Abortion in Chile: The Long Road to Legalization and its Slow Implementation

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Abstract

Until as recently as September 2017, Chile was one of the few countries in the world that did not permit abortion under any circumstances. Although the Health Code had permitted therapeutic abortion (i.e., on health grounds) from 1931, this was repealed in 1989 as one of General Pinochet's last acts in office. It took more than 25 years to reverse the ban. Finally, a new act was approved allowing abortion on three grounds: when a woman's life is in danger, when there are fetal anomalies incompatible with life, and in the case of rape. Since the law allows abortion only in limited cases, most women must continue to seek illegal abortions, as previously. In this paper, we explore the historical context in which Chile's 2017 bill was finally passed. We then analyze the legislative debate leading up to the passage of the law. Lastly, we present the results of a community-based participatory research effort carried out by an alliance between feminist and human rights organizations. Chile's law was passed almost two years ago, and this research shows the persistence of various obstacles that hinder women's access to legal abortion, such as the use of conscientious objection, a lack of trained health care providers, and a lack information for women.

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Introduction

Until as recently as September 2017, Chile was one of the few countries in the world that did not permit abortion under any circumstances. Although the Health Code had allowed therapeutic abortion (i.e., abortion on health grounds) beginning in 1931, the law was repealed in 1989 as one of Pinochet's last acts in office, leaving women to seek terminations clandestinely. There were several attempts to amend the abortion law, but none of them were successful until 2017, when the law was changed to allow abortion on three grounds: when a woman's life is in danger, when there are fetal anomalies incompatible with life, and in the case of rape. Since the law permits abortion only in these limited cases, most women with an unwanted pregnancy must continue to seek illegal abortions.

The law establishes several requirements to access an abortion: in the cases of risk to life and fetal anomalies, these conditions must be confirmed by a medical team (one doctor for the first category and two doctors for the latter). In the case of rape, the confirmation must come from a team composed of a social worker and a psychiatrist or clinical psychologist. There are no time limits established for the first two grounds. In the case of rape, the time limit is 12 weeks for women over 14 years old, and 14 weeks for those younger than 14. The law also introduced a two-person professional team (known as *dupla* in Spanish) consisting of a social worker and a psychologist to provide information and support to women during the clinical decision-making process and to provide, if requested, accompaniment during the abortion. Following the law's passage, the Ministry of Health drew up clinical guidelines and protocols to be used for the procedure.[1]

The law requires the approval of a doctor to confirm that the legal requirements are met for life-health risks and fetal anomaly, and in the case of rape a psycho-social team confirms the pregnancy gestational age and coherence of the statement regarding the rape. As part of the regulations attached to the law, public health services must guarantee access to legal terminations of pregnancy through 69 specialized high-risk obstetric units. The primary care system has become the gateway to identify and provide information to women who are eligible for an abortion on any of the three legal grounds and to refer them to a hospital where there is a high-risk obstetric unit.

To date, the implementation process has faced many challenges. First, since the law's passage, many clinicians have expressed conscientious objection and refused to implement the law. Second, all legal abortions must take place in high-risk obstetric units (although medical abortion pills can be used in the case of rape). Third, in March 2018, when the implementation phase was just getting off the ground, Chile changed governments from a center-left coalition (which had introduced the law and managed to secure its approval in Congress) to a right-wing alliance that had fervently opposed the law and was now doing what it could to prevent its successful implementation.

This paper starts by start by reviewing the historical context of the Chilean feminist movement's struggle to advance reproductive rights generally and abortion rights specifically, as well as the road to the legalization of abortion on three grounds in 2017. Despite the law's limitations, it was considered a milestone regarding women's rights in Chile, given that abortion had been completely banned since 1989. Hence, the law has an important symbolic power both culturally and politically.

Second, we present a reflection on the legislative debate and the challenges facing the implementation of the new law. In particular, we analyze lawmakers' discussion of central issues during the legislative debate: medical confidentiality, time limits for abortion, and the regulation of conscientious objection. We also explore limits of the law's implementation by drawing on the results of a community-based participatory research project carried out by La Mesa Acción por el Aborto (known as La Mesa) and Fondo Alquimia in alliance with women's groups in seven locations: Desnudando in Aysén; Observatorio de Género, Salud y Pueblo Mapuche in Araucanía; Marcha Mundial de Mujeres in Biobío and Santiago; Matriavisión in Valparaíso; Resueltas del Valle in Huasco; and Qispy Wayra in Antofagasta. The process was led by Gloria Maira and Lieta Vivaldi collaborated in

the final analysis and report.

Finally, we discuss some implications of having a restrictive law, the use of conscientious objection, and the organization and delivery of abortion services.

Historical context

In the early 20th century, the fight for abortion in Chile involved both the medical community and the feminist movement. The medical community recognized poverty and child mortality and the impact of clandestine abortion as an important health risk for women.[2] In 1931, therapeutic abortion was legalized via the Public Health Code, and shortly after (1936), a group of physicians from the Chilean Medical Association proposed legalizing abortion for socioeconomic reasons, though this was not approved.[3] Their argument was that allowing only therapeutic abortion would not deal with most clandestine abortions, which remains true to this day in spite of the current reform.

Meanwhile, the women's movement started to articulate its demands regarding legal abortion. The Movimiento pro Emancipación de la Mujer Chilena (founded in 1935), fought for women's suffrage and promoted women's reproductive rights as an integral part of political and economic equality for women.[4] From the beginning, it advocated for access to family planning and the legalization of abortion. The group claimed that "with respect to our biological bodies, our actions will not stop until we call the attention of scientific and legal authorities to the distress caused to poor working women who are forced to get pregnant and to give birth repeatedly."[5]

Abortion was subsequently submerged as an issue for feminists but reappeared 25 years later thanks to members of the medical community concerned with high rates of maternal morbidity and mortality due to clandestine abortion. The government introduced family planning in the 1960s to tackle the problem.[6] The organization most involved with women's reproductive health and collaborating with the national family planning program was the Chilean Association for the Protection of the Family (APROFA), which has been affiliated with the International Planned Parenthood Federation since 1967.

Legal abortion was not part of feminists' demands under Salvador Allende's socialist government (1970–1973). However, members of the medical community led a process to liberalize abortion through medical practice. In the Barros Luco Hospital, the team of obstetrician-gynecologists serving a working-class Santiago district began to perform legal abortions based on the understanding that they were "therapeutic" because poor women with unwanted pregnancies would otherwise seek high-risk abortions and possibly die as a result. From March to September 1973 alone, it is estimated that this hospital carried out approximately 3,000 abortions.[7]

Initial steps toward an abortion law

In 1973, the dictatorship introduced pro-natalist policies, and by 1989, abortion was prohibited under all circumstances: "No action will be taken in which the aim is to cause an abortion."[8] That same year, a national reproductive rights network—the Foro Abierto de Salud y Derechos Sexuales y Reproductivos—was established. This network, which consisted of 30 women's organizations, began promoting a bill to legalize abortion. However, during the 1990s, political interest in introducing legal reform on abortion was virtually nonexistent, and none of Chile's political parties supported this initiative. In fact, the only bill introduced to reinstate the repealed law on therapeutic abortion was never even tabled for debate.

During this period, the international context regarding sexual and reproductive rights changed. In Latin America, a regional campaign to decriminalize abortion—the Red de Salud de las Mujeres latinoamericanas y del Caribe—was launched. At the global level, two United Nations conferences (Cairo in 1994 and Beijing in 1995) were influential in promoting changes on abortion law reform.[9] In Chile, specific events revealed the strength of a new narrative on reproductive rights.[10] For example, in 2010 an abortion hotline was launched, providing women with information on how to use the abor-

tion pill safely and effectively at home. Moreover, in 2008, an articulate women's defense of the distribution of the morning-after pill called for a massive rally, the *Pildorazo*.[11]

Between the early 2000s and 2012, 11 bills were presented in Parliament that would have permitted abortion in some circumstances.[12] Furthermore, the election of a right-wing government in 2010 led to political activity that permitted the issue of abortion to come to the forefront. In 2011 alone, three bills seeking to partially legalize abortion were tabled in the Senate, but all three were rejected in April 2012.[13]

Michelle Bachelet became president again in 2014, supported by the coalition Nueva Mayoría. Active feminist members of this center-left coalition forced the inclusion of abortion in Bachelet's government program.[14] From their perspective, Bachelet's former role as head of UN Women and the perceived willingness of different political actors to consider the legalization of abortion presented an important opportunity. Within the coalition, the progressive members wanted to legalize abortion on demand, but the most conservative members would not to go farther than permitting abortion on the three grounds the country now has. The bill that was ultimately proposed represented a middle ground. For the first time since 1931, a Chilean president was ready to introduce a bill.

During this same period, La Mesa was taking shape, changing from a loose network of individuals and organizations to a structured coalition. There were quite different views within this coalition on the political impact of the abortion bill and the strategies needed to achieve the decriminalization and legalization of abortion. On the one hand, some considered the bill so restrictive that it made no sense to support its passage, because it would not change the lives of women with respect to their right to choose or change the illegal status of most abortions. On the other hand, others, although cognizant that the bill was restrictive, argued that it would allow for the protection of the lives and agency of at least some women and would be an opportunity to open a public debate on abortion.[15]

In addition, among those who supported a liberalization of the abortion law, some supported free and legal abortion while others did not care whether there would be government-provided services, positioning themselves as supporters of self-induced medical abortion. In this context, a combination of feminist and human rights organizations and individuals (both academics and activists) reached a consensus that La Mesa would promote the approval of the bill, as long as it safeguarded some aspects that were considered an ethical imperative, such as maintaining the ground of rape in the bill, which was the most contested of the three grounds.

Legal abortion on only three grounds: Confrontation over the limited scope of the reform

In January 2015, President Bachelet introduced a bill to liberalize abortion on three grounds: risk to the woman's life, fetal anomaly incompatible with life, and rape.

The legal reform took two and a half years of debate in Congress.[16] It represented a golden opportunity for those in favor of and those against abortion (including activists, social organizations, members of the medical community, religious organizations, and the like) to advance their arguments. For instance, the Health Committee of the Chamber of Deputies organized a two-day public hearing in September 2015 in which 89 people presented their arguments; of these, 20 were medical doctors, including 13 who were against abortion. The large majority of participants were individuals and organizations against the law reform.

The original bill suffered important amendments. The final text contained more restrictive regulations in several areas, including the definition of the grounds, time limits, and confidentiality, among others. Conscientious objection (CO) was one of the issues that experienced the most modifications during the legislative process and again (in the Constitutional Court) after it was passed, as will be discussed below.[17]

The bill was timid regarding the scope of the legal grounds; it never included risk to the pregnant woman's health, instead phrasing it as a "risk to

life," and during the debate this too was changed from "current and future life risk to life" to just "current risk to life." The ground of fetal anomaly incompatible with life was also very conservative, considering that most countries' abortion laws on fetal anomaly permit abortion for serious anomalies rather than fatal ones only.[17]

On the ground of rape, the upper time limits were reduced from 18 weeks to 14 weeks for girls under 14 years of age. It takes time for someone to be able to report rape, let alone seek an abortion. Furthermore, given the lack of expectation of pregnancy in a child, these reductions in the time limit were very serious restrictions.

With respect to confidentiality, the bill incorporated a human rights framework, upholding the rights to health and privacy by providing for the protection of women requesting a legal abortion and for those who experience health complications due to illegal abortion. In cases of risk to life and fetal anomalies, the general rule to keep medical records confidential, including the name of the patient, was applied. But in the case of women who request an abortion on the ground of rape, legislators eventually incorporated a provision requiring hospital directors to inform the Office of the Prosecutor whenever a woman requests an abortion due to rape, thus allowing the prosecutor to proceed with a criminal investigation. Women may well not wish this to happen, and they are supposedly not required to be part of the prosecution, but how this works out in practice remains to be seen. As a violation of confidentiality, however, it is very problematic.

In the case of illegal abortion, there are contradictory mandates regarding medical confidentiality for women seeking treatment when they experience complications. There are other contradictory mandates as well. While health care providers in both the private and public sectors must report women who have had an illegal abortion who seek care for complications, divulging confidential information received while on professional duty is considered a crime.[18] In the original bill, no woman who undergoes an illegal abortion could be reported, interrogated, or receive treatment contingent on the disclosure of information about her medical condition, or have her health status divulged. This provision was rejected, in complete disregard for international human rights standards and recommendations on the issue.[19]

Conscientious objection: From the exception to the general rule

In the original bill introduced by President Bachelet, CO was considered as permitted only for those health personnel who are directly involved in the abortion procedure: physicians. However, the public and legislative debate went far beyond that incorporating not only physicians but all health personnel directly involved.[20] This includes anesthetists, midwives, nurses, and nurses' aides. These workers must state their objection in writing, but there is no need for it to be substantiated.

After the Law was approved by the Congress in August 2017 a group of legislators filed a constitutional writ before Constitutional Court and prior to the enactment of the law. The Court in August 2017 allowed the recognition of institutional CO (Sentencia Rol N° 3729 (3751)-17 CPT, 28 de Agosto de 2017). The institutional objection was argued fervently by Catholic University during the legislative debate defending religious universities regarding the enforceability of the law for the provision of abortion services.

Even after all these substantive, and restrictive, changes and the passage of the bill in September 2017, there followed an 18-month-long administrative litigation on the regulation for health care services. Two protocols on CO were issued. The first one was changed 10 days after President Pinera took office. However the Office of the Comptroller General (Contraloría General de la República) ruled that the second protocol was unlawful because it had included institutional objection to private clinics that received public funding. A third regulation was published the 23th of October 2018. This opened for conservative legislators to take the matter to the Constitutional Court to rule on the scope and the basis for institutional objection. In January 2019, the court finally

settled the issue. The law as it now stands allows any private health institution to refrain from providing abortion services, based not only on religious or moral grounds but also on the right to association and the protection of the autonomy of private organizations and individuals.[21]

The court's ruling also permits private health institutions that provide gynecological and obstetric services at the primary and tertiary care level, including those that receive public funding, to invoke institutional conscientious objection. The constitutional basis for this ruling is the notion that, according to Chile's Constitution, private entities have visions or ideologies and hence must be respected. The court recognized the special status of Catholic hospitals due to the long tradition of health services in collaboration with the public health care system and the Catholic University is recognized by law in a special status. However, it went a step further by failing to make a distinction between confessional (Catholic) institutions and those that do not declare any type of religious ideology.[22]

So far, five institutions have registered to be exempt from complying with the law, and in one case a clinic declared an objection to providing abortion only on the rape ground. The Constitutional Court's ruling disregards the impact of its decision on women's right to health care. It states that institutional CO does not restrict women's rights to life or integrity because the objecting institution must provide an abortion when a woman's life is at risk, while for the other two grounds women can receive abortion care from a public health institution.[23] Despite recognition of CO abortion remains easily accessible in some countries, such as Portugal, England, and Norway, but in others like Italy CO is a stumbling block because many doctors use it.[24]

The implementation of the law: Monitoring progress from a feminist perspective

La Mesa and Fondo Alquimia invited six local organizations from the northern, central, and southern parts of the country to monitor the law's implementation in their geographical regions because it was a major concern of the feminist organizations. The idea was to identify practices and discourses that were either facilitating or hindering access to abortion in public health facilities.

Our qualitative research effort was carried out from September 2018 to February 2019. It involved 62 interviews with health care professionals who play a direct role in the law's implementation—namely, obstetrician-gynecologists, midwives, psychologists, and social workers. These individuals were working in a total of 15 primary care clinics and 8 hospitals with high-risk obstetric units. Additionally, 8 health care union representatives were interviewed, 7 focus groups with women were conducted, and 136 women were surveyed.[25] The interviews with the health personnel explored the training of health personnel and the existence of protocols and other instruments that guide, inform, assist and make referrals when needed in addition to the situation of sexual and reproductive rights in each territory.

Our survey was based on the premise that the implementation of any new health service is challenging and requires capacity building, staffing, training, regulations, workflows, infrastructure, and supplies. In the case of abortion in particular, it also involves dealing with a change in legal context (from prohibition and prosecution to partial legalization) and with deep-seated cultural and personal beliefs that cannot be expected to change overnight.

Our findings reveal that the disorientation that had characterized the early days following the law's passage has now been reduced. At first, health practitioners were trying to "catch up with the law," using trial and error to develop procedures for identifying those women entitled to a legal abortion and to ensure a smooth referral process. In some areas, this was even seen as an opportunity to strengthen the public health network. Moreover, in some places, health staff found that the use of the Ministry of Health's technical guidelines was an opportunity to improve service delivery, to positively contribute to women's psychosocial well-being in relation to reproductive loss and to provide social and psychological support for those women who have been raped.

We also found that there is an important

gap between written legal standards regarding information, confidentiality, privacy, and respect for women's decision making, and what actually happens in practice. The shortcomings seem to be associated with a mentality of "we cannot do much more," whereby health care personnel argue that there is no space for better infrastructure or systems. Such a response may be due to a lack of willingness to provide the services or fear of involvement. It seems to be consistent with our other finding that, in all of the locations studied, good implementation relies heavily on whether the *dupla* and the medical team involved in the provision of abortion are personally committed to overcoming the barriers.

Both declared and undeclared CO were an additional barrier that we identified. One gynecologist in a high-risk obstetric unit said that some health care staff avoided dealing with patients who might require an abortion: "'That patient does not exist for me, I'm an objector.'" Furthermore, some participants described situations in which indirect objection was manifested, such as by imposing additional requirements, particularly in cases of abortion requested on the ground of rape. "All kinds of barriers are put in place; for instance, the stuff required to be admitted at the hospital, like documents that must be signed... although it is not mandatory to sign them." Other interviewees said that some physicians did not respect the woman's right not to see or hear about the ultrasound examination: "They show them the scan and ultrasound forcing women to look at it, or they talk about god or things like that."

Access to information and legal abortion

In order to ensure the exercise of the right to a legal abortion, women's access to information is crucial. We found that women were not properly informed by the public health care system. Our interviews and focus groups revealed a lack of knowledge about when abortion is permissible and where to seek information and advice. This lack of information is particularly harmful for girls and women who are pregnant as a result of sexual violence and who have such a short time frame to get an abortion.

The Ministry of Health has not produced or made informational material available in health care facilities, and individuals must rely on the information posted on the ministry's website.[26] As of March 2019, when we completed our research, the only flyers and posters available to the public were those produced by local health personnel themselves, which had limited circulation.

The primary care system could potentially play a role in informing women, but there is an oversight of the Ministry of Health in addition to a lack of appropriate and effective guidelines on how and what to tell women about their health conditions and the possibilities for obtaining a legal abortion. Some participants said that there were a number of cases in which women were referred by midwives and physicians to the High Risk Obstetric Units without sufficient information. In some cases, midwives were explicitly instructed to withhold information from women regarding their health condition. One person reported, "Here [in the primary health care center] we all depend on what the doctor says, and the doctor did not inform the patient [on her condition]. I could not go over his authority, but I told the doctor that this patient was a candidate [for an abortion], but the doctor told me that we should not get involved but that he was going to make a referral to the high-risk obstetrics unit."[27]

In high-risk obstetrics units, where abortions are carried out, our research reveals that scarce information is provided to women about the techniques that may be used, whether surgical or with pills. In some cases, there is information available to women, but it is highly technical and not easily understood.

Training and protocols

In the six areas we studied, training for health personnel in primary care facilities and in high-risk obstetric units is limited to professionals who are directly involved in the abortion procedure, leaving aside other personnel who may also interact with women during the process.

In addition, the training implemented by the Ministry of Health has been restricted to technical aspects. In this respect, training should also incorporate value changes to reduce the prejudices and myths often associated with abortion, which are especially prevalent regarding women and rape. According to one member of a *dupla*, "We are questioned by physicians and other staff if the patient is making the story up, if it is true or not … They also ask us if the patient follows the accompaniment program, because if the woman does not, they argue she was lying."

Another problem arising from physicians' lack of training is the question of how to determine when the woman's life is at risk and whether the identified fetal anomalies are incompatible with life. Several interviewees described situations in which there were differing medical opinions on these questions among the team members who would perform the abortion and the non OB-GYN specialists who are consulted. The real issue here is that there is often uncertainty in medical assessments of this kind, differences of opinion are normal and it is unclear whether OB-GYN opinions are paramount. How to resolve them is problematic when the question is not about appropriate medical treatment but about whether the prerequisites of a legal abortion are met. One physician told us:

> *We had some disagreements with other colleagues … regarding a patient who had chronic renal failure … The risk of that patient's health deteriorating due to her pregnancy was very high. Nevertheless, the opinion of the nephrologists was that she could continue the pregnancy … It was a difficult case for everyone, because she fulfilled all the requirements, but the opinion of the internists opted for the continuation of the pregnancy. The patient's health condition worsened and finally she terminated the pregnancy … It was not an abortion; it was a premature birth, the newborn died anyway. But she could have been saved all that suffering for months of knowing what was going to happen.*

Our research indicates that obstetrician-gynecologists may not have the final word about the medical condition of a woman who needs and wants an abortion. According to the law, only one diagnosis is required for cases of risk to a woman's life. However, in practice, other specialists appear to get involved, making the diagnosis more cumbersome, especially if there are contradictory opinions on how to proceed.

Discussion

Legalization represents an important step forward, and many observers expected an active resistance by providers in complying with the law. As our survey reveals, the implementation of the abortion law has created serious challenges and stumbling blocks that prevent women from accessing legal abortions. This might be one of the explanations for the low number of women who have requested a legal abortion since the law's passage.

According to projections by the Ministry of Health, there should be 2,500–3,000 legal abortions per year, the majority (67%) of which are expected to be requested on the rape ground.[28] The actual numbers reveal another story. For the period September 2017– December 2018, the Ministry of Health reported 769 cases in which an abortion was permitted: 343 on the life ground, 311 on the fatal fetal anomaly ground, and 115 on the rape ground (in other words, only 15% of the total). It is possible that the difference between the ministry's initial estimates and the actual numbers might be due not to miscalculations by health authorities but rather to shortcomings in the implementation of the law.

This limited and limiting law does not guarantee autonomy or reproductive rights for girls and women. In fact, a medical opinion is required to certify any of the three legal grounds. Only once a woman overcomes this hurdle can she access an abortion—it restrains reproductive autonomy.

From a health care system perspective, moreover, it is highly questionable whether all abortions must be carried out in high-risk obstetric units. Abortion in the case of rape could be delivered in primary health settings via medical abortion pills, given that the time limit is 12 and 14 weeks; it would make the procedure more accessible considering the multiple factors (such as age, geographic location, and social class) that prevent women and girls

from reaching specialized obstetric units.

Access is also influenced by the level of information that women and girls have, impacting differently depending on their socioeconomic conditions, ethnic origin, disability among others. It possible that a lack of information is one of the reasons behind the currently low number of abortions requested on the rape ground.

Imposing time limits on teenage victims of rape or incest fails to consider the circumstances and the often challenging task of detecting early pregnancies. It is plausible that this restriction will make it impossible for girls to access legal abortions. Indeed, the data collected to date show that the rape ground is the least-cited ground for abortion requests, contradicting the Ministry of Health's initial estimates.

It is also possible that requiring hospital directors to file a report with the Office of the Prosecutor whenever a woman requests an abortion on the rape ground may discourage women from asking for help.

Allowing the wide use of CO has also created barriers, which was predicted from the outset. In fact, according to the most recent Ministry of Health report, the number of objectors has increased over time.[29] As of June 2019, one out of two obstetricians in public hospitals had declared themselves objectors in cases of rape (50.5%), one in four in cases of fatal fetal anomaly (28.6%), and one in five in case of risk to life (20.7%). For objectors in the case of rape, this represents a 5.3% increase compared to June 2018 data. Although there is no systematic information about what is happening, anecdotal evidence from physicians reveals that women are having problems accessing abortion as a result of individual and institutional objectors.

The refusal to provide abortion services has led to situations that significantly affect women's dignity and physical and mental integrity. Such scenarios even include the suspension of abortion procedures already underway.[30] On the positive side, committed providers, including physicians and midwives, have begun forming networks to help women overcome some of the barriers.[31]

The protocols are in place, but they are not being followed to the extent necessary to support the delivery of care under the conditions set out in the law. The current administration has an anti-abortion stance that shows little regard for informing women of their rights—it has been women's organizations that have been making efforts to conduct awareness-raising campaigns, trainings, and informational seminars aimed at increasing knowledge of where and under what circumstances women can get an abortion.[32] Likewise, legal actions have been taken to make the government compliant with the law.

Training health care providers on the content of the law and its regulations, building capacity among health care teams, and debunking myths and prejudices are essential to the delivery of care that is respectful of women's rights. Given the current context of increasing CO among health care providers, efforts will have to be made to hire staff who are supportive of women's need to access abortion. In some hospitals, health authorities cognizant of the problem have made calls to hire individuals who are committed to providing abortion care.

What's next? Some final thoughts

Chile's new abortion law represents a cultural change: abortion has come "out of the closet" and is finally being provided and discussed more openly. At the same time, the reform offers an opportunity to remove the social stigma around abortion, and women to continue to mobilize around reproductive autonomy.

The government, in addition to having a negative obligation to refrain from interfering with women's reproductive choices, also has positive obligations to provide financial and social support and to ensure that women's choices are effectively realized.

Unsurprisingly, the implementation of the law is still far from reaching that point. As our research shows, the restrictions established by the law itself, coupled with the lack of will to increase women's access to legal abortions, are important challenges.

Chile's new abortion law meets minimum state obligations concerning human dignity, in-

tegrity, and the right to health. However, its recent legalization of abortion, although an important advancement, is helping few women; it is crucial to move forward to remove the obstacles currently standing in the way of women's access. Here, there is an important role for women, feminists, and committed providers to play in dismantling practices and discourses in which women are foreordained to become mothers.

The limitations shown by our initial examination of the law's implementation must be considered in the context of a 40-year ban. Therefore, not only is it critical to train health care providers, but it is also necessary to foster a cultural change within the health profession that encourages respect for women's needs and rights. Any reform on abortion legislation is destined to encounter a range of problems—in order to move forward, we will must consider the best way to reduce the burdens and barriers created by the implementation of the new law.

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