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Abortion Policies and Practices in Chile: Ambiguities and Dilemmas

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Abstract: *Abortion is not legal in Chile even to save the woman's life or health. This situation creates serious dilemmas and vulnerabilities for both women and medical practitioners. Abortion incidence has probably decreased since 1990, when data were last studied, due to increased use of contraception and lower fertility, and deaths and complication rates have fallen as well. Misoprostol is available, but Chilean hospitals are still using D&C for incomplete abortions. Although Chilean medical professionals should by law report illegal abortions to the authorities, less than 1% of women in hospital with abortion complications are reported. There are two loopholes, one legal, one clinical. "Interruption of pregnancy" after 22 weeks of pregnancy is legal for medical reasons; this may save some women's lives but can also force prolongation of health-threatening pregnancies. Catholic clinical guidelines define interventions solely aimed at saving the woman's life, even if the fetus dies, not as abortion but "indirect abortion" and permissible. Since 1989, three bills to liberalise the law on therapeutic grounds have been unsuccessful. The political climate is not favourable to changing the law. Conservatives have also not succeeded in making the law more punitive, while the governing centre-left coalition is divided and the associated political risks are considerable. ©2007 Reproductive Health Matters. All rights reserved.*

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CHILE is one of four countries, with El Salvador, Malta and most recently Nicaragua, where there is no legal exception to the ban on abortion to save the woman's life. Recent reports on abortion in El Salvador¹ and Nicaragua^{2-4*} have highlighted the tragedies and human rights violations from these laws. According to studies in Chile⁵ and worldwide, low-income women and adolescents account for the great majority of abortion complications, since they have recourse only to unsafe abortions, a situation of tremendous

social inequity. Since all abortion services operate clandestinely in Chile, very little is known about actual practice or the profile of women having abortions. To the extent possible, this article aims to shed light on both hidden and official practices and policies related to abortion. The section on abortion practice is based on a study by Shepard,⁶ and the section on abortion policies on Casas' recent legal research and experience as an advocate.

Historically, Chile has been one of the most progressive countries in Latin America on reproductive health issues. In 1964⁷ under Eduardo Frei, a Christian Democratic President with close affiliation to the Catholic church, Chile became the first Latin American country outside of Cuba to inaugurate a publicly subsidised family

**Rosita* is a recent documentary dramatising Nicaraguan authorities' opposition to access to a legal abortion for a nine-year-old girl whose pregnancy resulted from rape.

planning programme, motivated by widespread concern about exceptionally high mortality from complications of illegal abortions. The programme was highly effective. Maternal mortality from unsafe abortion decreased from 107 per 100,000 live births to 5 in 2000.^{8,9} A 1931 law on therapeutic abortion allowed abortion to safeguard a woman's life and health, but was repealed by the military dictatorship in 1989, shortly before a democratic government came to office.

Incidence of abortion and abortion practices⁶

Reliable data are lacking on the incidence of induced abortion and the public health consequences. More than 99% of induced abortions are not reported at all, disguised as a different procedure or reported as spontaneous abortion in public hospitals.* The number of pregnancies, spontaneous abortions, high-risk pregnancy-related conditions, fetal abnormalities and post-abortion morbidity therefore all suffer from under-reporting. There is only anecdotal evidence on unsafe practices, including insertion of catheters and other traditional methods. These have probably decreased since 1990 due to the availability of misoprostol, which is widely known and used in Latin America to induce abortion, especially up to nine weeks after the last menstrual period.

As in most countries, misoprostol is legally available on prescription in Chilean pharmacies for treatment of stomach ulcers. It is also used legally on obstetric wards for inducing labour and to treat and prevent post-partum haemorrhage. Some doctors and midwives provide misoprostol to their private patients for abortion. The drug and instructions on its use is available over the Internet through Chilean websites and on the black market. The cost ranges from 38,000–50,000 Chilean pesos (US\$73–100) for four to six pills, much higher than in developed countries.

* To protect both women and hospital staff from prosecution, hospital patient data reported to the Ministry of Health do not differentiate between spontaneous and induced abortion.

All the published literature on abortion in Chile quotes estimates from an Alan Guttmacher Institute study,^{10,11} based on 1990 data, which showed Chile as having one of the highest abortion rates in the world. Given decreases in both fertility and abortion complications in the past 15 years, these estimates are out-dated.

According to a 2001 Ministry of Health Quality of Life and Health Survey,¹² in 1990 there were 44,468 hospitalisations for abortion (spontaneous and induced), while in 2001, there were 34,479, a decrease of 22%. While the author (Shepard) could not duplicate the full methodology of the original study, her estimates, using the same correction and multiplier factors, suggest that the total number of abortions may also have decreased by 22% in 2001, with a 9% decrease in the abortion rate in Chile.⁶ Both decreases occurred during a period in which the population of women of fertile age rose by 23%. This decrease in abortions of 22% is higher than the 16% decrease in births during the same period. These estimates should be taken with caution, since they are based on hospital data, and experts attribute the reduction of hospitalisation related to abortion to the increasing use of aseptic procedures and antibiotic therapy among clandestine abortion providers, the increasing availability of misoprostol and increased contraceptive use.[†]

In the maternal mortality data for 2001, there were four reported deaths due to abortion, and in 2002 seven, as compared to 29 deaths in 1990. Chile's maternal mortality ratio for 2003 was approximately 14 per 100,000 live births (Personal communication, Dr René Castro, Ministry of Health, Director, Women's Health Programme, March 2006). This compares favourably to most Latin American countries

† While many assume that the use of misoprostol would reduce the rate of serious abortion complications as measured by hospital-based abortion statistics, the effect is not straightforward. Anecdotal reports and research in other countries such as Brazil suggest that some women using misoprostol without medical supervision end up in hospital either because of incomplete abortion or because they are uninformed about normal side effects such as bleeding. It is also likely that more women feel able to seek post-abortion care than in the past.

(Argentina's rate for 2001 was 70), but is still three times higher than in the USA and Canada.¹³ Very young adolescents aged 14 and under have limited access to contraception, as evidenced by the high ratio of 3,392 reported abortions to 994 live births in this age group in 2003.¹⁴ Given the low number of deaths, it is likely that morbidity is the most significant consequence of unsafe illegal abortion in Chile; however, there are no data.

Post-abortion care in Chilean hospitals: out of date and contradictory

According to several informants and the Obstetrics Manual of the School of Medicine, Catholic University,¹⁵ dilation and curettage (D&C) is still used for post-abortion care in the first trimester in Chile. This method is more intrusive and risky than vacuum aspiration and medical abortion, both recommended by WHO for many years now.¹⁶

There is no systematic information on other aspects of post-abortion care in Chile, although there are individual accounts of emotional abuse, and in some cases physical abuse, such as D&C without anaesthesia. Casas⁵ recounts several cases of egregious human rights violations when women are reported to the authorities.

"...as the nurses interrogated her and the doctors lectured her, she watched her hands going transparent from the blood loss... 'I remember the nurses telling me that if I didn't give them the name of the doctor who gave me the abortion, they would let me bleed to death'" (16-year-old)¹⁷

Legislative provisions on medical confidentiality are contradictory. On one hand, medical personnel have a legal obligation to report possible crimes to the authorities.¹⁸ On the other, professionals are legally excused from declaring in court information they received in confidentiality from patients.¹⁴ Such provisions exist in most Latin American countries, but in Chile, there is no consensus on how the legal conflict should be resolved. However, the Inter-American Human Rights Court recently declared that protection of medical confidentiality should be the prevailing interest in the reporting of crimes.¹⁹

Whatever the legal ambiguities, the number of abortion cases reported to the criminal justice

system since the advent of democracy has decreased significantly and was less than 0.5% of hospital-based abortions in 2001, or less than 0.01% of all criminal investigations of the Prosecutor and Public Defenders' Offices. By all accounts, hospital-based cases tend to be reported to the authorities only when death is viewed as likely, or in cases of uterine perforation, since these incur a hospital audit.⁵ In 2000, 46 women were found guilty of abortion and 31 in 2001.^{20*} According to the Prosecutor's Office data, of 69,960 criminal inquiries in 2003, 29 were related to abortions.^{21†} In recent years, women who are prosecuted are no longer sent to jail; the prosecutor imposes "conditional dismissal", which means that the women have to report monthly to the prosecutor's office for over a year.

Most medical professionals⁶ cite medical ethics as the main reason why more than 99.5% of Chilean doctors and midwives do not report women to the authorities. Very few mention doctor-patient confidentiality. The other main reason cited is that if women fear being reported they will delay coming to a hospital and arriving in a worse condition. Others say that even when medical professionals are strongly opposed to abortion, the judicial process is so time-consuming that most doctors are not willing to get involved.

Inducing labour or performing a caesarean section at or above 22 weeks of pregnancy is currently treated by the medical profession as "interruption of pregnancy", not abortion. However, if the doctor cannot demonstrate that the procedure was medically indicated, s/he could risk prosecution, as there are no official medical guidelines on such cases. In one high-profile case highlighted in the media in 2003, a woman with a molar pregnancy was denied an abortion in spite of public support by the Medical College for her request. Finally, at 22 weeks, "interruption of pregnancy" was performed after she had developed severe health complications.²² Reportedly, the Minister of Health had to visit

*These statistics are incomplete, since at the end 2000 a new criminal justice system was gradually implemented with parallel registries.

† This information corresponds to six regions where the new justice criminal system was implemented.

the Cardinal to explain after the resolution of the case was announced.

Medical professionals interviewed⁶ had varying opinions on what to do if a woman's life is threatened. While there may be more leeway in practice than the current law allows, there is no uniform policy regarding medically-indicated abortions. Although the law names no exceptions, medical practitioners and some criminal law scholars say that interventions to save the woman's life are not breaking the law, even when they result in fetal loss of life.^{23,24} Using the same arguments, some Chilean Catholic scholars and authorities have also said that current laws allow doctors to save the woman's life.²⁴ This argument hinges on Catholic definitions of abortion based in canon law. In current Catholic hospital care guidelines in Chile and the USA,^{15,25} a pregnancy can be terminated before viability to save the woman's life, even if it causes the death of the fetus. This is viewed ethically by the church as "indirect abortion" because the main intent is to save the woman's life; the loss of the fetus is an unfortunate and secondary consequence.

The case of ectopic pregnancies illustrates this widespread interpretation of the law. Most informants⁶ agreed that Chilean doctors will terminate an ectopic pregnancy, because the woman would inevitably die long before viability otherwise. However, two cases in a Catholic hospital were reported of doctors who waited until the fetal heartbeat ceased before intervening, thus putting the women at risk. In 2002, in the public health insurance records, there were 408 surgical procedures for ectopic pregnancies, suggesting that the total number of procedures nationwide was much higher.^{26*}

The Chilean Catholic University's Obstetric Manual¹⁵ mentions other examples of conditions that justify "indirect abortion": massive abnormal uterine bleeding, acute fatty liver and septic ovarian infection. Shepard⁶ encountered

opinions on other cases in which therapeutic grounds would apply:

- Advanced cervico-uterine cancer or ovarian cancer in which hysterectomy is required – Informants stated that this would be done in all hospitals.
- Other cancer during pregnancy – Most of those interviewed believed that Chilean doctors would provide radiation and chemotherapy when clinically indicated, in spite of potential damage to the fetus, but several believed that many doctors would force a woman in early pregnancy to delay treatment, two cases being cited. One expert recounted that until 2006, the majority of medical students in a bioethics course at one of the public universities, when presented with such a case, voted to delay treatment. Abortion would not be considered a legal option, but all say that it is legal to treat the cancer without performing an abortion at any gestational age.
- Molar pregnancies – Some molar pregnancies are life-threatening, resulting in cancerous growth, and chemotherapy is needed. In the case cited earlier, several people believed that if the case had not gone public, it would have been easier for the woman to find a doctor to perform the abortion.
- Anencephaly – In these cases, abortion would be illegal and most hospitals would not perform them, because the condition is not life-threatening for the mother. A court case in Brazil set a legal precedent in 2004 allowing induction of labour for this condition since the fetus has no possibility of independent life.²⁷ In Argentina, the Courts have ruled that induction of labour of a pregnancy over 22 weeks could not be deemed an abortion under the Criminal Code, so doctors are allowed to induce labour.²⁸
- Rape or incest – All said that abortions for this cause are not performed in hospitals, even in extreme cases. In January 2005, the high-risk pregnancy of a nine-year-old Chilean girl who was raped by her step-father received media attention, with women's NGOs advocating that an abortion be performed. The girl was placed under state protection in a children's home because the mother knew of the sexual abuse.²⁹

*These figures correspond to FONASA, which allows free choice of doctor in the public health system. Assuming that the same rates apply in all other establishments, there may be more than 1,800 cases of ectopic pregnancy per year, since the free choice of doctor system accounts for 36% of care.

New political and legal developments

Chile is a socially conservative society, even as it projects an international image as one of the region's most modern, progressive and stable democracies. Indicative of this contradiction is the delay in permitting divorce until 2005.³⁰ With regard to abortion, little has changed in the last 17 years since the end of the military dictatorship.

Since 1989, the country has seen three unsuccessful efforts to liberalise the law: in 1991, 2001 and 2006-07 (*Boletín Legislativo* No.499-07, No.197-11 and No. 4845-11 respectively). By contrast, the conservative right has put forward legislation that would impose harsher sentences on those found guilty of abortion. Even under the dictatorship, anti-choice legislators were not able to impose harsher sentences, and four similar bills between 1990 and Bachelet's election in 2006 were defeated as well, although one in the Senate in 1998 lost by only one vote. A 2003 Ministry of Health provision allowed medical death certificates in cases of miscarriage when the parents claim the remains for burial.* Although in most western countries this a practice is based on parental demand, in the case of Chile members of Congress tabled a bill in 2007 on the same issue arguing that the fetus is a person from the moment of fertilisation ("conception" in their language), requiring that it be treated the same as a person (*Boletín Legislativo* No.5261-11).

Since Bachelet's election in January 2006, there has been a flurry of anti-choice legislative activity. Seven bills have been introduced in little over a year, including one that proposes that decriminalisation of abortion would require a Constitutional amendment, requiring a 60% majority for approval. (*Boletín Legislativo* No.4121-07). This and an identical bill proposing the same amendment to the Criminal Code were presented less than two weeks after Michelle Bachelet took office.

Today, abortion is creating unprecedented bedfellows. For example, a recently created "Right to Life" bench in Congress includes

right-wing opposition deputies as well as Christian Democrats and others from the centre-left governing coalition (*Concertación*), which received support from 61 of 120 deputies.³¹ Four deputies, two from the *Concertación* and two from the opposition, have gone so far as to propose a new provision in the Criminal Code for anyone causing injury or harm to the unborn, the woman exempted (*Boletín Legislativo* No.4307-07). While such a bill might provide redress for women in cases of fatal harm to the fetus, due to negligence,³² in this context it was probably intended as a stepping stone to granting fetal personhood. Much of the judicial debate on emergency contraception in Chile since 2001 has also involved the legal status of the fetus.^{33,34} The same deputies presented another bill in January 2007 proposing the construction of three monuments in honour of the unborn victims of abortion (*Boletín Legislativo* No.4818-24).

Other bills either clarify or add restrictions to existing provisions in the Criminal and Health Codes. One proposal bans all surgical or clinical procedures, treatment, therapy or the prescription or administration of a drug with the intent to procure an abortion (*Boletín Legislativo* No. 4447-11) though it does not include cancer treatment that can cause miscarriage. One other includes abortion, *inter alia*, in a list of criminal offences for which it would be harder for a prosecutor to suspend criminal investigations (*Boletín Legislativo* No.4320-07). Still another would disallow the application in the Criminal Code of attenuating circumstances, such as lack of previous convictions, to abortion cases (*Boletín Legislativo* No.4350-07).

Bachelet's office has generally remained silent whenever the abortion issue arises in the media or the Congress. Since 1990, all Ministers of the National Women's Secretariat (*Servicio Nacional de la Mujer*), including the current Minister, have repeated the same mantra: abortion is "not on our legislative agenda". This is a reflection of chronic internal tensions on any issue involving sexuality and reproduction,³⁵ which reached a high point during the debate on emergency contraception that has raged since 2001.³⁴

Any proposal to allow therapeutic abortion is difficult in this climate. Two Deputies who tabled a bill in November 2006 to decriminalise abortion in the first 12 weeks of pregnancy

* Decreto 216/03 Ministry of Health, Official Gazette, 17 December 2003, which modified the *Reglamento General de Cementerios* 357, June 1970.



THOMAS HOEPEK / MAGNUM PHOTOS

Celebration of the inauguration of President Bachelet, Santiago, Chile, 2006

encountered a hysterical response from the opposition, who said it should be barred from the legislative process as unconstitutional. The Chamber, led by a progressive Social Democrat, acquiesced by ruling the bill inadmissible, causing much uproar.³¹ Some Christian Democrats threatened their party would leave the governing coalition if the bill continued its legislative process. These arguments were legally flawed and politically dishonest; changes to the Criminal Code do not require a constitutional amendment (*Boletín Legislativo* No.4121-07).^{36,37*}

*These distortions in the democratic legislative process, alongside manipulation of information, have characterised the political process on several issues recently.³⁵ Sex education books and clinical guidelines have been censored when the Catholic church or its allies pressured Ministers to prevent the circulation of information deemed contrary to the teachings of the church. For example, a publication for parents as part of the sex education programme in 2005, *¿Y ahora, qué digo?*, was shelved because it contained content on masturbation.

In spite of Executive efforts to restrain the turmoil over this issue within the governing coalition, a second bill was tabled on therapeutic abortion with broader provisions than the law in force until 1989. In addition to exceptions to save the woman's life and health, the bill included exceptions in cases of rape and when the fetus is seriously malformed. This was deemed admissible, but when pressed, the government said that not even therapeutic abortion was on the Executive's legislative agenda.³⁸

Since the 1990s, the Chilean government has ignored repeated recommendations from international human rights committees on restrictive Chilean abortion laws, policies and practices: from the Human Rights Committee in March 1999, the CEDAW Committee in June 1999, the Committee of the International Covenant on Economic, Social, and Cultural Rights in 2004, and the Committee against Torture in 2005. Most recently, in 2006, the UN Committee on the Elimination of Discrimination against Women recommended that Chile review its legislation on abortion.³⁹

In contrast to the conservative political elite, Chileans hold more progressive views on the issue. A representative poll of women in October of 2006 found that 75%, 71% and 68% of women, respectively, approved legalising abortion in cases of risk to the woman's life, rape or serious fetal malformation.⁴⁰ However, as the delays in legislating on divorce in Chile proved, favourable public opinion alone is not yet sufficient to embolden elected politicians to stand up to the political pressures of the Church and their allies.

Discussion

While restrictions on abortion affect all women, the burden is heaviest for low-income women who depend upon public health care institutions, where there is also more state oversight. Most of the harm to women is unseen and unknown, with no research data: the emotional trauma of seeking an illegal procedure or carrying an unwanted child, the health consequences when pregnancy is contra-indicated or from unsafe procedures, the trauma of facing criminal prosecution if caught, and death for the unlucky few.

The dilemmas faced by medical professionals in cases where women's health is threatened are considerable. The lack of medical guidelines on when interruption of pregnancy is permissible, accompanied by fear of prosecution, place both medical professionals and women in a highly vulnerable position. When pregnancy seriously threatens a woman's health, physicians must wait until 22 weeks to terminate the pregnancy. Some postpone cancer treatment and even delay dealing with ectopic pregnancy, causing additional risks to the woman's life and health.

Medical decision-making under these circumstances is highly discretionary and fraught with ethical and legal perils.

In clear-cut cases where ending a pregnancy is necessary to save a woman's life, Catholic clinical guidelines allow an "indirect abortion" in a country where abortion is not permitted to save the woman's life. While this "safety valve" allows physicians to fulfil a duty to women, it also creates a climate of ambiguity and denial due to lack of specific medical guidelines or legislation that would unequivocally protect women's health, and protect both women and physicians from judicial involvement.

The current political situation in Chile does not seem to favour a change in the law on abortion. The Bachelet government acted courageously to defend universal access to emergency contraception in public health services, and as a result has confronted criticism and dissension from within its own ranks on this highly popular health measure. Recent efforts to liberalise abortion laws or policies in Uruguay, Brazil and Mexico suggest that change in Chile may depend on the political will of the medical community to take on this political challenge and seek to change the status quo. Without the public leadership of this influential community, political leaders are unlikely to assume the considerable political risks associated with liberalising Chile's law.

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References

1. Hitt J. ProLife nation. New York Times Magazine. 9 April 2006.
2. Lynch A. Nicaragua's abortion ban claims another victim. 16 February 2007. RH 3. Reality Check blog. At <www.rhrealitycheck.org/blog/2007/02/16/nicaragua-s-abortion-ban-claims-another-victim>. Accessed 10 March 2007.
3. Pan American Health Organization. Derogación del Derecho al Aborto Terapeutico en Nicaragua: Impacto en Salud. Nicaragua, February 2007. At: <www.ops.org.ni/index.php?option=com_remository&Itemid=34&func=fileinfo&id=292>. Accessed 22 August 2007.
4. Rosita A. Bullfrog Films, 2006. Summary at: <www.bullfrogfilms.com/catalog/rosita.html>. Accessed 11 March 2007.
5. Casas Becerra L. Women prosecuted and imprisoned in Chile for abortion. *Reproductive Health Matters* 1997;4(9):29-36.
6. Shepard BL. Report on abortion practices and policies in Chile: results of a literature review and survey of experts. Report for Ford Foundation, Andean and Southern Cone Office, 2006. (Unpublished)

7. Jiles X. De la Miel a los Implantes. Historia de las Políticas de Regulación de la Fecundidad en Chile. Santiago: Corporación de Salud y Políticas Sociales, 1992.
8. Schiappacasse V, Casas Becerra L, Vidal P, et al. Chile: Situación de la salud y los derechos sexuales y reproductivos. Santiago: SERNAM, Instituto Chileno de Medicina Reproductiva, Corporación de Salud y Políticas Sociales, 2003.
9. Dides C. Aportes al debate sobre el aborto en Chile: derechos, género y bioética. *Acta Bioethica* 2006;12(2):219-29.
10. Singh S, Wulf D. Clandestine Abortion: A Latin American Reality. New York: Alan Guttmacher Institute, 1994.
11. Singh S, Wulf D. Estimates of abortion levels in six Latin American countries. *International Family Planning Perspectives* 1994;20:4-13.
12. Foro de Salud y Derechos Sexuales y Reproductivos/Red de Salud de las Mujeres Latinoamericanas y del Caribe. Atención humanizada del aborto inseguro en Chile. Santiago: 2003 and 2005.
13. World Health Organization. World Health Report 2005: Make Every Mother and Child Count. Geneva: WHO, 2005.
14. Casas Becerra L. Informe en derecho: confidencialidad de la información médica, derecho a la salud y consentimiento sexual de los adolescentes. *Revista de la Sociedad Chilena de Obstetricia y Ginecología Infantil y de la Adolescencia* 2005;12(3):94-111.
15. Poblete J. Interrupción del embarazo. In: Oyarzún E, editor. *Manual de Alto Riesgo Obstétrico*. Santiago, Chile: School of Medicine, Pontifical Catholic University of Chile. At: <http://escuela.med.puc.cl/paginas/Departamentos/Obstetricia/AltoRiesgo/Interrupcion_embarazo.html>. Accessed 10 March 2007.
16. World Health Organization. Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva, 2003. At: <www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf>. Accessed 8 April 2006.
17. Ross J. Illegal abortions rampant in Latin America. Women's E-News. 28 November 2004.
18. Casas Becerra L, Isla P. Confidencialidad de la Información Médica: Análisis Jurídico de la Situación en Chile. Confidencialidad de la Información y Consentimiento Informado en Salud Sexual y Reproductiva. Santiago: CORSAPS, 2002. p.91-118.
19. Inter-American Court of Human Rights. De la Cruz-Flores v. Peru. Judgment of 18 November 2004. [in Spanish]. Series C, No.115. At: <www.corteidh.or.cr/docs/casos/articulos/seriec_115_esp1.pdf>.
20. Maturana C. Derechos Sexuales y Reproductivos en Chile a Diez Años de el Cairo. Santiago: Foro Red de Salud y Derechos Sexuales y Reproductivos/Red de Salud de las Mujeres Latinoamericanas y del Caribe, 2004.
21. Defensoría Penal Pública. Defensa de Mujeres en el Nuevo Sistema Procesal Penal. Santiago: Centro de Documentación No.4, December 2005.
22. Informe Anual sobre Derechos Humanos en Chile. Hechos 2003. Santiago: Facultad de Derecho Universidad Diego Portales, 2004. At: <www.derechoshumanos.udp.cl/>. Accessed 22 August 2007.
23. Bascuñán A. La licitud del aborto consentido en el derecho chileno. *Revista Derecho y Humanidades* 2004;10:143-81.
24. Besio M, Chomali F, Neira J, et al. Aborto Terapéutico. Consideraciones médicas, éticas, jurídicas y del Magisterio de la Iglesia Católica. Santiago: Facultad de Medicina, Centro de Bioética, Centro de Estudios Jurídicos Avanzados, Pontificia Universidad Católica de Chile, 2002.
25. United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Health Care Services. 4th ed. 2001 At: <www.usccb.org/bishops/directives.shtml#partfour>. Accessed 8 April 2006.
26. Ministry of Health, Chile. The FONASA system. Diagnóstico 2002. (Unpublished)
27. Ferreira da Costa LL, Hardy E, Duarte Osis MJ, et al. Termination of pregnancy for fetal abnormality incompatible with life: women's experiences in Brazil. *Reproductive Health Matters* 2005;13(26):139-46.
28. Hooft P. Anencefalia: consideraciones bioéticas y jurídicas. La ausencia de un substrato biológico mínimo ¿genera diferencia moral? *Acta Bioethica* 2000;6(2):268-82.
29. La Nación. SENAME se querrá por abusos a niña de 9 años embarazada. 11 January 2005. At: <http://216.72.168.50/prontus_noticias/site/edic/2005_01_11_1/home/home.html>. Accessed 23 August 2007.
30. Shepard BL. The double discourse on sexual and reproductive rights in Latin America: the chasm between public policy and private actions. Running the Obstacle Course to Sexual and Reproductive Health: Lessons from Latin America. Westport CT: Praeger, 2006.
31. El Diputado Walker tiene una visión utilitarista del poder. *La Nación*. 19 November 2006. At: <www.lanacion.cl/prontus_noticias/site/artic/20061118/pags/20061118210027.html>.
32. European Court of Human Rights. Vo v. France. Application No.53924/00. Grand Chambers Judgment 8 July 2004. § ECHR 2004-VIII. At: <www.echr.coe.int>. Accessed 24 August 2007.
33. Casas Becerra L. La Batalla de la Píldora, el acceso a la anticoncepción de emergencia

- en América Latina. *Revista Derecho y Humanidades* 2004;10:183-208.
34. Casas Becerra L, Contesse J. La píldora del día después. At: <www.gvdireito.com.br/casoteca/Default.aspx?PagId=HJEFVQRK>. Accessed 24 August 2007.
35. Casas L. Women and reproduction: from control to autonomy? The case of Chile. *American University Journal of Gender, Social Policy & the Law* 2004;12(3):427-51.
36. Casas L. Aborto: el no-debate sobre aborto. *El Mostrador*. 30 November 2006. At: <www.elmostrador.cl/modulos/noticias/constructor/noticia_new.asp?id_noticia=203969>. Accessed 11 March 2007.
37. Casas Becerra L. Del aborto y otros cuentos y la transición democrática. *Revista Foro Chile XXI* 2007;7(65):10-2.
38. Salinas C, Cisternas H. Ejecutivo no planea legislar sobre aborto terapéutico. *El Mercurio*. 9 March 2007. At: <<http://diario.elmercurio.com/2007/03/09/nacional/nacional/noticias/8402ED49-5AFD-479F-9772-A2ACFE3EE7B7.htm>>. Accessed 9 March 2007.
39. CEDAW. Final Observations of CEDAW Committee: Chile, CEDAW/C/CH/CO/4, 25 August 2006.
40. Centro Regional de Derechos Humanos y Justicia de Género Humanas/Instituto de Asuntos Públicos de la Universidad de Chile. *Encuesta Mujer y Política* 2006. At: <www.humanas.cl/documentos/Encuesta%202006.pdf>. Accessed 6 March 2007.

Résumé

L'avortement n'est pas légal au Chili, même pour sauver la vie ou la santé de la femme. Cette situation crée de graves dilemmes pour les femmes et les praticiens, et les rend vulnérables. L'incidence de l'avortement a probablement diminué depuis 1990, date de la dernière analyse des données, avec l'utilisation accrue de la contraception et la baisse de la fécondité; le nombre de décès et de complications a aussi reculé. Le misoprostol est disponible, mais les hôpitaux chiliens utilisent encore la dilatation et le curetage pour les avortements incomplets. Les soignants sont tenus de notifier les avortements illégaux, mais moins de 1% des femmes hospitalisées pour des complications sont signalées. Il existe deux lacunes, l'une juridique et l'autre clinique. « L'interruption de la grossesse » après 22 semaines de gestation est légale pour raisons médicales; elle peut sauver la vie de certaines femmes, mais oblige aussi à prolonger les grossesses à risque. Les directives cliniques catholiques définissent les interventions destinées uniquement à sauver la vie de la femme, même si le fœtus meurt, non comme un avortement, mais comme un « avortement indirect » autorisé. Depuis 1989, trois projets de libéralisation de la loi pour motifs thérapeutiques ont été refusés. Le climat politique n'est pas favorable à un amendement légal. Les conservateurs n'ont pas non plus réussi à rendre la législation plus punitive, alors que la coalition de centre-gauche au pouvoir est divisée et les risques politiques d'un assouplissement des lois restrictives sont considérables.

Resumen

En Chile, el aborto no es legal, ni tan siquiera para salvar la vida o salud de la mujer. Esta situación crea graves dilemas y vulnerabilidades tanto para las mujeres como para los profesionales médicos. La incidencia del aborto probablemente ha disminuido desde 1990, último año en que se estudiaron los datos, debido al aumento en el uso de anticonceptivos y al descenso en fertilidad; además, las tasas de muertes y complicaciones también han disminuido. Misoprostol está disponible, pero en los hospitales chilenos aún se utiliza el legrado uterino instrumental (LUI) para el aborto incompleto. Aunque la ley exige que los profesionales médicos chilenos denuncien abortos ilegales a las autoridades, menos del 1% de las mujeres en hospitales con complicaciones son reportadas. Existen dos lagunas: una jurídica y una clínica. La "interrupción del embarazo" después de 22 semanas de gestación es legal para indicaciones médicas, lo cual puede salvar la vida de las mujeres pero también forzar la prolongación de embarazos que ponen en riesgo su salud. Las directrices clínicas católicas definen las intervenciones cuyo objetivo exclusivo es salvar la vida de la mujer, aun si el feto muere, no como aborto sino como "aborto indirecto" y permisible. Desde 1989, los tres proyectos de ley para liberalizar la ley por motivos terapéuticos fueron infructuosos. El clima político no es favorable para cambiar la ley. Los conservadores tampoco han logrado hacer la ley más punitiva, mientras que la coalición gobernante de centro-izquierda está dividida y existen considerables riesgos políticos en abogar por leyes menos restrictivas.