time span of interest (August 2019 to August 2020) and searching for notable and recurring themes in the content which related to the research questions and the relevant

theoretical frameworks. Specifically, I sought to answer: 1) which barriers to reproductive justice are occurring following liberalization of abortion; 2) how are womxn navigating these barriers. I was also curious to understand what this may convey about how womxn in Colombia understand their right to abortion.

I compiled a dataset of posts, including relevant comments on these posts, contained within the Facebook group from between August 2019 to August 2020. I did not want to exclude the experience of seeking abortion under the COVID-19 pandemic entirely from the data set, as posts from the outset of the public health crisis could highlight the existing challenges of access and how they were perhaps intensifying due to factors like closures of clinics, impacted economy, and limited mobility. However, I did not want this to dominate the data set, therefore I chose to assess posts from the creation of the group to a year later, around 5 months into the implementation of major COVID-19 policies in the country. Comprehensively exploring how COVID-19 has impacted access in Colombia and how those seeking abortion are navigating this is an important objective for a different research project.

I excluded posts which were less directly related to the research questions. For instance, those relating to birth control – there were numerous which asked for recommendations of types of birth control or questions about side effects. Notably, in numerous posts about unplanned pregnancies, womxn mentioned their methods of birth control "failing" them which pointed to the various reasons why womxn may face unplanned pregnancies which are not encompassed by the three exceptions of Colombian abortion law. Additionally, I excluded posts promoting events or sharing articles unless they included relevant discussion of personal experiences. Ultimately, my dataset contained 65 chains of communication – meaning 65 posts and their responding comments.

I chose to carry out manual extraction and qualitative analysis due to limitations of data analysis software with Facebook posts contained in a private group, also for translation purposes as all posts were written in Spanish. User-generated texts from relevant posts and comments were copied and pasted onto a single word document. Following this, I identified and coded notable words and phrases which served as markers for priori themes such challenges fulfilling reproductive rights and how womxn chose to manage these, while maintaining an open perspective for emergent codes which may not directly fit within expectations. Categories were then constructed based upon this collection of codes. In this step of analysis and organization of codes into relevant categories, I detected consistent and interlinking themes among the data, conveying a narrative of contemporary landscape of abortion access in Colombia.

Some of these categories included: "barriers," "expectations of care," "uncertainties," and "advice." Within the uncertainties category, for instance, sub-categorizations included: "legality/eligibility," "cost/affordability," "safety," and "location/accessibility." I aimed to identify and map the diverse ways which these posts indicated how those facing unwanted pregnancies exercise their agency. Namely, the ways which womxn choose, or recommend others, to manage their unwanted pregnancies and barriers to abortion they may face.

Throughout this thesis, Facebook posts are coded as a letter-number combination to identify them as the number of the post, and/or as a comment or sub-comment of the post. For instance, "1)" refers to the first post in my dataset and "1a)" refers to the first comment on the post. "1ai)" would refer to a sub-comment, meaning a response to 1a), and so on.

6 Key Barriers to Abortion in Colombia Post-Liberalization

My analysis of *ABORTO* 💝 *COLOMBIA* found recurring themes in accessing abortion which were being warned about as early as 2010 (Amado et al), by research literature on barriers

since Decision C-355. For instance, delays imposed by healthcare or insurance providers and infrastructural challenges in rural areas and small towns. This points to how, despite this legal achievement and further attempts by the Constitutional Court to solidify womxn's right to abortion following C-355, deeply embedded social and economic inequalities continue to determine the options available to womxn when facing an unwanted pregnancy. This supports an argument contained in the framework of reproductive justice; that legal rights to abortion are not enough to ensure reproductive well-being and autonomy when the socio-political and economic contexts in which individuals live constrain their ability to attain this health service with dignity and security.

Within the dataset, womxn faced logistical barriers falling mainly within the categories of: (i) financial; (ii) informational; and (iii) geographic. While I attempt to delineate the experiences of womxn in *ABORTO 💚 COLOMBIA* into categories, it was apparent that these barriers often overlap and reinforce one another. It was also evident that these barriers are more prevalent among womxn who are already in marginalized positions. For instance, for those who are in a state of financial precariousness, the cost to travel to a healthcare facility might already make their hope for a legal abortion out of reach. As the dataset contained posts from the outset of the COVID-19 pandemic, this analysis also contributes to an understanding of how these barriers have been intensified. Nandagiri et al. emphasize that even prior to the pandemic, reproductive health experiences and factors were stratified and affected womxn differently across "axes of race, ethnicity, age, marital status, class, gender and sexual identity, immigration status and others" (2020). This public health crisis has not necessarily created new inequalities but rather, has illuminated pre-existing ones which shape access to sexual and reproductive health care.

The following sub-sections will explain these categories of barriers that emerged within the dataset and will draw upon relevant shared experiences and narratives by womxn in ABORTO 💊 COLOMBIA. The final sub-section will discuss how these barriers, and the ways womxn choose to navigate them, have adjusted in the context of the COVID-19 pandemic.

6.1 Financial Barriers to Accessing Abortion

Financial barriers appeared to be the foremost concern of womxn seeking abortions throughout the dataset. The extent of womxn depending on health insurance coverage to afford their abortion was substantial. This was conveyed through the numerous posts seeking to clarify which insurance providers had agreements with clinics such as Oriéntame or Profamilia (2, 21, 21d, 21f, 28fiv, 33bi, 48aiii) and how much an abortion would cost with or without health insurance coverage (1, 21h, 35, 39b). This underscored how insurance coverage is an important factor to consider for how womxn perceive the accessibility of abortion. It is notable that even though universal health coverage aims to ensure affordability of abortion in Colombia, real or perceived financial barriers continue to be a strain for many.

This may be in consideration of the fact that, even if abortion services are technically free at public facilities in Colombia, there are often external costs to obtaining an abortion – for instance, travelling for a consultation and then again for the abortion itself, or taking time off paid work or domestic labour. For some households, this extra cost may simply place abortion access out of reach. It is also apparent that some womxn avoid public health facilities despite free abortion services, suggested by numerous posts with spoke of expectations of low-quality care and difficulty accessing services. I speculate that this may be why clinics outside the public sector, such as Profamilia and Oriéntame, are repeatedly mentioned and recommended to one another in the group, as they are perceived as safer options. These specific reproductive health

providers feature prominently in womxn's abortion decision-making process, at least in the context of *ABORTO 🤍 COLOMBIA*. This points to their significant role on the current landscape of abortion in Colombia and what this might indicate about how womxn are choosing to navigate particular barriers to care, such as provider resistance, as I elaborate on in Section 7.1.

The impact of insurance providers within the abortion-seeking process is also accentuated in the situation wherein insurers refuse or delay authorization of the procedure (51, 59), placing additional emotional burden on womxn as they attempt to manage their unwanted pregnancy and wait to find out if they can afford an abortion. For instance, LPA wrote:

> *Chicas me encuentro totalmente desesperada, angustiada me estoy enloqueciendo*
> *Publiqué hace poco sobre mi caso.*
> *Todavía no me llaman de profamilia para decirme si mi EPS autorizó el procedimiento mío que es la interrupción de mi embarazo como saben tengo 20 semanas y ya está muy avanzado.*
> *No sé si estoy tan desesperada que hoy apenas es martes y como veo que no me han llamado pues me desespero pero en realidad quisiera que me ayuden con sus opiniones xq he estado tan mal emocionalmente que no paro de llorar y pensar cada día que pasa en que voy hacer?*
> *Ayúdenme por favor*
> Girls I find myself totally desperate, distressed I'm freaking out
> I recently posted about my case.
> They still haven't called me from profamilia to tell me if my EPS authorized my procedure which is the termination of my pregnancy as you know I'm 20 weeks old and it's already very advanced.
> I don't know if I'm so desperate that today is just Tuesday and as I see they have not called me because I desperately want you to help me with your opinions because I've been so emotionally badly that I can't stop crying and thinking each passing day what am I going to do?
> Please help me (59).

Notably, an administrator of the group replied and claimed that when an abortion involves authorization by the EPS, the public health plan, it is usually delayed as the procedure is free and the EPS "…*son medio hartas con eso"* (…are a bit fed up with it) (59c). Moreover, they stated that authorization can depend on the type of EPS. This apparent inconsistency when it comes to health insurance coverage undercuts the principle of universal healthcare in the context of abortion and contributes to stratification of care, with access to 'better' insurance or more

financial resources enabling more straightforward access to abortion. It also raises the question of which factors contribute to certain insurance providers delaying or denying authorization for abortion services, even in circumstances where it is lawfully permitted.

An additional person, MAOF, shared their experience facing delays and financial barriers, prefacing it with: "I would like to tell my experience since I would never want anyone to go through what I had to go through..."[23] MAOF described how they went to Profamilia for a consultation under the impression that the abortion would be free, but discovered afterwards that their health insurance provider did not authorize the procedure for them. As they didn't have the financial resources to pay for the procedure out-of-pocket, which would cost them more than 600,000 Colombian pesos (approximately 200 Canadian dollars), they went directly to their insurance provider:

> *cuando llegue dije que necesitaba autorizar un IVE, y todos me quedaron mirando, sin prestar atención ellos me dijeron que debía sacar una cita con médico general para que me autorice por que al parecer la orden del médico de profamili(el cual pague la consulta) no me sérvia, con mucha paciencia saque la cita y dos días después fui a la peor consulta de mi vida...*
> when I arrived I said that I needed to authorize an IVE, and everyone stared at me, without paying attention they told me that I should make an appointment with a general practitioner to authorize me because apparently the order of the doctor of profamilia (which I paid for the consultation) was not valid, with much patience I made the appointment and two days later I went to the worst consultation of my life…
> *después me dijo que tenia que colocar en el sistema que yo estaba en embarazo y debía mandarme todos los exámenes pertinentes como ecografias, pruebas de sangre, infinidad de cosas y luego tendría que hablar con una psicóloga, una trabajador social y una agente de la fiscalia para que me autoricen el IVE, al ver que este proceso sentí miedo pues el me hizo sentir como una persona horrible así que le dije que no, que no me autorice esos tramites…*
> he told me that I had to put in the system that I was pregnant and I had to send all the necessary tests like ultrasounds, blood tests, lots of things and then I would have to talk to a psychologist, a social worker and an agent of the prosecutor to authorize the IVE, when I saw this process I felt scared because he made me feel like a horrible person so I told him no, not to authorize me those procedures… (51).

[23] *Quisiera contar mi experiencia puesto que nunca quisiera que nadie pase por lo que tuve que pasar…*(51).

MAOF proceeds to depict an emotional[24] and demeaning experience, again being told by their insurance provider that they did not authorize the procedure and to return a week later. In the end, MAOF resorted to paying for the high cost of the procedure themself. They conclude their account with:

> *Bueno quería compartir esto por que no debería ser tan difícil el acceso a estos tramites, un abrazo a todas ustedes mujeres que están pasando por esto, espero encuentren una amiga que las apoye o aquí que todas podemos hablar.*
> Well I wanted to share this because it should not be so difficult to access these procedures, a hug to all of you women who are going through this, I hope you find a friend to support you or here we can all talk. (51)

Nandagiri et al point out that by applying the lens of structural violence at all points in an abortion trajectory, regardless of the outcome, we are able to observe particular factors in action and the ways which they may cause individual "humiliations, discriminations, recriminations and injustices" (2020). Even though MAOF was ultimately able to obtain a legal abortion from the health system, this was following a process of financial strain, emotional duress, and unnecessary bureaucratic delays. These elements echo in various other womxn's experiences shared throughout *ABORTO 💚 COLOMBIA.*

Numerous times in the dataset, womxn mentioned that a reason they did not want to carry their pregnancy to term was their precarious economic circumstances (51, 52, 53, 54, 56, 62bi). While a commenter pointed out that raising a child would ultimately be more costly than the abortion itself (11a), it is evident that for many womxn in the group, pursuing a legal abortion poses an immediate financial strain. It was unclear whether in each circumstance the cost burdens were real or perceived – for instance, in some cases the financial barrier could be

[24] "*me puse a llorar y le pedí que me dejen salir del consultorio a lo cual el doctor dijo que tenía que esperar a que llegue la psicóloga, la trabajadora social y la agente, cuando llegó la psicóloga al verme llorando me dejó ir…*" (I started to cry and asked to be let out of the office to which the doctor said that I had to wait for the psychologist, the social worker and the agent to arrive, when the psychologist arrived, seeing me crying, she let me go…) (51).

attributed to lack of knowledge regarding abortion's eligibility for universal insurance coverage or available avenues for pursuing an affordable abortion, such as socioeconomic evaluations at some private clinics. This points to how lack of information and financial challenges can intersect as barriers to abortion. Nevertheless, it is evident that costs associated with legal abortion services can constrain womxn's options and places additional burden on them as they attempt to navigate these barriers.

6.2 Lack of Information as a Barrier to Abortion

The fact that *ABORTO 💝 COLOMBIA* has grown to be an active community of several thousand womxn within two years, points to how it has grown into a resource for advocating for reproductive justice for many. One aspect of its utility is the sharing of information and resources which promote safe access to abortion. This serves to address significant knowledge gaps which appear among womxn and interfere with their capacity to fulfil their right to abortion. When systems fail to provide diversely situated womxn with the information necessary to exercise agency over their lives and bodies, reproductive justice is limited. Prevalent lack of information was reflected by the numerous questions posed in the group regarding the legality, cost, and location of abortion services.

While lack of information may not be as tangible or direct of a barrier as denial by a healthcare provider, for instance, it stood out for its prevalence within the group. Widespread lack of information regarding insurance coverage and eligibility, and how this can manifest as a financial barrier, was addressed in the previous section. This section will primarily address lack of clarity surrounding the legal status of abortion as this appeared to contribute to emotional stress, delays in accessing abortion, and the impulse to pursue abortions outside of the formal

health system. In this sense, lack of information regarding one's right to lawfully access abortion serves as a deterrent and barrier to pursuing safe and timely abortion services.

6.2.1 Lack of Clarity Surrounding the Legality of Abortion

Despite extensive coverage of the outcome of Decision C-355 in 2006, the use of misinformation campaigns by anti-choice organizations and politicians and the withholding of information by providers opposed to abortion has contributed to obstructing access to accurate information (Küng et al, 2018). The stigmatizing impact of these efforts, also outlined in Section 2.2.1, are profound. According to a study released by the Colombian Ministry of Health and Well-Being and the United Nations Population Fund, many womxn who meet the criteria for obtaining legal abortions, including pregnancy due to rape, are afraid to seek these services in the health system out of fear of criminalization (UNFPA & Min Salud, 2014).

The ambiguity surrounding the legality of abortion in Colombia was underscored in the context of *ABORTO 💟 COLOMBIA* by numerous posts expressing concern about whether their case was eligible for legal abortion (27, 45, 48ai, 49hii, 62a, 62b) or assuming that it was not and pursuing the route of abortion outside the formal health system (11b, 32a, 48, 49b, 58). There is evidently a burden placed on womxn to navigate this lack of clear information when facing an unwanted pregnancy. For instance, by seeking information from strangers in a Facebook group.

A comment chain was initiated by AA, who posted in the group asking what their options would be if they weren't able to access abortion through their insurance. They enquired: "*que otras opciones faciles y economicas existen?"* (what other easy and economic options exist?) (49). Numerous individuals responded, outlining options such as consulting Profamilia or adding on their own questions. SA responded:

> *Que pena mi ignorancia! Pero en profamilia hacen el procedimiento aunque no estén las 3 causales?*

> What a pity my ignorance! But in profamilia they do the procedure even if the 3 causes are not present? (49ji)

In another post emphasizing that abortion is a right in Colombia, someone replied:

> LR: *Pero según lo que sé, es que funciona solo para 3 casos en especifico*
> But as far as I know, it works only for 3 specific cases.

To which, another group member added:

> LT : *hola así es y en algúnos casos tampoco aplica*
> Hello yes, and in some cases it does not apply either

While comments such as these indicate an awareness of the three indications specified in Colombian abortion law, they seem to echo a limited understanding which overlooks health on social grounds. Given that qualitative research has found it is not uncommon for healthcare providers in Colombia to take a narrow approach to the health exception to deny womxn abortions (Küng et al, 2018; Stanhope et al, 2017; Stifani et al, 2018), it can be presumed that this perception has been internalized by womxn. In consideration of the Colombian Constitutional Court's clarification that health is a comprehensive concept which includes both physical and mental elements, this is a misguided interpretation of one's right to abortion which may prevent womxn from seeking the service when they have the right to access it. For example, ML made a post enquiring if anyone was selling pills[25] to induce abortion or knew where to find them in Santa Marta, a port city. When someone recommended that they consult Oriéntame for an abortion instead, they replied: "*Pero tengo una duda, mi decision es propia, no por salud ni*

[25] Using the Facebook group to sell abortion drugs is explicitly forbidden by the administrators of ABORTO 💜 COLOMBIA. One of the group rules is listed as: "*ESTÁ PROHIBIDA LA VENTA DE MEDICAMENTOS En este grupo NO VENDEMOS medicamentos para abortar y no permitimos la venta de estos, cualquier miembro que los ofrezca o recomiende a quien los venda en comentarios o por interno será expulsado*." (THE SALE OF MEDICINES IS FORBIDDEN In this group we DO NOT SELL abortion drugs and we do not allow the sale of these, any member who offers or recommends who sells them in comments or internal will be expelled.) This does not seem to be for the purpose of discouraging use of medication but rather, to protect members from being scammed or potentially endangering themselves. For instance, administrators have posted recommended protocol for safely ingesting misoprostol for abortion and have emphasized the safety of medical abortion in previous posts.

nada" (But I have a doubt, my decision is my own, not for my health or anything) (48).

Additional posts expressing uncertainty include:

> *Qué tan rápido puede ser acceder a este, si la causalidad del aborto es porque no me siento capaz o simplemente no quiero tenerlo?*
> How fast can I access it, if the reason for the abortion is because I don't feel capable or I just don't want to have it? (62)

> JD: Hola señoritas ustedes saben si profamilia o que otra entidad en cali me puede ayudar para iniciar un proceso de aborto? Realmente no deseo tener el bebé por mi conduccion economica y no se si me acepten por esa situación.. Podrian indicarme que entidades me pueden ayudar para hacer un aborto seguro.. Ya que ayer me hiban a vender unas pastas de cycotec por internet y me dio mucho susto
> Hello ladies, do you know if profamilia or any other entity in cali can help me to start an abortion process? I really do not want to have the baby *because of my economic handling and I do not know if they will accept me for that situation*.... Could you please tell me which entities can help me do a safe abortion? Yesterday they were going to sell me some cycotec[26] pills on the internet and I was very scared (Italics added for emphasis) (53).

There is evidently a lack of clarity surrounding the right to access abortion. This contributes to a lack of legitimacy surrounding the choice to abort. Even if a womxn feels that they are not capable of supporting an unwanted pregnancy, and are enduring the mental stress that goes along with this, they may not be sure if this is a valid or eligible reason in the eyes of the health and legal systems.[27] Lack of understanding of the legal framework is perpetuated when healthcare service providers themselves have knowledge gaps or overlook certain administrative and judicial decisions about legal abortion, imposing a restrictive interpretation of the three clauses established by Decision C-355. ED asked: *Chicas una pregunta hasta cuando semanas se puede realizar un procedimiento?* (Girls, a question up to how many weeks can a procedure be done?). Two commenters emphasized that there is no time limit in Colombia, while another commented to say that where they had their abortion, they were informed by their healthcare provider that it

[26] Referring to a brand name for misoprostol.
[27] A core value of reproductive justice (RJ) is the right to parent children in safe and healthy environments (Ross & Solinger, 2017) – if an individual feels that they are unable to do this and are forced to carry a pregnancy to term anyway due to structural barriers to safe abortion, this perpetuates marginalization and structural violence.

was up to ten weeks and six days (27b). This is an example of the erroneous information which can be shared by healthcare providers and accepted as fact due to their positions of authority.

Lack of clear information regarding the rights and responsibilities surrounding abortion access can evidently leave space for womxn to have their rights violated. For instance, AO asked if abortion has a jail term, whether they report it or not (45). LC responded and addressed the paradoxical existence of abortion as both a right and a crime in Colombia, while pointing out that the health exception can be taken advantage of to access an abortion legally. It emerged that AO was being threatened by someone informed about their pregnancy who claimed that they were going to put them in jail, a severe example of how lack of clarity surrounding the legal framework of abortion can make one vulnerable to having their rights violated.

It is evident that there continues to be confusion about the legal status of abortion, and the health exception and what it encompasses, in particular. This is notable considering C-355 has been in effect for more than a decade. Nandagiri et al. have described sustained lack of knowledge and information channels, in addition to abortion stigma, as forms of 'cultural violence' due to their ability to legitimize structural violence in the context of abortion (2020). It is in the context of this barrier that we can observe the utility of *ABORTO 🤍 COLOMBIA* which has grown to serve as an informal information network. Structural violence is made obvious when individuals and communities construct solidarities to resist and contest violent conditions. The numerous efforts of members of the Facebook group to address the prevalent lack of clarity surrounding the legal right to abortion has revealed how it serves as a barrier to their access. Indeed, it points to a theme regarding the landscape of abortion access in Colombia in terms of how womxn are navigating this through rights information-sharing on feminist networks like *ABORTO 🤍 COLOMBIA*, as will be explored in Section 7.3.

6.3 Geographic Barriers to Accessing Abortion

As has been highlighted in previous research literature across contexts, one's ease of access to legal abortion is often influenced by geographic factors, such as distance from cities. Based on posts contained in the dataset of *ABORTO 🤍 COLOMBIA*, it was confirmed that womxn located in small towns or rural areas may especially face challenges accessing abortion. For instance, HGL posted on behalf of the friend of their younger sister, who was having difficulty accessing a legal abortion:

> *yo tla dirigí allá, sin embargo es una niña de pueblo que difícilmente puede viajar a Bogotá y ya está haciendo lo posible para poder escaparse*
> *Lo que a mí me preocupa es que es menor de edad y no sé si tenga problema al momento de asistir sin sus padres...*
> I went there [Profamilia], but she is a small town girl who can hardly travel to Bogota and is already doing her best to escape.
> What worries me is that she is a minor and I don't know if she will have a problem attending without her parents.... (44b)
> *pues ella está intentando solicitar cita en profamilia y viajar a Bogotá y así realizar e procedimiento de manera segura*
> she is trying to request an appointment at profamilia and travel to Bogota to perform the procedure safely. (44ciii)

There are various mentions in the dataset of travelling to a nearby city to obtain a safe abortion (29e, 30, 44b, 57b). As discussed in Section 6.1, this can contribute to cost burdens of abortion. This echoes discussions of geographic disparities in past studies on abortion access in Colombia, as cities such as Bogotá have a concentration of reproductive medical services. Geographic disparities may be exacerbated by infrastructural limitations – for instance, Colombian abortion regulations necessitate facilities comply with specific requirements according to their level of complexity, ranging from primary-level to tertiary-level institutions. Once a pregnancy is more than 15 weeks, its termination must be performed at a facility with more complex infrastructure. Rural or remote areas are less likely to have facilities which meet these requirements for abortion care beyond the first trimester, which necessitates that womxn in

these areas may have to travel to obtain the service, costing money and time (Vivas and Valencia, 2020). Geographic barriers contribute to delays in accessing services which poses an emotional and physical burden, in addition to logistical complexities accessing abortion. Stigma surrounding late-term abortions, in addition to this, entails more challenges being granted lawful abortion. As highlighted by Viviana Bohórquez, a feminist Colombian lawyer, it can be extremely challenging for a womxn to get an abortion past 20 weeks of pregnancy in the country (Moloney, 2016).

Another factor impacting those based in rural or more isolated areas is less access to accurate information regarding the legal rights and responsibilities contained in Colombia's abortion framework. For instance, JM posted with their dilemma, stating specifically that they were eleven-and-a-half weeks pregnant therefore they could still have an abortion (even though there is no legal time limit in Colombia) "but I do not live in any city, I am in a small town."[28] The statement, "but I do not live in any city," indicates the understanding of abortion access being concentrated in cities. They stated that they were refused an abortion by their hospital as the doctors there were afraid to give the authorization and potentially go to jail. This displays a concerning lack of information regarding one's right to and responsibility to provide a safe abortion (in the case of the healthcare providers) and exemplifies the urgency of access to accurate information regarding one's right to abortion and the obligation of healthcare providers to ensure their access to it. Additionally, it points to how a dearth of available staff willing to provide abortion care at a facility can present a significant hurdle where the options of facilities are limited and proper protocol to conscientious objection are not followed. For instance,

[28] "*…pero no vivo en ninguna ciudad estoy en un pueblito…"*(8).

promptly referring a womxn to another healthcare provider willing to perform an abortion when conscientious objection is expressed.

It is worth pointing out that geographic marginalization is not restricted to rural areas, which is not significantly explored in previous research literature.[29] A womxn described their desperate situation and mentioned that they were located in Soacha, Bogotá – an informal settlement located at the south of Bogotá with limited infrastructure and one of the highest concentrations of internally displaced persons (IDPs) in the country (Donnell, 2017). DH wrote:

> hola chicas ...
> les quiero resumir mi historia, en este momento de mi vida estoy desesperada ya que tengo un embarazo no deseado producto de que fallaron las pasta anticonceptivas que uso , tengo 31 años con un hijo de 11 años , estoy trabajando y no cuento con apoyo de nadie , de verdad traer un bebe a este mundo a pasar necesidades es una irresponsabilidad ya que no tengo ni dinero ni tiempo para volver a empezar de cero , desde que supe por una prueba de sangre que estaba embarazada mis deseo son interrumpir el embarazo ya que no quiero ni deseo tener otro bebe , les escribo con el fin de una ayuda , ya que no consigo donde comprar ni quien me venda las misoprostol o citotec , estoy en bogota , soacha alguien que pueda ayudarme a conseguirla estaria agradecida
> hello girls ...
> I want to summarize my story, at this moment in my life I am desperate because I have an unwanted pregnancy due to the failure of the birth control pills I use, I am 31 years old with a son of 11 years, I am working and I have no support from anyone, truthfully to bring a baby into this world to spend necessities is an irresponsibility because I have no money or time to start from scratch, Since I learned from a blood test that I was pregnant my desire is to terminate the pregnancy since I do not want or wish to have another baby, I am writing for help, since I cannot find where to buy or who sells me the misoprostol or cytotec, I am in Bogota, Soacha someone who can help me get it would be appreciated.

Their location in an underserved and impoverished area of the city likely constrains their options accessing a legal abortion. In the situation of DH, financial, informational, and geographic barriers converge to hinder their access to a safe abortion, even in the context of a liberalized abortion regime.

[29] Aside from rural/urban divides, I came across a text addressing the geographic context of former conflict zones (Medicos sin Fronteras, 2019) throughout the review of literature. However, urban informal settlements were largely overlooked as a context to explore barriers to abortion within Colombia.

Another example of how these barriers can intersect is contained in a post from MJ, who writes on behalf of a friend that also became pregnant after a failed birth control method. MJ laments that where they are located, there is no Oriéntame and they were recommended to go to the nearby city of Dosquebras however, they could not afford the tickets and Profamilia did not respond to their messages. According to MJ, their friend did not know what else to do "but she needs to buy the pills at least" (*pero necesita comprar las pastillas por lo menos*) (30).

Evidently, womxn sometimes attempt to navigate geographic barriers to legal abortions by searching for medication to order or purchase in their local context to induce an abortion. This is reflected by numerous posts by womxn in *ABORTO 💝 COLOMBIA*, questioning where to buy pills – *pastillas*. Although medical abortion outside of the clinical context can be a safe means of ending a pregnancy, inadequate or inaccurate instructions or ineffective pills can lead to significant health complications. For instance, incomplete abortion, prolonged pregnancy, or even potential infection or morbidity due to remaining fetal parts (Gerdts et al, 2018; Gerdts et al, 2020; Sedgh et al, 2016). Indeed, a study on womxn's experiences using drugs acquired in the informal sector to induce abortion in Colombia found that womxn often receive incomplete information on how to properly and safely use misoprostol (Moore et al, 2021). In light of this, the various comments and posts outlining the protocol for properly self-inducing abortion with misoprostol were seeking to alleviate this common risk.

There were posts throughout *ABORTO 💝 COLOMBIA* wherein womxn had ingested the pills without clearly knowing how to use them, with one experience included in the dataset involving medical complications from an incomplete abortion (55). Risky situations which arise from desperation and lack of information such as these underscore a notion proposed by the conceptual lens of structural violence – that harm is caused when structural factors combine to

produce violent conditions within which womxn attempt to make their decisions (Nandagiri et al, 2020). While there are a range of ways which womxn may try to navigate geographic barriers for attaining a safe abortion, such as travelling to the nearest city or locating abortion drugs in their local context, it is clear that this involves an additional burden of some kind, whether it be financial, emotional, or physical.

6.4 The COVID-19 Pandemic & Barriers to Abortion

Including posts in the dataset from the first six months of the pandemic (March 2020 to August 2020) allowed observation of how certain barriers intensified and certain situations become more *desesperada* (desperate) for womxn seeking abortion in Colombia. Especially given how conditions imposed by the pandemic have affected circumstances that make pregnancies less feasible for some. For example, widespread loss of employment drastically affecting household finances and mental health, as well as lockdown measures potentially trapping womxn within abusive domestic environments (Gomez Sarmiento, 2020).

At the outset of the pandemic, the Colombian government assured the public of the continuity of voluntary abortion services. This was in the context of stay-at-home orders imposed in March 2020 which ultimately lasted until September 2020. In late March of 2020, Oriéntame launched a consultation service to be delivered via telephone and WhatsApp (the instant messaging smartphone application) to guide women on performing a self-managed medical abortion, within the situations permitted by law (Pilecco, et al., 2021). In cases deemed eligible, medication would be sent by mail. As innovative as this means of safe abortion provision is, it is likely not enough to overcome certain barriers for many womxn facing unwanted pregnancies– most clearly those living in circumstances where they lack access to a reliable mobile connection or device. Moreover, this service is only available for those with less than nine weeks of

pregnancy. For womxn with unwanted pregnancies farther along, this leaves limited options for navigating obstacles to abortion during the pandemic.

The extent of how barriers to access can overlap in the context of the pandemic was further conveyed by SPC, posting on behalf of their sixteen-year-old friend, and explaining that the nearest Profamilia and Oriéntame clinics were far from where they are located. Moreover, that due to the state of emergency they were unable to travel, and it was too costly for them to afford Oriéntame's telemedicine service. Due to these converging circumstances, SPC was asking where and how they could "get the pills" (32a). There are various other posts, between March 2020 and August 2020, where womxn sought to locate affordable pills to medically induce abortion themselves (39c, 41, 52, 54, 63) indicating their perceived limited options in the clinical context.

Notably, *Las Parceras*[30] *- Línea y Red Feminista de Acompañamiento en Aborto (*Feminist Abortion Support Network and Hotline) is feminist network which was recommended numerous times during the pandemic component of the dataset for their abortion accompaniment services (29a, 30a, 34b, 42a, 42c, 44bi, 59c).[31] Commenters shared that it was possible to download a private wire smartphone application to contact them and arrange a way to find a safe abortion. However, HGL pointed out that their friend was not able to download the application due to internet connection problems, which was also why they were posting on their behalf in the group (44ci). During the pandemic, reaching clinics such as Profamilia and Oriéntame or feminist networks like Las Parceras appears feasible with a mobile or internet connection, and with access to a device like a smartphone or computer. However, a significant portion of womxn in

[30] "*Parcero/a*" is a Colombian slang term for "friend," pointing to the network's function as a non-judgemental support and accompaniment network.

[31] This supports the point made by Pilecco et al, 2021, that difficulty accessing a legal abortion provided by the state has contributed to an increased demand for feminist organizations in the context of Latin America.

Colombia do not have consistent access to these amenities. As of December 2019, nearly half of the country lacked mobile internet access, as reported by Colombia's Ministry of Information Technologies and Communications (Gomez Sarmiento, 2020).

These circumstances also impact the ability of womxn to contest denials of legal abortion services in the context of the pandemic, due to the *tutela*[32] legal mechanism being moved to an online platform in July 2020. In response to an individual commending this move for enabling ease of access for womxn, WZ pointed out:

> *Tristemente si es un problema para millones de colombianas que no tenemos ni internet ni computador en nuestros hogares. Y mucho más para quienes ni siquiera saben usarlos.*
> Sadly, it is a problem for millions of Colombian women who have neither internet nor computers in our homes. And much more for those who do not even know how to use them (37n).

Even when one has access to mobile connection, there are numerous posts where womxn are unable to reach Profamilia (30, 42di, 44biv, 61) or Las Parceras on the phone (30, 44bii), with a commenter replying to a post in July 2020 that Las Parceras was receiving more than 25 calls a day at that point and advising the original poster to keep trying to call (30a). This points to how both established clinics and feminist networks have been struggling to meet the reproductive health needs of womxn during the context of the pandemic. Womxn's options pursuing safe abortions are contracting, especially for those who were already experiencing the brunt of structural inequalities in Colombia.

7 The Landscape of Abortion Access in Colombia Post-Liberalization

Throughout analysis of *ABORTO 🤍 COLOMBIA*, two notable themes emerged which appear to characterize the landscape of abortion access in Colombia, which will be discussed in

[32] Roughly translated as "guardianship" in English, the *tutela* is an accountability mechanism which is supposed to guard individual rights, as outlined by the Colombian Constitution of 1991. In the context of abortion, this legal instrument enables womxn to appeal for the right to attain an abortion through the judicial system when facing unjust denial.

detail below: (i) womxn's reliance upon the NGO private clinics, Profamilia and Oriéntame, to access safe and non-judgmental abortion care; and (ii) the utility of legal protections and knowledge of legal rights as a self-advocacy tool for ensuring access to abortion. Indeed, my analysis revealed the regularity of womxn sharing information about the legal right to abortion in order to support others in advocating for themselves. These two themes contribute to answering the second research question of how womxn are navigating ongoing barriers to abortion post-liberalization.

On the whole, these two themes are interrelated, and portray a context wherein access to legal abortion is not consistently guaranteed nor expected by many womxn in Colombia. Moreover, as I will delve into in the following sections, these themes exemplify how provider's attitudes and ideologies continue to influence the abortion-seeking process and place undue burdens on womxn navigating the process.

7.1 Reliance on Service Providers Perceived as Non-Judgemental: "Respetan más tu decision" [33]

When womxn posted asking where to access abortion, two names came up repeatedly in recommendations – Profamilia and, to a lesser degree, Oriéntame.[34] For instance, Profamilia is mentioned 77 times in the dataset and Oriéntame is mentioned 24 times. Both are major private, non-profit womxn's healthcare providers in Colombia. They were already established institutions for providing post-abortion care and contraception prior to 2006 and then took the lead in establishing clinical abortion services in several cities across Colombia when the law changed. The *Asociación Pro-Bienestar de la Familia Colombiana* (Profamilia) was founded in 1965 as an affiliate of the International Planned Parenthood Foundation (IPPF) to provide community-

[33] "They respect your decision more" (49d).
[34] Their names roughly translate into English as "Pro-family" (Profamilia) and "Guide Me" (Oriéntame).

based family planning services to womxn. Meanwhile, the Oriéntame Foundation was established in 1977 to provide comprehensive services for post-abortion care (de Hart et al, 2002). Prior to C-355, Oriéntame was crucial for treating womxn who were facing complications from unsafe abortions and unable to pay private doctors so that they would not be forced to go to public hospitals and risk arrest (Reproductive Freedom News, 1995). Notably, Profamilia and Oriéntame were also instrumental in ensuring that misoprostol would be registered for use in medical abortion and in introducing the use of mifepristone[35] in Colombia (Stifani et al, 2018). More than a decade later, a majority of legal abortions performed in Colombia take place in their clinics.[36] One can see how both providers have been able to establish legitimacy as advocates for safe abortion prior to and since C-355.

Throughout the numerous comments in *ABORTO* 💚 *COLOMBIA* referring to Profamilia and Oriéntame, a theme emerged regarding what precisely about these providers influenced womxn to repeatedly recommend them to one another, and what this might suggest regarding significant barriers to and expectations for abortion care.

Throughout the dataset, there was repeated reference to the clinics in the context of supportive care (2,4, 12a, 44d, 46a). Moreover, emphasis on how they are respectful of sexual and reproductive rights (4, 33b, 49d, 62bii). Commenters described them as offering 'better' or 'best' attention and service (12d, 17a, 17b, 33d, 37g, 37o, 46a, 62bi) and as guiding womxn through their decision and process, in the context of both abortion and sterilization (4, 17b). Additionally, they seemed to be perceived as a non-judgemental option, as exemplified by a post

[35] Medication used in combination with misoprostol to bring about the end of a pregnancy.
[36] According to statistics by the Health Department of Bogotá, 97% of abortions in Colombia are provided by these two clinics (62% by manual vacuum aspiration and 36% with medication) (Stifani et al, 2018).

where someone wrote on behalf of their friend seeking an abortion who was wary of judgemental doctors. Profamilia and Oriéntame were recommended by two different commenters (17a, 17b).

This appears to contrast with providers in the public health system, for which the expectations that they were more likely to present obstacles to abortion and to give *malas atenciones* – poor attention – was voiced. This was also evident in experiences of seeking sterilization procedures, as outlined in Section 8. For instance, in response to someone's enquiry if a particular EPS had an agreement with Oriéntame or Profamilia, AJ replied:

> *Hola si lo hay hice mi proceso así, sanitas me dio un mucho apoyo utilizo, lo bueno es que desde profamilia gestionan todo interne te para que tu no tengas que tolerar las malas atenciones de otros servicios.*
> Hello, I did my process this way, sanitas gave me a lot of support, the good thing is that from Profamilia they manage everything internally so that you don't have to tolerate the bad care of other services. (2a)

Given how some womxn described facing obstacles at various stages of the abortion-seeking process, such as when searching for a clinic or waiting for authorization from an insurance provider, this statement could be interpreted as referring to being exposed to less "bad care" at the hands of other individuals involved in the process. Namely, those who may carry their own biases against abortion or sterilization. Profamilia is seemingly perceived as a safe space for providing quality reproductive care. This could be seen in the support offered to a 16-year-old planning on being sterilized as soon as they reach legal age. They asked for advice as they were scared that if they resorted to a tutela to ensure that they receive the operation, it would be carried out incorrectly on purpose – "*puede sonar estúpido pero me causa pánico…"* (it may sound stupid but it makes me panic…). Someone else echoes this stress, saying:

> CB: *También vivo con ese miedo de que me hagan mal la operación apropósito.*
> *Y sería mejor ir a profamilia.*
> I also live with the fear that they will do the operation wrong on purpose.
> And it would be better to go to profamilia. (33c)

Another instance of how Profamilia is perceived as circumventing barriers imposed by institutions involved in the abortion-seeking process, such as insurance providers, is contained in the following comment:

> SA : *Lo mejor es que te comuniques directo a Profamilia, pues si consultas previamente a tu EPS lo más posible es que te pongan trabas, pero el ideal de Profamilia es distinto, respetan más tu decisión.* The best thing is for you to contact Profamilia directly, because if you consult your EPS beforehand, they will most likely put obstacles in your way, but Profamilia's approach is different, they respect your decision more. (49)

7.2.1 Respect for Sexual & Reproductive Rights

Profamilia was recommended more than once as a clinic which respects the definition of health as encompassing mental health when assessing eligibility for abortion. This is noteworthy given how a critique of Colombia's abortion policy has been that two of the three clauses can be difficult for womxn to prove to healthcare providers – namely, rape and risk to the mental health (González-Vélez & Castro González, 2021). As previously mentioned, some interpret the inclusion of mental health in the Constitutional Court decision as rendering abortion legal. This is due to the psychological implications and pressures that may come with *any* unwanted pregnancy or with forced maternity. However, this clause is subject to interpretation of the healthcare provider and sometimes this interpretation can be restrictive.[37] Profamilia, however, was perceived as more often taking the more holistic approach to health and granting abortion when it was requested. This approach is reflected in the experiences outlined in the following comments.

> JR: *a mi en Profamilia me dijeron que allá si tú vas y dices que quieres una interrupción y te la hacen eso es todo tu ere quien importa*

[37] A study on access to abortion under the health exception law included a significant quotation from an NGO partner in Colombia: "The barrier that we face is that in many places the woman cites the health exception and the response she gets from the service providers is: but you are not sick or you are not dying…In other words, a totally restrictive interpretation of the health exception" (Küng et al, 2018) .

> I was told by Profamilia that if you go there and say you want an abortion, they do it, that's all about you that matters (3g).
> RD: *En pro familia cuentan con una ruta de atención en aborto seguro, asesoría psicológica, medica y post aborto, las sedes de profamilia están por todo el pais, su linea nacional es (018000110900) reconocen que el aborto es un derecho y es legal en Colombia, en su página web puedes pedir una cita*
> In Profamilia they have a safe abortion care route, psychological counseling, medical and post abortion, the headquarters of Profamilia are all over the country, their national line is (018000110900) recognize that abortion is a right and it is legal in Colombia, you can make an appointment on its website (4).
> SAM: *en el caso de riesgos para la salud física y psicológica de la mujer aplica el que un embarazo no sea deseado puesto que este trae bastantes implicaciones para la vida de la mujer... Por esta razón Profamilia se convierte en una opción legal y segura.*
> in the case of risks to the physical and psychological health of women, that applies to an unwanted pregnancy since it has enough implications for the life of women... For this reason, Profamilia becomes an option legal and secure (4aii).

The expected ease of access at Profamilia compared to other clinics is indicated by the response to someone asking about alternative solutions in the case where clinics which provide abortions safely and legally charge a high amount, as their EPS does not have an agreement with them. One of the commenters recommended :

> AR: *Pues te toca mentir es la única ir a 71rofamilia* [Profamilia] *decir que estuviste en una discoteca u que cuando saliste alguien abuso de ti que no dijiste nada por vergüenza y que ahora estas embarazada y no lo quieres tener es la única manera que te lo realicen de una manera no tan costosa*
> Well, you have to lie, it is the only way to go to 71rofamilia and say that you were in a discotheque or that when you went out someone abused you and you didn’t say anything out of shame and that now you are pregnant and you don’t want to have it, it is the only way to have it done in a less expensive way (1d).

Notably, Profamilia is recommended more than once with the specification that they do not require authorization from the parents of the patient. This suggests that this is perhaps a bureaucratic barrier that some womxn seeking abortion might face or expect. For instance, someone posted on the behalf of a classmate who was pregnant and looking to abort without the knowledge of their mother. SA responds:

> *Profamilia es la opción más segura.... Y puede resultar gratis si su EPS tiene convenio... No necesita autorización de sus papás ni nada*
> Profamilia is the safest option. .... And it can be free of charge if your EPS has an agreement... You don't need authorization from your parents or anything (11a).

AL echoes this recommendation, stating that in Profamilia, they do the procedure without requiring the need of parental authorization (11e). Requesting the authorization of parents to carry out an abortion for someone 14 years or older constitutes the violation of the right to privacy and autonomy, as highlighted on Profamilia's website.

Despite these positive expectations of care, it is apparent that Profamilia is not always without barriers. Healthcare providers at Profamilia are also capable of imposing their own views on patients. For instance, a womxn wrote in response to questions about where someone could access tubal ligation said:

> *En profamilia se supone pero prepárate para el sermón de tu vida* 🙄[38] *y que no te la practiquen eventualmente*
> In profamilia you are supposed to [be able to access tubal ligation] but prepare yourself for the sermon of your life [eye-rolling emoji] and to not have it practiced eventually (49a).

Additionally, another person shared how their friend requested a sterilization and was denied by a doctor at Profamilia and offered an appointment for an intrauterine device (IUD) instead. When AGA responded that this is illegal and asked whether they denounced it, MD replied:

> *yo sé yo le dije lo mismo pero ahí entramos a lo de siempre ... nadie se atreve a exigir. Que rabia y fue en profamilia* 🤬
> I know, I told her the same thing, but that's where we get into the same old .... no one dares to demand it. What a rage and it was in Profamilia [swearing, enraged emoji]) (28aii).

[38] *Emojis*, graphic facial expressions which can be embedded in text communications on Facebook, are included and described in relevant comments due to their capacity to provide emotional information which otherwise would be found in traditional face-to-face interactions, such as tone of voice (Tannen et al, 2015).

In this particular case, it is unclear whether there were other potential factors which contributed to the commenter's friend being denied a tubal ligation, such as their age. This highlights a limitation of this source of data whereby context in shared anecdotes may sometimes be missing. Nevertheless, in both cases, surprise or disappointment is expressed at denial occurring at Profamilia which points to its broader reputation as a safe space for respecting sexual and reproductive health rights.

7.2.2 Supportive Abortion Care

Profamilia and Oriéntame were frequently recommended as providing the best service, which many seem to define in terms of supportive care, as both are mentioned as accompanying womxn through their decision. For instance:

> PVP: *En orientame es muy buena atención y te acompañan en todo, el costo pues varía y pues miran tu situación cuanto podría costar. Es muy bueno y te ayudan a planificar de una vez*
> Orientame offers very good attention and they accompany you in everything, the cost varies and they look at your situation and how much it could cost. It is very good and they help you plan at once (17b)
> AM: *hola es súper seguro y legal, allá te explican todo. Personalmente lo recomiendo, más que cualquier otro lugar*
> hello it is super safe and legal, they explain everything there. Personally I recommend it, more than any other place. [in reference to Orientame] (29ciii)

Both Profamilia and Oriéntame appear to endorse informed decisions regarding abortion, offering comprehensive information on their websites and during appointments. For instance, counselling is a central part of abortion care at these private clinics. Counselling has been identified as a key aspect of quality abortion care as a means for women to "receive accurate information regarding the abortion procedure, to understand their legal rights and to discuss personal, emotional and social issues they experience throughout their abortion experience" (Cockrill and Gould, 2012; Joffe, 2013). It also serves to reinforce the legitimacy of abortion

procedures, addressing women's fears about safety and legality and subsequently reducing internalized stigma (Keefe-Oates, 2020).

When taken on its own, this theme may not be novel in terms of assessing the landscape of abortion access in Colombia. However, in relation to other emerging themes of the dataset, the finding that womxn in ABORTO 🤍 COLOMBIA frequently rely on and recommend these two private abortion providers due to their reputation of respect for reproductive rights contributes to an understanding of barriers to safe and respectful abortion care in Colombia and how womxn navigate this.

This theme seems to point to how fear of perceived stigma[39] in the public health system may also be a tangible concern which affects womxn's decision-making when it comes to deciding on pathways to abortion. This fear of judgement or discrimination from healthcare providers based on abortion is further underscored by the several posts identifying a fear of healthcare providers knowledge of past abortions. Namely, expressed concern about whether doctors would be able to notice during medical examinations whether they had an abortion in the past or about disclosing to their doctors that they had an abortion in the past (23, 23a, 31, 31a). The responses to these posts and comments largely sought to reassure one another and assuage these concerns. For instance, ESR stating in response: *No hay forma. Y si la hubiera, ¿y? Son doctores, linda. Ellos viven en un día día donde frecuentan pacientes con esa realidad.* (No way. And if there was, so what? They're doctors, honey. They live in a day where they frequent patients with that reality.) (31d).

These concerns regarding perceived stigma within healthcare settings may be a factor driving womxn to pursue the services of abortion providers such as Profamilia and Oriéntame,

[39] Namely, how an individual perceives other people's attitudes regarding abortion and how this affects their expectations for judgement, rejection or discrimination due to these attitudes (Cockrill et al, 2013).

who are mostly mentioned in the context of supportive and non-judgemental care, and respect for individual rights. Each provider, at least according to reputation, seem to avoid the barriers that many womxn in the group voice concern about. For instance, they appear to present less bureaucratic obstacles, and they support in planning and decision-making. In essence, they seem to foster an environment which respects womxn's autonomy and individual situations. This womxn-centred approach is something which may be lacking in some spaces throughout the public health system in the context of abortion, at least according to the perceptions and experiences of womxn in this group.

While Profamilia and Oriéntame are valuable as trusted providers of safe abortion or sterilization services, an issue lies in the fact that they are not consistently reachable for womxn in Colombia, with locations in specific cities that are perhaps less reachable for womxn in rural areas, for instance.[40] Additionally, as they are both private health institutions, there may be uncertainty among womxn about whether they have the ability to afford the services at either clinic, as reflected by numerous womxn posting to ask this (discussed in Section 6.1). If womxn do not feel secure requesting an abortion at a different provider, perhaps fearing exposure to stigmatization, this limits their options when facing an unwanted pregnancy. The fact that safe abortion and quality care appears to be more readily accessible in private clinics compared to public facilities can also be interpreted as reflective of stigma not only related to abortion, but also surrounding poor womxn and womxn of minority groups who are more likely to rely on the public health system (Castro, 2019). This arguably reflects a discriminatory legal regime in the

[40] As of 2021, Oriéntame has ten clinics in the cities of Bogotá (4), Dosquebradas (1), Barranquilla (1), Medellín (1), Cúcuta (1), Villavicencio (1), and Ipiales (1). All the clinics offer medical abortion, counselling for unwanted pregnancies, and post-abortion care, however, only three offer surgical abortion services with two of those being in Bogotá. Meanwhile, Profamilia has clinics which provide abortion services in 24 cities across Colombia, but their website does not specify at which medical abortion or surgical abortions are available.

sense that, wherein the three exceptions criteria are inconsistently implemented in the public health system, women of higher socio-economic status are able to access abortions more easily from private doctors. This underscores how abortion access is a matter of social inequality, and thereby injustice.

7.3 *Use of the Law as a Shield: "La ley protege tu decisión"*[41]

As highlighted in previous research literature and in my own research findings, lack of information regarding one's rights to abortion has been identified as a significant barrier to pursuing and accessing it. This has not been helped by misinformation efforts by institutional activists such as anti-abortion State officials following Decision C-355, who purposefully sought to obscure access to accurate information regarding abortion from both healthcare providers and abortion-seekers. Within the dataset, and beyond the selected time span, I observed multitudes of posts and comments seeking to clarify the costs, insurance coverage, location, safety, and legality of abortion. It is arguable that lack of knowledge of these elements of accessibility add extra time, stress, and uncertainty when facing an unwanted pregnancy. Notably, I also observed numerous responding comments emphasizing the legal rights of the womxn, and legal obligations of healthcare or insurance providers; reassuring one other based on the existence on these rights; and encouraging the use of these rights as a tactic to pressure healthcare or insurance providers into giving them access to desired procedures. What is compelling about this theme is not merely the laws and legal protections themselves but how womxn are using and applying them in navigating barriers to abortion, speaking to the second component of my research questions.

[41] "The law protects your decision" (32h).

It is apparent that many womxn rely on knowledge of laws and regulations as a tool for self-advocacy in their pursuit of reproductive health services. This seems to offer a means of protection against unjust barriers expected or imposed by healthcare providers or institutions. Furthermore – this points to how legal protections can counter the normalization of barriers constructed by healthcare providers and contribute to holding not only healthcare providers accountable for obstructing access to abortion or sterilization, but also institutional figures such as judges or insurance providers. However, it can also be argued that these legal protections should not have to be resorted to in the first place.

7.3.1 Being Informed About Legal Rights as a Self-Advocacy Tool

Ignorance of the law can enable abuse of the law by healthcare providers, which many in the group attempt to resist by informing themselves of the law beforehand. There are various references to being "prepared" and arriving to appointments "informed," in the case of possible resistance from healthcare providers. This theme was prevalent in the context of both sterilization and abortion.

For instance, someone outlined, step-by-step, how they obtained a sterilization operation. The individual identifies that the time and effort put into creating and sharing the post with others in the group was motivated by the fact that: "…when I had this procedure done, I realized that people don't really know their rights and I personally was led to believe that I couldn't have it done."[42] Notably, one of their recommended steps included: "3. I printed out the law and the letter of consent (in case I ran into another doctor who wanted to deny me my rights, but fortunately did not need them)"[43]. This highlights a lived experience of being misled about one's

[42] *Hago esta publicación porque al realizarme este procedimiento me di cuenta de que la gente no conoce realmente sus derechos y a mí personalmente, me quisieron hacerme creer que no me lo podía hacer.* (7)
[43] *3. Imprimí la ley y la carta de consentimiento (por si me topaba con otro médico que me quisiera negar mis derechos, pero no las necesite afortunadamente)* (7)

legal rights and learning from one's experience to recommend preparation and knowledge as a tool for navigating potential barriers.

Another womxn told of an experience requesting a tubal ligation and being mocked and denied by the doctor due to their age (20 years) and lack of children. BQ said that: "Thanks to everything I have read in this group I was informed and I already knew that they do it."[44] Nevertheless, they describe how the doctor reacted to being told this in a negative way while forwarding the request to the gynecology office, as well as a request for oral contraceptives. BQ then asked the members of the group what they should say during their gynecology appointment, as "with the attitude I saw today from the doctor (…) I know that this procedure is going to be long and stressful." (13)

The responses to this post further reflected the value placed on knowing one's legal rights. For instance, ESR explains how the "*El mero derecho del libre desarrollo de la personalidad…" (*the mere right of free development of personality) is a fundamental right that entails that in this particular situation, they do not require anyone's signed consent "since you have determined that you don't want children and that's it."[45] Additionally, ML claims that this is what "they," assumingly referring to healthcare providers, say to "manipulate" patients who want to pursue surgical sterilization and that the poster must let them know that "there is a law here!" (13e). Someone else recommended following the advice of the "*compañeras"* (comrades) and to bring a copy of the decree printed out and to threaten to submit a complaint to the health secretary (13fiv).

While it appears reassuring for many womxn in the group that the law contains protections and mechanisms of accessing abortion in the situation that it is denied to them, it is

[44] *… gracias a todo lo que he leído en este grupo me informé y ya sabía que si la hacen…* (13)
[45] *… ya que has determinado que no quieres tener hijos y listo* (13a)

apparent from quotations such as the above that along with this, there is an apparent expectation of having to use the knowledge of legal rights in a forceful or litigious manner.

> IS: *Ley 1412 de 2010 dice que el único requisito para acceder a eso es tener 18 años, no se la pueden negar. Tiene que ir con la ley en la mano y decir que si no se la hacen los entutela.*
> Law 1412 of 2010 says that the only requirement to access this is to be 18 years old, it cannot be denied. You have to go with the law in your hand and say that if you don't have it done you will be put under tutela (28d)
> MR : *Te aconsejo que te asesores muy bien, hay una ley con la que puedes presionar, toda mujer mayor de 18 años tiene derecho a realizarse este procedimiento y si sientes que están vulnerando ese derecho puedes demandar. Presionalos de esa forma y estoy segura que no te joderan.*
> I advise you to get good advice, there is a law that you can use to add pressure, every woman over 18 has the right to have this procedure done and if you feel that this right is being violated you can sue. Pressure them in this way and I'm sure they won't screw you over (49e).
> AJ : *Te aconsejo qué llegues bien informada y dispuesta a amenazar con demandar a quién sea, has valer tú derecho, un abrazo desde Pasto.*
> I advise you to arrive well informed and ready to threaten to sue anyone, you should assert your right, a hug from Pasto (49f).

Notably, Law 1412 of 2010 is mentioned in two other posts in the context of assuring womxn of their right to sterilization if above the age of eighteen (7, 37b). This further reflects how womxn employ rights discourse and information-sharing to counter resistance and to reaffirm their rights to one another and in healthcare settings.

7.3.2 Alternative Methods of Obtaining Desired Reproductive Health Services

Womxn also resort to alternative legal mechanisms to circumvent barriers to obtain requested reproductive services. For instance, the tutela legal mechanism was repeatedly mentioned and recommended for use when facing unjust obstacles to abortion within health institutions (3h, 8, 9a, 10, 22b, 28bii, 37a, 37b, 37h, 49b, 49i). Also, seeking legal recourse from institutions such as the Gender Office of the Ombudsman's office (22b) or filing a complaint with the National Superintendent of Health (commonly referred to as the "*Súper Salud*"), the entity responsible for enforcing compliance with health system regulations (35b, 37d, 59d). This

was largely recommended as a last resort when womxn were facing delays or denial from healthcare or insurance providers, or in anticipation of this occurring.

While filing a tutela or official complaint may serve as an effective tool for applying legal pressure and pursuing one's legal right to a particular service, this is a process which costs time and money and encumbers womxn to fight for a reproductive service they may already have the right to. Moreover, some womxn suspect that this may place their chances in the hands of other institutional actors who may also hold biases. As outlined by someone (AMRM) in a comment: "I do not recommend filing tutelas... sometimes judges are more conservative and anti-rights; besides, each tutela opens the door for the court to review issues already resolved..."[46] This indicates a worry that each tutela will expose established rights to further examination and potential retreat.

Tutelas were also recommended numerous times in the context of sterilization. The context of filing a tutela in the case of abortion is somewhat more urgent, however, given its time-sensitive nature. Womxn should not have to turn to the potentially arduous process of navigating the legal system and bureaucracy and exposing themselves to potential further biases, to affirm their legal access to abortion. As pointed out by a commenter, ESR: "The problem with abortion is that there is no time for countermeasures. While they are answering my tutela, I am 16 weeks along."[47] This also has detrimental consequences since delays in accessing abortion contribute to risk to the womxn's life and health as while fetal size increases, so does the risk of complications (Mizana et al, 2020). Subsequently, provider attempts to delay access to lawful abortion for womxn also delays access to safer abortion services.

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[46] *"No recomiendo poner tutelas... a veces los jueces son mas conservadores y anti derechos; ademas cada tutela abre la puerta para que la corte vuelva a revisar temas ya resueltos..."(22ª).*

[47] "*Es que de puertas para adentro siguen haciendo lo que quieran y el problema con el aborto es que no hay tiempo para las contramedidas. Mientras me responden la tutela, tengo 16 semanas." (3e).*

The pursuit of lawful abortion and sterilization was repeatedly framed and understood as a 'fight' throughout posts in ABORTO 🤍 COLOMBIA, even in cases where it was lawful. Ultimately, this theme reflects a contradictory relationship with reproductive law and rights in Colombia. Womxn often rely on the existing legal system as a tool to protect and safeguard their right to controversial reproductive health services such as abortion and female sterilization. Meanwhile, these rights are subject to interpretation in terms of their meaning and applicability by those who act as gatekeepers to these services. As argued by Colombian reproductive rights advocate and researcher, Ana Cristina González-Vélez, under the indications regime, doctors, administrators, and judges play a regulatory role. They act as "moral entrepreneurs" who use their power to impose and normalize their personal judgments through discourse and practice—essentially, to impose their own moral views through the provision of services (2018). The prevalence of this, and the understanding of this as unjust manipulation, is reflected in the following comment:

> LC: *hay que pelear por un derecho básico como es el decidir cuantos hijos tener o en este caso no tener. En nuestra constitución está escrito que podemos decidir pero al momento de elegir no tenerlos nos ponen peros. Es anticonstitucional y muchas veces quedó impune porque nadie se atreve a denunciar. Pero yo no voy a dar mi brazo a torcer.*
> we have to fight for a basic right such as the right to decide how many children to have or in this case not to have. In our constitution it is written that we can decide but at the moment of choosing not to have them they put obstacles in our way. It is unconstitutional and often goes unpunished because no one dares to denounce it. But I am not going to give my arm to twist. (28cv)

The indications regime in Colombia entails that abortion access can be highly variable as it is subject to interpretation of healthcare providers. This can mean that abortion is more difficult to access in some contexts or, in provider settings such as Profamilia and Oriéntame, can actually enable the advancement of clauses like 'risk to health.' Nevertheless, this inconsistent interference in womxn's decisions constrains their reproductive health options, or

expectations of care, which links this situation to the notion of structural violence in terms of restricted choices and autonomy.

8 An Unexpected Finding: Unjust Barriers to Female Sterilization

Notably, numerous posts and comments contained in the dataset mentioned instances of unjust barriers being placed by healthcare or insurance providers before other forms of reproductive healthcare services. Specifically, against tubal ligation, *trompas ligaduras,* a surgical form of female sterilization which closes, cuts, or ties the fallopian tubes.[48] This was an emergent theme which I had not considered prior to data collection but that surfaced continuously throughout the preliminary scan of data and underscored how contentious gendered expectations of motherhood abound in healthcare settings. The fact that this issue repeatedly emerged in a group dedicated to abortion rights, suggests that it is not only in the realm of abortion care where womxn's reproductive autonomy is limited but that broader issues exist when it comes to reproductive justice in Colombia. This unexpected finding points to the fact that abortion rights do not exist in a vacuum. If there are unjust barriers placed before abortion which are linked to its stigmatization, it is logical that this manifests in attempts to obstruct womxn's attempts to assert reproductive autonomy as they pursue other sexual and reproductive health services.

Sterilization, like abortion, has historically been surrounded by moral and ethical disputes, such as religious opposition, which contribute to its controversy as a family planning method (Lawrence et al, 2010; Leite et al, 2004). As highlighted by Eve Patil and Jeffrey T. Jensen in their discussion of this topic in the context of obstetrics and gynecology, the term

[48] Tubal ligation is referred to numerous times as "Pomeroy" in the Facebook group, which refers to one of the most common surgical methods of tubal ligation.

'sterilization' can evoke an involuntary or coercive process (2015), especially in the historical context of Latin America.[49] They propose the term "permanent contraception" as an alternative which considers a womxn's active and informed decision to conclude childbearing. "Voluntary sterilization" is another possible differentiation used in literature. I want to acknowledge the alternative language for this procedure and its relevance, however, as the womxn in the context of this Facebook group themselves freely employ the term "sterilization," or "*esterilización*," I will continue to use it throughout this paper.

The increasing use of sterilization as a method of contraception in Colombia, identified over the course of 2005 to 2010, has been identified as a "concerning trend in light of historical concerns about coercive sterilization practices occurring in Colombia" (Folch et al, 2017). However, personal discussion of sterilization in the context of this Facebook group seem to reflect the choices of womxn themselves to pursue this service for their own personal reasons. It is noteworthy that sterilization has historically been targeted at marginalized womxn in Colombia in a coercive manner yet when womxn are choosing to access this service through the healthcare system of their own accord and autonomy, they face obstruction. This speaks to how the reproductive roles of womxn, particularly marginalized womxn, continue to be subject to governance and judgement.

As highlighted by Luna and Luker in their examination of the development of reproductive justice movement, by examining the reproductive disciplining some groups experience, we can also highlight the reproductive privilege of others (2013, p.328). This speaks to the idea of stratified reproduction, wherein women have historically experienced reproduction

[49] For instance, in Colombia, forced sterilizations carried in the context of armed conflict. Forced sterilizations, in addition to rampant sexual violence and forced abortions, were a widely documented violation of reproductive rights systemically carried out by military guerilla groups such as the Revolutionary Armed Forces of Colombia (FARC) (Human Rights Watch, 2016).

differently according to the intersection of their identity positions of race, class, gender, age, and sexual identity (Colen, 1986). This can also be interpreted as the different 'worthiness' that society assigns to women and their reproductive processes (Castro, 2019). In the context of sterilization, it would appear that womxn are likely to be deemed more suitable or 'worthy' of accessing this procedure once they've already fulfilled their social obligation of producing children.

In Colombia, the only legal requirement for access to sterilization is to be of legal age, 18 years old. Law 1412 of 2010 frames tubal ligation, in addition to vasectomies, as a means of encouraging responsible parenting which is to be authorized for free. Nevertheless, provider resistance to tubal ligation appeared in various womxn's experiences shared in the group. For instance, womxn receiving misinformation from healthcare providers regarding the right to access the procedure, such as being told that they were too young (7a, 13, 13d, 28a, 28f, 37), even when of legal age, or that they must have a child before being able to access this health service (7a, 12b, 13, 28f). Both of these reasons speak to a deficient respect for or, at least, a discomfort with womxn's bodily autonomy, especially when it comes to making a decision which contravenes societal expectations of motherhood. Moreover, gratuitous requirements imposed by healthcare providers reproduces stigma surrounding this service as it conveys an implicit distrust of womxn's decision to not have children.

The potential for these stigmatizing attitudes to influence a doctor's decision to deny or obstruct access to a sterilization is exemplified by an anecdote shared by a commenter in response to a post from someone considering tubal ligation who wanted to hear the experiences of other people and whether they had faced any challenges in accessing the service. In the responding comment, OU described how they ultimately had no problems accessing the

procedure, but added that their doctor had helped them to fill out the form for the procedure and had purposely added extra information not technically required:

> *…pusimos que mis papás estaban de acuerdo (que no) y que mi pareja también (nisiquiera tenía pareja en ese momento) pero fue precisamente porque el me dijo que así sería más díficil que médicos más conservadores me la negaran o pusieran problema …*
> …we put that my parents agreed (no) and that my partner also agreed (I didn't even have a partner at that time) but it was precisely because he told me that this way it would be more difficult for more conservative doctors to deny me the procedure or to make a problem… (22)

The notion that the permission of a womxn's parents or male partner regarding a decision for their own body could improve their chances of not facing resistance, as explicitly stated by a doctor himself, is striking. Moreover, it is indicative of the persistence of the archaic perception of female members of society as property of their parents or male partner. In the context of the healthcare institution, this blatantly disrespects womxn's right to reproductive autonomy. OU could be perceived as privileged to access the 'insider' perspective of their doctor who appeared to have their best interests in mind, however problematic their way of ensuring this was. Not every patient is comfortable, or even encouraged by a figure of authority, to lie when faced with unreasonable pressure or questions such as these. This expectation can place womxn in an uncomfortable situation to navigate and problematically situates their relationship context, specifically having a male partner, as an identity position which holds advantage in accessing certain reproductive health services.

Similarly, ESR shared the anecdote of a friend who wanted to have a sterilization procedure following their second child. The clinic allegedly asked for a signed consent from her husband. While the friend had no issue with asking her husband for a signature, she filed a tutela nevertheless as, "the policies of a company cannot be above the rules of the law" (3e). While the friend chose to utilize the tutela mechanism to hold the clinic accountable, they could have provided their partner's consent with ease and accessed the service, while someone without a

partner would potentially face a more complicated situation. This tangible or felt expectation places unjust pressures on womxn attempting to access a service they legally have the right to.

The influence of certain identity positions while accessing sterilization procedures in Colombia is further underscored by a different comment thread, initiated by a post asking about others' experiences with tubal ligation. The original poster (LC) replied to a comment with a follow-up question, asking if it is likely that if one pays for the procedure, the healthcare provider would not "*ponen tantos peros?*" – put so many "buts"? Essentially, the post asks whether healthcare providers would object less if a patient paid out-of-pocket for the procedure as opposed to relying on public health insurance coverage. This question suggests an underlying expectation of better access to care if one has the means to pay for it. A commenter (ML) replied:

> *Claro que si! Y ps he conocido chicas que pagaron se operaron super fácil! Y tambn he conocido chicas que pagando abortaron fácil y rápido! Yo estaba dispuesta a pagarla sino me la hacían gratis, pero bueno me la hicieron gratis! Igual iba a peliar y a discutir en caso tal no me la quisieran hacer, pero no fue necesario porque todo salio relax!*
> Of course! And I've known girls who paid and they had the surgery super easy! And I've also known girls who paid to have abortions easily and quickly! I was willing to pay if they wouldn't do it for free, but they did it for free! I was still going to fight and argue in case they didn't want to do it, but it wasn't necessary because everything went smoothly! (28fiii)

This response underscores the belief that if one has higher socioeconomic status, they are less likely to face resistance to accessing more stigmatized reproductive health services. This perception has grounds in reality as Paula Avila Guillen, a Colombian human rights lawyer, has critiqued the current legal system as discriminating against "poorer women who rely on the public health system" where the three-exceptions abortion law is inconsistently implemented, while rich women can access abortions more easily from private doctors (Nugent, 2020).

In another comment thread, NA reiterated the notion that the public health system tends to have more doctors who will unjustly deny the sterilization procedure:

> *Pero tú puedes ir a profamilia (si tu eps tiene convenio con ellos) y solicitar la cita. Lo recomiendo mas por profamilia porquebpor las eps suele verse mucho médico que te la niega por joder aun cuando no pueden hacer eso.*
> But you can go to Profamilia (if your EPS has an agreement with them) and request an appointment. I recommend it more by Profamilia because the EPS usually has a lot of doctors who deny it to you for shit, even though they cannot do that (26aiii).

Additionally, a commenter (SA) providing advice to a self-identified 18-year-old curious about sterilization procedures also claimed that EPS would put obstacles in their way, while Profamilia would be more likely to respect the decision of the individual (49d). This touches upon a reason why private clinics such as Profamilia may be preferred by those seeking more contentious reproductive health services, as outlined in Section 7.2. A commenter, LB, shared their experience wherein they consulted their EPS, attended "all the appointments," but was ultimately denied the operation due to their age. As they stated, "… *a partir de eso se ha vuelto toda una situación muy tediosa con la EPS"* (… from that point on, it has become a very tedious situation with the EPS) (49c).

Notably, there is an evident expectation of resistance from healthcare providers when seeking this service. Numerous posters recommended that womxn arrive to their consultation well-informed and prepared to fight for their right and to resort to legal measures if necessary. A womxn shared their personal experience (in response to two separate posts) resorting to these tactics which ultimately 'worked,' after a drawn-out process. However, they described it as an unpleasant experience:

> WZ: Get pissed! it's the law, it's your body and your right, that's how it was for me, every time I went into a clinic, I told them very seriously and without beating around the bush: "well, I'm here to get authorization from the pomeroy, if I don't have your authorization in 15 minutes when I leave here, I'm going to tell them". I did not give them room to interfere, whatever they told me I answered them: "that is your opinion not mine, it is my decision and I thank you for not interfering, or are you going to be in charge if I get pregnant? (And so it worked, it was 6 months from appointment to appointment) I did not have to go to court. It is sad that even for this it is necessary to have guts (37l).

> Free in the eps, I had the Pomeroy, which is to cut the tubes.The first time a social worker of the eps told me that they did not operate without children, which I believed, but then I realized that it is a lie, by law they must do it if you are of legal age even if you do not have children. Then when I arrived with that argument the gynecologist sent me back to planning, which is also a mistake, since they were sending me back in the process, the gynecologist who treats you is the same one who operates on you and they do that because they do not want to. A doctor can refuse but not the eps. But finally the lady who attended me in planning gave me the names of the professionals who are in favor of the Pomeroy, from then on I had to not believe them at all and every time an appointment came in I told them, I am coming to get the order of the Pomeroy if you do not give it to me in 10 minutes, the tutela, they sent me to a social worker and a psychologist. The process lasted 6 months, and even on the day of surgery being without clothes ready on the stretcher, several nurses and the same doctor came to ask me if I was sure. It was horrible, I had to be very serious and aggressive, since I was tired of giving explanations (12b).[50]

This person's shared experience reveals how womxn can be passed from professional to professional, with seeming little regard for any stakes in their situation. As WZ points out, they felt that they had to have "guts" and to display aggression throughout the process in order to be taken seriously and to eventually attain the procedure. Moreover, it conveys how their choice was repeatedly distrusted and questioned by the healthcare providers they encountered, and their autonomy overrode. These aforementioned experiences also seem to reflect an abuse of power or, at very least, a problematic patient-doctor dynamic in which healthcare providers utilized their positions of authority to impede their patients' decisions.

The connection between female sterilization and abortion both being reproductive healthcare services which transgress ideals of motherhood, thereby traditional ideals of femininity, while facing routine institutional resistance is clear. This recurring theme found within the Facebook group reinforces the notion that stigma surrounding abortion stems from the fear of womxn exerting reproductive autonomy and resisting entrenched gendered expectations of motherhood. Cook and Dickens (2014) echo this in their research on Reducing Stigma in Reproductive Health, pointing out how stigma surrounding women's sterilization stems from its

[50] See Appendix B for original Spanish text.

perception as “their dishonourable denial of the duty and virtue of motherhood.” This overlaps with stigma surrounding abortion which, as articulated by Kumar et al (2009) in their conceptualization of abortion stigma, may stem from the perception of choosing to abort a pregnancy as an assertion of women’s “moral autonomy” that is deeply threatening to social norms. Womxn who seek abortions, either clandestinely or through formal health systems, may be perceived as challenging the inescapability of motherhood and ‘defying reproductive physiology’ (Kumar et al, 2009). This root cause of abortion stigma is applicable also to the context of sterilization, as a definitive choice to not produce children.

9 Conclusion

The title of this thesis makes reference to a post included in the research dataset, extracted from a feminist Facebook group that serves as an abortion information-sharing and support network for womxn based in Colombia – ABORTO 🤍 COLOMBIA "SOMOS LA RESISTENCIA👽” This particular post caught my eye as the author deftly criticized the double standard and depoliticization perpetuated by discourse comparing a womxn’s decision to terminate her pregnancy with a man’s decision to abandon his family. In their post, they articulated how the choice to abort compromises one’s body and inner peace, if temporarily, but that in the end it is a choice which entails taking conscious responsibility for one’s own life and the potential life growing within them. It is a decision based on one’s “desires, plans, opportunities and resources” (CS).

I respected this post for compassionately capturing the nuance behind a personal choice which has long been demonized, along with the womxn making it. Historically, womxn have been made to shoulder the burden of this decision in addition to the judgement, criminalization,

and vitriol that has come with it. This has been sustained by structures like organized religion and oppressive gender norms, as exemplified by the context of Colombia.

While legal reform expanding reproductive rights, like decision C-355 of 2006, are certainly worth celebrating, they evidently should not be the final goal for ensuring reproductive justice. When these rights exist in the context of profound inequality, across lines of gender, sexuality, race, ethnicity, class, and more – they will not be met consistently. The functions and very existence of ABORTO 💟 COLOMBIA reveal these structures of inequality in action by expressing barriers to reproductive justice that womxn endure through the recurring questions and concerns that they share in search of support. By circulating pro-choice and feminist commentary and advice, the administrators and numerous members of the group are actively countering stigma surrounding abortion and reinforcing the legitimacy of the personal decision to undergo procedures such as abortion or sterilization. This thesis emphasizes that this Facebook group represents a counterhegemonic space where womxn are resisting oppressive power dynamics in their emphasis on compassion surrounding the decision to abort and condemning discrimination when they face it within health, legal, and social institutions.

This thesis has sought to further understanding of the landscape of legal abortion access in Colombia, in the specific context of a liberalized abortion regime. Throughout interpretation of data and emerging themes, it became apparent that these findings could be grounded in the theoretical framework of abortion stigma. Stigma is not universal and manifests in various ways at different levels. This thesis research lays bare structural stigma, defined by Mark L. Hatzenbuehler (2016) as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized." In this case, the

stigmatized are those who pursue abortions or female sterilization in Colombia, particularly poor, childless, and/or young womxn.

The findings of this thesis research were divided into three analytical sections. The first addressed the major barriers to legal abortion in Colombia, categorized into financial, informational, and geographic barriers. These are barriers which are disproportionately experienced by womxn in marginalized positions – for instance, those with little financial resources or located in underserved and isolated areas. Furthermore, they have been exacerbated and complicated even further in the context of the COVID-19 pandemic and it's responding policies, as observed in this thesis research. Building on these findings, this thesis also outlined two themes characterizing the landscape to abortion access in Colombia and answering the research question of how womxn are navigating barriers to abortion. The first theme was the reliance on the major private reproductive health providers, Profamilia and Oriéntame, which was largely due to the perception that they *respect* womxn's abortion rights, seemingly in contrast to facilities in the public health system. This indicated that womxn pursue and value service providers with who they believe they will likely not experience complications or resistance while seeking abortion, which can cause significant emotional burden. Additionally, that when their reasons for aborting may not fall within narrow interpretations of the three causes, these two organizations are more reliable providers for ensuring access. However, ability to access these services is influenced by factors such as the health insurance one is eligible for or whether one has the information or capacity to reach these providers.

The second theme was the prevalent expectation of provider resistance and the use of law and rights discourse as a tool to pressure and pre-empt providers from blocking access to services, such as sterilization and abortion. Posts relating to this theme convey an institutional

environment wherein womxn depend on legal protections and their knowledge of them to defend against provider resistance to granting them access to abortion or sterilization. Moreover, one wherein these exceptions position healthcare providers as moral gatekeepers to abortion as they have the power to impose their own interpretations of law, whether lawful or not. While legal mechanisms exist which enable womxn to circumvent abortion denial, such as the tutela, the data indicated that womxn do not always have the luxury of time to pursue this avenue and might fear low quality care as reprisal if their tutela is successful.

The challenges imposed by abortion denial links to an additional unexpected but compelling theme which emerged throughout the dataset – specifically, the barriers invoked by healthcare providers during the process of seeking access to female sterilization. These barriers, including delays and misinformation, overlapped with barriers to abortion found in previous literature and in my own analysis. This unexpected theme links to the primary interests of this paper as it confirms underlying social dynamics of barriers to abortion imposed within healthcare settings. Namely, the stigma surrounding reproductive health services that seemingly refute motherhood and thus, entrenched gender roles in Colombian society. This can be reflected in the misinformation that womxn pursuing sterilization received, such as that they needed to have already produced children, or the pressure to have consent of a male partner. As highlighted by medical anthropologist, Rayna Rapp (2001): ‘‘when reproduction becomes problematic, it provides a lens through which cultural norms, struggles, and transformations can be viewed.” The finding that female sterilization facing challenges from healthcare providers is not uncommon underscores how motherhood is a prized cultural institution in Colombia. Thus, the manifestation of stigma arising from this ideological belief is the obstruction womxn face and expect when they have made a decision to undergo this service. This represents the

infantilization of womxn in the health system and disrespect for their autonomy by failing to take their decisions to not pursue motherhood seriously.

As seen in Krauss' investigation in the context of Mexico, while legal 'exceptions' have proven to be a powerful strategy for creating avenues of access to legal abortion, they paradoxically maintain abortion as an object of criminal law and a moral transgression in some circumstances worthy of punishment. The abortion law reform of 2006 in Colombia has also failed to live up to the "aspiration that abortion could be freed from its moral ambiguity through the language of law" (Krauss, 2018). This is confirmed by the interrelated themes which emerged in this analysis, which speak to how womxn continue to face undue barriers to abortion and how they are choosing to navigate them. Analysis of content contained within the Facebook group, ABORTO 💝 COLOMBIA, created more than a decade following C-355, portrays how womxn's autonomy are still not consistently respected in healthcare institutions.

Limitations of this study in terms of representation should be acknowledged, as they echo gaps in previous literature on barriers to abortion in terms of neglected populations and should be considered a priority for future research on this area. First, this research drew upon the perspectives of those with internet access, aside from those who were specifically posting in the group on behalf of friends or acquaintances. Therefore, the analysis does not necessarily contain insight into the experiences of those living in circumstances whereby they do not have consistent internet access. These are crucial perspectives to elevate given how their positionality likely is a factor which contributes to challenges accessing safe abortion, such as being in an underserved area.

Additionally, the data source was not convenient for consistently accessing information regarding the identity positions of each poster– such as race or education levels – and how this

may have played a role in their experiences. Understandings of relevant aspects of their identities was based on their disclosures, which mostly touched upon factors such as marital status, age, or socioeconomic status. Moreover, this paper contributes to research on barriers to abortion as experienced by women, however, there is a lack of exploration of the abortion experiences of those who do not identify with this social category. I did not come across posts in the dataset which specified gender identities other than female and it was not clear whether any of the posters were transgender or non-binary. However, it is important to emphasize that abortion access is not only cisgender women's issue. As addressed before, abortion stigma frameworks largely theorize upon gender norms, such as gendered archetypes surrounding women. These gender norms are oppressive for those who do not adhere to the gender binary as well and it is worth seeking to understand how these experiences may intersect to produce barriers to abortion, given their histories of exclusion.

Nevertheless, this paper hopes to have shed light on the landscape of abortion access in Colombia, more than a decade following major legal reform, and the barriers which persist. Moreover, it aims to highlight the ways womxn are individually and collectively resisting and navigating barriers to the reproductive health services they hold the right to. In the context of an ongoing public health crisis which has further constrained the ability to achieve reproductive justice, elevating womxn's voices and experiences on this topic is crucial.

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Appendices

Appendix A

Excerpt from a post on the *Ni Una Menos* Facebook page, entitled "*Llamamiento al Paro Internacional de Mujeres – 8 de marzo 2017"* (Call for an International Women's Strike – March 8, 2017):

Paramos porque nos faltan las víctimas de femicidio, voces que se apagan violentamente al ritmo escalofriante de una por día sólo en la Argentina.

Nos faltan las lesbianas y travestis asesinadas.

Nos faltan las presas políticas, las perseguidas, las asesinadas en nuestro territorio latinoamericano por defender la tierra y sus recursos.

Nos faltan las mujeres encarceladas por delitos menores que criminalizan formas de supervivencia, mientras los crímenes de las corporaciones y el narcotráfico quedan impunes porque benefician al capital.

Nos faltan las muertas y las presas por abortos inseguros.

Nos faltan las desaparecidas por las redes de trata; las víctimas de la explotación sexual.

Frente a los hogares que se convierten en infiernos, nos organizamos para defendernos y cuidarnos entre nosotras.

Frente al crimen machista y su pedagogía de la crueldad, frente al intento de los medios de comunicación de victimizarnos y aterrorizarnos, hacemos del duelo individual consuelo colectivo, y de la rabia lucha compartida. Frente a la crueldad, más 102eminism.

Appendix B

Facebook comments contained in the dataset from the same individual, in response to two separate posts in ABORTO 🤍 COLOMBIA:

WZ: Emputarse! Es ley, es tu cuerpo y tu derecho, así me tocó a mi, cada que entraba a un colsultorio, les decia muy seriamente y sin rodeos: "buenas vengo a que me autorice el promeroy, si en 15 minutos que salga de aquí no tengo su autorización, les entutelo". No les daba espacio a que se metieran, cualquier cosa que me dijeran les respondía: "esa es su opinión no la mía, es mi desición y le agradezco no interfiera ¿o acaso ud se va a hacer cargo si quedo embarazada?" (Y así funcionó, fueron 6 meses de cita en cita) No tuve que llegar a entutelar. Es triste que hasta para eso toque tener caracter. El problema es que desde el 31 de julio de este año, la tutela ya no se puede hacer en papel, solo se puede virtualmente en una plataforma nueva. (37l)

WZ : Gratis en la eps, me hice el Pomeroy que es cortar las trompas. La primera vez una trabajadora social de la eps me dijo que no operaban sin hijo/as, lo cual le creí, pero luego me di cuenta que es mentira, por ley deben hacértela si ya eres mayor de edad así no tengas hijo/as. Luego cuando ya llegue con ese argumento el ginecólogo me devolvió a planificación, lo cual también es error, puesto me estaban devolviendo en el proceso, el ginecólogo que te atiende es el mismo que te opera y hacen eso porque no quieren. Un médico se puede negar pero no la eps. Pero finalmente la señora que me atendió en planificación me dio los nombres de los profesionales que si están a favor del Pomeroy, a partir de ahí me toco no creerles nada y cada que entraba una cita les decía, vengo a que me de la orden del Pomeroy si no me la da en 10 minutos los entutelo, puesto me mandaron a trabjadora social y psicólogo. El proceso duro 6 meses, y aún en el día de la cirugía estando sin ropa lista en la camilla, vinieron varias enfermeras y el mismo médico que si estaba segura. me tocó ser muy seria y agresiva, puesto que estaba cansada de dar explicaciones. (12b)