


Regulatory authorities are limiting telemedicine's potential to deliver legal abortion care to everyone in Colombia

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Introduction

In Colombia, abortion was decriminalised in 2006 by a constitutional court ruling in cases of rape, incest, endangerment of the woman's life or health, and fetal malformations incompatible with life. Despite changes in the law, women and other pregnant people continue to struggle accessing legal abortion care. Many pregnant people have cited mistreatment by health practitioners, denial of services, and fear of being reported to the police, as barriers to legal abortions.¹ Recent evidence suggests that barriers to abortion care have deepened throughout the pandemic.² Mobility restrictions introduced by the government in response to COVID-19 resulted in more pregnant people delaying their abortions. Furthermore, various health institutions stopped providing contraceptive and abortion care, contravening the Ministry of Health's demands to keep delivering essential health care. Because of the potential of mobility restrictions to seriously harm the population's health, Colombia rapidly strengthened access to care through telemedicine, which is the provision of health care through information and communication technologies (ICTs). Following the government's advice, one of Colombia's largest abortion clinics, Fundación Oriéntame (Oriéntame), integrated telemedicine into abortion care provision.

The administration of medical abortion via telemedicine reframes abortion care within the health care system. Through telemedicine, women and

other pregnant people can access support in different components of abortion care via online or phone consultations. They can be counselled, given detailed information about abortion medication, and sent misoprostol either alone or in combination with mifepristone to their homes (or other preferred locations) by safe providers. This modality of care makes safe abortion potentially available to all populations with internet access, phones, and mailing addresses. In fact, telemedicine is proving to be a safe, effective, and acceptable alternative for women and other pregnant people in different settings.^{3,4} A growing body of literature is demonstrating that, when provided with counselling, high-quality medications, and instructions (verbal, written, or both) by trained practitioners, medical abortion via telemedicine is as safe as in-person medical abortion. As many as 94% of individuals with gestations of 10 or less weeks are estimated to have completed medical abortions through telemedicine, which is almost identical to the percentage of individuals who have completed in-person medical abortions (93%).⁴

Where legal, abortion through telemedicine contradicts the understanding that safe and legal abortions only occur within clinical settings. It also reduces some of the barriers pregnant people experience when accessing in-person care (i.e. travel time and costs, taking time off work or education, and anti-choice protesters).³ Furthermore, access to safe abortion is improved for people in areas where unofficial and often

misinformed vendors are the primary source of information or medication for inducing an abortion.⁵ Providing abortion through telemedicine also challenges the notion that a pregnant person bears little or no agency in their abortion. Thus, ICTs can be used to receive support for different aspects of abortion care (counselling, pregnancy diagnosis, dispensation of medications, and follow-up), which places pregnant people as active participants of their own health.

During the COVID-19 pandemic, the provision of abortion through telemedicine has become increasingly important as it facilitates access to reproductive health while responding to the (often very restrictive) mobility measures taken by various governments. In different settings, barriers to sexual and reproductive health care were exacerbated by these measures. In fact, extended lockdowns resulted in women facing difficulties to access both contraceptive and abortion care, while experiencing an escalation in domestic violence.⁶ Some estimates indicate that these barriers may have led to 1.4 million unintended pregnancies in lower and middle income countries.⁷ Because of the potential of mobility restrictions to seriously harm the population's reproductive health, a number of international organisations, including the World Health Organization, rapidly recommended governments to strengthen access to reproductive care through telemedicine.

In Colombia before the Covid-19 outbreak, the Ministry of Health (MOH) and the Ministry of ICTs had developed policies to regulate the use of telemedicine. The most significant policy was Resolution 2654, issued in 2019 by Colombia's MOH, which permitted the use of telemedicine for medical consultations. Before this resolution, telemedicine was only permitted in a few circumstances, mainly to facilitate provider-to-provider communication. Following the Colombian MOH's recommendations, various providers adopted telemedicine to deliver health care during the pandemic. Telemedicine licencing procedures include monitoring visits to the health facilities that want to provide this modality of care by a group of regulatory authorities. These authorities are employees of local health secretariats of the MOH who are trained to audit health facilities' compliance to regulations in cities and municipalities. As the first clinic to provide legal abortion through telemedicine in Colombia, our experience with these audits at Oriéntame is that, at least in the licencing process for the provision of abortion

care through telemedicine, there were critical inconsistencies between what the MOH's policies demanded and what the regulatory authorities demand during their visits. In the next sections of this commentary, we will address these inconsistencies by arguing that they limit broader access to legal abortion in Colombia and ignore telemedicine's potential to expand access to timely and quality reproductive health care.

Access to abortion care through telemedicine in Colombia

Data from 2019 indicates that 60% of Colombia's poorest population cannot access the internet.⁸ Insufficient internet infrastructure as a result of geographic factors (i.e. mountain ranges, hills, and valleys), dispersed populations, and scant financial resources prevent full connectivity.⁹ Access to mobile internet is more limited for women, especially for those living in remote areas. Thus, women in Colombia are 17% less likely than men to have access to quality mobile internet, and even less likely if they live in rural areas.¹⁰ Furthermore, women living in rural areas have low digital literacy which impedes their access to these technologies.⁹ These gender gaps pose significant challenges for broadening access to reproductive health through telemedicine in Colombia.

These limitations have been visible in our experience of providing abortion care through ICTs. We have provided care to rural women who have smartphones that are only capable of running a few apps. Furthermore, many of them have mobile internet plans that can only access certain social media apps (including Facebook, Instagram, and WhatsApp), and restrain internet access to other apps, including those related to healthcare services. In addition to the limitations of their smartphones and mobile plans, many of them have low digital literacy, and find it troublesome to navigate through the internet. Because of these circumstances, telemedicine consultations should be accessible through the most basic cell-phones and mobile plans. Furthermore, they should be accessible through phone calls. In fact, current policies in Colombia do not demand the use of health apps or internet for medical consultations via telemedicine. Instead, Resolution 2654 indicates that ICTs can be used to deliver health care. Nor does this resolution require getting electronically signed consent from patients

when providing legal abortion care, recognising that this requires digital skills that many people in Colombia do not have. In fact, this resolution states that telemedicine providers can state in the clinical records that the patient voluntarily agrees to receive health care through ICTs (including phone calls) but cannot electronically sign an informed consent.

Despite MOH's flexibility for telemedicine providers, during audits, regulatory authorities have demanded that Oriéntame ask patients to download a health app for abortion consultations so that their personal information is kept private. Even more, they have demanded that we incorporate digital signatures or audio-record patient's verbal consents; this second alternative is, in fact, very demanding in terms of technological capacity and financial expenditures. Because pregnant people often find it troubling to access healthcare apps and digitally sign the consents, we have had to give close personal assistance to them, which is time-consuming in relation to the number of users attending online abortion consultations every day. Instead of encouraging the adoption of telemedicine, these unrealistic requirements may end up dissuading abortion providers from delivering abortion care via telemedicine.

In addition to the inconsistencies we have mentioned, it is troublesome that current telemedicine policies in Colombia do not take into account that some telemedicine (abortion or any other healthcare) providers, are likely to send medicines to their patients. These policies only consider sending prescriptions to patients, and assume that they will acquire the prescribed medications at pharmacies. It is important to keep in mind that abortifacients in Colombia cannot be purchased without medical prescription, and that although they are legal, pharmacists often refuse to sell these medications even to a person that has a prescription.⁵ Although sending abortifacients to pregnant people by legal abortion providers could dramatically increase access to legal abortion care, current legislation is rather insufficient in this matter. In fact, Colombian policies only consider that pharmacies send medications to patients through specialised pharmaceutical transport operators, which are significantly more expensive than standard transport operators. Paradoxically, pharmaceutical transport operators often depend on standard transport operators to deliver medications in remote areas. However, it is worth considering

that regulatory authorities have been flexible in this matter because of the pandemic, allowing Oriéntame to send abortifacients via standard courier service. Our fear is that the MOH might rescind this flexibility once the emergency resulting from the Covid-19 outbreak ends.

By reason of these failures to clearly regulate abortion through telemedicine, women have adopted different alternatives to secure their access to this modality of care, sometimes risking their confidentiality. They have resorted to acquaintances to (a) get a device with the capacity of downloading apps for online consultations and (b) to receive abortifacients at physical mailing addresses. For instance, an indigenous woman from Colombia procured help from people outside her community to prevent her peers from learning of a pregnancy for which she'd be socially sanctioned. She found support from a woman in a nearby peri-urban area who helped her access an online consultation. In some cases, rural women who lack physical mailing addresses have asked people located in peri-urban areas to receive the medication kits sent by Oriéntame for their abortions. This support provided by acquaintances is deeply comforting for women, even if it involves risking their confidentiality. Yet, it is troubling that the most vulnerable women risk their privacy even when their reasons for choosing abortion through telemedicine were, to some extent, based on keeping their abortion private.³ Even more, those located in remote rural areas may have resorted to telemedicine because is the only way to access legal abortion care. It is almost impossible not to question why some pregnant people would choose to go through all this, instead of resorting to unofficial (and misinformed) misoprostol vendors, who are easily reachable. In this scenario, excessive demands on technological devices and transport operators for legal abortion seekers are detrimental to reproductive rights. This may end up pushing women and other pregnant people to turn to informal – and often unsafe – means to end an unwanted pregnancy.

How can these challenges be confronted?

Regulatory authorities urgently need training to better audit telemedicine abortion providers without compromising women's and other pregnant people's needs. Ideally, people wanting to terminate a pregnancy should be able to access high-

quality abortion care easily. Therefore, we consider it fundamental that the MOH clearly indicate that current telemedicine regulations do not demand the use of health apps for providing abortion care, and that patients can be cared for with simpler technological platforms. For example, patients could access online consultations through links to web pages or instant messaging apps that are private and secure. Even more so, access to legal abortion care could dramatically increase if phone consultations were clearly recognised by the Colombian government as viable means to deliver high-quality reproductive health. We also consider it necessary that regulatory authorities recognise the implications of demanding electronically signed consents for abortion care. While paperwork is a proof-of-evidence that abortion through telemedicine is legal care, the MOH's policies indicate that providers can write in the patient's records that although the patient cannot provide an electronic signature, they voluntarily agree to receive health care through telemedicine.

If regulatory authorities keep demanding excessive requirements for providing abortion through telemedicine, women and providers will continue to bear the burden of ineffective and costly care.

In addition to training regulatory authorities, expanding access to internet coverage for remote areas is urgent, as it improves rural people's access to timely reproductive health care. While expanding internet coverage, it is important that the government addresses the digital gender gap by securing rural women's access to ICTs. If this is not undertaken, ICTs for health care will continue to be out of reach for the most marginalised.

Disclosure statement

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