The Lack of Correlation Between Legality and Safe Abortion: The Effect of Abortion Stigma, Culture and Religion on Women's Decision-Making

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ABSTRACT

In the modern-day debate surrounding women's sexual and reproductive health, the need for abortion services is an evident occurrence when women face unwanted pregnancies. During 2010 and 2014, an estimated 56 million induced abortions occurred each year worldwide. Out of the 56 million, 25.1 million of them were unsafe, with 97% of these occurring in developing countries. As a continuing moral debate, the legal status of induced abortion has long been considered as the answer to easy and safe access to abortion services. However, it is not only criminalization of abortion that can adversely impact access to pregnancy termination but also failure to regulate the practice properly. Indeed, through the examples of South Africa and Colombia, this thesis explores how culture, religion and stigma act as discursive resources to oppose and limit safe access to legal abortion. While international initiatives have triggered growing global sensitivity to abortion as a woman's sexual and reproductive right, the reluctance to accept abortion as a moral and human right, leads women to undergo unsafe abortion. Both South Africa and Colombia have liberal legal abortion frameworks that respect the rights-based approach of International Human Rights Law but are juxtaposed with a community that evinces high levels of religiosity as well as adherence to traditional belief systems. This results in a broad range of cultural, religious, regulatory and health system barriers that deter access to abortion and leads to the emergence of abortion stigmatization. Moreover, the unacceptability of and the inaccessibility to abortion services do not affect a woman's decision to have an abortion. In fact, structural and contextual constraints to women's lives affect their free choice to terminating their pregnancy. Indeed, being embedded in such sociocultural and religious contexts affect the decision-making of women.

I conclude that abortion stigma exemplifies the fact that abortion needs to be more than recognized as a human right and that law needs to be more than just words on paper. Implications are required to resolve this lack of correlation and to achieve transparent laws in order to ensure acceptable, accessible and lawful abortions services without fear of stigmatization.

RÉSUMÉ

De nos jours, la santé sexuelle et reproductive des femmes invoque constamment le débat sur le recours à l'avortement lorsque celles-ci font face à des grossesses non désirées. De 2010 à 2014, environ 56 millions d'avortements ont eu lieu annuellement dans le monde. De ces 56 millions, 25,1 million étaient des avortements non-médicalisés et risqués, dont 97% produits dans les pays en développement. Il a toujours été avancé que la décriminalisation et le statut juridique de l'avortement soient considérés comme la réponse à l'accès sûr de ces services. Toutefois, la criminalisation de l'avortement n'est pas l'unique source d'impact négative sur l'accès aux services, le manque de réglementation de la loi en pratique représente aussi une autre source. En effet, à travers les exemples de l'Afrique du Sud et de la Colombie, cette thèse examine la manière dont la culture, la religion et la stigmatisation agissent en tant que barrière, limitant et opposant l'accès sûr à l'avortement légal. Elle explore aussi que même l'aide des initiatives internationales qui ont déclaré l'avortement comme un droit de la femme ne suffit pas car la réticence des communautés en Afrique du Sud et en Colombie à accepter l'avortement comme un droit humain et moral, conduit les femmes à se tourner vers l'avortement non-médicalisé. En effet, les deux pays sont connus pour avoir un cadre juridique libéral sur l'avortement basé sur une approche fondée sur les droits des hommes. Cependant, ils sont juxtaposés à une communauté qui manifeste un niveau élevé de religiosité ainsi qu'une adhésion aux croyances traditionnelles. Ceci conduit à l'émergence de barrières culturelles et religieuses ainsi que des barrières de régulation dans le système de santé qui empêchent l'accès à l'avortement et entraînent l'apparition de la stigmatisation. De plus, il a été démontré que l'inadmissibilité et l'inaccessibilité des services d'avortement n'ont aucune incidence sur la décision d'une femme d'avorter. A contrario, l'environnement hostile d'une femme peut la pousser à avorter. En effet, le fait d'être intégré dans un contexte socio-culturel et religieux influe sur la prise de décision des femmes.

Enfin, la stigmatisation de l'avortement illustre le fait que la pratique médicale ne doit pas être simplement reconnu comme un droit de l'homme, et que le simple statut juridique en Afrique du Sud et en Colombie ne suffit pas. Des mesures sont requises pour résoudre ce manque de corrélation et pour atteindre une transparence des lois afin d'assurer l'acceptabilité et l'accessibilité aux services légaux et sûr des avortements sans crainte de stigmatisation.

INTRODUCTION

In the modern-day debate surrounding women's sexual and reproductive health, the need for abortion services is an evident occurrence when women face unwanted pregnancies. During 2010 and 2014, an estimated 56 million induced abortions occurred each year worldwide. More than a third of pregnancies do not end in the birth of a baby[1] and, with a global annual rate of 35 abortions per 1000 women of childbearing age (15-44), 25% of pregnancies ended in abortion.[2] Many factors push a woman to turn to abortion: from wanting to stop or postpone childbearing, to socioeconomic or age conditions, or even to avoid the stigmatization of bearing a child as a single parent. Abortion has always been and continues to be one of the most controversial debates in health and legal matters. It elicits profound emotions in all of us, irrespective of our opinion towards it, and is a never-ending divisive subject in religion, politics, culture, health, freedom, equality, and law.

The World Health Organization[3] (WHO) has found that 46 million abortions occur each year in developing countries, while only 7 million occur in developed countries; and abortions related deaths are hundreds of times more common in Latin America and Africa.[4] In developed countries where abortion is legal, safe and available, maternal mortality due to the procedure is very low. For example, in Canada during 1976 and 1994, 0.1 deaths per 100,000 legal abortions

[1] Alan Guttmacher Institute (1999) Sharing responsibility: Women, society and abortion worldwide New York: Alan Guttmacher Institute.
[2] Sedgh, G., et al. (2016). Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends. *The Lancet*, *388*(10041), 258-267.
[3] Further on referred as WHO.
[4] World Health Organization. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems, Geneva: WHO, 2012.

occurred.[5] However, in developing countries or countries with strong cultural and religious traditions, legality does not assure safety. Out of the 56 million abortions, 25.1 million were unsafe, with 97% of these occurring in developing countries. As a continuing moral debate, the legal status of induced abortion has long been considered as the answer to easy and safe access to abortion services. However, the notion that legality equals safety is too simplistic. Highly restrictive laws are not associated with lower abortion rates, and comparing the rates in countries where abortion is legal (34/1000), with countries where abortion is prohibited or only allowed to save a woman's life (37/1000), the difference is nonsignificant.[6] These findings show that it is not just criminalization of abortion but also failure to regulate the practice properly that can adversely impact access to pregnancy termination. The WHO, which produced technical and policy guidance on what is considered a safe abortion[7], first recognized unsafe abortion as a serious public health problem in 1967. It defined unsafe abortion as a procedure to terminate an unintended pregnancy undertaken either by individuals lacking the necessary skills or in an environment that does not meet basic medical standards or both.[8] The notable factor is that women turn to unsafe and backstreet abortions regardless of the law. One of the main reasons is that safe abortion services are frequently unavailable and inaccessible due to a variety of reasons ranging from legal and policy restrictions[9], lack of accessible and affordable abortion services, lack of knowledge among women[10], and fear of being stigmatized by the community.[11]

[5] Supra 2.
[6] Supra 2.
[7] World Health Organization. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems, Geneva: WHO, 2012.
[8] *Ibid*, p.18
[9] Assifi, A. R., Berger, B., Tunçalp, Ö., Khosla, R., & Ganatra, B. (2016). Women's awareness and knowledge of abortion laws: A systematic review. *PloS one*, *11*(3), e0152224
[10] Ibid
[11] Kumar, A., Hessini, L., and Mitchell, E.M., (2009) Conceptualising abortion stigma. Culture, Health and Sexuality, 11 (6), 625–639.

Moreover, the issue of abortion arises in a panoply of national and international settings.[12] The legal approach to abortion has evolved and is still evolving from criminal prohibition towards accommodation as a life and health-preserving option.[13] This momentum for liberalization comes from international recognition and adoption of the concept of a safe and dignified practice of reproductive health.[14] Women's reproductive and sexual rights in international human rights law were the subject of two UN conferences conducted in 1994 and 1995. They endorsed and legitimized the concept of women's reproductive rights as a fundamental human right. In 1994, article 16 of the International Conference on Population and Development Program in Cairo, Egypt, states that:

> "these [reproductive and sexual] rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children […]. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[15]

The following conference took place in Beijing in 1995. The 4th World Conference on Women stated that:

> "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[16]

[12] Jewkes, R., Brown, H., Dickson-Tetteh, K., Levin, J., & Rees, H. (2002). Prevalence of morbidity associated with abortion before and after legalization in South Africa. *BMJ*, *324*(7348), 1252-1253

[13] Cook, R. J., & Dickens, B. M. (2003). Human rights dynamics of abortion law reform. *Human Rights Quarterly*, *25*(1), 1-59

[14] Ibid.

[15] United Nations Population Fund. (5–13 September 1994). *The International Conference on Population and Development, Programme of Action.* Cairo: United Nations Population Fund. Further on referred as the Cairo Program.

[16] The United Nations. (1995). *Fourth World Conference on Women.* Beijing: The United Nations, New York. Further on referred as the Beijing Platform.

Both initiatives address the significance of reproductive health, and how this fits into the broader framework of human rights.[17] Abortion as an issue of sexual and reproductive health should guarantee the availability, accessibility, quality and acceptability of safe access to abortion rights services.[18]

Abortion entails considerations of the sanctity of life, sexual morality, religion, and multiple fundamental human rights. Over decades of the abortion debate, the two extremist movements mostly argued are the pro-life and pro-choice movements. The former movement surrounds the main argument that an embryo and a fetus are considered human, and the act of abortion is murder. The latter reflects the unarguable choice of a woman's autonomous right to control her body. However, the law labels the "destruction" of an embryo or fetus an ethically or morally significant act, which gives reason to regulate abortion as something more than a personal decision or medical procedure but as a social activity.[19] Even though the primary two arguments are the base of the abortion debate, opinions about abortion differ considerably across the globe and reflect the diversity of laws.[20] The laws vary from liberal regulation on abortion to limited access to abortion services, to complete prohibition of the practice. Regions are essential when it comes to the debate, as they differ dramatically in cultural, religious and historical backgrounds. This diversity forges different moral arguments and value systems across societies. Regions such as Latin America are wholly Catholic, and the Church has a decisive political role. Africa is also a region where the contemporary debate is very prominent, as its societies embody traditional and

[17] *Supra* 9.
[18] United Nations Human Rights, Office of the High Commissioner (2014) Women's rights are human rights. United Nations Publications. HR/PUB/14/2
[19] Erdman, J. N. (2017). Theorizing Time in Abortion Law and Human Rights. *Health and Human Rights*, *19*(1), 29
[20] Adamczyk, A. (2013). The Effect of Personal Religiosity on Attitudes Toward Abortion, Divorce, and Gender Equality. *EurAmerica*, 213-253

religious attitudes. Indeed, historically, the power of the state has depended, in part, on the ability to represent the society's culture and traditions of what constitutes a family and to shape ideologies concerning gender, sexuality and women's reproductive roles.[21]

Thus, while international initiatives have triggered growing global sensitivity to abortion in many countries, the reluctance to accept abortion as a moral and human right, leads women to undergo unsafe abortion for many reasons. Over the past two decades, the scientific evidence, technologies, and human rights rationale for providing safe abortion care have advanced considerably.[22] Despite these advances, a broad range of cultural, religious, regulatory, and health system barriers that deter access to abortion continues to exist in many countries, and the numbers and proportion of unsafe abortions continue to increase, especially in low- and middle-income countries. These barriers lead to the emergence of abortion stigmatization in societies. In fact, stigma is a negative attribute ascribed to women who seek to terminate a pregnancy and marks them as inferior to ideals of womanhood.[23] Abortion stigma persists due to systems of unequal access to power and resources, affecting the view of gender roles and proving the inequality and control of female sexuality.[24] Strong opinions and morals against abortion not only lead to stigmatization but also to a panoply of consequences: the restriction of information to legal and safe services, the unmet need of modern contraceptive methods, gender roles discrimination, lack of knowledge of the law and unsafe abortions.

[21] Rylko-Bauer, B. (1996). Abortion from a cross-cultural perspective: An introduction. *Social Science & Medicine*, *42*(4), 479-482

[22] World Health Organization. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems, Geneva: WHO, 2012.

[23] Kumar, A. (2013). Everything is not abortion stigma. Women's Health Issues, 23(6), e329-e331

[24] Link, B., and J.C. Phelan (2001) Conceptualizing stigma. Annual Review of Sociology 27: 363–85

Therefore, there is a clear need to break this vicious cycle. This thesis explores how culture, religion and stigma act as discursive resources to oppose and limit safe access to legal abortion. The role of culture has expanded in an unprecedented way into the politics and economics of societies[25] and is utilised to restrict women's sexual and reproductive health and human rights. Thus, I argue that the lack of correlation between legality and safe abortion is apparent in many countries and needs to be addressed. Through the examples of South Africa and Colombia, I show that even though abortion has been liberalized and legalized in these countries, abortion stigma is very prominent in both societies, leading women to feel insecure about turning to legal abortion services. However, statistics show that at the end of the day, women will undergo an abortion whether it is legal or not, because, while they are aware of its illegality, immorality or hazardous nature, the social and economic realities of everyday life are the most salient factors in their decision-making.[26]

Indeed, the key to understanding the decision of women to turn to unsafe abortions is the awareness that circumstances dictate choices. In South Africa and Colombia, where religious and cultural values dictate peoples' lives and where unemployment and gender roles rule the community, can we say that women exercise and enjoy their right to access abortion?[27] Undeniably, religious and cultural barriers are not the only barriers affecting a woman's choice of abortion. Circumstances and aspects of a woman's life – such as financial hardships, unemployment, being single and uneducated – affect her decision-making as well.[28] These individual values and situational factors mediate the influence of religion and culture on moral

[25] Macleod, C., Sigcau, N. & Luwaca, P. (2011) Culture as a discursive resource opposing legal abortion, Critical Public Health, 21:2, 237-245, DOI: 10.1080/09581596.2010.492211
[26] Supra 19.
[27] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, Chicago, 30(1), 83-95
[28] Ibid.

decision-making. I argue, through the theory of human development, that a rights-based approach is not enough to implement safe and legal access to services.[29] The theory of human development has a common focus on broadening human choice and explains through three components – socioeconomic development, emancipative values and democracy – that the capability of human beings to choose the life they want should be the ultimate measure of social progress.[30]

I am not criticizing the legalization of abortion, as it is a crucial step for reducing high maternal mortality and morbidity. My argument is that the law is more than just words on paper and needs to be implemented into social practices and attitudes to avoid women turning to clandestine and unsafe abortions. Being surrounded by abortion stigma and social pressures raises questions about women's freedom of choice and their stance on the abortion practice. The right to practice abortion in contexts where many structural constraints on a woman's life exist is limited. Indeed, the theory of human development will manifest that developing countries such as South Africa and Colombia may be resistant to exercise and enjoy the practice of abortion due to a lack of socioeconomic development, strong conformity values and the non-implementation of rights as effective in practice.

Thus, my thesis will make evident that the lack of correlation between the theory of law and its implementation is due to cultural and religious norms driving social attitudes to stigmatize abortion and to limit women's right to practice safe and legal abortion.[31]

[29] Welzel, C., Inglehart, R., & KLIGEMANN, H. D. (2003). The theory of human development: A cross-cultural analysis. *European Journal of Political Research*, *42*(3), 341-379.
[30] Ibid.
[31] Burris, S. 2006. Stigma and the law. Lancet 367: 529–31

Methods:

To be able to address this issue, a wide-ranging and systematic review of research in this area was carried out using bibliographic indices. Through PubMed, Westlaw, Philosopher's Index and Google Scholar, I aimed to find concrete information on abortion, its relationships with law, culture and religion, as well as the different stages of the stigmatisation of abortion. Indeed, I divided my research into five initial sub-sections and search terms:

- Abortion and the law: human rights and women's rights,
- Abortion and culture
- Abortion stigma
- Unsafe abortions
- Bioethical principles and abortion

After having a broad idea of the different relationships, I then went on to concentrate on South Africa and Colombia by starting to incorporate the countries as terms into the platforms. Studies of health professionals in Africa and Latin America helped me find relevant information on South Africa and Colombia: through PubMed, using search terms such as "South Africa AND abortion AND culture", enabled me to find important articles. The Alan Guttmacher Institute's surveys were the most significant source of information in this area as necessary data and numbers helped with the comparison of both countries at an international human rights level. Likewise, the WHO is a vital source of information on statistics regarding the number of deaths due to abortion and the number of unsafe abortions occurring in each region of the world. The WHO's report on unsafe abortion defined the whole basis of my unsafe abortion argument. It provided me with the necessary definitions and international requirements to avoid unsafe abortions all over the world. Finally, the Global Database of Abortion was essential in comparing South Africa and Colombia

regarding legal abortion and determining that they are compatible to compare. All these approaches confirmed that my choices of South Africa and Colombia would help me support my argument throughout my thesis.

Indeed, the choice of South Africa and Colombia as examples for this thesis relates to the various similarities of both countries when it comes to abortion. First, despite the legalization of abortion in both countries, the social stigma attached to abortion, traditional moral values and fear of rejection by the community continues to limit the use of safe abortion services. Since the key decision in 2006 in Colombia[32], fewer than 3000 legal abortions were done, while between 320,000 and 450,000 backstreet abortions take place every year[33]. In South Africa, there was a positive impact on maternal morbidity and mortality thanks to the Choice on Termination of Pregnancy Act.[34,35] However, the social abortion stigma, traditional moral values and the fear of rejection by the community continues to limit the use of the service[36] and pushes women to search for secrecy and to rely on unsafe abortion. Second, as post-colonial countries, they ascribe high importance to cultural traditions and religion as guiding their everyday life. Tables 1 to 4 demonstrate the similar indicators South Africa and Colombia share as well as the similarities in the regulation of their abortion laws. The legal grounds and gestational limit, additional requirements, and clinical and service-delivery aspects are all going to be further discussed in upcoming chapters.

[32] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia)* decriminalized abortion and broadened its legalization, allowing abortion in cases of rape, incest, fetal malformation, or when life or health of women or fetus is/are in danger.
[33] Moloney, A. (2009). Unsafe abortions common in Colombia despite law change. *Lancet*, *373*(9663), 534
[34] The *Choice on Termination of Pregnancy Act 1996* replaced the *Abortion and Sterilization Act (1975)*, making it a country with very liberal abortion legislation.
[35] Department of Health South Africa (2004) in Macleod, C., Sigcau, N. & Luwaca, P. (2011) Culture as a discursive resource opposing legal abortion, Critical Public Health, 21:2, 237-245, DOI: 10.1080/09581596.2010.492211
[36] Ibid

Table 1. Indicators (out of 196 countries)

	South Africa	Colombia
Gender inequalities index (value)[37]	0.394 (2014)	0.393 (2014)
Gender inequalities index (rank)[38]	90 (2014)	89 (2014)
Population – urban (%)[39]	64.801	76.436
Maternal mortality ratio (per 100,000 live births)[40]	138 (2013)	64
Percentage of women aged 20-24 who gave birth before age 18[41]	15 (2009-2013)	20 (2009-2013)
Adolescent birth rate (births per 1000 women aged 15-19)[42]	45.5	50.2
Percentage of secondary school completion rate for girls[43]	0.958 (2013)	1.023 (2013)
Unmet need for contraception (% married women aged 15-49)[44]	13.8 (2004)	8 (2010)

Table 2. Legal Grounds and Gestational Limit for Abortion Services

	South Africa	Colombia
On request	✓	×
Economic or social reasons	✓	×
Fetal impairment	✓	✓
Rape	✓	✓
Incest	✓	✓
Intellectual or cognitive disability of the woman	✓	×
Mental Health	✓	✓
Physical Health	✓	✓
Health	Not specified	✓
Life	✓	✓
Other		✓[45]

[37] See http://hdr.undp.org/en/composite/GII
[38] Ibid
[39] See http://api.worldbank.org/v2/en/indicator/SP.URB.TOTL.IN.ZS?downloadformat=excel
[40] Supra 13.
[41] See https://www.unfpa.org/sites/default/files/pub-
[42] Supra 13.
[43] See http://hdr.undp.org/en/content/population-least-secondary-education-femalemale-ratio-ratio-female-male-rates
[44] See http://data.worldbank.org/indicator/SP.UWT.TFRT
[45] Other refers to: the pregnancy is the result of a criminal act of unwanted artificial insemination or unwanted implantation of a fertilized ovum.

Table 3. Additional Requirements to Access Safe Abortion

	South Africa	Colombia
Conscientious Objection	No written policies	✓
Authorization of health professional(s)	✓[46]	✓[47]
Authorization in specially licensed facilities only	✓	×
Judicial authorization in cases of rape	Not specified	×
Police report required in case of rape	Not specified	✓
Parental consent required for minors	×	×
Spousal consent	×	×
Compulsory counselling	×	×
Compulsory waiting period	Not specified	×

Table 4. Clinical and Service-delivery Aspects of Abortion Care

	South Africa	Colombia
National guidelines for induced abortion	✓	✓
Methods allowed	Not specified[48]	Not specified[49]
Country recognized approval (misoprostol)	✓	✓
Where can abortion services be provided	✓	✓
National guidelines post-abortion care	✓	✓
Where can post-abortion care be provided	Not specified	Not specified
Contraceptive included in post-abortion care	✓	✓
Who can provide abortion services	✓[50]	✓[51]

[46] One health professional is required when the gestational age of the pregnancy is between 13 to 20 weeks. Two are required after 20 weeks.
[47] One health professional required. Although a health professional must "certify" the indication of health risks, the woman is the one entitled to decide whether to continue or terminate the pregnancy ("Solamente ella es la que tiene la decisión para continuar o interrumpir un embarazo cuando represente riesgo para su vida o su salud certificado por un médico" – Judicial Decision, source 10)
[48] Methods allowed varies to the gestational age of the pregnancy. Vacuum aspiration and combination of mifepristone and misoprostol are allowed up to 20 weeks, whereas the method of only misoprostol is allowed up to 13 weeks.
[49] The methods of dilation and evacuation, and vacuum aspiration are allowed up to 15 weeks, whereas the use of only misoprostol is allowed up to 10 weeks. The combination of mifepristone and misoprostol is not available in Colombia.
[50] Nurses, midwives and doctors can provide abortion services.
[51] Only doctors and speciality doctors can provide abortion services.

I therefore, intend to explore in more detail the relationship abortion has with legality as a national right and a human right. The evolution of abortion from criminalization to a fundamental human right is important to understand, as it will help to analyse how a rights-based approach is not enough to implement abortion as a safe and legal practice (Chapter 1). I then intend to concentrate on cultural traditions and religion as discursive resources opposing legal abortion and leading women to seek unsafe abortion due to the unceasing social, cultural and religious stigmatization. Through the theory of human development, I argue that structural societal constraints and regulatory and health system barriers continuously impede safe access to abortion services in South Africa and Colombia (Chapter 2). I finally examine what implications might be implemented to resolve this lack of correlation between legality and safe abortion, and to achieve transparency in rights to request and undertake acceptable, accessible and lawful abortion without fear of stigmatization (Chapter 3).

CHAPTER 1 – ABORTION'S RELATIONSHIP WITH LEGALITY

The legality of abortion is an ongoing debate that combines issues of criminalization, morality, health rights, women's rights and human rights. Abortion's relationship with the law has always been and remains a complex one, as countries around the world each have different views on how the law should engage, or not, with abortion. Some see the law as an acceptable instrument to express and enforce the moral prohibition of abortion by criminalizing the practice. Others see the application of criminal sanctions as detrimental to women, whereas others protect abortion and place it within a spectrum of services to which women have safe access as a matter of human rights and social justice.[52] Amado perfectly describes the complicated relationship abortion has with legality. He states that society must learn to recognize that "what certain individuals ought to do because of the particular view of the Good (matter of ethics), is not necessarily what all individuals must do (matter of the law)."[53]

Therefore, it is crucial to understand the evolution of the legal approach to abortion from criminal prohibition (section 1) to accommodating abortion as a life-preserving human right (section 2).[54] Moreover, Section 3 will present some regulatory and health system barriers that exist and may limit safe access to abortion services as they are implemented due to specific moral arguments. This will enable me to efficiently address the overall strain that culture, religion and stigma have on legality and safe abortion. In other words, I intend to demonstrate that in countries

[52] Cook, R. J., & Dickens, B. M. (2003). Human rights dynamics of abortion law reform. *Human Rights Quarterly*, *25*(1), 1-59
[53] Amado, E. D., García, M. C. C., Cristancho, K. R., Salas, E. P., & Hauzeur, E. B. (2010). Obstacles and challenges following the partial decriminalization of abortion in Colombia. *Reproductive Health Matters*, *18*(36), 118-126
[54] Supra 52.

where the social and political resistance to abortion is strong, a substantial impact on the ability to access safe abortion exists.

Section 1 – Unwanted Pregnancies and the Need to Decriminalize Abortion

The legal environment surrounding abortion is a significant factor affecting women's ability to end an unwanted pregnancy[55], and decriminalizing abortion is the first step in accepting the services as a need and right to women all over the world. In this section, it is first necessary to address the issue and limitation that the morality of abortion has with the law, to better understand the need for decriminalization. The laws and regulations of South Africa and Colombia will then provide a better idea of each country's position on the abortion debate.

1.1 The Morality of Abortion: Unwanted Children and Consequences

One of the biggest anti-abortion arguments relates to personhood. Personhood is the quality and condition of being considered as a person, a human being. The anti-abortion movement considers that an embryo and a fetus are a person and the deliberate termination of embryonic or fetal life constitutes an unjustified, immoral and criminal termination of a human life; i.e. murder. However, parents have a moral responsibility and constitutional obligation to bring into this world only children who are wanted, loved, and provided for[56]; and prohibiting these fundamental human and moral rights to children can lead to immoral and criminal behavior. However, if abortion is

[55] Allan Guttmacher Institute. 1999. Sharing responsibility: Women, society and abortion worldwide New York: Alan Guttmacher Institute

[56] Prescott, J. W. (1976). Abortion or the unwanted child: A choice for a humanistic society. Journal of Pediatric Psychology, 1(2), 62-67

considered as committing murder and is criminalized, different questions arise in connection with bringing unwanted children into the world. First, do adults have the right to bring unwanted children into the world? Does the fact that they are unwanted restrict their fundamental human rights and educational needs, rendering them neglected and abused? Is it not more moral and human to prevent a life than to permit a life that may experience deprivation? Therefore, is mere physical existence our highest goal and greatest moral burden as a society? Alternatively, is it the quality of human life?

All these questions are essential to consider before going into further detail on how abortion is practised in the world and its effect on women in different societies. History has shown that consequences of having unwanted children are not just limited to the children in question but affects the society as a whole. A Scandinavian study in 1966, showed that unwanted children are more than twice as likely to suffer the social, emotional, and educational disadvantages as wanted children[57]; leading them to a path of criminal and illegal actions. In Levitt's book on Freakonomics[58], he studied the crime rates of the USA in the late 1980s and early 1990s. He described that starting 1995, contrary to what criminologists thought, teenage crime rates went down and fell more than 50% within five years. In his opinion, one factor that had significantly contributed to the massive crime drop of the 1990s was the legalization of abortion in 1973 after the historical case of *Roe v. Wade* that lead the Supreme Court of the USA to legalize abortion across the States.[59] Levitt went on to argue and explain that a child born into a disadvantaged family and environment is far more likely to engage in criminal activity. Indeed, the millions of

[57] Ibid
[58] Leavitt, S. D., & Dubner, S. J. (2005). Freakonomics. "Where have all the criminals gone?" in *A Rogue Economist Explores the Hidden Side of Everything. Harper Perennial* p.115-145
[59] Roe v. Wade, 410 U.S. 113 (1973)

women who went and had an abortion at the aftermath of the legalization were most probably models of adversity – poor, unmarried, teenagers for whom illegal abortions were too expensive and hard to get. The legalization was, therefore, a drastic and distant effect seen years later.

Many would argue that this explanation is very utopic and very hard to prove, to which I agreed. However, Levitt went on to sustain his argument by calculating numbers and comparing the rate of crimes in the States that already had legalized abortion before 1973. In New York, California, Washington, Alaska, and Hawaii, legal abortion was available for at least two years before *Roe v. Wade*. Indeed, those states saw crime begin to fall earlier than the other states. Between 1988 and 1994, in the five states where abortion was legal, violent crime fell 13% compared to other states; and between 1994 and 1997, their murder rates fell 23% more than those of the other states.[60]

Finally, the anti-abortion movement believes that countries that criminalize abortion respect human life, meaning that societies that permit and practice abortion would be characterised as disrespecting the quality of human rights.[61] One cross-cultural study in 1954 compared 11 cultures that severely punish abortion to 12 cultures that do not.[62] This study proves that decriminalization of abortion does not equate with disrespect and violation of human rights:

- 55% of the cultures that punished abortion practised slavery, while 92% of cultures that did not punish abortion, did not practice slavery.
- 100% of cultures that punished abortion practised polygyny, while 58% of those that did not punish abortion did not practice polygyny.

[60] Supra 58, p. 141
[61] Supra 52.
[62] "A Cross-Cultural Study of Factors Relating to Pregnancy Taboos", unpublished doctoral dissertation, Radcliffe College, Cambridge, (1954) (Codings used in R. B. Textor).

- 73% of cultures that punished abortion allowed the practice of killing, torture and mutilation of enemies in warfare, while 80% of the other cultures did not practice such actions.

These findings do not support the anti-abortion point-of-view that abortion encourages a more violent society. Instead, it provides support for the opposite point-of-view. Even though these studies are dated, they share a global image that the practice of abortion leads to a moral, humanitarian and dignified quality of life, whether for the fate of the unwanted children or for the women that had the unwanted pregnancy. Adopting these findings to a modern day shows the need for decriminalization across nations, and guarantees women's autonomy and respected dignity.

1.2 Decriminalization and the Effect of Human Rights in South Africa and Colombia

Laws criminalizing abortion not only ignore the dire consequences of unwanted pregnancies but also display a profound disregard for women's ability to make autonomous and moral decisions.[63] Over the years, the legal approach to abortion has evolved from criminal prohibition to accommodation as a life and health-preserving option. The international adoption of the concept of reproductive health has re-conceptualised criminal abortion laws as human rights violations. Therefore, wider recognition that the resort to safe and dignified healthcare is a fundamental human and women's right has been internationally endorsed and legitimized through UN conferences, notably the Cairo Programme and the Beijing Platform.[64] Abortion laws have

[63] Supra 55.
[64] United Nations Population Fund. (5–13 September 1994). *The International Conference on Population and Development, Programme of Action.* Cairo: United Nations Population Fund ***and*** The United Nations. (1995). *Fourth World Conference on Women.* Beijing: The United Nations, New York.

evolved around the world through courts and human rights tribunals, interpreting human rights to recognize the concept of reproductive health and associated rights of access to safe abortion services.[65] Some national courts addressed the obligations of the conferences and took steps to reform their restrictive and criminalized abortion legislation.

South Africa enacted the Choice on Termination of Pregnancy Act in February 1997. The Act permits termination of pregnancy upon a woman's request up to and including 12 weeks of gestation, under certain defined circumstances from the 13th to the 20th week and in limited circumstances after the 20th week. Before 1997, the legal termination of pregnancy was very strict and limited, leading to only 800-1,000 legal abortions performed, whereas 6,000-120,000 illegal abortions were performed for the same period.[66]

While South Africa liberalized its existing legislation[67] of abortion in 1997, Colombia decriminalized the practice of abortion, following a decision of the Constitutional Court of Colombia in 2006.[68] Before 2006, the Penal Code of Colombia prohibited abortion in absolute terms. However, in 2006, the Attorney General went on to challenge the Penal Code and measured it against the more liberal values of the new Colombian Constitution of 1991,[69] which includes the commitment to comply with the country's international responsibilities under human rights treaties. The Attorney General agreed that voluntary termination of pregnancy should not be a crime in rape and incest situations, when the pregnancy presents serious risks to the woman's life,

[65] Supra 52.
[66] Department of National Health and Population Development (1991) in Dickson, K. E., Jewkes, R. K., Brown, H., Levin, J., Rees, H., & Mavuya, L. (2003). Abortion service provision in South Africa three years after liberalization of the law. *Studies in Family Planning*, *34*(4), 277-284
[67] The Abortion and Sterilization Act (1975) (RSA) ACT 2.
[68] Constitutional Court of Colombia, Decision C-355/06 (2006)
[69] Cook, R. J., Erdman, J. N., & Dickens, B. M. (2007). Achieving transparency in implementing abortion laws. *International Journal of Gynecology & Obstetrics*, *99*(2), 157-161

physical or mental health, or when there is fetal malformation or severe illness. He argued that the analysis of the principle of the protection of human dignity contained in the Constitution render criminalization of abortion in the above circumstances an irrational and disproportionate punishment for women and a violation of women's rights.[70] The judgment of the Constitutional Court of 2006 reflected this approach and decided that the Penal Code's legislation on abortion be unconstitutional. The decision gave attention to women's rights, noting that:

> "The 1991 Constitution expressly sets out the goal of recognizing and enhancing the rights of women, as well as of reinforcing these rights by protecting them effectively and decisively. Thus, women are now entitled to special constitutional protection and their rights must be recognized and protected by government authorities, including those within the legal system, without exception".[71]

Legislation in both South Africa and Colombia show the importance of human rights and the influence international human rights law has in individual countries. Therefore, it is crucial to understand the position abortion has as a human right, and more specifically as a women's right.

Section 2 - Abortion as a Human Right and a Woman's Right

The rise of abortion as a human right pushed states to recognize sexual and reproductive health as a priority in women's equal and human rights. Governments deliberately liberalizing their abortion laws in recent decades is a first step towards ensuring respect for health and welfare of women. Therefore, I address in this section the modern human rights dynamics of abortion law

[70] Ibid.
[71] Supra 67, Section 6.

reform[72]. I argue that abortion needs to be recognized as a human right, and explain how abortion needs support from various ethical and human rights principles. Rights and principles relating to life, liberty, dignity, non-discrimination and due respect for difference, and equality of citizenship are particularly relevant to reproductive health and self-determination. As the development of the content and meaning of these rights in the context of abortion can vary given the distinct cultural and political approaches to sex and gender, I will concentrate on the examples of South Africa and Colombia.

2.1 The Recognition of a Reproductive Health Right and its Framework

Modern thinking on abortion law directs policy and legislation away from the historical preoccupation of criminalization and punishment and towards the protection and promotion of women's sexual and reproductive health and prevention of unsafe abortion. The current momentum for liberalization comes from the international adoption of the concept of reproductive health, and broader recognition that the resort to safe and dignified healthcare is a fundamental human right.[73] The 1994 Cairo Conference's Program recognized the importance of human rights in protection and promotion of reproductive health. It defined reproductive health as:

> "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide

[72] Cook, R. J., & Dickens, B. M. (2003). Human rights dynamics of abortion law reform. *Human Rights Quarterly*, *25*(1), 1-59
[73] Ibid.

if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, […], and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[74]

The concept of reproductive health has been internationally endorsed and legitimized through UN conferences and treaties. For example, by article 12(1) of the International Covenant on Economic, Social and Cultural Rights, member states recognize "the right of everyone to the enjoyment of the highest standard of physical and mental health". This right requires health care services to feature availability, accessibility, acceptability and adequate quality and covers safe and accessible abortion services. Indeed, a woman's death or disability due to unsafe abortion represents a failure of prevention and control of unplanned pregnancy, access to medical care or/and human rights protection.[75]

The right to the highest attainable standard of health, of which reproductive health is part, is central to the protection and promotion of human rights. The rise of liberalization and legalization of abortion laws in countries show the vital place human rights has in national courts. However, in practice, human rights are interrelated and interdependent, since a violation of any one of a right is a violation of another. Therefore, clarifying the different rights that affect reproductive health is essential to further understand the relationship abortion has with human

[74] United Nations Population Fund. (1994). *The International Conference on Population and Development, Programme of Action.* Cairo: United Nations Population Fund, supra note 7.2
[75] Supra 72.

rights. The most important one is human dignity and how it affects the right to life, liberty and security of the person. It is essential to consider human dignity as a principle of life, liberty and security even if the law already permits abortion access because legality does not ensure safety. If women still turn to unsafe abortions, the law is not being implemented in a way that respects the human dignity of women. The principle of human dignity is a fundamental human right and offers women the possibility of choice and autonomy in the case of abortions. However, women's choice and autonomy to have an abortion will be seen to be restricted by the circumstances in their community and lives.[76]

2.2 Human Dignity: A Principle of Life, Liberty and Security

First, the right to life has been invoked to support opposing claims: on behalf of the embryo and fetuses, and on behalf of women. It affects a question of legal protection, life and security of both the embryo and women. The debate on when legal protection of human beings starts varied from culture to culture over the years. Some believe that life begins at conception, others say that it starts at the stage of "quickening",[77] while others argue that life starts when the child breathes on its own. The highest courts in many countries have declared that legal protection originates at live birth. Legislations are known to have open-ended words that lead judges to interpret on a case-by-case basis. In South Africa, the 1996 Constitution provides in section 11 that "everyone has the right to life".[78] When the Choice on Termination of Pregnancy Act was enacted in 1997, the Minister of Health was sued for declarations that the Act is unconstitutional, because a fetus is

[76] Chapter 2 will further address this issue.
[77] Evidence of quickening relates to a time surrounding the end of the first trimester and beginning of the second trimester of pregnancy, when the first movements of the fetus can be felt (about 12th or 13th week of gestation)
[78] The Constitution of the Republic of South Africa (1996), section 11

included in the "everyone" expression, and that life of a human being starts at conception. In *Christian Lawyers Association of South Africa v. The Minister of Health*[79], the judge refused the declarations stating that "everyone" is an alternative legal expression to "every person", and on historical grounds in South Africa, legal personhood commences only at live birth.[80] The judge emphasized that his judicial task is not to resolve conflicts about biological facts, moral values and social effects, but to make clear determinations of the law.[81] Not all countries separate the cultural traditions from their legal determinations. In several countries, such as Colombia, the intention to give effect to religious faith is expressed in the legislation where it declares the protection of human life from conception. Before the liberalization of abortion in 2006, in a Constitutional Court decision of 1994[82], it was held that the right to decide the number and spacing of one's children is protected by the Constitution. However, that right was not to be infringed by the criminalization of abortion, because – acting under the Roman Catholic traditions – this right could be exercised only until the moment of conception. This decision still holds nowadays if the abortion needed is not met under the requirements (rape, incest, health and fetal malformation).

Moreover, constitutions are required to protect individual's liberty and security of their body. Security interests relate to denial of health care services that threatens individuals lives or well-being. Regarding abortion, women seek to have the free choice and the liberty to control their fertility not only to secure their lives and health but also because lack of control incapacitates them from pursuing opportunities in their life. The Preamble of the Choice on Termination of Pregnancy

[79] *Christian Lawyers Association of South Africa v. The Minister of Health* [1998]
[80] The judge stated that "the question is not whether the conceptus is human but whether it should be given the same legal protection as you and me".
[81] Supra 52.
[82] Sentence C-133, Constitutional Court of Colombia (1994)

Act states that it recognizes "that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies".[83] Some courts are importing notions of health into the meaning of the right to security of the person. For example, the Supreme Court of Canada found that the harmful physical and emotional health impact of the delay to receive an abortion was a denial of the right to security of the person. However, the right to liberty and security have more obvious threats. In 1998, the Chief Justice of Canada stated that: "Forcing a woman, by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person".[84] Thus, establishing that it was on this basis that the Supreme Court of Canada found the criminal prohibition of abortion to be unconstitutional.

2.3 The Principle of Non-Discrimination

Another crucial human right is the right to non-discrimination. This right requires us to treat women seeking abortion services without discrimination. Women are often discriminated against in this domain because societies and governments fail to treat women according to their sexual and reproductive health differences. The right to sexual non-discrimination, as well as ethnic and racial non-discrimination, are types of discrimination women face every day.

[83] The Choice of Termination of Pregnancy Act (1997) (SA)
[84] *R. v. Morgentaler v. The Queen* [1998]

2.3.1 Sexual Non-Discrimination

Under article 12 of the Committee on the Elimination of Discrimination against Women (CEDAW)[85], member states agree to "take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning".[86] The Committee characterizes the refusal of medical procedures that only women require, such as abortion, as sex discrimination. Moreover, gender discrimination is another notion of sexual discrimination related to a social, cultural and psychological construct. Human reproduction is often viewed through a gendered lens that blames women both for a couple's infertility and for an unplanned pregnancy. The gender-based inequalities are present in countries such as South Africa and Colombia. Due to religious and cultural factors, gender roles imbalances exist in such communities. In fact, men tend to have a more explicit choice not to accept the responsibility of paternity, while women – faced with no right to abortion – are subjected to raising the child, and to being stigmatized as a single mother.[87] In such a situation, women would most likely turn to unsafe abortions, taking away their right to safe healthcare due to gender discrimination.[88] Therefore, the general recommendation of human rights declarations is that States have obligations to respect, protect and fulfill women's rights to healthcare. This necessity to protect women against sexual discrimination required the removal of barriers to access to care when these barriers are only against women. Consistent with the Women's Convention's recommendations, national

[85] Further on called the Women's Convention
[86] Convention on the Elimination of Discrimination against Women (CEDAW) (1979), General Recommendation 24, supra note 14, art. 12.
[87] Varga, C. A. (2003). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in family planning*, *34*(3), 160-172.
[88] Moloney, A. (2009). Unsafe abortions common in Colombia despite law change. *Lancet*, *373*(9663), 534.

courts are beginning to recognize the sex discrimination that exists in their societies. When they realize that no practice or health care services are legally denied for men, and only barriers exist against women, it is clear that appropriate measures need to be taken to ensure the necessary right to healthcare to women.[89] The lack of response to sex and gender discrimination in South Africa and Colombia is furthered discussed in Chapter 2, where gender roles are presented as consequences of strong cultural and religious traditions reigning both countries.

2.3.2 Ethnic and Racial Non-Discrimination

In some countries, women of particular ethnic or racial groups are discriminated against the exercise of their reproductive rights. Both the International Convention on the Elimination of All Forms of Racial Discrimination and the Women's Convention require member states to ensure not only equality between men and women but also adequate development and protection of specific racial and ethnic groups. Many countries have accommodated the rights presented in international human rights conventions negatively; meaning that their liberalized laws are restrictive to minorities in their societies. For example, by failing to allocate safe public resources to provide necessary abortion services, or to require healthcare providers or facilities to perform those services, governments create rights only for people with financial means. This restriction and discrimination could be seen in South Africa's former Abortion and Sterilization Act of 1975, that limited access to lawful abortion to primarily socio-economically advantaged women. The South African Institute of Race Relations conducted a study in 1997 that presented statistics of abortion rates during the period of the act's operation (1975-1997). Only 800 to 1,200 women were

[89] Ibid, supra note 15, Gen. Rec. 24, ¶ 17

qualified for legal abortion. Out of these, 66% were white and from an urban middle-class background. This is poignant information because these statistics were at a time when whites constituted 16% of the general population of South Africa. On the other hand, unofficial estimates state that 120,000 illegal abortions took place per year, and 44,000 pregnancies resulted in backstreet abortions. Out of the 44,000, the predominant number of women were Black and poor.[90] Thus, the South African Parliament recognized the contribution of a liberal abortion law to equality of the sexes and races in its Preamble to South Africa's Choice on Termination of Pregnancy Act 1997. It states that this act "[recognizes] the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa".[91] The language used signifies that modern South Africa has been shaped in response to the history of racial discrimination. This approach to abortion law reform reflects similar experiences in other countries, where it has been long recognized that high socioeconomic classes and women associated with influential families in their communities have been immune from restrictive abortion laws.[92]

Opposite to these privileged women, are prejudiced and powerless women who are poor, young and marginal to their societies. One example is the case of Afro-Colombian women who continuously face various forms of discrimination on grounds of both sex and race in health and more specifically on reproductive and sexual health.[93] Indeed, only 49% of Afro-Colombians were found to be enrolled in the health system in 2003.[94] The racial inequity in the health system in

[90] Ngwena, C. The History and Transformation of Abortion Law in South Africa, (1998), 30 ACTA ACADEMICA 32–68 at 8–9
[91] The Choice of Termination of Pregnancy Act (1997), p. 2.
[92] Supra 52.
[93] Cook, R. J., Dickens, B. M., & Fathalla, M. F. (2003). Reproductive health and human rights: integrating medicine, ethics, and law. Clarendon Press.
[94] Rodriquez-Caravito, C., Sierra, T. A., & Adarve, I. S. (2008). Racial Discrimination and Human Rights in Colombia: A Report on the Situation of the Rights of Afro-Colombians. Bogotá : Universidad de Los Andes, Facultad de Derecho, CIJUS, Ediciones Uniandes.

Colombia leads to the unsafe performance of health services to the Afro-Colombian population and does not guarantee the fundamental right of achieving overall physical and social well-being.[95,96] Therefore, the Committee on the Elimination of Racial Discrimination has recommended in various concluding observations on the report from Colombia that government programmes need to be more responsive to the needs of indigenous and Afro-Colombian women as they are continuously subjected to multiple forms of discrimination including race and ethnicity.[97]

Therefore, racial discrimination manifests itself against women of ethnic or racial subgroups in a variety of ways and in different circumstances. These manifestations include a subgroup's poorer access to care and greater vulnerability to abuse and exploitation of their reproductive capacity and sexuality.[98] These examples from both Colombia and South Africa show that the health status among population groups varies by race and ethnicity, indicating differential access to health care services, information, and education necessary for health protection.

2.4 Women as Equal Citizens

The abortion-related discrimination that women suffer on the grounds of sex and gender, adding the risk of discrimination on the grounds of race and ethnicity, illustrates the violation of their right to equality.[99] Gender inequality, unfortunately, is a status that many women occupy in their families, communities, and legal systems. When abortion is criminalized or restricted by the

[95] Ibid.
[96] WHO (World Health Organization). 1946. Constitución de la Organización Mundial de la Salud. Principios Básicos, available at http://www.who.int/governance/eb/who_constitution_sp.pdf , accessed in April 2008.
[97] UN, Committee on the Elimination of Racial Discrimination (1999). Concluding Observation on Colombia, para. 15.
[98] Supra 93.
[99] Supra 52.

law, states are seen to use their bodies in a way that they do not consent to and to use their power into forcing women to deliver children against their will. If compared to men who are not forced by law to render bodily services; women, who are labelled criminals in some societies for being autonomous, can be seen as lesser citizens. In their article, Cook et al. explain that women's lack of equality and bodily integrity under laws that deny them reproductive self-determination is increasingly perceived as a violation not only of human equality but also of full citizenship.[100] A citizen in democracies is a full participant that has free will and voluntary abides by the law. In the case of women seeking an abortion in a restrictive country, she is no longer voluntarily abiding by the law. Denial of a recognized human right forces women to go against their will, threatening their citizenship. This vision of citizenship as possession of equality of power of participation in a democracy represents the faith societies have on political institutions to enhance social participation of individuals. The notion of women citizenship as a factor of non-discrimination is vital to understand women's healthcare practices in democracies such as South Africa and Colombia. The lack of correlation between the rights offered and the free practice of those rights is due to the government's absence in attending to the issue of abortion stigma. Codifying rights as free legal choices are not enough for them to become effective and respected in societies such as South Africa's and Colombia's.

However, constructions of women's citizenship vary according to the social, cultural, political and legal context of a country. In Latin America, for example, two dynamics exist. One represents the assurance that women have equal rights and duties with men. The second is women's ability to engage in social and political movements – such as feminist movements of reproductive

[100] Ibid, p. 43

rights. These movements have been particularly active in Latin America, and have facilitated survival strategies into political and legal demands for access to services. Feminist movements fight to be recognized and respected as subjects of the state and not objects and engines of development. In this context, the right to safe abortion represents the achievement of women's control of their destinies[101] and their need for political, civil and economic support as well as for their cultural rights. Therefore, for abortion to be safe and legal, respect for women's citizenship in the countries in which they live is crucial.

Nevertheless, while International Human Rights Law accepts society's morals as a legitimate aim sufficient to set limits on access to abortion, it requires that those limits be transparent, rational, and proportionate.[102] In the case of abortion services, regulatory and health system barriers that deter access to safe abortion continues to exist. In South Africa and Colombia, those barriers restrict women's human rights and emphasize adverse effects – such as their right to full information, to liberty and security, to non-discrimination, and to full citizenship.

Section 3 – Regulatory and Health System Barriers Deterring Safe Access to Abortion

Most abortion regulations and laws establish limits to access safe abortion. Even in countries with liberal laws, some restrictions exist.[103] They address issues such as gestational age, consent requirements, the health exception and conscientious objection. These limits should not be considered as negative effects of the law. On the contrary, establishing limits for the practice of

[101] Ibid, p. 45
[102] Erdman, J. N. (2017). Theorizing Time in Abortion Law and Human Rights. *Health and Human Rights*, *19*(1), 29.
[103] For South Africa's and Colombia's legal limits, refer to Tables 2-4 on pp. 8-9

abortion is part of the safe regulatory process of a medical procedure. It is the way those limits are implemented and used in practice that presents the way in which the barriers deter from safe access to abortion. Indeed, the regulatory barriers presented first will lead to the cause of health system barriers: a lack of knowledge and awareness of the legal abortion information.

3.1 The Right to Conscientious Objection

Health-care professionals or institutions that have an allegiance to a religion or strong moral and philosophical values condemn abortion and exempt themselves from providing or participating in abortion care. In 2008, the Constitutional Court of Colombia ruled that physicians have a non-absolute right to conscientious objection[104], recognizing healthcare providers' right to refuse to provide a service on the basis of their freedom of religion. The Court defined conscientious objection to be based on moral, philosophical or religious convictions, and doctors who object to performing an abortion are required to immediately refer the woman to another doctor. As a regulatory and health system barrier, conscientious objection is unique because of the tension existing between protecting and respecting women's rights, and healthcare providers' right to exercise their freedom of thought, conscience and religion.[105] Although International Human Rights Law protects this right, Article 18 of the ICCPR stipulates that freedom to manifest one's religion or beliefs may be subject to limitations to protect the fundamental human rights of others.[106] However, health care providers were found to inappropriately use their conscientious objection right and spread wrong information regarding abortion services purely for self-interest.

[104] Constitutional Court of Colombia, Decision T-209/08 y Auto 279/09
[105] Johnson, B. R., Kismödi, E., Dragoman, M. V., & Temmerman, M. (2013). Conscientious objection to provision of legal abortion care. *International Journal of Gynecology & Obstetrics*, 123(S3).
[106] International Covenant on Civil and Political Rights, Article 18. United Nations; entry into force 23 March 1976

Even though it is illegal, some studies found that institutions go as far as refusing to employ staff members unless they share the same view regarding abortion, hence, violating the human right duties of non-discrimination in recruitment for employment[107,108].

CEDAW has criticized countries such as Colombia, which has allowed healthcare providers' conscientious objections to deny women's access to legal abortion services. States may find themselves internationally accountable under human rights conventions for failing to ensure proper behavior to serve women's health interests. Moreover, women's human rights of liberty and the security of abortion choice are diminished when healthcare providers deliver services not only without respect for patients' autonomy but also judgmentally.[109] In countries such as Colombia and South Africa, physicians and healthcare providers may approach women as being immoral and end up judging them for having an unplanned pregnancy.[110] Not only are healthcare providers responsible for such unethical approaches and treatments, but governments are liable when they fail to take measures to discipline and eliminate practices that deny women's human rights.

There is a threat of women being unjustly denied abortion services because physicians themselves do not provide the right information.[111] They act as a gatekeeper to abortion access,

[107] Cook, R. J., & Dickens, B. M. (2003). Human rights dynamics of abortion law reform. *Human Rights Quarterly*, *25*(1), 1-59.
[108] Stanhope, K., Rochat, R., Fink, L., Richardson, K., Brack, C., & Comeau, D. (2017). Physician opinions concerning legal abortion in Bogotá, Colombia. *Culture, health & sexuality*, 1-15.
[109] Supra 107, p. 52
[110] Fink, L. R., Stanhope, K. K., Rochat, R. W., & Bernal, O. A. (2016). "The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia. *International Perspectives on Sexual and Reproductive Health*, *42*(2), 71-80.
[111] Cook, R. J., Erdman, J. N., & Dickens, B. M. (2007). Achieving transparency in implementing abortion laws. *International Journal of Gynecology & Obstetrics*, *99*(2), 157-161

and the existence of conscientious objection in legislation helps them achieve that role. Unfortunately, physicians may not only be guilty of using their conscientious right to enforce their values on women seeking an abortion; in the case of Colombia, physicians may misrepresent the law when it comes to the health exception as well. Regulatory barriers such as conscientious objection and the health exception are crucial to have in regulating the abortion practice for it not to be too liberalized. Thus, the problem is not the regulatory barriers per se, but the application and interpretation of them in countries where there is a clear lack of knowledge and awareness about the practice of abortion and the law.

3.2 The Health Exception

The health exception has been interpreted in different ways across different countries. It refers to a legal ground of abortion and is defined as the risk to a woman's health if the pregnancy continues. Gonzalez Velez further defines it as "the possibility or likelihood of an adverse effect on or harm to the woman's health if the pregnancy continued would make an abortion legal".[112] According to WHO, the risk of an adverse effect is sufficient, and the harm does not need to occur.[113] From this perspective, the health exception is perceived to have a positive impact in reducing mortality and morbidity as the right to health is interdependent with the right to life and, therefore, gives content to the health exception to include physical, mental and social well-being grounds as health risks.

[112] González Vélez, A. C. (2012). "The health exception": a means of expanding access to legal abortion. *Reproductive health matters*, *20*(40), 22-29. p. 22
[113] World Health Organization (2002) World Health Report: Reducing Risks, Promoting Healthy Life. Geneva: WHO.

Following the 2006 decision to legalize abortion in Colombia[114], the health exception was taken up in other countries in the region, and in 2008, a virtual regional forum was created that served to build a shared conceptual understanding of the health exception, its scope and interpretation within a human rights framework.[115] The key change happened in 2012 in Colombia, when *La Mesa por la Vida y la Salud de las Mujeres* (La Mesa)[116] decided to conduct a qualitative assessment of the interpretation of the health exception, and the changes it has led to in the practice of health professionals in the Latin American region. Using two questionnaires that were distributed to health professionals and institutions across the region, the study collected data on the number of abortions per year and the number of abortions where the health exception was applied. The data from two private institutions in Colombia was collected.[117] Two decisions by the Constitutional Court of Colombia contributed to the broad application of the health exception: rulings T-585/10 and T-841/11. In the latter judgment, the Court recognized that:

(i) Health is a comprehensive concept that includes both physical and mental aspects,

(ii) It is not necessary for a risk to life to exist, it is enough if there is a threat to health, and

(iii) It is essential to respect women's reproductive autonomy.

Thanks to the broader interpretation of the health exception, a major change was seen in Colombia over the years. Figure 1 shows the results of the number of abortions per year and the number of abortions under the health exception per year between 2006-2011 in two institutions in Colombia.

[114] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia*
[115] Supra 107, p. 23
[116] La Mesa (Advocates for Women's Life and Health) is comprised of individuals and organizations advocating the decriminalization of abortion in Colombia. It was one of the driving forces in the formation of a regional consensus on the health exception and one of the main organizations that has promoted training on the health exception with its allies, both nationally and internationally
[117] Supra 107.

Table 5 – Tables from the *La Mesa* study of 2012

Table 1. Total numbers of abortions by legal grounds, Orientame, Colombia, 2006–2011						
	2006	2007	2008	2009	2010	2011
Total abortions	**7**	**29**	**55**	**858**	**2,112**	**4,066**
Risk to health or life	2	6	31	844	2,093	4,052
Sexual violence	5	23	23	11	19	13
Fetal malformation	0	0	1	3	0	1

Table 2. Total numbers of abortions by legal grounds, Profamilia, Colombia, 2006–2011						
	2006	2007	2008	2009	2010	2011
Total abortions	**0**	**2**	**13**	**17**	**382**	**1,349**
Risk to health or life	0	0	7	3	353	1,321
Sexual violence	0	2	6	14	29	28
Fetal malformation	0	0	0	0	0	0

Source : González Vélez, A. C. (2012). "The health exception": a means of expanding access to legal abortion. Reproductive health matters, 20(40), pp. 27-28

Even though this study shows a positive effect of the health exception interpretation – increasing from 7 to 4,066 and 0 to 1,321 in five years – it is still seen that in Latin America and more specifically in Colombia, the application of the exception has been limited in certain regions. Indeed, Orientame is situated in central Bogota whereas Profamilia is in the rural areas of Bogota.[118] The substantial difference in numbers between abortions made by the legal ground of risk to health or life in both clinics (4,066 in Orientame to 1,349 in Profamilia) represents the effect

[118] Supra 107.

that education, socioeconomic and demographic measures have on the interpretations of the concepts of health, risk, life and autonomy.[119] These interpretations come from the stigmatization that still exists in communities: from the physicians and health care providers, from a void in the understanding of the need of health on social grounds, and from the fear of denial of abortion services. Another legal limit that is also debated on moral, medical and legal grounds, is the restriction of abortion depending on the gestational age of the embryo/fetus.

3.3 Gestational Age Limits

While gestational limits are officially defined as medical and moral restrictions that are required to restrict abortion, the WHO's guidance on safe abortion describes them as access barriers, and thus, as human rights concerns, especially in late-term pregnancies. As there will always be unwanted pregnancies and the need for abortion services later in pregnancy, gestational limits are seen as blurring boundaries to safe and accessible abortion services.[120] These gestational restrictions may be set at both the policy or implementation level. Indeed, in South Africa, the gestational age limit is incorporated into the law. The Act of 1997 permits termination of pregnancy up to and including 12 weeks of gestation, under defined circumstances from the 13th to the 20th week, and in limited circumstances after the 20th week. Whereas in Colombia, no specification of gestational age limits exists in the 2006 decision[121]. However, in practice, limits are implemented by physicians and institutions. This lack of gestational age limit complicates

[119] Ibid.
[120] Erdman, J. N. (2017). Theorizing Time in Abortion Law and Human Rights. *Health and Human Rights*, *19*(1), 29.
[121] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia*

abortion provision for clinics, and even more for women in their second trimester, as abortion providers tend to reject a late pregnancy.

Erdman argues that gestational age proves an arbitrary means of regulating access to abortion and runs afoul of human rights protection against arbitrary laws.[122] Gestational limits are seen as a moral regulation and as originating from social spheres rather than medical ones. However, they present significant problems for women's access to care. In practice, women face a subjective calculus from physicians. They assess, question, and decline requests on a case-by-case basis, especially in later pregnancies. In a 2014 study, researchers interviewed two clinics each in South Africa and Colombia, between 2012 and 2013, and found that 20% of women from the South Africa sample (n=60) were turned away due to gestational age, while 2% were turned away from the Colombia sample (n=225). Plus, the mean of the gestational age in weeks by ultrasound differed with 9.9 in South Africa, and 6.6 in Colombia.[123] Even though the results are based on minimal samples, they still show that women face denial of legal abortion. Second trimester and later abortions often lack professional and public support, leading to excessive access restrictions. These restrictions arise from the interpretation of the law rather than their explicit terms.[124] Consequences appear as physicians end up not only refusing late-term pregnancies but also near-late-term pregnancies while presenting their denial as medically justified.[125] An example is physicians who send home women to wait for their turn as they are fully booked, leading them

[122] Supra 120.
[123] Gerdts, C., DePiñeres, T., Hajri, S., Harries, J., Hossain, A., Puri, M., & Foster, D. G. (2014). Denial of abortion in legal settings. *J Fam Plann Reprod Health Care*, jfprhc-2014.
[124] Ibid
[125] Canes-Wrone, B., & Dorf, M. C. (2015). Measuring the chilling effect. *NYUL Rev.*, *90*, 1095.

to be rejected as their pregnancy has by then moved into the second trimester and is accordingly prohibited.

Erdman goes further in pointing out that the stigma of abortion may lead to the adoption of non-evidence-based practices around informed consent in the clinical setting. In my opinion, she goes too far when arguing that physicians tend to over-mention the risks of a late-pregnancy abortion – such as "you may experience a kind of mini-labor". She claims that this information may communicate something of the moral significance of the act. Informed consent, thereby, "becomes a means by which to compel women to reckon with the moral significance of the act".[126] She concludes that physicians use informed consent in a coercive manner that degrades the treatment and that goes against the rights of freedom of conscience. However, her arguments block out all moral and social spheres of abortion. In any other medical situation, physicians tend to present the risks and expectations that come with the procedure. It is all about how the informed consent is formulated. I agree that abortion providers can present the procedure as demeaning and dangerous, thus changing the woman's mind but Erdman does not provide an alternate formulation. She presents the argument as if informed consent is coercive when it comes to late-pregnancy abortions when informed consent is needed as a legal, moral and medical right of the patient.

On a separate note, gestational age limits are also a critical factor in selecting the most appropriate abortion method. In the WHO's safe abortion guidelines[127], it lists all appropriate

[126] Supra 120.
[127] World Health Organization. (2012). Safe abortion: technical and policy guidance for health systems. World Health Organization, pp. 3-4 Box 3 and 4

methods from 9 weeks to more than 14 weeks. The methods differ from vacuum aspiration, dilatation and evacuation, to misoprostol and mifepristone. Abortion methods and their gestational limits in South Africa and Colombia are presented in Table 6. Abortion methods are essential to mention as South Africa and Colombia vary in their use due to cultural and religious norms. The relevance of methods will be further discussed in Chapter 3, but it is necessary to show how they vary depending on gestational age.

Table 6 – Abortion methods and Gestational Limits in South Africa and Colombia[128]

Methods	**South Africa**	**Colombia**
Vacuum aspiration	Up to 20 weeks	Up to 15 weeks
Dilatation and evacuation	Not specified	More than 15 weeks
Mifepristone-misoprostol	Up to 20 weeks	Not available
Misoprostol only	Up to 13 weeks	Up to 10 weeks

These results show how different gestational limits are applied in countries. However, it is difficult to answer the question of why it is moral, healthy, or just to deny a woman an abortion after a certain gestational age. This requires a greater understanding of the morality, health system and legal system of a country, which leads to comprehend the social sphere of the society being studied.

Moreover, all the regulatory and health system barriers just mentioned are supported and support the lack of knowledge and awareness of abortion information. In other words, due to the lack of knowledge and awareness of both citizens and providers, the ability to abuse regulatory and health system legal limits is made possible.

[128] World Health Organization and The United Nations' Global Abortion Policies Database: http://srhr.org/abortion-policies/

3.4 The Lack of Knowledge and Information about Lawful Services

The lack of knowledge and awareness of abortion information is a universal limit to safe services. Women's power to participate freely in the activities of reproductive health significantly depends on their access to information. The United Nations Development Program recognizes the interdependency of political freedom and participation of individuals in their respective societies, as well as the importance of being knowledgeable and enjoying good health.[129] However, incorrect knowledge of laws may affect how women enter the health system or seek services, likely contributing to the disconnect between official laws and their practical applications.[130] Regarding reproductive health and self-determination, the Women's Convention requires that women have "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[131] The Cairo Conference of 1994 and the Beijing Platform of 1995 require governments to remove all legal, medical and regulatory barriers to reproductive health information.[132] Both in South Africa and in Colombia, women tend to lack the knowledge on the legal standards of abortion. In 2016, Assifi et al. conducted a systematic search of articles published between 1980 and 2015 to provide a synthesis of evidence and summary of women's knowledge of the legal status of their country and the accuracy of that knowledge on the specific legal grounds and restrictions of their abortion laws.[133] In a South Africa study of 2002, out of a sample of 11,725 articles; 52.9% knew that abortion was legal. The knowledge on the specific legal grounds varies as well. In another study of 2006 articles, out of 295 women, only

[129] United Nations Development Programme, Human Development Report 2002 53 (2002)
[130] Assifi, A. R., Berger, B., Tunçalp, Ö., Khosla, R., & Ganatra, B. (2016). Women's awareness and knowledge of abortion laws: A systematic review. *PloS one*, *11*(3), e0152224.
[131] Women's Convention, supra note 14, art. 10(h).
[132] Cairo Programme, supra 8, ¶ 7.20; and Beijing Platform, supra note 9, ¶¶ 103, 107(e).
[133] Supra 52.

20% knew of the existence of gestational limits.[134] In a third study in 2005, in the Gauteng Province of South Africa, out of 46 women who had unsafe abortions, 54% did not use legal facilities because they did not know about the law, while 16% knew of their legal rights but not a legal facility.[135] Others who knew about the law, feared the staff (17%), feared breaches of confidentiality (6.5%), or thought they were too far along in their pregnancies to comply with the law (6.5%).[136] The legislative reform did not end the stigmatization of abortion in both South Africa and Colombia and this is due to the lack of resources and implementation from the government and non-government organisations. The recurring fact in all studies was also that women's level of general awareness and knowledge varied widely based on their geographical region, wealth and education. While 62.1% of urban women knew that abortion was legal, only 28% of rural women did. Therefore, access to and provision of correct information is a key determinant on the pathway to safe abortion; and the absence of accurate knowledge leads to fear of violating "non-existing" laws, deterring women from seeking healthcare services. The right to information is a human right, and in the context of abortion, lack of information results in women turning to backstreet and unsafe abortions. Complications arising from such abortions raise maternal deaths and abortion-related morbidities, placing a high strain on limited health system resources and leading to negative consequences for women.[137] Indeed, the decrease of maternal morbidity and mortality in South Africa and Colombia was not substantial even after the legalization and liberalization of abortion in both countries as many women still chose backstreet

[134] Ibid, p. 5
[135] Jewkes, R., H. Rees, K. Dickson, H. Brown, and J. Levin. (2005), The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. BJOG: An International Journal of Obstetrics and Gynaecology 112: 355–9
[136] Ibid.
[137] Ibid.

abortion over legal and safe ones.[138] For example, researchers in 2000 repeated a 1994 study in South Africa to calculate the impact of legislative change on the rate of unsafe abortions.[139] The incidence of incomplete abortions per 100,000 women aged 12-49 was 362 compared with 375 in 1994, and the rate of incomplete abortions per 100,000 live births was 44 compared to 42 in 1994. Moreover, in Colombia, estimates suggest that in 2008 most abortions were performed illegally and unsafely, and 24-53% of illegal abortions from 2006-2008 resulted in complications.[140] Therefore, the substantial unmet need for information on the abortion legal context in countries leads women to risk their lives by seeking unsafe abortions. This barrier can be the result of cultural and religious traditions creating stigmatization among communities and preventing women from seeking information, but it also presents the impact that lack of adequate support from governments has on women in diverse social and cultural societies.

Conclusion

This chapter has studied the place abortion has at a national and international legal setting. Countries, such as South Africa and Colombia, have come a long way from decriminalization to legalization and liberalization of the practice of abortion. Constitutions aim at implementing safe and accessible abortion services and reducing maternal mortality and morbidity. They tend to follow international human rights law and prohibit behaviors such as discrimination and gender inequality.

[138] Jewkes, R., Brown, H., Dickson-Tetteh, K., Levin, J., & Rees, H. (2002). Prevalence of morbidity associated with abortion before and after legalisation in South Africa. *Bmj*, *324*(7348), 1252-1253
[139] Ibid.
[140] Fink, L. R., Stanhope, K. K., Rochat, R. W., & Bernal, O. A. (2016). "The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia. *International Perspectives on Sexual and Reproductive Health*, *42*(2), 71-80.

However, some reluctance exists in societies that still lead women to turn to unsafe and backstreet abortions. Since abortion receives more scrutiny than it warrants and more regulation than it needs as a medical intervention, unsafe abortion remains one of the four leading causes of maternal mortality and morbidity. One of the main reasons for them, as we have seen, is that safe abortion services are frequently unavailable and inaccessible due to a variety of reasons ranging from regulatory restrictions, and lack of knowledge and awareness of abortion services. Although the international human rights community accords States the opportunity to take into account the cultural and religious traditions, as well as moral convictions that are prevalent in their societies; States have obligations to respect, protect and fulfill rights related to women's sexual and reproductive health. This concept has a history of being discriminated against, causing a constitutional principle such as non-discrimination as non-sufficient by itself to ensure women's de facto equality. Even with the protection of International Human Rights Law and the legislation available toward safe abortion; a rights-based approach is not enough as violations of women's sexual and reproductive health rights are frequent and are often deeply ingrained in societal values about women's sexuality.

Therefore, chapter 2 will analyse and describe the leading cause of the lack of correlation between legality and safe abortion. Cultural and religious traditions cause abortion stigmatization, which results in women turning to unsafe and backstreet abortions. It will become evident that social barriers are not the only cause of abortion stigma. Structural and contextual constraints of the real-life circumstances of women have an impact on their decision-making and show that a rights-based approach is not enough to ensure the acceptability and accessibility to safe abortion services.

CHAPTER 2 – ABORTION STIGMA IN A CULTURALLY DIVERSE AND STRUCTURALLY CONSTRAINED SOCIETY

Why do 20 million women risk their lives worldwide when abortion has the status of a woman's sexual and reproductive right? Why do women in South Africa and Colombia turn to backstreet termination of pregnancy when safe and legal services are provided?

After seeing abortion's relationship with national and international law, Chapter 2 will explore how culture, religion and abortion stigma are deployed as discursive resources to oppose the acceptability and accessibility of safe and legal abortion services in multi-layered sociocultural countries, such as South Africa and Colombia.

Indeed, as a mostly Protestant country, South Africa is a multiethnic society encompassing a wide variety of cultures and languages. Home to over 55 million people, its pluralistic makeup is reflected in its substantial number of rural inhabitants who firmly believe and live on cultural traditions. In fact, views on abortion are sharply divided along racial lines: while 54% of Black Africans believe that abortion is morally wrong, only 19% of White Africans believe the same.[141] Colombia shares similarities with South Africa as an ethnically diverse country that possesses a rich cultural heritage. With a population of 49 million, more than 90% adhere to Christianity and 70% practice as Roman Catholics.[142]

[141] Vincent, L. (2011). South Africa's Abortion Values Clarification Workshops—An Opportunity to Deepen Democratic Communication Missed. Journal of Asian and African studies, 46(3), 264-277.

[142] Cely, B., *Mauricio, W., "Descripción cuantitativa de la pluralización religiosa en Colombia" (2012). Universitas humanística 72: 201–238. – bdigital.unal.edu.co*

When faced with a sensitive practice such as abortion in cultural, ethnic and religious countries, stigmatization surrounds various controversies: reproductive physiology, normative sexuality, demographic and political trends, and family dynamics. As abortion debate pushes societies to call into question a variety of values, individuals tend to feel their views, morals and values threatened. All people are influenced by the dominant religious, cultural and political values of their society, leading to stronger opinions about abortion. The more religious, morally traditional and politically conservative individuals are, the less they approve of abortion, of sexual morality and gender equality. Stitka and Tetlock state that "conservatives perceive individuals to have more control over the cause of their need and experience more negative reactions in different situations".[143] In other words, people with traditional and conservative beliefs about reproductive health are more likely to hold pregnant women responsible for their unwanted pregnancies. Indeed, traditional and conservative beliefs come from an array of discourses – such as culture, politics and religion. Cultures such as the South African and Colombian ones are more sensitive to social roles and the influence of others in the social context, making health-related stigma a very present threat to women's choice. Values, ideologies and concepts relating to abortion are culturally and religiously constructed, harrowing the definitions of motherhood, womanhood, family, personhood and abortion cross-culturally. Moreover, being embedded in such sociocultural and religious contexts affects the decision-making of women. Indeed, the influence of religion and cultural traditions are not absolute; individual values and situational factors mediate the influence of culture and religion on moral decision-making.[144] Therefore, I argue that while women consider

[143] Skitka, L. J., & Tetlock, P. E. (1992). Allocating scarce resources: A contingency model of distributive justice. Journal of Experimental Social Psychology, 28, 491–522. in Sahar, G., & Karasawa, K. (2005). Is the personal always political? A cross-cultural analysis of abortion attitudes. *Basic and Applied Social Psychology*, *27*(4), 285-296

[144] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, 30(1), 83-95. Chicago

their religious and cultural values as the only reasons for their abortion decision, their immediate life circumstances and needs caused by their surrounding environments take precedence. The primary factors contributing to the abortion decision are financial constraints, abandonment by partners, and fear and shame from the family, religious and cultural community that are against abortion.[145] The practice is seen as a disgrace and carries an active and very present social stigmatization.

Therefore, I argue in this chapter that even after decriminalization and legalization, cultural, religious and gender roles barriers have continued to impede access to legal abortion (section 1). Women opt to seek an unsafe and secret abortion not only to avoid the stigma of having an abortion but also to avoid the stigma of becoming pregnant. Early childbearing remains a cause of considerable embarrassment and failure, making abortion a necessary and attractive option. However, women seek unsafe abortions not only due to cultural and religious discourses but also due to various other factors that these discourses cause. In a society where abortion stigma is dominant, denial of legal abortions, ignorance of the law and demographic and educational factors also affect a woman's decision to have a backstreet abortion (Section 2). To conclude, abortion stigma exemplifies the fact that abortion needs to be more than recognized as a human right and that law needs to be more than just words on paper. Questions arise on whether women have free choice or if they are governed by social norms. In other words, the legalization of abortion is not what pushed most women to seek an abortion, but it is the situation of their countries and the environment in which they live in that require them to choose a practice they may not support. Scarce resources, financial hardships, unemployment, and community, partner and family

[145] Ibid.

relationships limit a woman's free choice and opinion about abortion as the religious and cultural stigmatization is the primary reason for her decision-making. This argument will be further discussed in Section 3 and will conclude that a rights-based approach offered by the international human rights law and the national law is not enough to implement safe and legal access to abortion services.

Section 1 – The Presence of Abortion Stigma in South Africa and Colombia

Women tend to remain silent about a procedure that millions of them undergo every year. This is because they are seen as defying long-held ideas of subordination to community needs.[146] Abortion stigma is a very present attribute in culturally and religiously diverse communities. Thus, after defining abortion stigma, this section aims to provide a clear understanding of how abortion stigma is perpetuated by systems of unequal access to power and resources, narrow and rigid gender roles and religious attempts to control female sexuality.

1.1 Abortion Stigma

Goffman defines stigma as "an attribute that is deeply discrediting" and that negatively changes the identity of an individual to a "tainted, discounted one".[147] Most definitions of stigma have two things in common:

[146] Kumar, A., Hessini, L., and Mitchell, E.M., (2009) Conceptualising abortion stigma. Culture, Health and Sexuality, 11 (6), 625–639.
[147] Ibid.

(1) The assumption that stigmatized people possess some attribute or characteristic that makes them different than others, and

(2) That being different from others devalues or denigrates that person in the eyes of other people in the society[148]

Health-related stigma develops across a broad array of cultural and social contexts.[149] In fact, dominant cultural beliefs link labelled persons to undesirable characteristics and negative stereotypes, making them experience status loss and discrimination within their community.[150] Stigma represents a symbol of disgrace, a sign of immorality or a reproach caused by dishonourable conduct. Thus, when such a compound practice as abortion is faced with religious, traditional and cultural norms, women who decide to terminate a pregnancy are confronted with a very present abortion stigma. Their decision to abort is highly contextual regarding culture and community and affects their life within that community. Abortion expels a woman from the normative category of a 'woman' and labels her as having undesirable characteristics that form a negative stereotype. Three areas demonstrate evidence of social and abortion stigma in cultural and religiously diverse countries:

(1) Self-induced stigma: women's shame, guilt and fear of reactions increase secrecy;

(2) Stigma from the community: negative moral consensus on abortion from the family, peers and the community;

(3) Stigma from the providers: medical and nursing staff are known to be judgmental and indifferent.

[148] Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., & Palomino, N. et al (2011). Social stigma and disclosure about induced abortion: Results from an exploratory study. Global Public Health, 6(Suppl. 1), S111–S125

[149] Supra 140.

[150] Link, B., and J.C. Phelan. 2001. Conceptualizing stigma. Annual Review of Sociology 27: 363–85

1.1.1 Individual and Community Stigma

Abortion is an invisible characteristic, i.e. it is not 'visible' as a physical deformity. Indeed, stigmatization does not have to result in discrimination because even in the absence of it, stigma may have a negative impact on the self-concept and actions of stigmatized people.[151] The mere fact of knowing how much abortion is stigmatized within her community influences a woman's decisions and behaviors, her overall well-being and her relationships with family and friends. In long-held norms of traditional, cultural and religious communities, women are expected to feel sorrow, shame and guilt when they opt for an abortion. As a sensitive issue, abortion not only involves sensitive personal information but is also associated with cultural sensitivity. Three types of individual stigma arise: internalized, felt and enacted stigma. First, in abortion stigma studies, women tend to report intense feelings of shame and judgment associated with having an abortion.[152] These feelings are associated with the internalized domain of stigma as it manifests the negative views that women hold against abortion and toward themselves. Then, felt stigma describes a stigmatized individual's perceptions of other people's attitudes toward abortion and their expectations for judgment, rejection or discrimination. The experience of other women's stigmatization within her community emphasizes her expectations when she is faced with the same situation. Finally, enacted stigma describes actual experiences with other people that demonstrate to women their loss of social status following an abortion.[153] The enacted stigma proves her expectations and her choice to seek a secret yet unsafe abortion. In addition to individual stigma,

[151] Supra 135.
[152] Ibid.
[153] Cockrill, K., Upadhyay, U. D., Turan, J., & Foster, D. G. (2013). Stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. Perspectives on Sexual and Reproductive Health, 45, 79–88.

women also face her community's stigma. In a 2007 study conducting interviews with women who had abortions, Goodwin analysed the consequences abortion had on their lives.[154] Some women did not get upset or experienced linear recovery, while other got depressed and remained depressed over time. The analysis of these interviews concluded that women who did not get upset or experienced a linear recovery tended to conceptualise the fetus as less human, reported having social support and described either a belief that abortion was supported by her society or an ability to defend against a belief that society is judgmental. Those who did get upset tended to view the fetus as more human, had a lack of social support and a belief that society is either overly judgmental or negates the impact that abortion can have on a woman.[155] These results show the importance of social and society support: lack of support affects the initial emotional response of a woman and pushes her towards secrecy and silence, closing herself off to society and her community. Moreover, her views and beliefs are intertwined with how society views abortions as women tend to try and find social beliefs to support or legitimize their action.[156] In South African and Colombian societies, the legality of the law does not help as abortion stigma is so strong that women prefer keeping silent and dealing with the consequences by themselves. In fact, possessing a stigmatized attribute can influence women's disclosure decisions and behaviors, have an impact on their physical, mental health and overall well-being, and even create conflict in their relationships with family, friends and her community.[157] Additionally, individual and community stigmas are followed by the abortion providers' stigma: the medical and nursing staff support tend to be unsympathetic and insensitive in Colombian and South African public and private clinics.

[154] Goodwin, P., & Ogden, J. (2007). Women's reflections upon their past abortions: An exploration of how and why emotional reactions change over time. *Psychology and Health*, *22*(2), 231-248.
[155] Ibid.
[156] Ibid.
[157] Supra 135.

1.1.2 Medical and Nursing Staff Stigma

Abortion legislation came into effect in South Africa and Colombia without any prior consideration of whether there would be health professionals available in sufficient numbers who would be willing to perform the procedure.[158] This resulted in women not having in reality the universal access to high quality, safe, legal abortion services envisaged by the change in the law. On the contrary, women tend to face obstacles that result from fundamental disagreements about abortion and misunderstandings regarding ethical, legal and medical requirements. The case of abortion represented a paradigm shift for the medical system more in Colombia than in South Africa as abortion was a crime before 2006. In the case of Colombia, physicians' attitudes and opinions are formed by social, political and personal factors making it difficult for physicians to understand legal abortion. Stanhope's study in 2017 tries to answer the questions of "what cultural and personal factors influence physicians' opinions about legal abortion?" and "how do these understandings influence women's access to legal and safe abortion?".[159] Three barriers were found to promote service providers' stigma: the lack of knowledge about the legal status of abortion; the appropriate use and limitations of conscientious objection;[160] and the circumstances under which a woman could access abortion. Abuse of conscientious objection can result in inequalities in access, creating excessive risks and stigma for poor women, young women, ethnic minorities, and other vulnerable groups of women who cannot afford to obtain alternatives

[158] Vincent, L. (2011). South Africa's Abortion Values Clarification Workshops—An Opportunity to Deepen Democratic Communication Missed. Journal of Asian and African studies, 46(3), 264-277 ***and*** Stanhope, K., Rochat, R., Fink, L., Richardson, K., Brack, C., & Comeau, D. (2017). Physician opinions concerning legal abortion in Bogotá, Colombia. *Culture, health & sexuality*, VOL. 19, NO. 8, 873–887.
[159] Stanhope, K., Rochat, R., Fink, L., Richardson, K., Brack, C., & Comeau, D. (2017). Physician opinions concerning legal abortion in Bogotá, Colombia. *Culture, health & sexuality*, VOL. 19, NO. 8, 873–887, p. 874
[160] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia*

services. Moreover, it is the misinterpretation of the health exception[161] accorded in the 2006 decision to legalize abortion in Colombia[162] that raises limitations to accessibility to safe and legal services. Physicians believe this exception to be limited to the life-threatening situation of the mother and the fetus, and rejects many women coming for an abortion for this reason. However, it also encompasses mental health and well-being, making the exception eligible to any pregnancy that a woman believes is a risk to her well-being. Another problem physicians take advantage of is gestational age: as the law does not provide a gestational age limit, physicians tend to reject women for reasons formed on their own beliefs. In all these situations, when a physician refuses to perform an abortion, he/she is legally bound to refer the woman to a colleague that is willing to perform one. Out of a sample of 49 physicians, only 50% has referred a patient to a colleague for an abortion.[163] The others were considered as extreme conscientious objectors, relying on religion and personal beliefs to reject and lecture patients for their decision.[164] Women's access to health services is jeopardized not only by providers' refusal of care but also by governments' failure to ensure adequate distribution of providers and facilities to offer abortion services. Indeed, the abortion stigma is emphasized by the lack of trained healthcare workers. Only one medical school curriculum in Colombia included abortion training in 2015.[165] The others taught abortion provision in the context of managing incomplete abortions or miscarriages. This lack of knowledge by physicians is an obstacle to providing high-quality abortion care and intensifies abortion stigma towards women seeking to terminate their pregnancy. It is important to clarify that regulatory

[161] See Chapter 1, Section 3.3
[162] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia*
[163] Supra 155. Table 1 p. 881
[164] Stanhope, K., Rochat, R., Fink, L., Richardson, K., Brack, C., & Comeau, D. (2017). Physician opinions concerning legal abortion in Bogotá, Colombia. *Culture, health & sexuality*, VOL. 19, NO. 8, 873–887, and Fink, L. R., Stanhope, K. K., Rochat, R. W., & Bernal, O. A. (2016). "The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia. *International Perspectives on Sexual and Reproductive Health*, *42*(2), 71-80.
[165] Ibid.

norms such as the health exception and conscientious objection are not the problem per se. In theory, they both need not be barriers to women seeking an abortion but are implemented to regulate the practice of abortion and respect everyone involved. However, as we have seen, not all claims reflect a genuine concern from healthcare professionals and these regulatory and health system barriers may be intended to discourage and limit women's access to legal abortion.[166] Other barriers exist and represent social consequences of abortion stigma. Physicians were found to unjustly deny legal abortions in Colombia for various reasons: some demand for a judge's authorisation, or reject a claim of rape, or even refuse the health insurance coverage.[167] The medical staff may also be found to lack public information about safe abortion and poorly define or narrowly interpret legal grounds for abortion.[168] When all regulatory, health system, cultural and religious barriers are combined, they may exacerbate inequities to access safe services or serve as an obstacle to seeking legal services altogether, increasing the likelihood of unsafe abortion.

As will be seen below, this fear of being stigmatized is enough for a woman to seek unsafe and secret abortions and not to turn to safe and legal services. In fact, the law is limited in its possibility to prevent stigma as it addresses behavior but does not necessarily change the attitudes that produce the behavior.[169] For example, there is no legal protection or remedy against being ostracised by one's family. Through the cultural, religious and gender roles barriers that exist in South Africa and Colombia, it will become evident that although abortion is legal in both countries, it still carries stigma as a de facto illegal practice.

[166] Johnson, B. R., Kismödi, E., Dragoman, M. V., & Temmerman, M. (2013). Conscientious objection to provision of legal abortion care. International Journal of Gynecology & Obstetrics, 123(S3).
[167] Amado, E. D., García, M. C. C., Cristancho, K. R., Salas, E. P., & Hauzeur, E. B. (2010). Obstacles and challenges following the partial decriminalisation of abortion in Colombia. *Reproductive Health Matters*, *18*(36), 118-126.
[168] Ibid.
[169] Burris, S. 2006. Stigma and the law. Lancet 367: 529–31.

1.2 Cultural, Religious and Gender Roles Barriers Continuously Impeding Safe Access to Legal Abortion

The clandestine aspect of abortion seems to be less about the legality or illegality of it and more about keeping it a secret from other people. Different studies made on the cultural, religious and gender roles norms and traditions that affect abortion stigma, all concluded that if abortion is done in secret, a woman can try to avoid the social consequences of her actions.

1.2.1 Sociocultural Barriers Aggravating Abortion Stigma

Values, ideologies and concepts relating to abortion are culturally and historically constructed as definitions of motherhood, womanhood, family and abortion vary cross-culturally. The norms and values of the family, the community, and society influence one's decisions. Suitability for motherhood and acceptability of abortion is determined by a host of individual characteristics including occupation, age, cultural circumstances and religion.[170] In South Africa and Colombia, motherhood is a respected and rarefied experience but only within specific circumstances – at the right age, at the right time and within the context of marriage. Thus, when pregnancy happens outside these circumstances, secrecy is maintained,[171] and motherhood contributes to guilt and stigmatization of society when the decision of abortion is made. Yet, at the

[170] Kumar, A., Hessini, L., and Mitchell, E.M., (2009) Conceptualising abortion stigma. Culture, Health and Sexuality, 11 (6), 625–639.
[171] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, 30(1), 83-95. Chicago.

same time, there is also an overwhelming sense of shame on account of the stigma attached to out-of-wedlock pregnancies that push women to seek an abortion.[172]

In 2011, a study was conducted in three villages in rural areas of South Africa.[173] While focusing on group discussions and hypothetical vignettes to stimulate talk, researchers found that although abortion was negatively viewed, there were apparent contradictions and conditional acceptance of abortion. Participants agreed that the positive impact of the Choice of Termination of Pregnancy Act (1997) is important and that abortion was a suitable option under particular circumstances such as rape, economic hardship and pursuing an education. However, when culture was referred to, an inevitable opposition was invoked. Abortion was represented as killing and destructing cultural values and traditions and as a practice that should be opposed to in the name of culture. Statements such as 'the government has given our children the permission to kill', 'abortion came with white people and undermines black culture', '[if terminating your pregnancy] you are no different to a witch'[174] refer to this fear that abortion is considered as the destruction of culture, values and nation. Moreover, older generations believe that the change in the law is a destruction of generational power relations. Participants said that the legal nature of abortion is constructed as allowing young people to act in ways that are hostile to the older generation as it is giving more rights and controls to the young and disempowering the older generation.[175] Therefore, the decision-making of a woman is mostly contextual and is influenced by the interaction of environmental factors, social and cultural norms, and personal convictions.[176]

[172] Ibid.
[173] Macleod, C., Sigcau, N. & Luwaca, P. (2011) Culture as a discursive resource opposing legal abortion, Critical Public Health, 21:2, 237-245, DOI: 10.1080/09581596.2010.492211.
[174] Ibid, p. 243
[175] Varga, C.A. (2002). Pregnancy termination among South African adolescents. Studies in Family Planning 33, no. 4: 283–98.
[176] Ibid.

Abortion stigma is the main reason women choose to seek an unsafe abortion. As Varga found in his 2002 study on the abortion dynamics and decision-making among rural and urban adolescents in KwaZulu in South Africa,[177] participants' opinions were universal regarding a girl's decision to choose to terminate her pregnancy via a backstreet procedure. One interesting statement from a participant was "legalization of abortion is new, but here the practice of abortion is old, even among the young. It was done a long time ago before the law changed, and most abortions are still backstreet because it is viewed as a disgrace to the community".[178] Even though early childbearing remains a cause of embarrassment and distress for teenagers and their families, and thus makes abortion an attractive option; abortion is a practice that goes against core moral, cultural and traditional believes of some societies. Shame, guilt and fear of family and societal reactions often contribute to women not disclosing both the pregnancy and the subsequent abortion. Opting for backstreet abortions may be a way to avoid facing the double stigma of two socially objectionable acts: the girl becoming pregnant and choosing to abort. South African and Colombian cultures are more sensitive to social roles and the influence of others in the social context. They see the woman as embedded in a web of relationships and her actions not only affect her life, but also have consequences for her family, her partner and her community.[179] In fact, the religious views and values present in communities also strongly affect abortion stigmatisation.

[177] Ibid.
[178] Ibid, p. 289.
[179] Sahar, G., & Karasawa, K. (2005). Is the personal always political? A cross-cultural analysis of abortion attitudes. *Basic and Applied Social Psychology*, *27*(4), 285-296.

1.2.2 Religious Barriers Aggravating Abortion Stigma

All people are influenced by the predominant religious values of the society in which they live in because these values are part of their culture.[180] Most religions support traditional family structures and gender roles resulting in religious people as less supportive of abortion. Religion and abortion stigma go hand in hand as women surrounded by the most influential religious beliefs have higher levels of self-judgment and higher perception of community condemnation.[181] They are more likely to be isolated from social support and to perceive their community as hostile to abortion. For example, in a 2011 study, Catholic and Protestant women were found to experience higher levels of stigma than non-religious women.[182] In a sample of 627 women, 25.6% were Catholics, and 19.1% were Protestants.[183] Through multi-variable regression analyses, the study shows, with a 95% confidence, that Protestant and Catholic women are more likely to worry about judgment and community condemnation than non-religious women.[184] These results illustrate the effect that religious affiliation has on the perception of abortion. Religious beliefs and behaviors are potent influences on attitudes about sexual morality and gender equality. Various other cross-cultural studies have found that people who have higher religious involvement and religious importance will have more disapproving attitudes about abortion and gender equality.[185] A 2013

[180] Faúndes, A., & Barzelatto, J. (2006). *The human drama of abortion: a global search for consensus*. Vanderbilt University Press.
[181] Cockrill, K., Upadhyay, U. D., Turan, J., & Foster, D. G. (2013). Stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. Perspectives on Sexual and Reproductive Health, 45, 79–88.
[182] Ibid.
[183] Ibid, Table 3, *Percentage distribution of women participating in a study of abortion stigma, by selected characteristics*, 2011, p. 84
[184] Ibid, Table 5, *Coefficients (and 95% confidence intervals) from multivariable regression analyses assessing differences in mean scores on the full scale and subscales, by selected participant characteristics*, p. 85
[185] Adamczyk, A. (2013), "The Effect of Personal Religiosity on Attitudes Toward Abortion, Divorce, and Gender Equality," EurAmerica 43: 213-253**,** Jelen, T. G. (2014), "The Subjective Bases of Abortion Attitudes: A Cross-National Comparison of Religious Traditions," Politics and Religion 7: 550-567, ***and*** Cockrill, K., Upadhyay, U. D.,

study measured the religious attendance and religious importance of various countries and how it affected the disapproval of abortion. The study found that for every unit of increase in religious attendance, disapproval of abortion increases by 0.09 units, and for every increase in religious importance, disapproval of abortion increases by 0.33 units.[186] Catholic-majority countries had a higher rate of religious importance and attendance, and of disapproval of abortion than Protestant-majority countries. For example, Colombia has a rate of 0.3 units in religious importance and 0.1 units in religious attendance, representing a mean of 9.0 in disapproval of abortion. South Africa has a 0 rate of religious importance but a 0.2 rate in religious attendance, with a mean of 8.41 in disapproval of abortion.[187] Moreover, a 2014 study found similar statistics that emphasize the association of religiosity with the disapproval of abortion.[188] If we focus on comparing Catholicism and Protestantism (Figure 1), we will find as the previous study found, that Catholics-majority countries are more prone to relate their religious values and views to the disapproval of abortion than Protestants-majority countries are. However, by comparing six religious groups on their abortion stances, the researchers found that in all models, the most important predictor is the index of sexual morality and respect for life.[189] Indeed, religious communities are reluctant to support neither sexual intercourse before marriage nor practices such as euthanasia as they root for pro-life arguments.

Turan, J., & Foster, D. G. (2013). Stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. Perspectives on Sexual and Reproductive Health, 45, 79–88.

[186] Adamczyk, A. (2013), "The Effect of Personal Religiosity on Attitudes Toward Abortion, Divorce, and Gender Equality," EurAmerica 43: 213-253, p. 234.

[187] Ibid, Figure 1 - Effect Sizes of Religious Attendance and Religious Importance by Country for Explaining Disapproval of Abortion (OLS Unstandardized Regression Estimates), p. 235

[188] Jelen, T. G. (2014), "The Subjective Bases of Abortion Attitudes: A Cross-National Comparison of Religious Traditions," Politics and Religion 7: 550-567.

[189] Ibid.

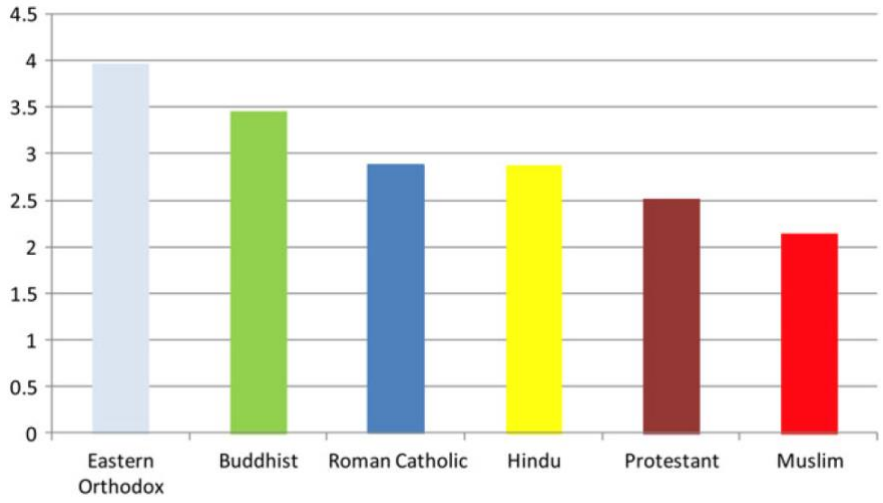


FIGURE 1. (Color online) Mean abortion attitudes by religious tradition.

Figure 1 - *Source: Jelen, T. G. (2014), "The Subjective Bases of Abortion Attitudes: A Cross-National Comparison of Religious Traditions," Politics and Religion 7: 550-567, p. 560.*

Nevertheless, these findings do not affect women with strong religious affiliations to seek abortion services. On the contrary, they have abortions at a similar rate to that of all women. The only difference is that abortion stigma is much stronger in their communities and leads them to seek backstreet abortions, so their decision remains secret and avoids public condemnation.

Finally, religious values and traditions affect societies in different ways depending on their culture. Negative attitudes are associated with conservative beliefs about when life begins, women's sexual behavior and women's roles in society. On the one hand, in Colombia, the disapproval of abortion is related to the strong conservative religious forces that hold political power and help shape the stigma of abortion surrounding the word 'sin'.[190] The Church is a vocal and influential opponent of abortion and even go as far as threaten doctors to be excommunicated

[190] Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., & Palomino, N. et al (2011). Social stigma and disclosure about induced abortion: Results from an exploratory study. Global Public Health, 6(Suppl. 1), S111–S125.

if they provide the services.[191] Abortion in Colombia is a question of Catholic morality and is not seen as a gender-rights issue. On the other hand, South Africa's religious values and traditions affect abortion stigma in a greater way on gender-based inequalities. As rural and urban societies in South Africa hold unequal attitudes toward the traditional role of girls and women, the community is more likely to disapprove of abortion and stigmatize girls and women for their social roles and unwanted pregnancies. Thus, the responsibility women carry is much more substantial as reproductive health and freedom in South African and Colombian cultures also affect gender equality issues.

1.2.3 Gender Roles Barriers Aggravating Abortion Stigma

The connection between gender roles attitudes and attitudes toward abortion may merely not be apparent to many people to whom the issue does not seem relevant. However, the relevance of access to abortion to female equality is of importance as the effect of abortion stigma pushes a woman to seek an unsafe abortion to avoid being seen as a 'lesser woman', a disgrace and an embarrassment to the community. A 2003 study examined the links between gender roles and the social impact of adolescent childbearing in rural and urban adolescents in South Africa.[192] It also aimed to demonstrate the influence of gender norms on the sexual dynamics that lead to unwanted pregnancies and unsafe abortions. Due to gender-based inequalities, early parenthood has a disproportionate and highly negative impact on girls. Whereas for young men, early fatherhood is an affirmation of masculine maturity and strength.[193] This value and impact of adolescent

[191] Moloney, A. (2009). Unsafe abortions common in Colombia despite law change. *Lancet, 373*(9663), 534.
[192] Varga, C. A. (2003). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in family planning, 34*(3), 160-172.
[193] Ibid.

pregnancy and parenthood are linked to cultural concepts of masculinity and femininity. The cultural importance of female fertility incorporates the ideas of womanhood and sexuality. In South Africa, a girl's respectability is gained by her being sexually available to her partner and allowing him to have the decision-making authority. This unequal decision-making authority pressures girls to engage in early and unprotected sex leading to unwanted pregnancies.[194] Indeed, the use of contraceptives is negatively seen, and girls who suggest to use them are perceived to be conducting themselves as highly inappropriate. However, girls also have the responsibility to avoid pregnancies as adolescent pregnancy is a mark of poor female sexual behavior and is viewed as a major setback with school disruption, economic strain, emotional stress and social stigma. What truly shows the gender-based inequalities in traditional and cultural societies such as South African ones, is that the boy's acceptance of paternity would maintain the girl's dignity.[195] Conversely, if the girl found herself faced with the humiliation of paternity refusal and stigmatized for getting pregnant, she ends up with no other choice than to terminate her pregnancy in extreme measures. Gender roles have an important impact on the stigmatization of women. The responsibility and respectability expected of women seem unfair and unjustified. As Gilbert and Sewpaul state: "It is an irony that amid the dominant discourse of men as providers and protectors, men abandon their partners and children and do not pay for child support, and that women are left to literally carry the baby. Yet women are the ones, not the men, who are demonized for the pro-abortion choices that they are often forced to make."[196] The gender-based inequalities between boys and girls at a young age comes from education and is passed down from older generations. Forcing a girl to respect her partner's wishes, to engage in unprotected sex and to avoid getting pregnant is too big

[194] Ibid.
[195] Ibid.
[196] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, Chicago, 30(1), 83-95, p. 87

of a responsibility to put on one person. The South Africa Department of Health Services' statistics of 2002 suggests that by the age of 19, 35% of girls have been pregnant and 30% have given birth at least once.[197] These statistics show that due to gender roles expected of girls, they are faced with a double stigma:

(1) The social stigma of not engaging in sexual intercourse, or engaging but asking for contraceptives, or engaging and getting pregnant and risking paternal rejection;

(2) The abortion stigma of getting pregnant and asking for an abortion.

Therefore, social and abortion stigma lead girls to extreme measures such as backstreet and unsafe abortions.

In this section, cultural, religious and gender roles barriers were seen to continuously impede safe access to legal abortion as young girls and women prefer keeping their abortion secret and out of the public's eye. However, the social barriers this section presented are the leading cause of the emergence of social persecution and consequences that lead women to unsafe abortions. Situational factors surrounding women's lives in South Africa and Colombia also cause the social persecution but more importantly affect a woman's decision-making autonomy. Abortion stigma is created due to social, cultural and religious values but is also strengthened by the structural constraints of the democracies – such as financial hardships, lack of education and unemployment.

[197] Supra 192.

Section 2 – Individual Values and Situational Factors' Effect on Decision-Making: A Restraint to Women's 'Free' Choice

As seen throughout the thesis, abortion raises controversial ethical questions, often linked to religious and cultural beliefs, which influence attitudes toward and decisions about abortion.[198] However, religious and cultural barriers are not the only barriers affecting a woman's choice of abortion. Circumstances and aspects of a woman's life – such as financial hardships, unemployment, being single and uneducated – affect her decision-making as well. These individual values and situational factors mediate the influence of religion and culture on moral decision-making and women's decision to abortion is also linked to their contextual realities.[199] This section aims to explain the effect contextual realities have on abortion decision-making and to conclude that women in religious and cultural communities such as South Africa and Colombia are faced with an obligation to abort more than a free choice.

2.1 Structural Constraints on Women's Lives Limiting Women's Decision-Making

As moral agents, women exercise responsibility and power as they seek to make decisions based on their interests and the interests of others.[200] However, in South Africa and Colombia, we have seen that women struggle with numerous religious and cultural values and life exigencies as they make their abortion decision. Worldwide, women decide to choose abortion for their personal

[198] Supra 191.
[199] Supra 192.
[200] Ibid.

reasons. However, the key to understanding the decision of women to turn to unsafe abortions is the awareness that circumstances dictate choices. In South Africa and Colombia, where religious and cultural values dictate peoples' lives and where unemployment and gender roles rule the community, can we say that women exercise and enjoy their right to access abortion? In the studies I have mentioned in my thesis, the majority of women interviewed felt the same way about abortion: it is an immoral, inappropriate act, a sin in the eyes of God and a disgrace to society, but sometimes it is needed in circumstances related to financial hardships, a lack of support from the partner, family and friends; being uneducated and young; being surrounded by stigma and fear, and so on. For example, in a 2016 study of 1167 South African women, nearly 60% cited financial concerns as one of their reasons for choosing to have an abortion.[201] In South Africa, the government administers and offers child support grants for low-income women; however, at ZAR 250 (roughly US$24.32) per month,[202] it is insufficient for covering the costs of childbearing as most women are unemployed and dependent on family members for financial support. In fact, women form 60% of the unemployed population in South Africa,[203] and those who are employed hold low paid jobs. In 2010, the average monthly income for an employed, Black individual in South Africa was ZAR 2167 (roughly US$151.69).[204] Thus, even for many working South Africans, the cost of an abortion at ZAR 143.76 (US$9.99) may be significant.[205] Moreover, the

[201] Lince-Deroche, N., Harries, J., Constant, D., Morroni, C., Pleaner, M., Fetters, T., ... & Sinanovic, E. (2017). Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis. *Contraception*.
[202] Singh, S. (2006). Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *The Lancet*, *368*(9550), 1887-1892.
[203] Trading Economics. (2012). Unemployment with primary education; female unemployment in South Africa. Retrieved from http://www.tradingeconomics.com/south-africa/unemployment-with-primary-education-female-percent-of-female-unemployment-wb-data.html
[204] Blanchard K, Lince-Deroche N, Fetters T, Devjee J, Durão de Menezes I, Trueman K, et al. Introducing medication abortion into public sector facilities in KwaZulu-Natal, South Africa: an operations research study. Contraception 2015;92:330–8 in Supra 184.
[205] Supra 201.

country's unemployment is also due to demographics and education problems. There is gross inequality in service availability and accessibility in both countries, especially when women live in rural areas or far from the central urban area. Dickson studied the inequalities of access services among urban and rural provinces in South Africa.[206] Nationally, 292 facilities have been designated to provide abortion services, but in 1999 only 32% were functioning, and among those, 27% were in the private sector.

Total number of health-care facilities, number of facilities designated to provide abortion services, and number of facilities providing abortion services, South Africa, 1999

Province	Total number of public-sector health-care facilities[a]	Number of public and private facilities designated to provide abortion services	Public and private designated facilities providing abortion services[b]		Private designated facilities providing abortion services		Public designated facilities providing abortion services		Percent of all public-sector facilities providing abortion services (percent)
			Percent	(N)	Percent	(N)	Percent	(N)	
Eastern Cape	(829)	(11)	91	(10)	10	(1)	90	(9)	1.1
Free State	(295)	(9)	56	(5)	20	(1)	80	(4)	1.4
KwaZulu Natal	(597)	(66)	12	(8)	25	(2)	75	(6)	1.0
Gauteng	(388)	(75)	44	(33)	45	(15)	55	(18)	4.6
Mpumalanga	(283)	(22)	27	(6)	0	(0)	100	(6)	2.1
Northern	(450)	(36)	14	(5)	0	(0)	100	(5)	1.1
Northern Cape	(188)	(2)	100	(2)	0	(0)	100	(2)	1.0
North West	(394)	(12)	75	(9)	22	(2)	78	(7)	1.7
Western Cape	(452)	(59)	24	(14)	29	(4)	71	(10)	2.2
Total	(3,876)	(292)	32	(92)	27	(25)	73	(67)	1.7

[a] Public-sector facilities include all clinics, community health centers, and hospitals that could be designated to provide abortion services according to the *South African Health Review* (2002).
[b] The numbers indicate facilities that were providing abortion services in the four weeks prior to the inquiry.

Table 7 – *Source : Dickson, K. E., et al.. (2003). Abortion service provision in South Africa three years after liberalization of the law. Studies in Family Planning, 34(4), 277-284.*

Table 7 above shows the inequality among provinces in the number of private and public facilities available and accessible in urban provinces (Gauteng) compared to the number of facilities available but not accessible in rural provinces (KwaZulu Natal, Mpumalanga). The low percentage of all public-sector facilities providing abortion services compared to private-sector

[206] Dickson, K. E., Jewkes, R. K., Brown, H., Levin, J., Rees, H., & Mavuya, L. (2003). Abortion service provision in South Africa three years after liberalization of the law. *Studies in Family Planning*, *34*(4), 277-284.

facilities in some provinces, also show the possibility of a bias in access toward women of higher socioeconomic status (with Gauteng having more than half of the private facilities in its province). In addition to demographic aspects, lower levels of education are associated with more conservative abortion attitudes.[207] In rural areas where education stops after primary or secondary school, women are raised in religious and traditional communities. Even women who see education as the way out from the cycle of poverty are struggling to obtain it. Therefore, under such dire circumstances, unsafe abortion becomes a viable option.

All these additional barriers to religion, culture and gendered power imbalances reiterate the struggle of the decision-making women must face. Strikingly, worldwide, the pro-choice and pro-life stances are the most common positions individuals assume when discussing abortion. Pro-choice advocates generally adopt a liberal feminist perspective that pushes for women's freedom of choice.[208] From a liberal feminist pro-choice stance, women are seen as having the right to exercise complete control of their bodies and autonomy in decision-making.[209] In this way, regardless of the side of the debate, each position engages with the issue of women's decision-making. However, basing one's argument on personhood and autonomy expels all other important factors essential to the discussion. For example, the pro-life and pro-choice dichotomy does not consider how women's choices are affected by contextual factors and circumstances. Women in South Africa and Colombia, specifically in religious, cultural and conservative communities, do not choose abortion only because they had the right to such choice or refuse abortion only because

[207] Adamczyk, A. (2013), "The Effect of Personal Religiosity on Attitudes Toward Abortion, Divorce, and Gender Equality," EurAmerica 43: 213-253.
[208] Smith, A. (2005). Beyond pro-choice versus pro-life: Women of color and reproductive justice. NWSA Journal, 17, 119–140.
[209] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, 30(1), 83-95. Chicago.

of personhood. The life circumstances and surrounding factors pushed them into making or not making the decision. What differentiates them from women in developed countries is the decision to seek unsafe and backstreet abortions rather than safe and legal services. Gilbert and Sewpaul use the notion of radical feminism to describe the women's choice as a constrained one, putting into question the pro-life/pro-choice dichotomy.[210] Indeed, religion in South Africa and Colombia promotes the sanctity of life and the importance of childbirth. As pro-life countries, most people do not approve of abortion on demand and presumes that if one is pro-life, one cannot or will not make a pro-abortion decision. However, as argued above, a paradox exists: pro-life women find themselves in situations that make them choose abortion. Contrarily, pro-choice arguments usually adopt a rights-based approach. Even though a rights-based approach promoted and implemented the legalization and liberalization of abortion as a human right all over the world, the implementation of it in South Africa and Colombia was not substantial as it ignored the fundamental aspects of power imbalances and the multiple social influences on the individual.[211]

One additional theory can be further described to understand the limitation of choice women have in South Africa and Colombia. The theory of human development has a common focus on broadening human choice and explains through three components – socioeconomic development, emancipative values and democracy – that the capability of human beings to choose the life they want should be the ultimate measure of social progress.[212] This theory is discussed in the section that follows.

[210] Ibid.
[211] Ibid.
[212] Welzel, C., Inglehart, R., & KLIGEMANN, H. D. (2003). The theory of human development: A cross-cultural analysis. *European Journal of Political Research*, *42*(3), 341-379.

2.2 Supplement Theory to why Legality is not Enough to Ensure the Full Practice of Women's Freedom of Choice: The Theory of Human Development

2.2.1 The Theory of Human Development

Welzel, Inglehart and Klingemann demonstrate that socioeconomic development, emancipative cultural change and democratization constitute a coherent theory of social progress they call human development.[213] They argue that its three components have a shared focus on broadening human choice:

(1) The socioeconomic development gives people the objective means of choice by increasing individual resources. Evolution of technological innovation, productivity growth, increasing incomes, rising levels of education and growing access to information are examples. These tendencies help to emancipate people from forming closed-in groups and minorities, and from weakening the vertical authority relations by strengthening horizontal relations. This would give people greater autonomy over their resources. In other words, socioeconomic development diminishes constraints on human choice by increasing individual resources.

(2) Emancipative values strengthen people's subjective orientation towards choice by means of their human autonomy and self-expression values. In traditional communities where conformity values subordinate human autonomy to community discipline, there tends to be fewer emancipative values that emphasize human choice. When growing

[213] Ibid.

individual resources widen the scope of possible human activities, people strive for autonomy and emancipation, strengthening their desire to have free choice and control over their decisions and actions.

(3) Democratization institutionalizes legal rights that guarantee free choices in people's private and public activities. However, it is crucial that these rights are not only formally guaranteed but are implemented in practice rendering them effective.

These components tend to occur simultaneously. For example, poor societies where citizens suffer scarce resources, tend to be dominated by conformity values that reflect constraints on human autonomy.[214]

Two linkages support the theory of human development: the means-motive linkage that connects emancipative values with individual resources, and the motives-rules linkage that connects effective rights to emancipative values.

First, in societies where resources are scarce, unemployment is high and opportunities are limited, the population's subjective values and autonomous choices are constrained. Due to social conditions, people are not able to strive for self-expression. In fact, a community suffering from scarce resources tends to be dominated by conformity values,[215] because more permissive social conditions create greater choice and higher satisfaction and fulfilment.[216] For example, Putnam reached similar conclusions in his description of differences between Italian citizens of the affluent North and the poor South. He found that Southern Italians distrust their fellow citizens as they tend to place emphasis on conformity values – such as group discipline, social control, hierarchy, moral

[214] Ibid.
[215] Ibid.
[216] Anand, S. & Sen,A. (2000). Human development and economic sustainability. World Development, 28(12): 2029–2049.

rigidity and strong authority – that prevail under restrictive human conditions.[217] Thus, this linkage between emancipative values and available resources originates at the individual level as individuals with more resources show a stronger emphasis on emancipation.

Second, the motives-rules linkage ties the effective rights of a democracy to the emancipative values of the country. Contrary to the means-motive linkage, this linkage manifests itself at a societal level. Living an emancipated life involves activities that require legal space on effective freedom rights. Indeed, there is a difference between formal democracy and effective democracy. A society may be a formal democracy such that all the basic freedom rights are legally guaranteed; however, without necessarily rendering these rights effective. In other words, democratization requires more than merely the codification of rights; it requires the implementation of them into social practices. Moreover, an effective democracy also requires its citizens to respect the rights in their actual behavior. To be able to accomplish that, societies primarily rely on their elites; i.e. citizens of a higher class with authority and integrity within the democracy.[218] These represent the government, social workers or whoever can render the law and rights as effective, such as the Church in religious communities. Indeed, the theory of human development emphases that this elite integrity is what distinguishes effective democracy from formal democracy.

However, the mere presence of freedom rights cannot alone create emancipative values among citizens. The need to merge the two linkages is necessary as resources and socioeconomic development is required to feed these values. Indeed, there is a direct, causal link between both linkages: to be practised effectively, the rights need corresponding values that are formed and

[217] Putnam, R.D. (1993). Making democracy work. Princeton, NJ: Princeton University Press.

[218] Ibid.

nourished by the possibilities and resources within a society. When there are too few resources and formal rights in a society, emancipative values are constrained – affecting an autonomous and subjective decision from citizens.

Finally, the two linkages of human development are not universal across cultural zones. The theory can only be considered as a general theory if cultural zones are differentiated. This means that zones that present the same cultural and historical traditions, the same religion, region and imperial legacies are grouped as to evaluate the theory equally. Indeed, the study of Welzel et al. measured emancipative values using the World Values Survey data. It covered 73 countries representing 80% of the world's population, divided them into nine cultural zones, and used a scale of factors summarizing several attitudes proposed as indicators of self-expression.[219] Those factors that are positively linked to emancipative values range from "tolerance of human diversity", "inclination to civic protest", "liberty aspiration" and "trust in people" to "high life satisfaction" and "weak religiousness". The theory of human development can be applied in various contexts through the different factors; however, how does this affect the subject of abortion in South Africa and Colombia?

2.2.2 Human Choice in South Africa and Colombia

In the two tables below, positions of South Africa and Colombia on the two linkages show interesting information. Firstly, South Africa rates a degree of 10 on the presence of individual resources, -0.6 strength of emancipative values and a degree of 40 on effective democracy. These results show that even though South Africa is seen as an effective democracy at the societal level,

[219] Ibid. Table 2 *The composition of emancipative values*, p.354. The five factors of emancipative values are tolerance of human diversity, trust in people, liberty aspirations, high life satisfaction, weak religiousness.

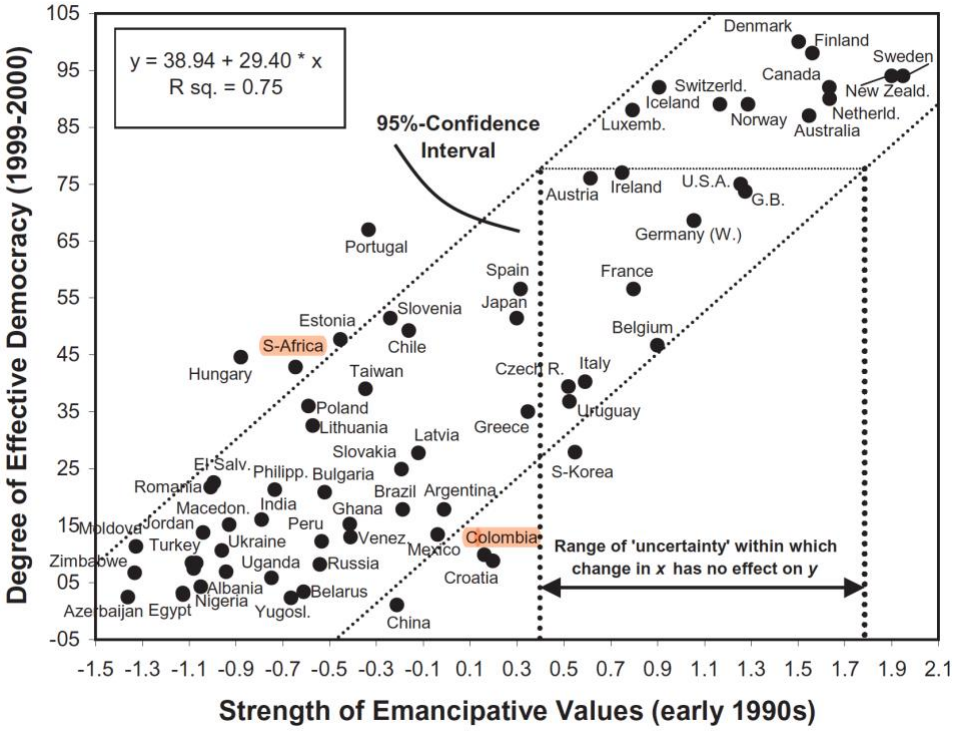
the lack of resources and the fragile emancipative values come from the individual level. In other words, even though the right to free choice on legal and safe abortion is present in South Africa, the lack of resources and opportunities offered to the population reveals strong conformity values and leads to constraints on social attitudes and human autonomy. The strong cultural traditions and gender roles inequalities limit the possibilities of women to practice the "freedom" rights offered by the government. With no support at the individual level from the societal level, women will turn to unsafe and backstreet abortions.

Secondly, Colombia rates a degree of 15 for the presence of individual resources, 0.15 strength of emancipative values and a degree of 10 on effective democracy. Contrary to South Africa, the results show stronger importance at the individual level than the societal level. The main problem in Colombia is that the right to abortion is merely codified but not effective. Colombia represents a formal democracy as religion has always influenced and continues to influence attitudes about abortion. Religion is found to have a linear and powerful effect on individuals even as nations develop and stabilize.[220] In the case of Colombia, the support of the 'elites' is very weak. The Church has the key place of authority in societies, and the reluctance of institutions and the medical staff to implement the law regresses Colombia to a formal democracy.

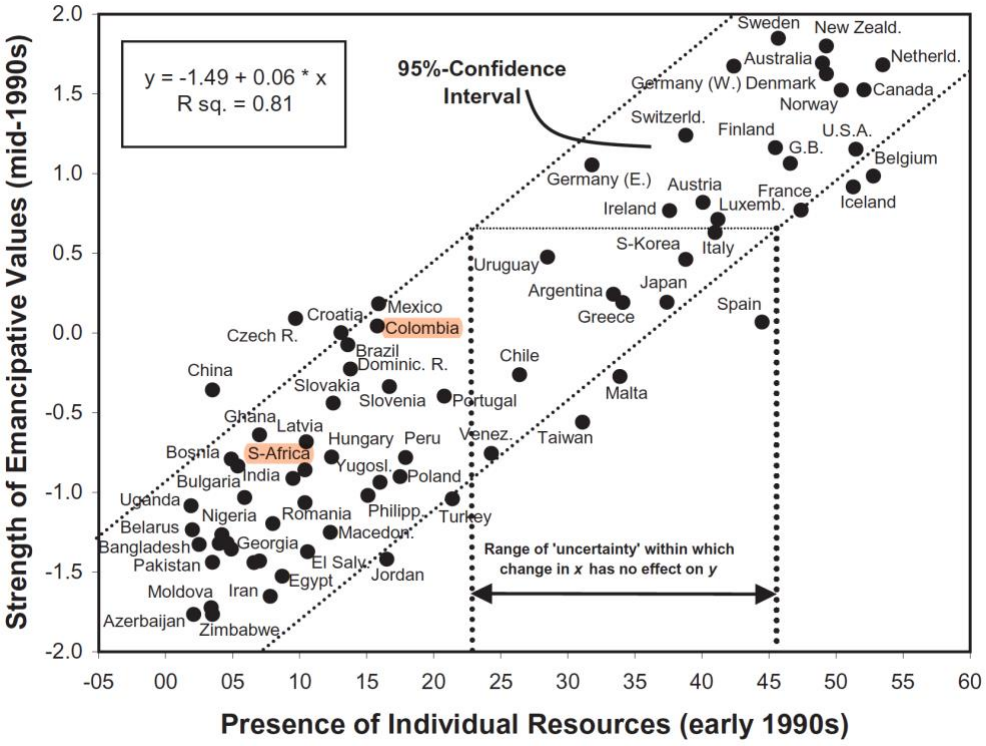
This theory supports the theory that a rights-based approach is not enough to ensure women's full freedom of choice on abortion. In countries where structural constraints at the individual and societal level exist, such as South Africa and Colombia, women face the need to abort unsafely due to abortion stigma.

[220] Adamczyk, A., & Pitt, C. (2009). Shaping attitudes about homosexuality: The role of religion and cultural context. Social Science Research, 38(2), 338-351.

Tables 8 and 9: <u>Source :</u> *Welzel, C. et al. (2003). The theory of human development: A cross-cultural analysis. European Journal of Political Research, 42(3), 341-379. pp. 368-369.*



<u>Figure 1A</u>. The means-motives linkage across nations.



<u>Figure 2A</u>. The motives-rules linkage across nations

Conclusion

Chapter 2 concentrated on the emergence of abortion stigma due to strong cultural, religious and traditional norms in South African and Colombian societies (Figure 2 below). Religious and cultural constructions of motherhood, pregnancy and marriage have contributed to women's reproductive health decisions. Always being surrounded by values and negative views on sexual morality, pregnancies and abortion engrave fear, shame and guilt on young girls and women. The social pressure on girls' role in society, the importance of religion and cultural traditions increase secrecy on a practice that is extremely common worldwide. Being embedded in a specific, multi-layered sociocultural context affects the meaning of abortion and the decision-making of women. Moreover, abortion stigma is strengthened by various medical aspects. Physicians and the medical staff are feared and are seen as judgmental and not helpful. They overuse their legal authority and abuse their rights, pushing away women from safe and legal services, and proving that culture and religion are deployed as digressive resources to oppose legal abortion. However, individual, community and providers' stigmas are not the only factors that lead women to choose unsafe abortions rather than safe and legal services. In South Africa and Colombia, there is a clear lack of knowledge and awareness on legal matters and contraception methods. There are also inequalities of access to safe services among lower classes, less educated and rural women compared to urban, higher educated and women of higher socioeconomic status. The structural constraints of women's lives push to question the actual choice women have in deciding to abort. While most women in South Africa and Colombia considered their pro-life, religious and cultural values in making the abortion decision, their life circumstances and needs and the needs of others around them took precedence. The primary factors contributing to the abortion decision are financial constraints, unemployment, abandonment by partners, and fear and

shame given familial, religious, and cultural sanctions against pregnancy outside of marriage. Thus, if reproductive health choices such as abortion should be free, safe, and legally available to women, women should be granted the socioeconomic freedom and cultural spaces to exercise such choices.[221] Indeed, the theory of human development invigorates the importance of human choice. For the law to be implemented into social practices and attitudes, South Africa and Colombia are required to offer the resources needed to amplify women's values and autonomy in practicing the rights given to them. This means that there is a need for further implications to ensure safe acceptability and accessibility of abortion services.

[221] Supra 209.

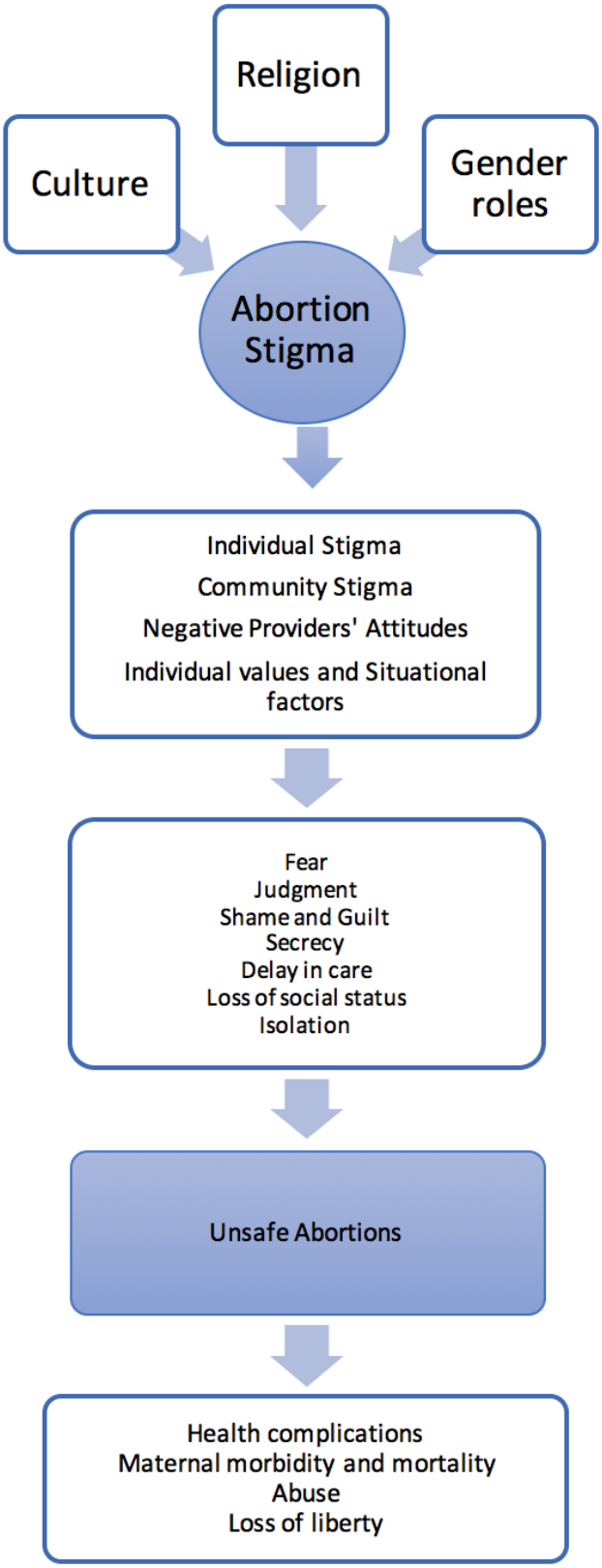


Figure 2 – Diagram of abortion stigma and its impact on women's choice to legal abortions

CHAPTER 3 – IMPLICATIONS NEEDED TOWARDS ACCEPTABILITY AND ACCESSIBILITY TO SAFE AND LEGAL ABORTION SERVICES

> "I think the way in which termination of pregnancies are done in the government clinics at the moment is really not working because it's not integrated with other services, it is completely overloaded and there's no privacy. It's just not a quality service and they really should be reviewed in its complete sense to really look again at policies of implementation and to make sure that this [Choice of Termination of Pregnancy] Act is implemented the way it should be".[222]

When women are faced with unwanted pregnancies, many turn to abortion services. Whether those services are safe and legal or not, women seek abortions for various personal reasons. However, the possibility of a safe and legal abortion is limited in religious and cultural countries such as South Africa and Colombia. The fear of stigmatization and persecution pushes women to seek unsafe abortions even where legal abortion services are provided. Chapter 2 presented the various barriers impeding safe access to abortions services in South Africa and Colombia: cultural and religious traditions and expectations, financial hardships, lack of knowledge and awareness on abortion and abortion services, and demographic and education factors leading to a strong abortion stigma. Moreover, women find themselves limited in practicing their right to seek an abortion. Both South Africa and Colombia represent examples of places in which women's choice is restricted due to structural and contextual constraints. I have argued that

[222] Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*, *9*(1), 296.

legality does not ensure safety and that merely passing a law without making changes to enforce it is not enough in societies such as South Africa and Colombia. Both the Choice of Termination of Pregnancy Act 1997[223] and the Court Decision of 2006[224] were not enough to ensure the full application of their purpose. Therefore, there is a clear need for further involvement by the governments and the community to ensure wider acceptability and accessibility to safe and legal abortion services. Indeed, more significant changes that do not only surround reproductive health rights are necessary. For example, health insurance companies must ensure the services are funded, health providers and services must provide safe abortions and the governments must provide easily accessible public information.[225] Moreover, enhancing women's access to education, economic opportunities, and creating cultural spaces that respect women are further changes that can reduce fertility rates, child mortality, unsafe abortions rates and even the abortion rate itself. These examples can be implemented through different methods.

Therefore, Chapter 3 will present the various implications that are needed to promise acceptability and accessibility of abortion services in strong cultural and religious countries governed by inequalities. It will expand on the different implications South Africa and Colombia's governments and communities can implement to ensure acceptability and accessibility of abortion services. On one hand, access to education should be prioritized by expanding the freedom and choice of women and ensuring easier access to information. This includes various steps the government and community are required to take by educating the adult community as well as the medical community about abortion (Section 1). Indeed, first, social work educators, researchers

[223] The Choice of Termination of Pregnancy Act (1997)
[224] *Decision C-355/06, May 10, 2006 (Constitutional Court of Colombia*: there is a need for public ownership of the 2006 Constitutional Court of Colombia decision.
[225] Amado, E. D., García, M. C. C., Cristancho, K. R., Salas, E. P., & Hauzeur, E. B. (2010). Obstacles and challenges following the partial decriminalisation of abortion in Colombia. *Reproductive Health Matters*, *18*(36), 118-126 ***and*** Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*, *9*(1), 296.

and practitioners have important roles to play in advocating for structural changes and in lobbying for policies that allow women expanded freedom and choice.[226] Second, structural changes include reducing poverty to prioritize gainful employment. However, gainful employment is also required to be equal. Governments have, therefore, an obligation to engage the community in challenging gender inequality, and assumptions and traditions about gender roles that place an unwarranted responsibility on women for motherhood and childbearing, and accept men as not taking responsibility for fatherhood (Section 1.1).[227] Finally, there is also a need to improve the services' reputation. Developing approaches for providing termination services in a manner that reduces women's exposure to hostile members of staff would promote access to safe and legal abortion.[228] Indeed, in both Colombia and South Africa, there are providers' problems associated with a general lack of adequate pre- and post-abortion counselling, punitive staff attitudes towards women seeking an abortion, overcrowded, overburdened and fragmented services, and difficulties with staff recruitment (Section 1.2).[229]

On the other hand, after explaining the stages to ensure easier access to information and better treatment of women seeking to terminate their pregnancy, I will present a different approach to plausible implications. The rate of unsafe abortions is not going to reduce rapidly, therefore, while governments continue to impose education to its people, they should also implement a harm reduction approach to ensure safer methods to unsafe abortions (Section 2).

[226] Supra 209.
[227] Sewpaul, V. (2013b). Inscribed in our blood: Confronting and challenging the ideology of sexism and racism. Affilia: The Journal of Women and Social Work, 28, 116–125.
[228] Jewkes, R. K., Gumede, T., Westaway, M. S., Dickson, K., Brown, H., & Rees, H. (2005). Why are women still aborting outside designated facilities in metropolitan South Africa?. BJOG: An International Journal of Obstetrics & Gynaecology, 112(9), 1236-1242
[229] Supra 222.

Section 1 – The Need for Abortion Education in South Africa and Colombia

1.1 Educating the Community

As we have seen through the various studies in South Africa and Colombia, adolescents are more understanding of the need for abortion.[230] However, their gender roles and religious views are passed down to them by the older generations. Thus, abortion education offered to adults is an attractive strategy that would ensure younger generations to feel more comfortable with the subject of abortion. Indeed, resistance to dominant discourses concerning abortion were mostly seen in studies focused on service providers and women who have had abortions. As mentioned above, Gilbert and Sewpaul found that women in South Africa who had terminated pregnancies challenged the notion of 'choice' and highlighted the structural constraints on their reproductive lives.[231] Therefore, Bloomer reported a study seeking to address the lack of knowledge on adult abortion community education and to offer insights into how education may foster resistance to patriarchal religious norms and abortion stigma.[232] Discussions in private spaces allow women to resist the silencing of abortion and discover a new meaning to abortion as a health, well-being and social justice issue. Regularising abortion should not be linked to formal mechanisms of political power. Instead, it should operate as a network of relations that interweave through social life at macro and micro levels.[233] In Bloomer's study, multiple themes of resistance to religious patriarchy, abortion stigma and the silencing of abortion arise in the talk of women. Four main

[230] Supra 225.
[231] Supra 209.
[232] Bloomer, F. K., O'Dowd, K., & Macleod, C. (2017). Breaking the silence on abortion: the role of adult community abortion education in fostering resistance to norms. *Culture, health & sexuality*, *19*(7), 709-722.
[233] Foucault, M. 1977. Discipline and Punish: The Birth of the Prison. New York: Pantheon.

themes emerged from the analysis of the discussion sessions: problematizing silence, problematizing anti-abortion education, lived experiences and rehabilitating religious discourse.[234] First, participants problematized the norm of silencing abortion, even amongst close friendship groups and family members. Individuals that support autonomous choices when faced with abortion are needed to break the silence and understand the complexity of abortion decision-making. Participants cited the importance of using real-life case studies in the program as access to abortion was especially restricted for women from lower socioeconomic groups and that neither churches nor political institutions acknowledged this.[235] Second, the problem of morally laden anti-abortion education kept surfacing in discussions. Religiously informed teachings had a fundamental effect on their views on abortion as children. Most participants spoke about how they had viewed these truths without questions, have adopted this belief all their lives and have passed it down to their children. One participant stated that "[The Catholic Church] forces people into making a stand on the issue without being fully educated and informed. The school system makes it worse. They cover abortion and euthanasia in a 45-minute lesson, and that is the box ticked for them."[236] Third, participants highlighted that the most impactful approach to challenging anti-abortion discourse was the use of real-life experiences case studies. These discussions are not aiming at changing the moral views of the women, but to purely show them the different situations and circumstances in which women may require abortion. Finally, the educational materials of the program had included the Christian Church's historical evolution stance on abortion.[237] Rehabilitating religious discourse led some participants to realize that they could be pro-choice and remain religious, something that they had previously considered contradictory. Therefore,

[234] Supra 232.
[235] Ibid.
[236] Ibid, p. 717.
[237] Ibid.

adult abortion education in community settings offers the possibility of creating discussion spaces for people to reflect on and resist oppressive norms regarding reproduction and abortion.[238] Bloomer's study presented an example of the importance of providing the space in which resistance may arise. It also showed that a rights-framework would not be sufficient to permit resistance to the anti-abortion discourse. The change of law in a society where religious, cultural and gender roles traditions have ruled everyday life, will not change society's stance or rights overnight. The legalization of abortion is new in both South Africa and Colombia, but the traditions and religious stances are old. Women have turned to unsafe backstreet abortions for a long time, and it is not by merely changing the law that this will change. Educating the older generations is a possible start. However, it is not enough as it is the medical community that has the upper hand to ensure safe access to abortion services. Without their support and engagement, women's pro-choice opinions will not prevent them from making recourse to choose unsafe abortions.

1.2 Educating the Medical Community

1.2.1 The Need for Change in the Medical Community

Various changes need to be done to further educate the medical community. Health services should be recognized in such a way as to ensure that an effective exercise of the freedom of conscience of healthcare professionals does not prevent women and adolescents from obtaining access to services to which they are entitled.[239] Indeed, when laws and policies do not take into

[238] Ibid.
[239] Johnson, B. R., Kismödi, E., Dragoman, M. V., & Temmerman, M. (2013). Conscientious objection to provision of legal abortion care. International Journal of Gynecology & Obstetrics, 123(S3).

consideration the multiple challenges inherent from conscientious objection, women's health and their human rights can be compromised. One option to reduce those challenges would be to implement regulations on how to invoke conscientious objection without jeopardizing women's access to safe and legal abortion services.[240] The lack of knowledge and awareness medical providers have on the limitations of their conscientious objection needs to be addressed and informing them on the importance of referral to another colleague should be priority. However, some extreme conscientious objectors will not even refer their pregnant patient to another doctor, putting her at risk of seeking an unsafe abortion. Some examples of implications include the involvement of the medical community in adulthood community education but between themselves as to not influence or intimidate women's opinions; sanctions against providers that go against their legal obligations; and more authority from the governments when it comes to the implementation of a human right in their society. In addition to providing guidance for providers' conscientious objection right to legal abortion, the WHO's safe abortion report highlights many health system principles that can facilitate equitable access to and availability of safe abortion.[241,242] Given that most physicians in Colombia and South Africa attended medical school when abortion was illegal, it is not surprising that they internalised the message that abortion should not be practiced.[243] Further training sessions should be provided and to further medical staff. In fact, as a remedy to shortages of willing providers of legal abortion care, states should consider improving access through training mid-level providers. Abortion care can be safely

[240] In the International Covenant on Civil and Political Rights, United Nations; entry into force 23 March 1976; Article 18 stipulates that freedom to manifest one's religion or beliefs may be subject to limitations to protect the fundamental human rights of others.
[241] World Health Organization. (2012). *Safe abortion: technical and policy guidance for health systems*. World Health Organization.
[242] Supra 239.
[243] Fink, L. R., Stanhope, K. K., Rochat, R. W., & Bernal, O. A. (2016). "The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia. *International Perspectives on Sexual and Reproductive Health*, *42*(2), 71-80.

provided by any properly trained healthcare provider such as nurses and midwives.[244] The Choice of Termination of Pregnancy Act allows for first trimester abortions to be performed by mid-level providers.[245] However, the shortage of healthcare providers who are willing or trained to perform abortions undermines the provision of the Act. In South Africa, training opportunities were described as sporadic and frequently subject to cancellation due to insufficient interest from providers and staff shortages making it difficult for those who wanted to undergo training to be released from their duties.[246] The willingness of staff to get involved in abortions is weak and presents an obstacle as many mid-level providers who are willing to provide abortions, decide not to do so as to avoid facing judgment and challenges from their colleagues.[247] Stigma and fear associated with providing or even assisting with abortion services appeared as a serious barrier to accessing training. Therefore, to ensure that mid-level providers and doctors seek new and additional training for safe and legal abortion services, governments and institutions should also implement values clarifications workshops and counselling sessions. With these methods, rather than simply taking the views of participants as given, the participants are given the opportunity to participate in discussion. This would more likely change their views as the process can shape not merely their preferences but also their values.[248] In fact, while the values clarification workshops are not implemented, South Africa has already sought to address the lack of correlation between abortion policy and the ethical views of the medical staff through these workshops.[249] By training and equipping healthcare workers and systems to provide safe abortion care, these workshops aim

[244] Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*, *9*(1), 296.
[245] The Choice of Termination of Pregnancy Act (1997), section 2(2).
[246] Ibid.
[247] Vincent, L. (2011). South Africa's Abortion Values Clarification Workshops—An Opportunity to Deepen Democratic Communication Missed. Journal of Asian and African studies, 46(3), 264-277.
[248] Ibid.
[249] Ibid.

"to educate health workers on the new abortion law; promote non-judgmental attitudes towards abortion; and to encourage health workers to treat women seeking abortions with dignity and respect".[250] Participants are presented with case studies highlighting the socio-cultural context surrounding a woman's unwanted pregnancy and abortion decision. These stories are meant to convince the participants that even if abortion is regarded as morally problematic, it is even more morally wrong to deny women in such circumstances access to safe and legal abortion services.[251] Therefore, there is a need for the workshops and counselling sessions to be implemented as they would help to reach a much larger proportion of the population of the medical community.[252] Another option would be to provide financial compensation for abortion providers. Currently in South Africa, abortion provision for mid-level providers is not recognized as a specialized skill. Thus, recognition in monetary terms should be considered as it may encourage more staff to volunteer.[253]

More importantly, the need to incorporate abortion curriculums in both Medical Schools and Nursing Schools is essential for the new generations of medical providers.[254] However, none of these changes will prosper if the manner in which they are provided is not changed too. The treatments of women within the health setting was seen as one of the major reasons women fear legal abortion services. Continuous judgment and reluctance to treat pregnant women in public

[250] Ibid, p. 267.
[251] Ibid. An example of a case study includes the story 'Why Did she Die' which introduces participants to Mia, a successful graduate and professional whose cheating boyfriend rapes her when she threatens to leave him. When she is faced with a hostile response from clinic staff she attempts to self-induce an abortion and when her efforts fail, she takes her own life.
[252] Ibid.
[253] Supra 239.
[254] Stanhope, K., Rochat, R., Fink, L., Richardson, K., Brack, C., & Comeau, D. (2017). Physician opinions concerning legal abortion in Bogotá, Colombia. *Culture, health & sexuality*, VOL. 19, NO. 8, 873–887.

health facilities is widespread in both South Africa and Colombia.[255] Mistreatment is a barrier to care as it deters women from seeking care. Through the studies in Chapter 2, I argued that physicians tend to divorce themselves from the normative implications of a woman's decision to abort. However, the moral or legal status of her decision should not be a reason to degrade, humiliate, mistreat or even reject her. Thus, physicians and the medical staff should also be reminded of the importance of forming a trust relationship with their patients. This is essential to avoid women seeking unsafe and clandestine abortions. The aim is for women to report that they value consultation with a physician not only for the technical aspects of abortion but also for being taken care and feeling cared for. Ultimately, by including legal knowledge, value clarification workshops, information about abortion methods and about forming relationships, it would ensure the safe and legal access to abortion services. In fact, the need to educate the medical community not only on abortion methods but also on contraceptive methods is crucial for the safety of abortion services.

1.2.2 The Use of Contraception: A Method to Make Abortion Rarer

A shared idea over of the world for reducing the rate of unsafe abortions is to avoid unwanted pregnancies in the first place. The best way to achieve that is to promote the use of contraception, especially in countries that reject this method. Campaigns to educate couples about the various methods, training for doctors and nurses in birth-control counselling, and making contraceptives easy to get are examples. Alas, in South Africa and Colombia, contraceptive methods are negatively seen, and women do it secretly or even lack the knowledge on

[255] Erdman, J. N. (2011). Access to information on safe abortion: a harm reduction and human rights approach. *Harv. JL & Gender*, 34, 413.

contraceptives. The Catholic Church continues to frown on contraception and many couples fear social stigma and mythical side effects – such as birth defects and general health problems.[256] In fact, negative myths and misconceptions about family planning are a barrier to modern contraceptive use.[257] Given that myths spread easily within communities, the prevalence of negative myths in a community affects the aggregate level of method use. Indeed, the Alan Guttmacher Institute found that 43% of unmarried sexually active women aged 15-24 in Colombia used no method of contraception, while 60% of unmarried women use no methods in South Africa.[258]

Moreover, lack of contraception access, and lack of awareness on contraception are the main reasons women have unwanted pregnancies. For example, a study in South Africa found that 85% of students in a rural area were not aware that a condom should be put on before the penis makes contact with the vagina.[259] However, primary methods for preventing unsafe abortions such as greater contraceptive use face social, religious and cultural obstacles. Even where abortion is legalized and liberalized, women and healthcare providers need to be educated about contraception and the availability and accessibility of legal and safe abortion. Otherwise, women facing the financial burdens and social stigma of unwanted pregnancies will continue to believe they have no other option than to risk their lives by undergoing unsafe abortions.[260] In Harries et al.'s study, a

[256] How to make abortion rarer. (2016, December 03) The Economist. Retrieved from https://www.economist.com/news/international/21711025-bans-and-restrictions-do-not-work-superior-birth-control-does-how-make-abortion-rarer

[257] Gueye, A., Speizer, I. S., Corroon, M., & Okigbo, C. C. (2015). Belief in family planning myths at the individual and community levels and modern contraceptive use in urban Africa. *International perspectives on sexual and reproductive health*, 41(4), 191.

[258] Guttmacher, A. Institute (1999) Sharing responsibility: Women, society and abortion worldwide New York: Alan Guttmacher Institute.

[259] Peltzer, K. (2001). Knowledge and practice of condom use among first year students at University of the North, South Africa. Curationis, 24(1), 53-57.

[260] Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality. Reviews in obstetrics and gynecology, 2(2), 122.

common perception amongst respondents was that contraceptive services in the public health sector were not only preferable to abortion but were essential to the health of women.[261] There were multiple barriers to this becoming a reality, including no contraceptive counselling, limited contraceptive choice and judgmental attitudes.[262] Unfortunately, the possibility that women were using unsafe abortions as a contraceptive method, referred to as repeat abortions, is a primary concern in South Africa and Colombia. The leading concern comes from the lack of family planning services, inadequate contraceptive counselling and difficulties in accessing services. Hence, contraceptive counselling, including post-abortion contraceptive counselling, need to be strengthened and integrated into abortion care. Indeed, women are likely to accept and use contraception when the service is offered as an integrated part of reproductive and post-abortion care. When medical providers provide women with the necessary contraception, and sex education is spread across schools and communities, the negative view surrounding contraception will slowly fade away.

1.2.3 The Understanding and Costs of Abortion Methods

The methods available vary by location and gestational age, but manual vacuum aspiration (MVA) is most commonly offered in the public sector for women in their first trimester. Table 10 below shows the abortion methods and gestational limits in South Africa and Colombia. Access remains limited and given that most of the women presenting for abortion services present in the second trimester, it is difficult to know which methods to use.

[261] Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. BMC *Public Health*, 9(1), 296.
[262] Ibid.

Table 10 – Abortion methods and Gestational Limits in South Africa and Colombia[263]

Methods	**South Africa**	**Colombia**
Vacuum aspiration	Up to 20 weeks	Up to 15 weeks
Dilatation and evacuation	Not specified	More than 15 weeks
Mifepristone-misoprostol	Up to 20 weeks	Not available
Misoprostol only	Up to 13 weeks	Up to 10 weeks

MVA and pills were and recommended by the WHO and developed as safe, efficient and acceptable alternatives to sharp curettage. MVA requires skilled providers, specialized equipment and maintenance or replacement of parts, which can make its use as a first-line abortion method challenging where access to abortion is restricted.[264] Pills – referred to in the literature as medical abortion – has few requirements, is simple to use and can be easy to access. Indeed, the combination of mifepristone and misoprostol is the leading standard in first and second-trimester medical abortion. The unavailability of this method and the restrictions of gestational limits on abortion methods in Colombia pushes women in second-trimester pregnancies to seek services elsewhere – i.e. using misoprostol alone in unsafe abortions. Medical abortion is also considered as preserving the resources of public healthcare systems as the amount of US$94 per patient is estimated to treat post-abortion complications in Latin America. This rounds up to an annual cost of US$ 108,000,000 to healthcare systems throughout the region.[265] However, even though medical abortion would cost less for the government, there is less information available on the costs of accessing a safe abortion than the actual abortion methods to women. In South Africa, for

[263] World Health Organization and The United Nations' Global Abortion Policies Database: http://srhr.org/abortion-policies/
[264] Dzuba, I. G., Winikoff, B., & Peña, M. (2013). Medical abortion: a path to safe, high-quality abortion care in Latin America and the Caribbean. The European Journal of Contraception & Reproductive Health Care, 18(6), 441-450.
[265] Ibid.

example, the law states that safe abortion in the public sector should be offered free to all women who do not have private health insurance.[266] In practice, some women are asked to pay not only for the abortion service but also for the transportation, a pregnancy test, sanitary supplies and pain medicine – which should be free of charge in the public sector.[267] Therefore, various solutions can be presented. Women's costs could be reduced by improving the availability of pregnancy tests and supplies in public health facilities as well as reducing the number of required visits to reduce transportation costs. Women tend to have to go to the clinic, book an appointment and to come back another day, resulting in extra recurring costs, when booking procedures in advance via telephone should be made available. Finally, increasing the number of facilities offering abortion services and opening them could help to eliminate travel to facilities and could reduce time and costs, especially to rural women from lower socioeconomic groups.[268] Many women arrive at facilities too late to have an MVA and sometimes even too late for medical abortions but travelled nonetheless because she did not know about the valid information. Understanding women's experiences and costs when seeking abortion care is essential for identifying barriers to care and emphasizing possible interventions to reduce those barriers. An example national public hospitals should follow is the work undertaken by international NGOs and partners in South Africa which provides free abortion and counselling services. Such interventions have played an important role in improving the quality and continuity of care, as well as the long-term health outcomes of women seeking an abortion.[269]

[266] Lince-Deroche, N., Harries, J., Constant, D., Morroni, C., Pleaner, M., Fetters, T., ... & Sinanovic, E. (2017). Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis. Contraception.
[267] Ibid.
[268] Ibid.
[269] Lince-Deroche, N., Fetters, T., Sinanovic, E., Devjee, J., Moodley, J., & Blanchard, K. (2017). The costs and cost effectiveness of providing first-trimester, medical and surgical safe abortion services in KwaZulu-Natal Province, South Africa. PloS one, 12(4), e0174615.

Section 2 – The Harm Reduction Approach: Safer Methods for Unsafe Abortions

We have seen that South Africa and Colombia represent the countries where the rate of unsafe abortions is the highest, even with the change of the law. One possible solution here would be to implement strategies to aim for reducing the harm in unsafe abortions. As communities' cultural and religious views are not likely to change and evolve fast, a harm reduction approach should be considered as a plausible option. This model is characterized as a harm reduction initiative to reduce abortion-related mortality and morbidity through the provision of health information and services.[270] The approach has been implemented in a variety of countries but it is in Uruguay that it was truly initiated.[271]

Not all clandestine abortions are equally unsafe. Medical abortion (pills) lends itself to numerous strategies to broaden access to safe abortion. While it demands to know how to use it and to understand the warning signs, medical abortion does not require technical skill and is safely self-administered by women with accurate information.[272] One medical abortion method is the use of the drug misoprostol. In contrast to other unsafe methods, misoprostol use is associated with reduced severity of complications and abortion-related deaths.[273] However, to realize the full potential of misoprostol to reduce abortion-related death and harm in unsafe abortion, the challenge is how to reach women with safer-use information. One model of access to information that could be implemented and used in South Africa and Colombia is the Health Initiatives Against Unsafe Abortion in Uruguay. In clinical consultation, physicians provide women who are

[270] Ibid.
[271] Labandera, A., Gorgoroso, M., & Briozzo, L. (2016). Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country. International Journal of Gynecology & Obstetrics, 134(S1).
[272] Supra 264.
[273] Supra 255.

ineligible for a lawful abortion with information on safer methods of pregnancy termination. Doctors do not prescribe the drug, nor give information on where and how to obtain it, but give all required information on how to safely use the drug. The model consists of a pre- and post-consultation. In the former intervention, a woman who presents with an unwanted pregnancy is offered various information and services[274]:

- A medical examination informing the woman about her pregnancy status
- Information on the law and whether she is lawfully entitled to a pregnancy termination under its provisions.
- If not, evidence-based information on the risks of different methods of backstreet abortion, including safer self-induced methods, such as misoprostol use. The information must include the legal status of the drug, the dose, routes, symptoms, side effects, mechanism of action, effectiveness, and problems of use at later gestational ages.
- Pre-abortion counselling sessions with information about available social support to inform of alternatives to abortion.

If the woman goes ahead with the abortion, she is encouraged to return for follow-up care and receives more information and services through:[275]

- A medical examination to confirm complete termination of pregnancy and follow-up care for possible complications or incomplete abortions.
- Information about contraceptive options to avoid future unwanted pregnancy.

For example, the model was implemented and tried in Uruguay. From 1991 to 2001, abortion accounted for 29% of maternal deaths in Uruguay. During a 2004-2005 pilot of the risk-reduction

[274] Ibid.
[275] Ibid.

programme in a public hospital, the number of abortion-related deaths in that hospital fell from an average of four per year to zero.[276] While these results are small, the statistics highlight the potential for the practice of safe medical abortion when women are well-informed and can access the appropriate medications. It is essential to keep in mind that the Model is not treated as an ideal model, but rather an actualized model or prototype of access to information through physician-patient consultation in a restrictive legal environment.

Another model of access to information is the provision of first trimester-medical abortion from afar. Dzuba presented 'Telemedicine': the use of information technologies, such as the internet, to provide clinical care from a distance and that would facilitate women's access to medical abortion information.[277] One example is the Dutch non-profit organisation Women on Web (WOW)[278] that sends mifepristone, misoprostol and a pregnancy test to women around the world and specifically in countries and regions where abortion is restricted and/or mifepristone is not available. It has trained counsellors and experienced clinicians that offer informational and clinical support to the women. In a 19 months' period, 738 women in Latin America received medications from WOW.[279]

However, other barriers must be dealt with for such models to work efficiently in both South Africa and Colombia. The cost of one misoprostol pill costs approximately between US$ 0.75 and $ 2.81 in the United States but can reach US$ 35 or even higher in Latin American countries.[280] Table 11 below shows that both Latin America and Sub-Saharan Africa are the

[276] Ibid.
[277] Supra 264.
[278] Women on Web, www.womenonweb.org.
[279] Supra 264.
[280] Ibid.

regions where misoprostol is the most expansive. This does not make sense when applied to two of the poorest regions in the world.[281]

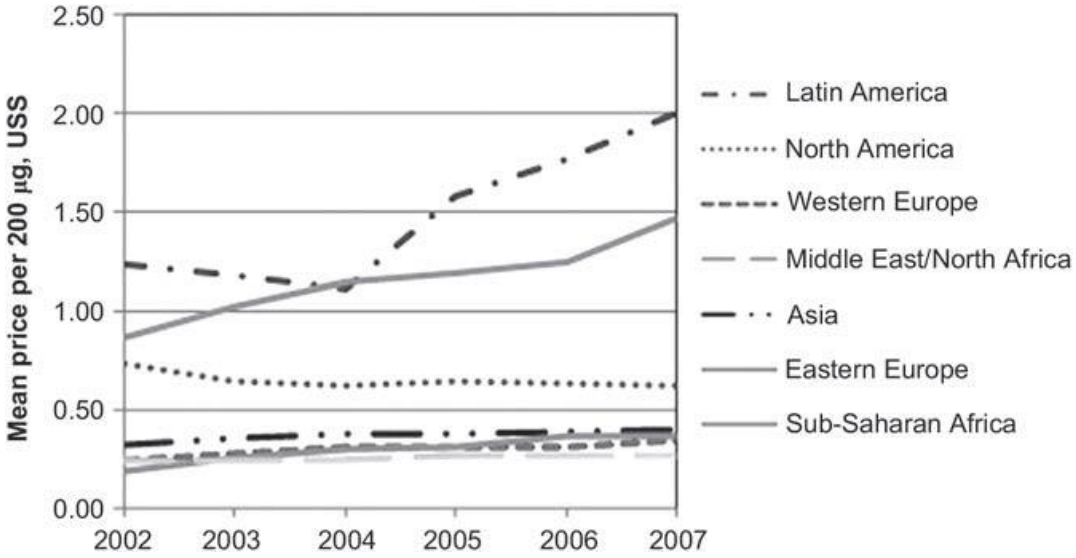


Table 11 – *Source: Dzuba, I. G., Winikoff, B., & Peña, M. (2013). Medical abortion: a path to safe, high-quality abortion care in Latin America and the Caribbean. The European Journal of Contraception & Reproductive Health Care, 18(6), 441-450.*

This again illuminates the need to reduce poverty and increase resources. Indeed, when women are supported to contribute to their care and those of their children, they are able to break the intergenerational cycle of poverty.[282]

[281] Ibid.
[282] Gilbert, I., & Sewpaul, V. (2015). Challenging dominant discourses on abortion from a radical feminist standpoint. Affilia, 30(1), 83-95. Chicago.

Conclusion

Governments have many options for facilitating proper access to safe and legal abortion. Ultimately, to mitigate the impacts of abortion stigma, the knowledge and awareness of information about and affordable services of abortion should be readily available and within reach of the entire population.[283] To accomplish safe access to abortion, states must provide comprehensive sexual and reproductive health information and services to women and adolescents, and eliminate regulatory and health system barriers that impede women's access to safe abortion services.[284] Chapter 3 presented a few possible implications to broaden the acceptability and accessibility of safe abortion services. The need to educate the communities as well as the medical community is a more than possible implication. Aiming for adult education is essential as they pass down their knowledge and beliefs to their children. It is crucial for them to understand the differentiation of being pro-choice and being Christian, and to distance themselves from traditional and conservative religious and cultural views about abortion. There is an obligation to spread the message that women with unwanted pregnancies are surrounded by structural and contextual constraints pushing them toward abortions. Therefore, broad and popular education is a start toward the acceptability of the practice of abortion. Second, educating the medical community is the implication that would lead towards accessibility of abortion services. Strategies such as including abortion services in the medical and nursing curriculums, training classes for mid-level providers and physicians, values rectification workshops, and counselling support for abortion providers are examples. In fact, the training and certification of registered midwives were identified as a critical step toward making high-quality abortion services accessible

[283] Johnson, B. R., Kismödi, E., Dragoman, M. V., & Temmerman, M. (2013). Conscientious objection to provision of legal abortion care. International Journal of Gynecology & Obstetrics, 123(S3).
[284] Ibid.

to all women. Unfortunately, staff shortages, as well as abortion stigma, are very present amongst the medical staff and effects the decision of various people to proceed with abortion services training. However, most importantly, the medical community needs to become more aware of the legal stance on abortion so that they do not abuse of their conscientious objection right. In this instance, governments should also include sanctions towards healthcare providers that do not follow the legal obligations toward safe access to legal abortion services. Chapter 3 then addressed the issue of financial hardships amongst the communities. Not only is the whole path to get an abortion costly, but abortion methods are too. In South Africa and Colombia, where poverty and lack of resources are high, governments are required to provide more health insurances and more public clinics that would provide the services for free. Finally, two important questions were asked: how to make abortion rarer? How to reduce the harm of an unsafe abortion? The first question is the most important one as it addresses a global issue of abortion. Contraception methods are incredibly necessary for reducing the rate of unwanted pregnancies and for avoiding the need for abortion services altogether. However, the Christian Church in South Africa and Colombia frown upon contraception and renders the subject taboo. Through campaigns to educate people about the various methods, training for doctors and nurses in birth-control counselling, and making contraceptives easy to get, there is a possibility to tackle the negative view of contraception in religious and cultural countries.

To conclude, given all the regulatory, health system and religious barriers, it is difficult to estimate how long it will take to implement different implications to ensure acceptability and accessibility of abortion services. Thus, the harm reduction approach can be an initial strategy while waiting for further change. The Uruguay Model[285] seems promising as it provides women

[285] Supra 255.

that are not eligible for legal abortions with the required information to seek safer methods to clandestine abortions. The pre- and post-abortion counselling sessions help women get the information on how to use misoprostol safely. This method will reduce the maternal mortality and morbidity rate and will avoid unnecessary consequences and health risk.

CONCLUSION

Why do women turn to unsafe abortions when safe services are legally permissible? Throughout this thesis, the lack of correlation between legality and safe abortion was addressed as the primary answer to this question. Understanding the reasons for this lack of correlation helped to tackle the issue in more depth. Indeed, due to the cultural and religious traditions as well as the structural and contextual constraints of South Africa and Colombia, these barriers are the leading cause of the limited decision-making and free choice of women, resulting in a higher rate of unsafe and clandestine abortions. The complexity of this subject shows how vital it is to understand the different stances and relationship abortion has within society.

First, I presented the relationship abortion has in national and international law. The recognition of abortion as a woman's sexual and reproductive health right was a necessary step to decriminalize abortion and to end women's subordination and discrimination in a 'man's world'. Indeed, the legal approach to abortion has evolved from criminalization towards accommodation of abortion as a life-preserving and health-preserving option. Both South Africa and Colombia have passed a law that legalized and liberalized the practice of abortion in 1997 and 2006, respectively. They have international human rights law obligations to respect, protect and fulfil those human rights. Women are entitled to the principles of human dignity, non-discrimination and equality. Despite these obligations, regulatory and health system barriers as well as the emergence and presence of abortion stigma, I have argued that all three principles are not well followed within societies such as South Africa and Colombia. The effect that reproductive freedom has on gender equality, stigmatization and the decision-making of women prove the argument that human dignity, non-discrimination and equality are not respected.

In fact, Chapter 2 concentrated on the various barriers that continuously impede toward the safe and legal access to abortion services. We have seen that even though South Africa and Colombia both have legal frameworks for abortion, they are juxtaposed with a community that evinces high levels of religiosity as well as adherence to traditional belief systems, leading to laws and regulatory offices not addressing access to clinics and services, to professional and the service obligations of physicians and other health professionals.[286] The result is the shaping of the stigma of abortion in both countries and the enhancement of the communities' disapproval of the practice. In both cultures, a woman who terminates her pregnancy is seen as defying long-held ideas of what motherhood and childbearing mean. She is made to feel shame and guilt for becoming pregnant at the wrong time and for deciding to have an abortion. The double stigma explained through the chapter is perpetuated by narrow and rigid gender roles and systematic attempts to control female sexuality. However, the abortion stigma is also sustained and aggravated by systems of unequal access to power and resources. The structural and contextual constraints of South Africa and Colombia reveals the conflict women face between social ideals and real-life circumstances. Through the theory of human development, I was able to prove that the lack of resources, the high rate of unemployment and poverty, the lack of knowledge and awareness about the law, the religious and cultural conformed values, and the lack of effectiveness of the freedom right of abortion restrain a woman's human choice when faced with a pregnancy. The life circumstances and surrounding factors of women push them into making a pro-abortion decision when they may be pro-life advocates – rendering their decision-making a constrained one. Hence, by combining the regulatory, social and real-life circumstances barriers, it is understandable that women turn to unsafe abortions.

[286] Vincent, L. (2011). South Africa's Abortion Values Clarification Workshops—An Opportunity to Deepen Democratic Communication Missed. Journal of Asian and African studies, 46(3), 264-277.

Finally, I argued in Chapter 3 the various possible implications needed to ensure acceptability and accessibility of safe and legal abortion services. I first concentrated on the need to deliver adequate information, education and communication concerning abortion in South Africa and Colombia. Public education, including the medical community, is the leading implication that needs to be implemented. It is through educating the masses on rectifying their values and understanding the position abortion has with their religious and cultural views that an intergenerational break of the disapproval of abortion will happen. Moreover, the governments have a crucial role to play in assuring that the law is known throughout the country. The lack of knowledge and awareness on the information of abortion services is the leading cause of women not turning to those services and medical staff abusing their power. Governments must ensure that the law is respected and applied in social practices but also that they are available to be used without consequences. Indeed, broadening economic opportunities to the population would break the cycle of poverty and unemployment and help women have a 'freer' choice to their decision-making. Clear policy guidelines need to be formulated for the management and provision of abortion services, and health professionals need to be included and take an active role in this process. Therefore, enhancing women's access to education, economic opportunities and creating cultural spaces that respect women and men equally, would reduce maternal morbidity and mortality as well as the abortion rate. Creating cultural spaces also includes the need to broaden the views on the methods of contraception. Even though the use of contraceptives is negatively seen in South Africa and Colombia for cultural and religious reasons, it is the only implication that would not only reduce the rate of unsafe abortions but most importantly reduce the rate of unwanted pregnancies and thus abortion in general. However, as communities' cultural and

religious views are not likely to change and evolve fast, I have argued that making unsafe abortion safer with medical methods should be an option that both South Africa and Colombia's governments should implement. I presented this solution through the Uruguay Model and concluded the importance of providing the adequate information for women in the use of misoprostol as a self-administrative way to abort.

To conclude, I believe that until having an abortion is considered as morally acceptable in South Africa's and Colombia's diverse societies; women will not have gained their full reproductive rights. A rights-based approach that international human rights law implements will not be enough for people to support the practice of abortion. The governments and the people must implement various changes and strategies to evolve. In fact, if nothing is done, the morality of abortion will not change, and it will always be easier for cultural and social resistant norms to undermine the legal right to abortion.

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