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**“La Política del Avestruz”:
The Regulation of the Black Market for Medical Abortion in Chile**

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Senior Honors Thesis

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Abstract. This thesis seeks to answer the overarching question of how the black market for medical abortion is regulated in Chile. In answering this question, this thesis responds to the two sub questions: why is the Chilean government ineffective at regulating the black market for medical abortion in Chile, and how have non-governmental actors filled this vacuum through informal regulation? Although the Chilean government has one of the highest levels of state capacity in Latin America, it has surprisingly allowed this black market to exist in almost complete impunity. In this thesis, I argue that although the Chilean government has the capacity to regulate this market, that government bureaucrats intentionally choose to ignore the existence of this activity in the efforts of upholding their professional norms and interests; the market leads to decreased abortion-related complications, to a reduction in the maternal mortality rate, and to decreased costs for clinics related to the upkeep of expensive emergency septic units. However, to combat some of the dangers that exist within an unregulated market, NGOs have emerged to create an informal regulation of the black market through three mechanisms: provision of information, exposure, and price reduction. Consequently, this thesis seeks to understand how both the formal and informal regulation by government officials and non-state actors of the black market for Misoprostol in Chile functions, and if these theories can be applied to other cases of illegal activity.

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CHAPTER ONE: INTRODUCTION

Despite its emphasis on progressive economics and politics, Chile remains one of six countries worldwide (including the Dominican Republic, Nicaragua, El Salvador, Malta, and the Vatican City) where abortion is banned in all cases (Buchanan 2015). Although a bill that would seek to legalize abortion for therapeutic purposes (if the pregnancy is the result of rape or incest, if there is fetal malformation, or if there is risk to the mother's life or health) is currently being reviewed by the Constitutional Commission before it moves to a debate in the Higher Chamber, the likelihood that this bill will become law is uncertain, as lawmakers are deeply divided over this issue (Amado et. al 2010, 119; Telesur 2016). As of 2017, in Chile, if a woman has had an abortion or a doctor has performed this abortion surgery, they can be subject to up to five years in prison (Jones 2014). As a result, many women resort to highly dangerous methods to induce abortion at home, which can include a variety of tactics from the insertion of catheters to a mix of traditional methods (Shepard 2007, 203). However, in the past fifteen years, the introduction of Misoprostol (known as *Misotrol* in Chile) as a method to medically induce abortion has changed the scenario for reproductive health in Chile drastically.

Misoprostol has become the method of choice for women who seek abortions in Chile. As abortion data is difficult to obtain, there is little survey data on the true numbers of abortions that are performed in Chile each year. However, in 1990 it was estimated that 160,000 abortions were performed annually (which is a rate of 45 per 1,000 for women aged 15-49). More recently, a study estimated that abortion rates could be anywhere from 60,000 to 300,000 each year (Prada and Ball 2016). Although the ratio of the number of abortions to abortion prosecutions is low, between January 2011 and September 2012, 310 cases of abortion were tried and prosecuted in

Chile, a number which is much higher than in most countries in the world (Casas and Vivaldi 2014, 72).

Misoprostol, a drug which is available through prescription to prevent stomach ulcers, has the side effect of inducing miscarriage (Casas and Vivaldi 2014, 73). Misoprostol has greatly reduced the risk of infection from abortion throughout the region of Latin America. In the Dominican Republic, the introduction of Misoprostol decreased the rate of severe complications related to abortion by 75% (Kulczycki 2011, 205). In Chile, the introduction of Misoprostol, along with improved access to contraceptives, has contributed to a drop in the country's mortality ratio from 55 deaths per 100,000 live births in 1990, to only 22 deaths per 100,000 live births in 2013 (Prada and Ball 2016). One academic, Ramiro Molina, argued that Misoprostol was the sole cause of the reduction of the rate of septic abortions in Chile, which used to be a large problem during the 1980s (Fernández 2014).

In 2014, Misoprostol could be purchased on the black market in Chile for prices ranging anywhere from US \$70-215 (although this price continues to rise with increasing demand) (Casas and Vivaldi 2014, 74). The market for Misoprostol exists partially as an online black market, which fills a demand for the drug all throughout Chile. Surprisingly, Misoprostol is both casual and easy to obtain in Chile. In the last five years, the market has surged through sites such as “Red Interactiva de Estudiantes” and community forums such as “todomercado.com.” Furthermore, Chilean reporters argue that even after five years of growth, the market “*todavía existe en total impunidad*” (still exists in complete impunity) (González 2007). Women report that Misoprostol is sold on “practically every street corner,” and that it is even easier to find on the internet; “I looked it up on the internet, and it was full of adverts, full, full, full, all saying “I sell Misotrol, I sell Misotrol”” recounted one woman who had sought to end her pregnancy

through medical methods (Jones 2011). Furthermore, the rates of prosecution of the illegal sale of Misoprostol are also low; between 2012 and 2014, there were only twenty cases brought to court of the illegal sale of abortive drugs (Fernández 2014).

Chile is one of the most politically and economically stable countries in Latin America. According to the Democracy Index 2014, it rates among the top countries in Latin America on functioning of government, and it has some of the lowest rates of corruption in the region, coupled with high rates of economic growth and freedom (Youngs 2015, 44). Miguel Centeno and Alejandro Portes argue that “the relationship between the state and the informal economy is...cyclically casual and negatively correlated. In general, the weaker the state, the greater the likelihood of an economy being able to escape its grasp” (Centeno and Portes 2006, 29). Consequently, in a strong and politically and economically stable state such as Chile, we would expect the government to be able to regulate informal or illicit economies that emerge within its borders. However, this has clearly not been the case with Misoprostol. As a result, this thesis seeks to answer the overarching question of how the regulation of Misoprostol functions in Chile. In answering this question, this thesis responds to two sub questions: why is the Chilean government ineffective at regulating the black market for medical abortion in Chile, and how have non-governmental actors emerged to fill this vacuum through informal regulation?

There has been a significant amount of research conducted on why countries in Latin America (and Chile specifically) have not legalized abortion, by authors such as Merike Blofield (2001) and Mala Htun (2003). These authors argue that the strength of anti-abortion movements coupled with public ambivalence has increased the political risks for politicians and parties so greatly that the coalition in favor of the legalization of abortion is prohibitively small (Htun

2003, 143). However, these arguments do not directly relate to the regulation of medical abortion, and cannot explain why the black market for abortion remains large in Chile.

Additionally, many sociologists have studied the relationship between government regulation and state strength, and the rise of informal and illegal markets. However, the majority of these authors support the thesis of Centeno and Portes: strong states contain only small and weak informal markets, which is not the case of Misoprostol in Chile (Centeno and Portes 2006, 29). Authors that focus on the rise of informal markets in areas with strong states tend to attribute their emergence to the diffusion of international labor costs, which causes businesses to move underground; the process of industrialization, which leads to low enforcement of previously set state standards (as a means of gaining a comparative advantage); and economic crises in the 1970s, which forced workers to seek whatever jobs (licit or illicit) that were available (Portes and Castells 1989, 29).

However, these causes are more illustrative of informal markets such as unlicensed taxi drivers, and are unable to explain why a government would be unable to regulate expanding black markets. Additionally, the scope of the study of black markets generally focuses on the ways in which these markets lead to the reduction of citizenship and to the rise of gangs, which is not illustrative of the rise of the illegal market for Misoprostol in Chile, as the sellers are individuals rather than gangs (Yashar 2013). Consequently, this thesis seeks to respond to this gap in the literature about the regulation of black markets, in the efforts to add to theories about the creation of black markets, the lack of government regulation, and the emergence of informal regulation.

Motivations for Research

Although Chile portrays itself as a modern and progressive country, it is actually a socially conservative society (evidenced by the fact that divorce was illegal until 2005) (Shepard and Becerra 2007, 206). In Chile, therapeutic abortion was legal between 1931 and 1989. However, during Pinochet's last few weeks in office, he included a "right to life" clause in the Chilean Constitution, that remains in Chile's Constitution today. This clause states that "every person has a right to life, and the law will protect the right of the unborn" (Casas-Becerra 1997, 29). The Chilean criminal legislation was modeled after the Spanish Criminal Code of 1950. However, while the Spanish code has been updated many times to adapt to changing contexts, the Chilean Criminal Code has remained unchanged (Casas-Becerra 1997, 29). Since 1989, there have been three attempts to liberalize the Criminal Code to allow therapeutic abortion in Chile, but they have all failed. This failure is largely due to the strong presence of opposition from Congress' Right to Life bench which includes both right-wing opponents and center-left members, such as the Christian Democrats. Furthermore, these groups have introduced several proposals that seek even greater penalization of abortion, including seven bills that were introduced in less than a year following Bachelet's election in 2006 (Shepard and Becerra 2007, 206).

The illegality of abortion is particularly problematic because it leads to large amounts of social inequity, as those who resort to unsafe abortion methods (leading to dangerous complications) are much more likely to be adolescents and poor women (Shepard and Becerra 2007, 202). These women either seek unsafe methods due to the prohibitive costs of abortion (illegality greatly increases the cost of safe abortion), or because of abortion stigma, which can lead women to choose clandestine methods of abortion in the efforts to maintain secrecy

(Blofield 2008, 403; Annik et al. 2016, 421-422). Additionally, even in countries where abortion is legalized under a limited number of circumstances, there are few countries that have hospital protocols to ensure the quality of abortion and post-abortion care (Kulczycki 2011, 205). Studies have found that the prohibition of abortion does not greatly decrease its use; rather it forces it to take place in potentially dangerous settings where its performance by untrained practitioners can cause infections and hemorrhaging (Blofield 2008, 403-404).

Furthermore, wealthy women (upper/middle class Chileans) are rarely ever charged with having abortions (and rarely have abortion-related complications) because they are able to have this procedure done by doctors in private hospitals, where they are treated for “appendicitis.” In contrast, poor women are much more likely to have to resort to “back alley” abortions that lead to complications that must be treated in public hospitals, where they may be reported to the police and face abortion charges (Casas and Becerra 1997, 35). In these cases, medical confidentiality is violated, as doctors are legally obligated to report potential crimes to the authorities, while at the same time the Criminal Procedures Code exempts them from having to reveal details about the abortion in court. This contradictory understanding of patient-doctor confidentiality has dangerous implications for the women involved. One 16-year old woman reported “I remember the nurses telling me that if I didn’t give the name of the doctor who gave me the abortion, they would let me bleed to death” (Shepard and Becerra 2007, 204). Cases such as these demonstrate that poor women in Chile experience differential treatment including violations of “the right to life, health, privacy, due process, legal representation, and equal treatment under the law” (Casas and Becerra 1997, 35).

The criminalization of therapeutic abortion has created an unequal society in Chile, where only wealthy women are able to fully realize their constitutional rights. The status of

abortion in Chile motivated this thesis, as the emergence and growth of the use of Misoprostol over the past fifteen years has dramatically changed the environment in Chile in regards to abortion (as described above). Misoprostol has become the method of choice for women who seek abortions (particularly young women with internet access), and it returns a degree of agency to those who are denied by the law the right to choose.

Misoprostol has helped to reduce levels of maternal mortality (as it replaces riskier methods of abortions and reduces abortion-related complications), but there is a darker side to an unregulated and illegal market; an “unregulated market implies wrong information and unavoidable misunderstandings” where counterfeit pills and dangerously high doses can put women who seek medical abortion at risk (Harper et al. 2007, 68; Casas and Vivaldi 2014, 74). Furthermore, academics have labeled the sellers of these drugs as “*verdaderas mafias*” (true mafias), that occasionally sell fake pills and often provide their clients with incorrect, and potentially dangerous, information about dosage (Informe Annual 2013, 95). As a result, this thesis seeks to investigate broad questions, such as how Misoprostol is obtained, how it is regulated, and how its presence impacts the scene of reproductive health in Chile. More specifically, I will try to explain why and how the black market for Misoprostol is able to flourish within Chile’s institutionally strong and socially conservative environment, and the ways in which NGOs have emerged to reduce the harms of this unregulated market.

What Forms Can Regulation Take?

In this thesis, I argue that regulation can take a variety of different forms. As Cross and Peña argue, regulation occurs as a way of socially managing risks that take place when individuals become involved in transactions with other individuals. Regulation and risk

management involve the reduction of uncertainty within interactions between individuals, to make these interactions more predictable, and to reduce asymmetries of knowledge that may exist between these individuals. With an increase in impersonal interactions, one of the state's roles has become regulating these interactions to ensure stability within the marketplace. The traditional role of the state has been to regulate this formal marketplace, which involves an area of state-approved practices of production and distribution (Cross and Peña 2006, 48-51). The difference between this formal marketplace and an informal marketplace is determined less by the products that are sold within it, and more by the ways in which the products are produced or sold (for example, clothing, medications, or automobile parts- which are legal commodities- may become part of an informal market based on the way that they were made or sold) (Portes et. al 1989, 15). Furthermore, some actors may decide to subvert the dominant regulatory system through the creation of "underground" or "black" markets which are defined by their illegality (such as illegal drug selling). The difference between the informal market and the illegal market is that in the informal market, products may be legal, but were produced in illegal ways, versus the illegal nature of the products sold on the black market (Cross and Peña 2006, 51).

In this thesis, I examine the different types of regulation that take place in the black market for Misoprostol (defined as "black" because Misoprostol is illegal outside of hospitals), and the different levels of regulation that take place within this market. In the figure below (Figure 1), I have created a diagram of the different forms that regulation can take. I have defined "formal regulation" as regulation by the state of a specific activity; whereas, I define informal regulation as the regulation of an activity by non-state actors, such as NGOs. In this diagram, I have also separated regulation into the categories of "strong" and "weak." The ways

in which “strong” or “weak” regulation occur depends on the types of actors involved, and the types of activities that they attempt to regulate.

In the case of strong, formal regulation, one example we see is the state regulation of the “formal marketplace” described above. In this case, strong, formal regulation can occur when the state intervenes in a market to become the “remedy” to market failures, preventing conflicts in the market place, and reducing these market failures. States can also act as strong, formal regulators of informal activities, such as street vending. For example, in Washington D.C., street vendors must get their permits from local governments, and if they do not have permits, they may be prosecuted (Cross and Peña 2006, 51-77). In the case of the government regulation for Misoprostol in Chile, one would expect this case to fit within the category of “strong, formal regulation” as one would predict that the government would crackdown on the sale and purchase of this illegal drug. However, we have not seen this outcome take place, and instead there is a flourishing black market for Misoprostol, with very little efforts made by the government to investigate or reduce its presence.

On the lower, right-hand corner of Figure 1, we have an area of formal, weak regulation. In this case, although regulation still occurs through the state, it is weak or ineffective. There are a variety of reasons why formal, weak regulation exists, which will be described in greater detail in Chapter 5. The result of weak, formal regulation is often the emergence of large informal or black markets. One of the reasons for weak, formal regulation is a lack of state capacity, meaning that although the state would like to shut down this informal or illicit activity, they may not have the resources to do so (Cross and Peña 2006, 29). However, weak, formal regulation may also be the result of deliberate decisions by government actors. For example, Holland’s theory of forbearance “or intentional and revocable government leniency towards violations of

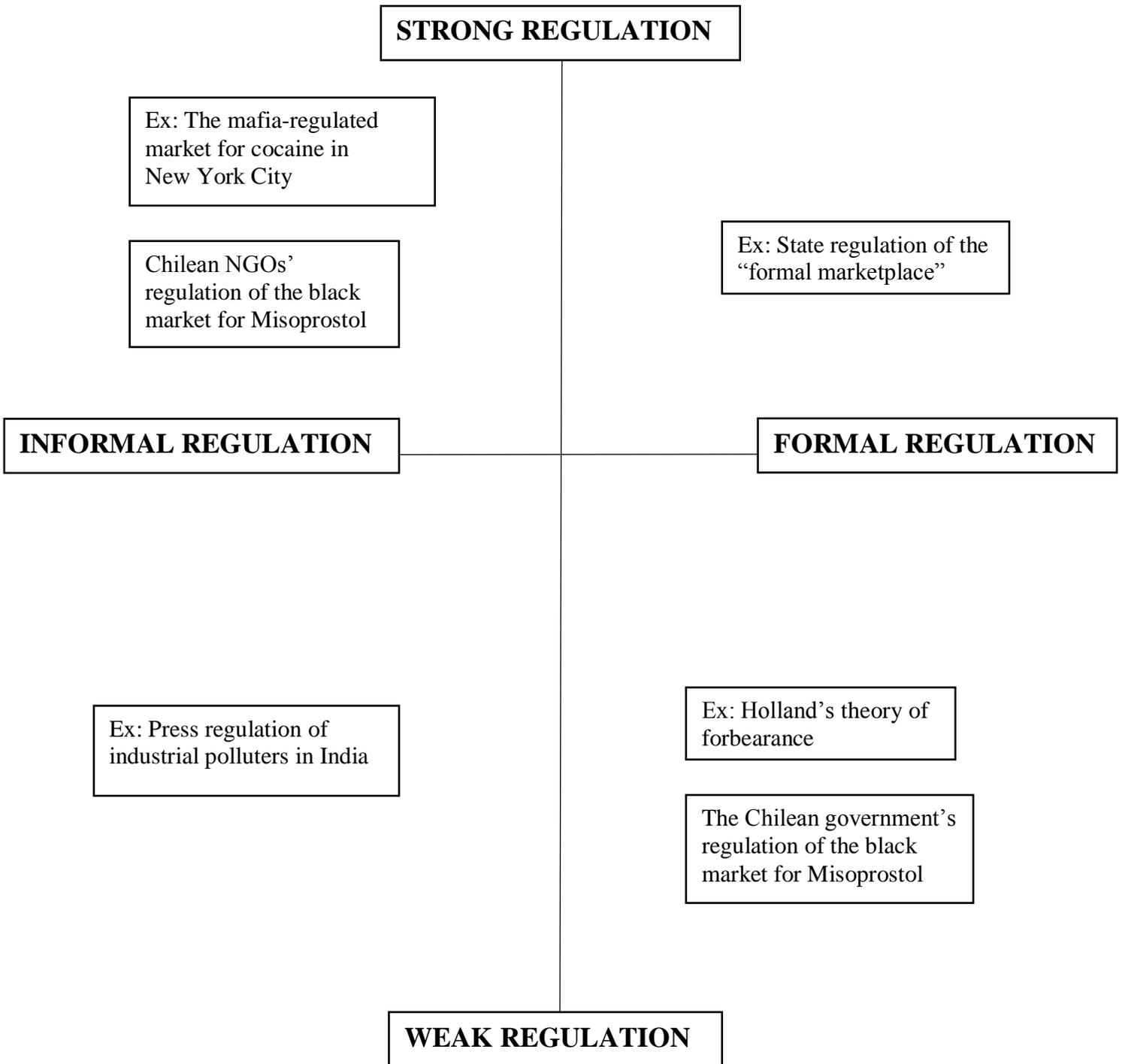
the law” describes how government officials may embark on a policy of formal, weak enforcement as a redistributive mechanism (Holland 2016, 233). For example, in the case of street vending in Santiago, Chile, Holland describes how mayors have used forbearance (not cracking down on street vendors) as a way of expanding welfare goods, in the efforts to gain support from poor voters (Holland 2016, 242). Moreover, the formal, Chilean government-run regulation of the black market for Misoprostol would fit within this category of formal, weak regulation. Although the Chilean government knows about the existence of this black market, and I will argue would have the capacity to regulate it, we have seen that there is very weak regulation of this market (a phenomenon that will be described further in Chapters 3, 4, and 5).

The lower, left-hand corner of Figure 1 represents the third form that regulation can take: informal, weak regulation. In the case where formal regulation is non-existent or weak, informal regulation can emerge in some cases to take its place. Informal regulation occurs when a non-state actor uses the resources at its disposal in an attempt to regulate a specific activity (which could be legal, informal, or illegal). For example, there are many cases where NGOs have attempted to regulate market activity through a variety of forms, from threatening to shame an actor (through public disclosures of information) that they view as engaging in harmful behavior (for example, posting an industries’ level of pollution) to pressuring formal regulators to increase enforcement standards. However, depending on the situation, a non-state actor may be able to have a large amount of influence on an actor’s behavior (leading to strong, informal regulation), or may be restricted in their ability to influence markets (leading to weak, informal regulation). For example, one case describes how in India, the press has appeared as an informal-regulator of polluting industries, as the government does not act as an effective regulatory force. Although news coverage did have some influence on polluters’ behaviors, the effect was not very large or

immediate, largely due to the fact that there was a lack in sustained publicity about the polluters' behaviors. Consequently, although the Indian press attempted to act as an informal regulator of polluting industries, its inability to create widespread change would place it in the category of "weak, informal regulation" (Kathura 2007, 403-417).

Finally, in the upper-right hand corner of Figure 1 exists the category of "strong, informal regulation." Strong, informal regulation often exists in cases of illegal markets, where the state is unable to enforce the norms and contracts of the market. In this case, non-state actors may materialize to take over the "power vacuum" that the state lacks the ability to fill, by providing the service of regulation to the population. One example of strong, informal regulation is the mafia-controlled market for cocaine in New York City. Mafia-style organizations often emerge in advanced societies, when the state makes an activity illegal. This illegal activity oftentimes leads to the creation of mafias that attempt to regulate competition and provide protection for members of the market, in exchange for a portion of the rent obtained from the illegal activity. In the case of the market for cocaine in New York City, mafias replace the state's role of enforcer through its "monopoly of the legitimate use of threat or force," and act as strong, informal regulators of this market (Cross and Peña 2006, 60). The informal regulation of the black market for Misoprostol in Chile would fit into the category of strong, informal regulation, although it is obviously extremely different from the mafia-controlled market for cocaine in New York City. In Chile, NGOs act as informal regulators of the black market for Misoprostol through a variety of mechanisms, from information provision to influencing the price of the medication (these mechanisms are detailed in Chapter 6). Because the Chilean state is unable to effectively regulate this illegal market, NGOs have taken on this role, greatly increasing the safety of this market for the women who seek it, in a process of strong, informal regulation.

Figure 1: Forms of Regulation



This theory about the ability of NGOs to regulate illegal markets is distinct from the majority of literature about informal regulation (which generally discusses NGOs' abilities to regulate formal or informal markets, rather than illicit markets), and contributes to a broader scholarly debate about this topic. Having described the concept of "regulation" that I use in this thesis; outlined the four different forms that regulation can take: strong-formal, strong-informal, weak-informal, and strong-informal; and situated the two different types of regulation of the black market for medical abortion in Chile (formal and informal) within this framework, as a means of contextualizing the different forms of regulation that this market has taken, I will now discuss my methods of data collection for this thesis.

Data Collection:

To provide evidence for my argument, I rely on a mix of eighteen semi-structured interviews, primary sources, and secondary sources. During the month of January, I conducted interviews in Santiago, Chile. Sixteen of these interviews were in person, and two were over Skype. I also received two email responses to a list of questions that I sent to two actors, an NGO employee (MILES Chile), and a pro-life lawyer and professor at Universidad Católica, Paulina Ramos Vergara, who were both unreachable for interviews. During my fieldwork, I interviewed seven categories of actors: members of national and international reproductive-health focused NGOs, government officials, doctors, constitutional lawyers, social workers, Masters students, and professors.

During this process, I interviewed three employees of feminist NGOs that provide women with access to information about Misoprostol. I interviewed Angela Erpel from the NGO *Línea Aborto Libre* (the Abortion Hotline), María José from *Con las Amigas y en la Casa* (With

Friends and in the Home), and I interviewed one employee who works for both *Línea Aborto Libre* and Women Help Women- an organization that provides information about the use of Misoprostol, and provides women with access to contraception, emergency contraception, and Misoprostol/Mifepristone. Additionally, I interviewed five people who work in government ministries: Dr. Juan Baeza who works for the Ministry of Health in Valparaíso, is the regional head of *el Programa de Salud de Adolescentes y Jóvenes* (the Program of Child and Adolescent Health), and is the regional coordinator of *Salud Sexual y Reproductiva* (Sexual and Reproductive Health), two officials who work for the Ministry of Health in Santiago, and are part of *la Programa de la Mujer* (the Women's Program) within the Ministry of Health (one, Dra. Paulina Troncoso is a gynecologist and professor, and the other, Mat. Eduardo Soto, is a midwife), and two women who work for the Ministry of Women and Gender Equity, and oversaw the creation of the *Ley de Tres Causales* (the Therapeutic Abortion Law).

During my fieldwork, I also interviewed six doctors: Dr. Ramiro Molina- a professor at la Universidad de Chile, a gynecologist/obstetrician, and the creator of an online sexual education course in Chile; Dr. Juan Pablo Beca, a professor at La Universidad de Desarrollo, the founder of the Center of Bioethics, and a surgeon (with a specialty in Neonatology); Dr. Mauricio Besio, a pro-life associate professor at La Universidad de Chile and a gynecologist/obstetrician; Dr. Fernando Zegers, a professor at la Universidad de Diego Portales, a gynecologist/obstetrician, and a medical expert to the UN in 2002; Dr. Rene Castro, a professor at La Universidad de Diego Portales, a gynecologist/obstetrician, and a past employee of the Ministry of Health; and Dr. Dominique Truan, a doctor who works in high-risk obstetrics in a private clinic.

Additionally, I interviewed two constitutional lawyers: Rodolfo Figueroa, a professor at la Universidad de Diego Portales who studies abortion as a constitutional right, and Yanira

Zuniga, a professor at la Universidad Austral de Chile who studies human rights, gender, and abortion, and attended (as an expert) a session of *la Comisión de Constitución del Senado* (which voted 3 to 2 in favor of the *Ley de Tres Causales*). In this process, I also interviewed one social worker, Luis Rodriguez, who works in primary healthcare, and works directly with patients and their families in Chile. I also interviewed one Masters student from La Universidad de Desarrollo, Nicolás Perry (who studied within the Bioethics Department), and who I got in contact with, and was supervised in his project by, Dr. Juan Pablo Beca. His project focused on the black market for Misoprostol and the impact of Women Help Women in Chile. Finally, I interviewed one professor from la Universidad de Chile within the Instituto de Comunicación e Imagen (The Institute of Images and Communication) about her work studying the online coverage and market for abortion in Chile. The majority of my interview contacts were gained through snowball sampling. My initial contacts were made by emailing Chilean authors of articles that related to my topic, such as Dr. Juan Pablo Beca, whose name I found after visiting the Ministry of Health's library and learning about his work. I also gained two contacts, Dr. Juan Baeza and Luis Rodriguez, through former honor's thesis student, Cam Coval's recommendation.

I had initially wanted to interview someone from *la Brigada del Cibercrimen* (the Cybercrime Brigade) within the Policía de Investigaciones (the Investigate Police) in Chile, but after making multiple calls, sending many emails, and visiting the Policía de Investigaciones (PDI) three times to request an interview, I came to the conclusion by the end of my fieldwork that it would not be possible for me to obtain this interview. Although this was an unfortunate circumstance, it meant that I could instead put my energy into trying to obtain interviews with a wide variety of actors. I decided to interview two pro-life actors (one doctor and one lawyer),

because I felt that it would be important in my thesis to balance the voices of some of the very strong pro-choice, lesbian/feminist actors that interviewed, and to provide a varied perspective and logic behind the conservative opposition to abortion, and the *Ley de Tres Causales*.

The second type of source that I used for evidence in my thesis was primary sources. I used documents from the Ministry of Health: Ordinance A15 number 1404 and Ordinance A15 number 1675 on patient-provider confidentiality, *Línea Aborto Libre's Manual: Línea Aborto Chile: El Manual*, the documentary *La Línea del Aborto*, and a variety of technical guides and research from organizations such as FLAGSOG, WHO, and MILES. I integrated these primary sources in a variety of ways throughout this thesis. I used the Ministry of Health ordinances to provide evidence for specific Ministry of Health Policy on doctor-patient confidentiality, to demonstrate the contradictions within policies related to hospital procedures in reporting abortions. I used the documentary *La Línea del Aborto*, and the manual *Línea Aborto Chile: El Manual*, to provide evidence for Chapter 6, on the informal regulation of the black market and the role of *Línea Aborto Libre* in this informal regulation. I used these technical guides primarily in describing international policies and procedures for Misoprostol, and in describing MILES' work in Chile. Finally, I also used a variety of different websites and Facebook pages from NGOs, such as *Línea Aborto Libre*, *Con las Amigas y en la Casa*, *Women on Web*; from online vendors of Misoprostol, such as *Vendomisotrol* and *Ventamisotrolchile*; and from the Chilean government, such as *#YoApoyo3Causales*. I used these websites to provide information about these different actors and organizations, and to learn more about how the black market for Misoprostol, and the informal regulation of this black market, functioned in practice.

The third type of source that I used for my thesis was secondary sources from a variety of different types of academics and newspapers. I used these sources throughout my thesis in a

combination of different ways. The first way that I used these sources was to provide a literature review within each chapter. In using these sources, I was able to situate each chapter within a scholarly debate about the topics being discussed, and was able to frame my argument in relation to this literature. The second way that I used these sources was to provide facts to back up my argument about a variety of different topics within this thesis, from the numbers of women arrested for abortion-related charges in Chile, to speculations about the numbers of abortions performed each year in Chile. The combination of my interviews with a variety of actors, who each added unique perspectives about the regulation of the black market for Misoprostol in Chile, with my primary and secondary sources, allowed me to gain a wide mix of opinions and data to provide evidence for my argument.

Overview of the Thesis

The overarching argument of this thesis is that the black market for abortion in Chile exists in a space of formal (governmental) and informal regulation that involves a complex variety of actors with differing motivations and levels of presence within this market. I make the argument that although the Chilean government has the ability to regulate this market, government bureaucrats intentionally choose to ignore the existence of this activity in the efforts of upholding their professional norms and interests. As a result, this thesis is titled “La Política del Avestruz” (the Politics of the Ostrich) because this is how one informant, Dr. Juan Pablo Beca, described the government regulation of this black market. Dr. Beca, similar to many of my informants, argued that although everyone knows that this market exists, they choose to ignore it. Consequently, like ostriches, government bureaucrats “stick their heads in the sand” and choose to ignore the presence of this illegal activity (Author interview with Beca, January 11, 2017).

These bureaucrats are motivated by the considerations that the presence of the black market for Misoprostol leads to decreased abortion-related complications, to a reduction in Chile's maternal mortality rate, and to reduced costs for clinics, related to the upkeep of expensive emergency septic units.

However, because there is a lack of formal, governmental regulation of the black market, there are also a variety of dangers that exist within this unregulated space. I make the claim that this black market encompasses a variety of sub-categories of black markets, that contain actors with a range of different motivations for selling the drug, from simply making a profit, to providing women with autonomy in their reproductive health. However, because there are differing motivations within this black market there are also many potential dangers, such as fake information and pills. Consequently, a variety of national and international NGOs have emerged to act as informal regulators of this black market. As a result, this thesis seeks to understand how both the formal and informal regulation by government officials and non-state actors of the black market for Misoprostol in Chile functions, and if these theories can be applied to other cases of illegal activity worldwide.

The objective of the second chapter of my thesis is to illuminate the history of abortion law in Latin America and Chile, the distinct societal actors that affected these laws, and how this history has affected the current situation of the emergence of a black market for abortion in Chile and in Latin America and the Caribbean (LAC). To accomplish this goal, this chapter includes a history of abortion law and reform in Latin America, from the creation of the first criminal codes during the 19th century, to pushes for reform following the military dictatorships of the 1970s and 80s. The next section discusses the influence of the Catholic Church on abortion law in Latin America, as one of the main reasons why Chile and countries in LAC have had difficulty in

liberalizing their abortion laws. Then, the chapter analyzes why Chile has had difficulties in liberalizing its abortion law, and ends with a description of the current situation of abortion and abortion laws in Chile, whose largely restrictive nature has spurred the creation of a black market for abortion in Chile, and a “need” for greater regulation.

The objective of the third chapter is to answer the question: What is the structure of the black market for Misoprostol in Chile, and how does it function? In answering this question, I break this chapter into three different parts, based on the three different types of black markets in Chile: the traditional black market for abortion, which can be broken into two subcategories of men whose main motive for selling Misoprostol is profit, and medical professionals, whose motivation for selling the medication is also to supply women with a safe means of aborting; the “parallel market” run by local and international NGOs; and the market fueled by wealthy women and private clinics. In detailing these three different types of black markets, I also respond to the questions: how is each type of market accessed, who/what drives each market, and how do transactions within each market occur?

The purpose of the fourth chapter is to respond to the question: how does the government regulation of the black market for medical abortion function? Having outlined in the previous chapter how the black market functions, in Chapter four, I seek to understand in what places of the black market government officials would be able to pursue regulation, and to what extent this regulation is actually occurring, as a way of demonstrating discrepancies between policies and enforcement. This chapter is broken into the categories of black market described above, and within each category, I first describe what “full regulation” would look like, and then demonstrate how this “ideal” is different from the actual experience of government regulation of these different categories of black market. I then examine a variety of cases where sellers and

providers of the market have actually been charged for providing women with Misoprostol or abortions, as well as cases where women who have had abortions and their “accomplices” have been prosecuted, as a way of demonstrating governmental priorities in the regulation of this black market.

In the fifth chapter of this thesis, I shift from discussing the ways in which governmental figures fall short in their regulation of the black market for abortion in Chile, to presenting three hypotheses for why the Chilean government has been unable or unwilling to implement the regulation of the black market for abortion. The first hypothesis that I examine is that there are differing levels of regulation based on the different types of actors involved in the market. The motivation behind this hypothesis would be that one could imagine that the government would be more willing to prosecute the traditional black market, which is run in a manner more associated with typical “criminals,” than the parallel market, which is made up of international NGOs that are well-known and respected, or the private market for abortions, which are conducted in private clinics by doctors who are also well-respected in Chilean society. The second hypothesis that I test is that levels of governmental regulation do not depend on type of actor, and rather, that a lack of regulation is due to bureaucrats’ desires to uphold the norms of their positions and to protect their interests (through the mechanisms of a drop in the maternal mortality rate/complications related to abortions, and a reduction in hospital costs). The final (alternative) hypothesis that I unpack is that low rates of government regulation are caused by a lack of information about the black market, and a lack of government capacity, rather than government officials’ conscious decisions.

The sixth chapter of this thesis seeks to answer the questions: Why did NGOs decide to take on the role of informally regulating the black market for Misoprostol in Chile, and how does

this informal regulation function? In answering these questions, I first outline the dangers of an unregulated black market for Misoprostol in Chile, which promoted NGOs to form or expand their missions to seek to regulate these unregulated spaces. I next highlight the literature about NGOs' tools in pressuring different actors, and will apply these theories to the case of the informal regulation of the black market for Misoprostol. Finally, I describe the three ways that these NGOs attempt to provide an informal regulation of this market: regulation through information, regulation through exposure of sellers, doctors, and clinics, and regulation through price reduction of the medication.

The final, concluding chapter of this thesis attempts to analyze the arguments developed throughout this thesis, as a way of situating these claims in a broader academic discussion about black markets, government regulation, and informal regulation. In this conclusion, I emphasize this thesis' theoretical contributions, areas for future research in the topics highlighted within this thesis, and potential limitations of this thesis' design. Finally, I conclude by mentioning two current developments in Chile in the area of reproductive health, which could have future implications for the black market for medical abortion in Chile: *el Ley de Tres Causales* and sexual education reforms.

CHAPTER 2: THE HISTORY OF ABORTION AND ABORTION LAW IN LATIN AMERICA AND THE CARIBBEAN

Introduction

Despite overall improvements in reproductive health in Latin America and the Caribbean (LAC) during the last twenty years, abortion remains a complicated and unsafe process. The maternal mortality ratio fell by forty-one percent between 1990 and 2008, birth rates dropped towards replacement rate, and contraceptive use has increased, spurring the downward trend in abortion rates throughout the region (Kulczycki 2011, 201-202). However, in 2008 abortion rates remained at a high level of approximately 4.2 million (reported abortions) conducted in Latin America each year (Kulczycki 2011, 202; Shepard and Casas 2007, 203). Furthermore, many of the abortions conducted in Latin America are conducted using unsafe, and oftentimes illegal procedures, and are performed on poor and young women who are left without options (Casas 1997, 31).

Consequently, this chapter seeks to answer the questions: what is the history of abortion law in Latin America and Chile, how have distinct societal actors affected these laws, and how has this history influenced the current situation of the emergence of a black market for abortion in Chile and in Latin America and the Caribbean? The purpose of this chapter within this thesis is to provide a historical overview of abortion law in Chile, and to provide insights into why this law is so restrictive, as a means of highlighting the reasons why the black market for Misoprostol has emerged in Chile and Latin America, and why its creation has been so influential for the women who attempt to access it. This chapter traces the history of abortion law from its conception to its current status in Chile and in countries in LAC, to demonstrate the origins and evolutions of this restrictive policy, and to provide a background and logic for the emergence of

black markets for abortion in Chile, and the need to regulate these illegal spaces. Consequently, this chapter begins by discussing early abortion law and health codes in the Latin America, as a basis for the restrictiveness of abortion laws that would follow. The second section focuses on abortion law and women's movements in Latin America during the 1990s and 2000s, which pushed for greater reproductive rights. The third section discusses the role of the Catholic Church on abortion law in Latin America, as one of the main reasons why Chile and countries in LAC have had difficulty liberalizing their abortion laws. Motivated by the third section, the fourth section of this chapter analyzes why Chile has been met with challenges in liberalizing its abortion law, leading to the creation of black markets for abortion. Finally, this chapter ends by discussing the current status of abortion law in Latin America, to demonstrate the development of these laws over time.

Early Abortion Law in Latin America

The first criminal codes in Latin America were modeled after the 1804 Napoleonic Code, which detailed family relationships in the Anglo-American world (Htun 2003, 46). This code had two major implications for the societal roles of men and women: men's marital power, which gave a man control over the household and his wife's "person and property," and "women's incapacity," which forbade women from exercising their rights without their husbands' approval (Htun 2003, 47). These legal restrictions on women were further influenced by Christian doctrine and Canon law, which were the first legal documents where abortion was criminalized and deemed as homicide (Htun 2003, 53). Canon law influenced the criminal codes adopted throughout Europe, and the first criminal code that was created in Latin America (which was

adopted by Brazil in 1830, and punished women and doctors who attempted to perform abortions) (Htun 2003, 54-55).

Chile's first criminal code was created in 1875, and was related to crimes against families and "public morality." This code criminalized the "malicious" performance of abortion, a framing of the issue that demonstrated the Catholic Church's strong influence on morality in Chile (Ortero Ruiz 2013, 12). The criminal code punished both women and doctors who performed abortion, and was echoed throughout many of the original criminal codes in Latin America (such as Argentina's and Brazil's) (Htun 2003, 55). In the 1920s and 30s, a range of circumstances where abortion would not be punished were introduced in Chile, such as in Chile's National Health Code of 1931, which decriminalized abortion for therapeutic purposes (Htun 2003, 56).

Latin American countries were among some of the first countries in the world to allow abortion in the case of rape. This provision was largely a response to movements that called for "compassionate abortion" following the rape of women by soldiers during WW1. These modifications to the traditional Latin American criminal codes were influenced by the work of the Spanish criminologist, Luis Jiménez de Asúa, and by ideas about eugenics and the necessity of providing abortions for mentally ill women who had been raped (Htun 2003, 56). However, military governments during the 1960s and 70s in Latin America, largely influenced by the Catholic Church, further enforced the concepts of family values, morality, and motherhood, and in some cases pushed back against the ideas of therapeutic and compassionate abortion (Htun 2003, 67). Overall, the original legal power-imbalances between men and women in Latin America, which created the countries' initial criminal codes, have continued to influence women's rights legislature and movements. Combined with a growing opposition from the

Catholic Church to abortion, these power-imbalances have largely contributed to the difficulty of reforming abortion laws in the 21st century.

Reproductive Rights Movements During the 1990s and 2000s

The response to the military dictatorships of the 1970s and 80s in Latin America was a watershed moment for women's rights movements in the region. Many women had been part of the protests to overthrow the region's military dictators, such as the *cacerolazos* in Chile and the women of the *Plaza de Mayo* in Argentina. However, in the process they largely side-lined their quests for women's rights to focus on fighting for the return of democracy. By the 1990s, the networks that had been created during the protests against the military dictatorships were again used to demand equal rights for women. Women's rights movements throughout the region argued that equal rights for women were required for the re-establishment of meaningful democracy in Latin America (Kane 2008, 363). These rights included controversial topics, all of which were protested by the Catholic Church, such as the right to divorce, sexual orientation, and abortion (Kane 2008, 363).

Furthermore, the reproductive rights movement of the 1990s was not only a regional movement, but in fact was part of a larger global trend. This movement brought together a variety of domestic and international organizations with the goal of improving reproductive health worldwide and decriminalizing abortion (Htun 2003, 149). Reproductive rights were a major focus of both the 1994 International Conference on Population and Development, that was held in Cairo, and the 1995 Fourth World Conference on Women, that was held in Beijing. During these conferences, for the first time unsafe abortion was addressed as an issue of public health, instead of just an issue of morality (Kane 2008, 363). Although the UN plans of action

that emerged from these conferences were not binding, the conferences themselves raised awareness for reproductive rights, and legitimized the concept of reproductive rights as human rights (Htun 2003, 150). Although these movements and conferences were influential in the region for garnering support for the decriminalization of abortion, antiabortion reforms, largely led by the Catholic Church, emerged as a powerful response (Htun 2003, 151).

The Catholic Church and Abortion in Countries in LAC

The Catholic Church has always been opposed to certain social issues including divorce, abortion, and contraception (Kane 2008, 363). In 1989, Pope Pius IX declared all forms of abortion to be immoral, and banned the practice for Catholics. He made the opposition to abortion one of the Church's key focuses for both his reign, and for his predecessor's, Pope John Paul II (1978-2005) (Blofield 2008, 400). With Pope John Paul II's reform of the Roman Catholic Church in 1978, he took a hard stand against abortion, contraception, and divorce. He particularly focused his efforts in Latin America, in the efforts to counter liberation theology. He was able to influence the Church in Latin America by appointing conservative bishops to many positions throughout the region (Htun 2003, 151). Following the return to democracy in Latin America, anti-abortion activists and Catholic Church leaders used the same democracy-promoting framework as abortion activists, but argued that in order to uphold human rights and democracy, Latin American countries were required to protect the lives of innocent fetuses, and forbid abortion. This rhetoric of the "right to life" was particularly effective, given Latin America's experience with brutal dictators and authoritarianism. Consequently, few politicians have felt comfortable advocating for the decriminalization of abortion (Htun 152, 2003).

The Church is able to influence public policy on abortion in Latin America through two different means: indirect and direct pressure. The state uses indirect pressures through its moral power and legitimacy. The Catholic Church is the most respected institution in many Latin American countries, and therefore, its bishops and their opinions are respected as well. According to a Latinobarómetro poll conducted in 2004, 71% of citizens stated that they had confidence in the Church, while 37% said that they had confidence in the president, and only 18% expressed confidence in political parties (Htun 2009, 336-7). As a result, the Catholic Church has been able to use its moral legitimacy to label politicians as immoral, thereby damaging their reputations and their electoral support (Htun 2009, 353). For example, one Argentine senator who sponsored a bill for the legalization of abortion lamented “no one has demonstrated interest in considering this bill. It is an impolitic issue for the political environment of our country” (Htun 2009, 344). In this way, the Catholic Church has almost an indirect veto over public policy, and can inhibit the liberalization of politicians’ views and public statements (Htun 2009, 338).

In a more direct way, in some conservative countries in LAC, such as Chile, the Catholic Church has an influence in public policy through Christian Democrat and right-wing parties. In some conservative Latin American countries, the Christian Democrats hold a large amount of influence in government, and many believe that the positions of the party should reflect the teachings of the Church (given the Christian Democrats’ philosophical and historical links to the Catholic Church). Many find in the Catholic Church’s doctrine “a legitimating discourse for their rejection of reform proposals” in areas such as abortion reform and divorce (Blofield and Haas 2005, 46-7). Following Pope John Paul II’s reform of the Catholic Church, that shifted the Church towards a focus on hierarchy, a large amount of pressure was placed on the Christian

Democrats to push back against reform in areas where the church has moral legitimacy, such as abortion (Blofield and Haas 2005, 39). Additionally, some members of the conservative right in Latin America also oppose reform that threatens the teachings of the Catholic Church.

Consequently, the influence of the Church on these two key parties has made liberalizing or decriminalizing abortion difficult in countries where the Church has historically held large amounts of power and moral legitimacy.

In Latin America, the Church has also had support in the antiabortion movement from international activists and evangelical Protestant Christians. The growth of an international conservative movement emerged in response to the decisions made in Cairo and Beijing, the increased centralization of the Catholic Church through Pope John Paul's reforms, and as a reaction to the 1973 United States Supreme Court decision of *Roe vs. Wade*. The Catholic Church and conservative activists saw the UN conferences and the legalization of elective abortion in the U.S as assaults on motherhood, Church doctrine, and the sanctity of human life (Htun 2003, 150-51). Antiabortion activists sought to stop the inclusion of any clauses related to abortion in the final UN documents from the two conferences. The international conservative movement also helped some domestic movements in Latin America in their framing of their anti-abortion agenda (Htun 2009, 340). Although some Catholic organizations, such as *Católicas por el Derecho a Decidir* (Catholics for a Free Choice), have emerged as a movement of transnational organizations that support liberalizing abortion on the basis of Catholic theology, the majority of Catholic transnational organizations are strongly against reform (Htun 2009, 339). Additionally, although evangelical Protestants pose a threat to the hegemony of the Catholic Church, they have also joined with the Church in the region-wide fight against the legalization of abortion (Kane 2008, 364).

Overall, the Catholic Church has played a large role in determining the outcome of abortion legislation in countries in LAC where the Church has a significant amount of influence in government, such as in Chile. The next section will build off this section's discussion of the influence of the Catholic Church on abortion law in LAC, to analyze the reasons why abortion law has been so difficult to liberalize in Chile, and why these difficulties have led to the emergence of a thriving black market for abortion and Misoprostol in Chile.

Why Abortion Law Has Been Difficult to Liberalize in Chile

In Chile, therapeutic abortion was legal between 1931 and 1989. The 1931 Health Code allowed abortion to save the life or health of a woman (Casas and Vivaldi 2014, 71). However, before leaving office, in 1989 General Augusto Pinochet included a "right-to-life" clause in the Constitution that stated that "Every person has a right to life, and the law will protect the life of the unborn" (Casas-Becerra 1997, 29). Some argue that this clause was introduced as part of Pinochet's policies of supporting population growth, while others believe that he outlawed therapeutic abortion as a means of spiting the women's movements that had protested his reign during the 1960s and 70s (Casas-Becerra 1997, 29; Stevenson 2012, 139). The abortion debate in Pinochet's office began in 1974, during the time when Pinochet's government commission was meeting to draft a new Constitution. One of the conservative members of the commission, Jaime Guzmán, was vehemently opposed to therapeutic abortion and believed that it should be outlawed before the return to democracy (Casas-Becerra 1997, 29). Since 1989, the Criminal Code on abortion has not been reformed, despite various efforts by women's rights organizations and legislators to create support for the movement (Casas and Vivaldi 2014, 72).

However, until 2006 only one proposal had been introduced to Congress to decriminalize abortion (which do not pass). Furthermore, in 2006, and twice in 2009, proposals were presented to Congress that sought to legalize abortion. None of these proposals were seriously debated (Stevenson 2012, 140). Scholars argue that there are two main reasons why it has been so difficult to liberalize abortion policies in Chile, and why therapeutic abortion is still illegal in a country that views itself in many cases as highly westernized and progressive. First, the Catholic Church has successfully been able to oppose efforts for the decriminalization of abortion, primarily through parties in government and through the strength of its organizations. Second, women's rights organizations in Chile have been unable to create a unified force in support of the decriminalization of abortion, encouraging President Michele Bachelet, during her first term, to focus her efforts on the slightly less controversial issue of emergency contraception.

Scholars argue that the first reason why efforts to liberalize abortion have largely failed in Chile is that the Catholic Church has traditionally had a significant influence over public policy and public opinion. The Church has the direct ability to influence the decisions of Congress through public sermons, personal ties with congressman, and moral legitimacy. In Chile, the right in Congress, specifically the UDI and the RN, and members of the PDC (the Christian Democrats) have strong ties to the Catholic Church, and hold significant sway in Congress (Haas 2010, 70). Between 1990 and 2000, the PDC was the largest party in Congress and controlled the presidency. Furthermore, since 1973, the political and monetary power of the economic elite (as represented by the right in Congress) has continued to grow (Blofield and Haas 2005, 40). Consequently, these groups (largely influenced by the Catholic Church) have been very successful at stymieing any reform of the abortion law in Chile.

In Chile, the main opposition groups to abortion, which are allied with the Catholic Church, are the *Legionarios de Cristo* (the Legion of Christ) and Opus Dei. These two organizations have been extremely effective in their campaigns against abortion and emergency contraception, and have exercised a large amount of control over mass media. Furthermore, they have been successful at framing issues of reproductive rights as “moral issues,” which has played a large role in swaying public opinion away from the liberalization of abortion laws (Peña et al. 2012, 152). Blofield and Haas have argued that bills that are framed as “moral” or “rights-based” have traditionally been very difficult to pass in Chile. “Rights-based” bills seek to give women more individual rights, such as the right to reproductive health and abortion, whereas “roles-based” bills are less controversial because they do not threaten the traditional family structure, or the role of a woman within that structure (such as bills that criminalize violence against women) (Blofield and Haas 2005, 37). Consequently, the expression of the Catholic Church, through political parties and pro-life organizations, has played a large role in stopping both reform and debate in Congress around issues of abortion and reproductive rights.

The second reason that scholars argue has made the liberalization of abortion laws particularly difficult in Chile is the relative weakness of women’s rights organizations, and their lack of unity proceeding the return to democracy in Chile. Although many women’s rights organizations in Chile have fought hard to support therapeutic abortion, their efforts have been eclipsed by the financial and numerical strength of oppositional, pro-life organizations. For example, in 1999 there were twenty-one women’s rights NGOs in Chile, whereas during the same time period, Opus Dei alone supported seventy private foundations that all had the mission of opposing the liberalization of abortion laws (Peña et al. 2012, 153). Consequently, women’s rights organization have had difficulties in providing enough pressure on the government, in

comparison to opposition groups, to influence government debate and decisions about abortion law in Chile. Secondly, women's rights organizations have been unable to effectively pressure the government for change because following re-democratization, they were no longer unified for a singular goal, began competing amongst each other, and had difficulties re-defining their missions. As a result, these organizations have been unable to create a diverse coalition in support of the liberalization of abortion, have acted more like interest groups than social movements, and have struggled to gain support from a wide range of societal actors for issues of women's rights (Tobar 2003, 274).

Consequently, in response to the strength of the opposition and the relative weakness of women's rights organizations, during her first term in the presidency, Bachelet decided to put the issue of abortion on hold. Instead, Bachelet focused her efforts on the slightly less controversial issue of access to the morning after pill. During this time period, Bachelet was careful not to publicize her own opinion about abortion, in the efforts to maintain support for her bill. This lack of support for abortion reform angered many women's rights organizations, who had hoped to see Bachelet as their champion of the issue. However, through Bachelet's efforts, in 2010 the Emergency Contraception and Sex Education law was passed, allowing access to emergency contraception to all women (Stevenson 2012, 140). During her second term, Bachelet has made the legalization of therapeutic abortion a priority on her agenda. With this large degree of presidential support for the issue, it is possible that the current bill pending in Congress (which calls for the decriminalization of therapeutic abortion) may gain traction where similar bills have failed (Casas and Vivaldi 2014, 70). Overall, Chile's history of a strong Church influence in politics, and relatively weak women's rights organizations, following the return to democracy, has made abortion reform especially difficult.

Due to the reasons described above, Chilean law has made it impossible for women to legally abort under any circumstances. However, this illegality has created a space for illegal markets to emerge to meet this relatively large, unmet societal need for abortions in Chile. Studies have found that making abortion illegal does not reduce the rate of abortions; rather, it forces abortions “underground,” and encourages women to abort using increasingly unsafe methods. Because it has been so difficult to reform abortion laws in Chile, based on Chile’s experiences with restrictive abortion law, the dictatorship, and the Catholic Church’s strong influence, we have seen the emergence of a thriving black market for abortion and Misoprostol in Chile, resulting in an increasing “need” to regulate this illegal activity. Having described the reasons why it has been difficult to liberalize abortion laws in Chile, I will now discuss the current situation of abortion law in countries in LAC, to demonstrate how these laws have evolved overtime throughout the region, and how black markets have emerged to fill societal demand where they have not.

The Current Status of Abortion and Abortion Law in Latin America and the Caribbean

The current status of abortion law in countries in LAC is that overall, elective abortion (the United States’ current abortion policy) is prohibited in the vast majority of these countries. Cuba, French Guiana, and Guyana are the only countries in the region that allow abortion without restrictions during the first trimester of pregnancy. On the other end of the spectrum, Chile, the Dominican Republic, El Salvador, and Nicaragua do not allow abortion under any circumstances. The majority of countries in LAC fall in the middle of this spectrum: they permit abortion in “therapeutic cases” meaning cases where the mother’s life or health is at risk, in cases of rape or incest, or in cases of fetal abnormalities. Additionally, in Argentina, a mentally ill

woman who has been raped may seek an abortion, and in a few countries in LAC (such as Venezuela) if a woman seeks an abortion on the grounds of maintaining her honor or the honor of a family member, she may be subject to less harsh penalties. Finally, the countries of Barbados, Belize, and Saint Vincent and Grenadines allow abortion on the basis of socioeconomic and health grounds (Kulczycki 2011, 206-7). For a full summary of the status of abortion in all countries in LAC, see Figure 2 below.

Figure 2: Legality of Abortion in Countries in Latin America and the Caribbean, 2016

Reason	Countries
Prohibited altogether, or no explicit legal exception to save the life of a woman	Chile, Dominican Republic, El Salvador, Haiti, Honduras, Nicaragua, Surinam
To save the life of a woman	Antigua and Barbuda, Brazil, Dominica, Guatemala, Mexico, Panama, Paraguay, Venezuela
To preserve physical health (and save a woman's life)	Argentina, the Bahamas, Bolivia, Costa Rica, Ecuador, Grenada, Peru
To preserve mental health (and all above reasons)	Colombia, Jamaica, St. Kitts and Nevis, St. Lucia, Trinidad and Tobago
Socioeconomic reasons (and all above reasons)	Barbados, Belize, St. Vincent and Grenadines
Without restriction as to reason	Cuba, Guyana, Puerto Rico, Uruguay
Source: Kulczycki, A. (2011). Abortion in Latin America: Changes in Practice, Growing Conflict, and Recent Policy Developments. <i>Studies in Family Planning</i> , 42(3), 199-220.	

Since the creation of their penal codes, few countries in Latin America have loosened or changed their abortion laws (Htun 2009, 349). However, there are two cases where abortion laws have been liberalized in Latin America: Mexico City and Colombia. Up until 2011, Mexico City had some of the strictest abortion policies in Mexico; abortion was only allowed in therapeutic cases. However, in 2007, Mexico City's legislative assembly legalized elective abortion during the first twelve weeks of pregnancy, and in 2008, the Supreme Court approved the

constitutionality of this law (Madrazo 2009, 266). This legislation was the culmination of decades of work and legal reforms by women's rights organizations, beginning with *Ley Robles* in 2000, which increased the number of legal exceptions to the full criminalization of abortion (Kane 2008, 367; Madrazo 2009, 266).

The case of the liberalization of abortion laws in Colombia followed similar patterns to those in Mexico City. In 2005, a lawyer named Monica Roa petitioned the Constitutional Court to review the article of the Colombian Penal Code that criminalized abortion in all cases. Similar to the Mexico City case, there was extreme pressure from the Catholic Church against decriminalization (Kane 2008, 367). Since 1975, five bills had been presented and subsequently vetoed that all attempted to address issues of unsafe abortion and decriminalization (Amando et al. 2016, 119). However, Roa's bill gained traction because she was able to build a large coalition, including healthcare officials and international organizations (such as Women's Link International) who were in favor of decriminalization. Consequently, in 2006, Colombian abortion law changed from a complete ban on abortion to the legality of therapeutic abortion. (Kane 2008, 366). The two cases of Mexico City and Colombia demonstrate that even in contexts where the Catholic Church has a large amount of influence, it is possible for countries to liberalize their abortion laws if the situation is ripe for reform. Having described the current situation of abortion law in countries in LAC, I will now provide an outline of the current status of abortion in these countries, as a response to the restrictiveness of abortion law within the majority of them.

The current status of abortion in countries in LAC is that there has been a consistent decline in abortion rates, largely due to increased access to contraception throughout the region. Between 1990 and 2008, abortion rates in Latin America were estimated to have declined from

45 to 31 abortions per 1,000 women. However, this rate is still much higher than in most European countries where contraceptives are more accessible, and abortion is legalized (Kulczycki 2011, 203). Although the rate of abortion in Latin American continues to decrease, there is still a high rate of deaths from unsafe abortions in the region, at about 1,100 deaths per year (Kulczycki 2011, 204). Furthermore, poor women disproportionality suffer more in Latin America than wealthy women due to the illegality of abortion, as they are unable to pay for the abortion procedure to be conducted in safe clinics (where wealthy women are able to access care), and instead must resort to unregulated and unsafe methods (Htun 2009, 342).

The introduction of Misoprostol to the region, and in many cases, the creation of a black market for this medication, has reduced the number of deaths and complications due to abortion. For example, in the Dominican Republic the introduction of Misoprostol decreased the rate of severe complications related to abortion by 75%. However, mortality rates from abortion are higher in the Caribbean (80 per 100,000) than in South and Central America, largely due to the fact that women in the Caribbean often must resort to unsafe methods to perform abortion, and have decreased access to post-abortion care. Furthermore, although most Latin American countries have passed laws to ensure access to emergency contraceptive care, seven out of seventeen countries in the region cite critical availability problems. Additionally, even in countries where abortion is legalized in limited circumstances, there are few countries that have hospital protocols to ensure the quality of abortion and post-abortion care (Kulczycki 2011, 205).

This inequality in access to care between poor and rich women, and between poor and wealthy countries, in addition to the lack of accountability and safety of abortion procedures, creates an environment where women are unable to achieve their rights to health and reproductive care. However, one of the results of the formation of the black market for abortion

in Chile, in response to the highly restrictive nature of Chile's abortion laws, is that it has reduced some of this inequality, making abortions more accessible to a wider sector of the population. But, a growth in the black market has also produced an increase in the visibility of this market, and the expectation of increased regulatory action against this illegal activity. Consequently, Chapter 3 of this thesis will describe the creation of different types of black markets for abortion in Chile, while Chapters 4, 5, and 6 will describe how the regulation of this market occurs.

Conclusion

In this chapter, I have provided an overview of the history of abortion law in Latin America, from its beginnings and influences by European criminal codes, to various reforms to these codes following WW1, to further reforms following the return to democracy and the growing power of women's rights organizations. I described the historical role of the Catholic Church in Latin America, and the ways in which it has influenced abortion law. Next, I highlighted the history and origins of abortion legislation in Chile, and discussed the reasons why it has been so difficult to liberalize abortion in Chile: the strength of the opposition and the weakness of the proponents. Finally, I provided a summary of the current status of abortion laws and abortion in countries in LAC. This historical chapter sought to provide a timeline of abortion laws from conception, to evolution, to current day, as a means of demonstrating why many of the abortion laws in countries in LAC, such as Chile, are so restrictive, and why black markets have emerged as a response. In the next chapter, I provide a description of the three types of black markets for abortion, and seek to answer the question, what is the structure of the black market for abortion in Chile, and how does it function?

CHAPTER 3: WHAT IS THE STRUCTURE OF THE BLACK MARKET FOR MISOPROSTOL IN CHILE, AND HOW DOES IT FUNCTION?

The black market for Misoprostol in Chile is fairly visible, but rarely studied. Although the majority of Chileans recognize that this market exists, and in most cases know how and where to access Misoprostol, very few studies and publications acknowledge its existence. As a result, one of the purposes of this chapter is to make this black market more visible, as a means of engaging with some of the academic debates surrounding black markets. One of the consequences of the lack of academic literature about this market is that this chapter primarily uses interviews and primary sources to chronicle the components of black market for abortion in Chile. In this chapter, I seek to answer the question: what is the structure of the black market for abortion Chile, and how does it function? In answering this question, I will be creating a context for discussing both the formal and informal regulation of each of the different aspects of the black market, which make up Chapters 4, 5, and 6 of this thesis.

In responding to this question, I first highlight literature about the forms that black markets can take, and the function that they provide for society, as a way of situating the different types of black markets for abortion in Chile within a larger scholarly debate. I next break this chapter into three different parts, based on the three different types of black markets in Chile. The first type of black market for abortion in Chile is the traditional black market, which is fueled by online websites and transactions that occur in Chile's metro systems. This traditional black market can also be broken into two parts. The first part of this market is profit-driven and dominated by men, whose main motivation for selling Misoprostol is to make money. The second part of this traditional market is run by medical professionals and individuals whose motivation for selling the drug is not only to make a profit, but also to supply women with a safe

means of aborting. The second type of black market for Misoprostol in Chile, which some refer to as “the parallel market,” is run by local and international feminist NGOs. These NGOs include Women Help Women and Women on Web, and seek to provide women with access to contraceptives and abortive drugs, as well as medical consultations, accompaniment, and accurate information about reproductive health. Finally, the third type of black market for abortion in Chile is fueled by wealthy women, and is broken down into private clinics in Chile, and in travel to hospitals in other countries where abortion is more accessible. This third type of black market drives a large amount of the inequality in access to care in Chile. In detailing these three different types of black markets, I also respond to the questions: how is each type of market accessed, who/what drives each market, and how do these transactions occur?

Literature Review of Black Markets.

There are multiple theories about black markets, and about different forms that black markets can take, different actors involved in these markets, and different motivations that drives these actors. The first type of black market that scholars have engaged with is an illegal activity that I have identified as the “traditional black market.” The traditional black market is characterized by the fact that it functions through underground transactions, occasionally operating through the internet, and involves individuals who are typically viewed as “criminals,” such as gang members. There is a variety of scholarly work that discusses the presence and impact of traditional black markets on society. Traditional black markets can take on a variety of forms, from illegal drug trafficking to illegal trade in body parts, but these markets all share the characteristic of having high rates of return, and are conducted with the sole purpose of acquiring large amounts of capital, no matter the impact on society (Naylor 2002, 16). However, I have

also identified a second type of this “traditional” black market, which still functions in the way that traditional black market operations occur (ex: through transactions on the internet and in metro stations), but the sole purpose of this market is not just money-making, it also has the purpose of making Misoprostol more accessible to Chilean women.

The second camp of literature about the purpose and form of black markets is that in some cases, they can provide important services to society, and are run for this purpose. Literature on black markets discusses certain societal benefits that black markets can provide. Rosen argues that “under certain conditions, the existence of an underground economy raises social welfare,” and other scholars have argued that black markets can provide economic opportunities to poor sectors of the population (Rosen 2005, 353; Castellanos and Portes 2006, 33). Similarly, the second type of black market for Misoprostol in Chile that I identified was the parallel black market. The “parallel market” is a concept that I developed from one of my interviews. During our interview, Maria José argued that individuals who engage in this market, international and local NGOs, do not view their work in providing women with medications as illegal activity, and do not associate themselves with the traditional black market; rather, they engage in this activity with the sole purpose of making Misoprostol more accessible to women who need it (Author Interview with José, January 12, 2017).

The most comparable black market to the parallel market for Misoprostol in Chile is the black market for prescription drugs or pain killers, which can also provide a societal good. Grzybowski argues that black markets can have a moral component “which seeks to meet a human need” (Grzybowski 2004, 28). For example, in cases of antiretroviral drugs, because they are so expensive, a black market has emerged to supply developing countries with high-quality, affordable antiretroviral drugs to combat HIV/AIDs (Grzybowski 2004, 28). The parallel market

for Misoprostol is similar in the way that it is also motivated by seeking to meet a human need, but is distinct in the actors involved (NGOs versus drug companies).

Finally, literature suggests that a third type of black market is illegal activity driven by public officials, with the motivation of making money. Scholars have argued that in some cases, public officials may be co-opted into being involved in illegal activity, such as an illegal drug trade, with the purpose of making large profits (Gill 2002, 537). Comparably, in Chile, the private market for abortion is run by doctors in private hospitals. This type of black market is fairly unique to the case of abortion, as it entails healthcare professionals' provision of an illegal medical service to women, generally for a high price. However, in both of these cases, well-respected members in society, doctors and government officials, are becoming involved in an illegal activity, motivated by profit. However, the provision of an illegal medical service is quite different than government officials' involvement in an illegal drug trade, and therefore, this element of the black market can provide insight into other, unexpected, arenas where black markets can function. Having engaged with the scholarly debate about the different forms that black markets can take, the different actors involved in these markets, and the different consequences of the presence of these markets on society, I will now break down the black market for abortion in Chile into its three types: the traditional black market, the parallel market, and the private market.

Type 1: The Traditional Black Market

The traditional black market for Misoprostol in Chile is based on access through websites, word of mouth, and posts on college forums. The traditional black market is “traditional” because it is run in a way more associated with a traditional black market, as it

involves sellers who carry the medications across the border into the country, and engage in monetary transactions in public places with the women who seek to access these medications. This market is primarily run through the internet and WhatsApp. Furthermore, this traditional black market can be broken down into two parts, based on sellers' motivations within this market, and the types of actors involved in these transactions. The first part of the traditional black market is dominated by men who are motivated by money, and therefore sell Misoprostol for a commercial focus. The second part of the traditional black market is dominated by medical professionals and individuals, whose motivation is to provide women with access to abortive drugs (as a means of giving them agency).

Profit-motivated

The first part of this traditional market is described by a woman from Con las Amigas y en la Casa, an NGO that runs a hotline that responds to questions about abortions, and works to provide women with information about Misoprostol and the process of aborting with this drug:

It seems that it's a very attractive market. Today, one of the characteristics of the black market for Misoprostol in Chile is that it's a market run by men, the majority who don't have any notion of a responsibility for the sale of the drug; rather, they do it to get an economic dividend. Because of this, they speculate with the price of the drug. We know of cases where women have paid a lot for one dose, about two-hundred dollars, for an abortion that's not even guaranteed because the seller doesn't make any promise with the sale (Author Interview with José, January 12, 2017).

This part of the black market can be lucrative because men are essentially able to charge whatever price they want for the drug, and they will always be able to find women who will pay, or are ignorant of the true worth of the medications. For example, the documentary *La Línea de Aborto*, which was created over a period of years starting in 2008 in response to a surge in these

types of hotlines, shows an interview with a man who sold Misoprostol on the black market in Chile (Author Interview with José, January 12, 2017). In the interview, the man describes how he began the lucrative business of selling Misoprostol on the black market:

Six or seven years ago I started doing this because I had the need to buy pills because my girlfriend at the time was pregnant. And after, I realized that it was a good alternative way of getting an income. And from that date, I have spent six or seven years selling Misoprostol (Rist and Chartier & Lopez Escrivá, 2016).

The man in this interview then goes on to describe how the only way that he is able to access this drug is by purchasing it abroad in Peru, Argentina, Brazil, or Paraguay, and bringing it back into the country. He also states that for the trip to be worth it, he needs to bring back at least sixty packets, or 210 doses. By selling each dose for 50,000 Chilean pesos (or \$77), a fairly inexpensive price, he is able to make a profit of 10,500,000 Chilean pesos (or \$16,338). Many of the men who dominate this traditional market advertise their sale of the drug by spraying their WhatsApp number on buildings, particularly in front of schools and universities (Rist and Chartier & Lopez Escrivá, 2016). In this way, some Chilean academics have argued that there are two types of this traditional black market, one which is visible (such as the online websites for Misoprostol) and one which is more invisible. This “invisible” market is based on these male sellers, whose products are often advertised by women themselves “*boca a boca*” (from mouth to mouth), which is generally the more dangerous type of the traditional market because it does not guarantee the quality of the drug (Author Interview with Perry, January 18, 2017).

Access-driven

The second part of the traditional black market for Misoprostol has less of a purely economic motivation, and instead, is driven more by medical professionals and individuals who

seek to provide women with the opportunity to abort using a safer approach (as opposed to more traditional methods which have higher risks of complications). In an interview with a member of Women Help Women, an organization that provides women in Chile, and worldwide, with Misoprostol, contraceptives, and access to reproductive health information, I was told that in relation to this second part of the traditional black market: “Yes, we know that there are doctors and medical personal that sell and facilitate the access to Misoprostol” (Author Interview with Anonymous, February 14, 2017).

This online aspect of the traditional black market for Misoprostol is very visible and well-known throughout Chile. Dr. Ramiro Molina, a professor at la Universidad de Chile and a gynecologist/obstetrician told me in an interview:

You put “Misotrol” in the web page, and you see that there are twenty pages. And they say where one can find it and where it is. And the metro station in Santiago is a good mechanism for selling Misotrol (Author Interview with Molina, January 13, 2017).

In this way, Misoprostol is very easy to access within Santiago, and its sale is driven by commercial interactions within metro stations throughout the city. As part of his research on the black market for Misoprostol in Chile, Nicolas Perez, a student of bioethics at la Universidad de Desarrollo, along with Dr. Juan Pablo Beca (the founder of the Center of Bioethics at the university) were curious about how these online websites functioned, and how many women were accessing medications through these websites. Consequently, they sent an email to one of the websites, vendomisoprostol.com to discover more about the process: “In fourteen hours, we already had the contact, and the only thing left to do was to make the bank transaction, in order to get the pills in a metro station” (Author Interview with Perry, January 18, 2017).

Furthermore, Perez stated that this was only one of twenty websites, and that the majority of these pages were associated with medical professionals, such as paramedics, technicians, and midwives (Author Interview with Perry, January 18, 2017). In searching “*Misotrol en Chile*” (Misoprostol in Chile), I also found at least twenty formal websites that sold Misoprostol, along with a long list of WhatsApp numbers from people who claimed to sell the drug. The most popular of these websites were “vendomistrol,” “Misotrol Chile,” and “Venta Misotrol Chile.”¹ “Vendomistrol” is an example of how the majority of these websites, that seek to provide women with access and information to these safer means of aborting, functions (see Figure 3).

Figure 3: Image of Website vendomisotrol.com



Source: 2016. Vendomistrol. Retrieved from <http://vendomisotrol.com/>. Last accessed: 4/27/17.

The mission statement of “vendomistrol” is:

¹ <https://www.vendomisotrol.com>, <https://www.misotrolchile.com/>, and <http://www.vendomisotrol.cl/> (last accessed 4/27/17).

This webpage is the response to all of the incorrect information that one can find on the Internet with respect to the application of said method. We are worried by the ignorance that exists about this and the application of unsafe methods that can harm women's health. It's because of this that our work is to collect information with solid foundations, in order to benefit those people that have chosen to make this important decision (venomisotrol.com, last accessed 4/27/17).

From this webpage, it is clear that the seller's motivation for creating the website was not only economical, but also has the purpose of combating some of the false information and medications that are present within the traditional black market in Chile. Although these actors are motivated by money, money is not their only incentive for selling Misoprostol. Many of the owners of the websites are healthcare professionals who understand that the black market involves large amounts of incorrect and potentially dangerous information (which will be described in greater detail in Chapter 6), and therefore, they also sell Misoprostol as a way of providing women with a safer, more reliable access to this medication.

On this webpage, one can purchase a combination of four pills of Misoprostol and six of Mifepristone for the cost of 60,000 Chilean pesos, or \$94. As the founders of pages like these are very aware of the high numbers of fake drugs sold online, they photograph the packets before sending them to different regions throughout Chile (vendomisotrol.com, last accessed 4/27/17).

Because Chile is highly urbanized, the majority of the sellers of these medications are located in big cities such as Santiago, Valparaíso, and Valdivia. However, the sellers also receive requests, through the internet, from women in other regions of Chile, and will send the drugs through Chilexpress (Western Union) (Author Interview with Erpel, January 25, 2017).

Deliveries within Santiago are completely personalized and are done in the metro stations that accommodate the client...the deliveries to regions are done through Chilexpress (Western Union) after the delivery of the money on the client's part, once the bank transaction is verified we send the product to our clients. For greater security, we show

the real photos of the product so that one can confirm that the product that will be sent corresponds to the one that is offered (vendomisotrol.com, last accessed 4/27/17).

Although many websites sell a combination of Misoprostol and Mifepristone (because this combination is more effective than solely taking Misoprostol), Mifepristone is more difficult to obtain from pharmacies in other countries in Latin America. This is the case because Misoprostol is more widely proliferated, due to its classification as an ulcer-reducing drug, while Mifepristone is essentially only associated with abortions, and is therefore prohibited in many Latin American countries (Author Interview with Zegers, January 17, 2017). Consequently, organizations such as Línea de Aborto Libre and Con las Amigas y en la Casa only provide Chilean women with information about the use of Misoprostol, because the majority of Mifepristone on the black market is fake. However, Angel Erpel argues that recently, Mifepristone has become more easy to obtain, and is becoming more widespread on the black market (Author Interview with Erpel, January 25, 2017). Furthermore, some sellers scam women into buying “uterine protectors” (which are a type of antibiotic) with their purchase of Misoprostol, although they are completely unnecessary (Author Interview with Anonymous, February 14, 2017).

One of the most difficult elements of my field research was attempting to discover where the majority of the Misoprostol that was entering the traditional black market was coming from, as most Chileans know that the market for Misoprostol exists, but they do not know how it enters the country. The consensus from my informants was that most of the medications came from Peru (and some other Latin American countries), and that some likely came from hospitals, since hospitals are the only institution in Chile that can legally buy Misoprostol. In response to this prompt, Dr. Ramiro Molina stated:

And in fact, in the majority of countries, Misoprostol is sold on the open market in all of the pharmacies. In fact, Peru. The quantity of Misoprostol that exists in Chile comes from what's bought in northern Chile from Peru, in Tacna. And Tacna is one of the biggest sellers, and the best clients are Chileans that bring it and put it in the black market (Author Interview with Molina, January 13, 2017).

Although the majority of the Misoprostol that enters the black market in Chile comes from Peru, some enters from other Latin American countries where it can also be bought fairly easily, such as Bolivia (under the name Cytotec) and Argentina (under the name Oxaprost) (Author Interview with Erpel, January 25, 2017). Finally, because this part of the traditional market for Misoprostol is internet-based, and often advertises through college forums, most Chilean women who access it tend to have slightly higher levels of education and incomes.

In general all types of women abort, there isn't a profile. But, specifically with Misoprostol, because of the idea of access to information, in general it's younger women that use it...but also women with a higher level of education. This has been a big challenge because poor women still abort with catheters, curettage, and with other methods. So in general, the women that abort with Misoprostol have access to information and they have access to the internet (Author Interview with Erpel, January 25, 2017).

Having described the traditional black market for Misoprostol, detailing both the profit-driven side, and the internet-based, access-driven side, and having answered the questions of where the medication comes from, how women get access to the medication, who is selling and using it, and how the transaction takes place, I will now move on to describe the second type of black market for Misoprostol in Chile: the "parallel market," that is run by local and international nonprofit organizations.

Type 2: The Parallel Market

The “parallel market” for Misoprostol, as one member of Women Help Women (WHW) preferred for it to be called, is run by local and international feminist nonprofit organizations that believe that women have the right to access abortions. In Chile, these international organizations make up a network with local nonprofit organizations, such as Línea Aborto Libre and Con las Amigas y en la Casa, which only provide information to women about how to abort, but do not give them the actual medications to do so. Furthermore, there are two main international nonprofits that work in Chile (and around the world) to provide women with Misoprostol: Women Help Women and Women on Web.

Women Help Women (WHW)

Women Help Women is an international organization with the vision that “the key to women’s autonomy is putting contraception and abortion directly in women’s hands,” and the motto that “when the government fails, women help other women get abortions they need” (2016 Women Help Women Annual Report 2016, 1). WHW was founded on September 28, 2014, and is based in sixteen countries on four different continents. WHW has a staff of twenty-six counselors and doctors that work as community leaders and educators in these countries. WHW conducts its work by partnering with activists and community health workers, and by using online services to provide women around the world with access to abortion and contraceptive medications. WHW also runs a multilingual information and counseling center, which functions sixteen hours a day and provides counseling in Portuguese, English, Polish, Spanish, Italian, and Thai. In 2016 alone, WHW received more than 60,000 emails, and worked with forty partner

organizations to provide 40,000 medical abortions around the world (2016 Women Help Women Annual Report 2016, 2).

Women Help Women facilitates women's access to safe abortions and provides them with information, and also with the medication. What we do as a group of women is to respond to emails in distinct languages...my job is to respond to emails and questions from women that want to abort, are in the process of aborting, or after they have aborted...also we give information about sexual and reproductive education in general. And, we have a group of doctors that provides consultations if there is a case that requires more medical information (Author Interview with Anonymous, February 14, 2017).

In Latin America, WHW works in five countries where access to safe abortions is restricted: Brazil, Chile, the Dominican Republic, Honduras, and Venezuela. In these five countries, WHW trained 350 activists as "information providers, hotline operators, or community abortion doulas" (2016 Women Help Women Annual Report 2016, 2). Since 2014, WHW has reached at least 50,000 women with unwanted pregnancies (2016 Women Help Women Annual Report 2016, 2). In Chile specifically, WHW has two employees; one that is based in Santiago the other in the south of Chile, that partner with local organizations: "In Chile we are in an alliance with feminist groups...we support the hotlines and help in creating some workshops and publications. We work with la Línea de Aborto Libre, which is located in Santiago and Iquique" (Author Interview with Anonymous, February 14, 2017).

WHW works in Chile by sending women medications for medical abortions (as a combination of Misoprostol and Mifepristone), and contraceptives (including contraceptive pills, emergency contraception, and condoms). To receive abortive medications from WHW, a woman must be above the age of eighteen, be less than nine weeks pregnant, and have filled out an online consultation (which is reviewed by WHW's medical staff). As WHW is a nonprofit, it asks for a contribution of 75 euros for the combination of Misoprostol and Mifepristone (\$80 or 51,233 Chilean pesos), but it makes accommodations for women who are unable to pay

(<https://womenhelp.org/>, last accessed 4/27/17). Finally, WHW sends the medications to women through the mail:

A discrete package will be sent as soon as possible. You will receive a tracking number to follow your shipment online within 3 business days. In most countries, you are allowed to receive medicines for your own use. The package is expected to arrive within 4-10 days, depending on your location... Access to the content or service may not be legal by certain persons or in certain countries. If you access the Website you do so at your own risk and are responsible for compliance with the laws of your jurisdiction (<https://womenhelp.org/>, last accessed 4/27/17).

By sending packages through the mail, WHW is able to reach women all throughout Chile in a fairly short period of time. However, as stated above, women who access WHW's service "do so at their own risk," and may be subject to prosecutions (<https://womenhelp.org/>, last accessed 4/27/17). However, this service provides women with access to accurate information and reproductive health products that are safer (and more guaranteed) than those that are available on the traditional black market in Chile, while promoting support for abortion and women's rights worldwide.

Women on Web and Women on Waves

Women on Web was created in 2005 by Rebecca Gomperts, the founder of the organization Women on the Waves. Gomperts created Women on Waves in 1999 when she realized that by using a Dutch-registered ship, that was therefore subject to Dutch law, she could bring the ship to countries where abortion was illegal, take women on board the ship, sail to international waters (twelve miles off the country's coast), and legally provide them with medical abortions. The Women on Waves ship has never travelled to Chile, but it has completed successful campaigns in Poland, Ireland, Spain, Portugal, and Morocco, and this year will begin a campaign in Guatemala (<http://www.womenonwaves.org/>, last accessed 4/27/17). As the ship

cannot reach a large number of countries, Gomperts decided to create Women on Web (WoW), in the efforts to provide medical abortions to more women worldwide.

WoW is a “telemedicine support service,” and an international collective that responds to thousands of emails every day from all around the world. There are five physicians that work for WoW worldwide. Women access WoW through their website, and are required to fill out an online consultation before being sent a combination of Misoprostol and Mifepristone (which has a 98% success rate). WoW only provides women with medical abortions if they live in a country where access to safe abortion is restricted, if they have no serious illnesses, and if they are less than ten weeks pregnant (<http://www.womenonwaves.org/>, last accessed 4/27/17). Women who request the medications also receive consultations through email, during and after the procedure, and are advised on how to access medical services to confirm that the abortion was successful or if they experience complications (Larrea et. al 2015, 1). If women do experience complications, WoW also counsels them on how to avoid criminal charges (Bazelon 2014). Since the website was created in 2005 (twelve years ago), “over 200,000 women from over 140 countries have completed the online consultation, approximately 50,000 women have received a medical abortion at home, and the helpdesk has answered more than 600,000 emails” (Online abortion service Women on Web is 10 years!, 2016). Furthermore, WoW is gaining popularity, and currently every month the helpdesk answers 10,000 emails in sixteen languages, and the website receives over one million visitors (Online abortion service Women on Web is 10 years!, 2016).

WoW provides women with the medications through its partnership with Kale Impex, an India-based company (Bazelon 2014). Women who request medications through WoW are asked for a 90-euro donation to pay for staff salaries and overhead, but if women are unable to afford the drug, they are not required to pay (although 79% of women do make the full donation)

(Larrea et al. 2015, 3). One study found that in 2014, of the 2,042 Latin American women that requested medications through WoW, the majority lived in Brazil (68.9%), did not have children (83.9%), had not had previous abortions (93.2%), and aborted before the 10th week of their pregnancy (74.5%) (Larrea et. al 2015, 3). WoW provides free medical abortions to women with Zika; however, Brazilian authorities have begun to crack down on packages sent to Brazilian women from WoW. WoW reported that many Brazilian women had complained that customs officials were confiscating their packages, and WoW was forced to recommend that women seek help through other means, such as travelling to public clinics in Mexico City (which is a pricey option, and thus, is unavailable to the majority of the Brazilian population) (Bazelon 2014).

One study, which was conducted by the *New England Journal of Medicine*, examined requests for abortions performed in Latin America in response to the Zika virus. The study found that in Latin American countries that issued warnings to pregnant women about the Zika virus, requests to WoW for medical abortions had increased significantly. This study used Chile as a control case, as the country did not issue warnings to pregnant women about the Zika virus, but women still accessed the website, and found that between November 17, 2015, and March 2, 2016, WoW received 442 requests for medical abortions from Chilean women (Aiken et. al 2016, 396-398). This number of requests was the second highest in Latin America (behind Brazil at 1,210 requests), and was almost twice as high as the third highest number of requests (Argentina at 270 requests). Nicolas Perez, who researched this topic commented:

In one-hundred and seven days there were 450 petitions...but this is the most formal number that we have, the true number should be 300% or 400% more...but also this platform is limited to a higher social class, who has access to the internet...and from there the question is how massive is the informal market, if there is a massive sale of this drug on the internet that is very formal, what is happening on the informal market? (Author Interview with Perry, January 18, 2017).

This study was important because there is little information about the true number of abortions taking place in Chile, and the number of women who attempt to access the black market every day. Although the study is unable to cover the full scope of the black market in Chile, it does provide a picture of the most formalized element of the market, proves that a black market for abortions in Chile does exist, and demonstrates that abortions continue to occur even when they are made illegal. Having described the more formalized “parallel” market for abortion in Chile, which is dominated by international NGOs such as Women Help Women and Women on Web, I will now outline the final type of black market in Chile: the market for wealthy Chilean women, which is accessed through private Chilean clinics and through the international market for medical abortions.

Type 3: The Private/International Market

The third type of black market for abortions in Chile is the most difficult to access because it requires money, resources, and contacts. This third type of black market can be broken down into two parts: local, private clinics, and international clinics in countries where access to abortion is less restricted. However, these two options are only accessible to women who are able to pay high prices, either to doctors in private clinics, or to travel to other countries in Latin America, or to the United States, where abortions are legal or are much more easily accessible than in Chile. This third type of black market highlights the vast economic inequalities within Chile, as well as the inequality in access to care that permeates the healthcare system.

Private clinics

Although less common today than in the past, there are still some private clinics in Chile, and doctors within these clinics, that will perform abortions. However, these procedures are very expensive and are only accessible to a small portion of the population:

Yes, there are clinics here. Women with money come with an “appendicitis” or another illness and they can abort easily in clinics that they know...because the doctors note that it’s an “appendicitis” so women with money don’t have problems doing this. Our problem is the poor women who can’t even access Misoprostol (Author Interview with Erpel, January 25, 2017).

As some doctors are willing to lie on women’s medical records, wealthy women are able to access clinics that they are familiar with, without the fear of prosecution or denouncement. Additionally, these clinics that have doctors who are willing to provide abortions are more common outside of big cities, such as Santiago. However, most women in these regions are unable to pay for the procedure, although it is much safer and more sanitary than the traditional abortive methods that poor women are often forced to use:

Yes I know that there are private clinics that provide abortions, but it’s very expensive. Normally, in small cities, like Talca and Concepción there’s some doctor that is dedicated to this, but it’s very costly...so the majority of people can’t access it (Author Interview with Anonymous, February 14, 2017).

Additionally, although private clinics are still an option that wealthy women use to abort, performing abortions is very risky for the doctor, and in recent years, these procedures have become less common. Dr. Paulina Troncoso, a gynecologist who works for the Ministry of Health in Santiago, and is part of *la Program de la Mujer* within the Ministry, describes some of the risks to doctors who secretly perform abortions:

I think there is a presence, but it's very risky. Because of the press, and because it's very possible that someone has a camera, and it's illegal. So it's very risky. Before I knew of some places where people went, but I think that each time there are less...if there are, it's very secret (Author Interview with Troncoso, January 26, 2017).

Furthermore, as there has been more discussion and acknowledgement of the presence of these abortive clinics, within hospitals there are now stricter protocols to ensure that doctors are not performing abortions. Dr. Domonique Truan, a high-risk obstetrician who works in a private clinic in Santiago, describes some of these strict protocols within her hospital:

Look, I think there are still clinics that do it, but few because there has already been a lot of discussion about this. For example, in the clinic where I work, if you want to perform a uterine emptying, two doctors need to confirm the absence of a heartbeat...now you need certification. So, from this discussion people are a bit more attentive, but still there are doctors that do secret abortions (Author Interview with Truan, January 30, 2017).

Although the practice of performing abortions in private clinics is becoming less prevalent within Santiago, which is largely influenced by the availability and ease of using Misoprostol to perform abortions at home, this practice still represents an inequality in access to care between the wealthy and the poor in Chile. Furthermore, this inequality is exacerbated by the fact that denouncements of women who arrive at hospitals with abortion-related complications almost never occur within private clinics, while in public clinics, where women of lower socioeconomic statuses are forced to go, these denouncements are much more common:

In private clinics no, they don't make denouncements. The registered denouncements in Chile are all from public hospitals. Because the private clinics protect their clients. (Author Interview with Truan, January 30, 2017).

Private clinics that perform abortions are such a visible part of Chilean culture, that the former Minister of Health, Helia Molina, publically stated "*en todas las clínicas cuicas, muchas*

familias conservadoras han hecho abortar a sus hijas” (in all of the elite clinics, many conservative families have made their daughters abort) (González and Castillo 2014). Ms. Molina was essentially forced to step down due to this statement, but she still said “*no se arrepiente de nada*” (I don’t regret anything), and did not apologize for making this comment (González and Castillo 2014). If the Minister of Health acknowledges the existence of the private market for abortions in Chile, it is clear that it is an important, and highly visible, element of the black market for abortions in Chile, which further emphasizes this thesis’ research puzzle of why the government is unable or unwilling to regulate this market. However, each day these private clinics do become less and less prevalent, as hospital protocols become stricter, and doctors become less willing to risk their jobs to perform these procedures. Consequently, another option for the wealthy in Chile is for them to travel to countries in Latin America where abortions are legal, or at least easier to access.

International clinics

The final element of the black market for abortion, that Chilean women access, is the international market for abortions. Wealthy Chilean women are able to pay to travel to countries or areas where abortion laws are less strict, such as the United States, Mexico City, and Colombia. This option is particularly important and accessed by women who have advanced pregnancies, and are unable to access the black market for Misoprostol in Chile (as this drug can only be used up to twelve weeks of pregnancy) (Línea Aborto Chile: El Manual 2012).

Women that have the opportunity can travel to the United States because now it’s very easy for Chileans to enter the United States without a visa. And I think it’s easy for women who have the chance to leave the country when they have advanced pregnancies. I know some people have gone to Mexico. But the majority stay here because it’s very easy to get the medication (Author Interview with Anonymous, February 14, 2017).

For wealthy women, it is easy for them to travel to countries, such as the United States, where they can have abortions performed in Miami. However, women without money are unable to access this option, and they are at the highest risk of having complications associated with their pregnancies, and a lack of support throughout the process. This inequality in access is especially apparent in relation to the three issues related to therapeutic abortion: risk to the mother's health, fetal malformations, and rape. Dr. Dominique Truan discusses how, from her position as a doctor in a private clinic, she is able to direct her patients who have one of these conditions to countries where they can abort, while the majority of the population is unable to access this option:

This is how all legal things are. The people who are always harmed are the people who are the most vulnerable; young people, those of a lower social class, because they don't have support. Because women that have money go to other countries. I have recommended to some women that they go to distinct countries when they have fetuses with malformations that are incompatible with life, and I have sent them to the United States, to Colombia, to Mexico. But again, only women with money have access to this solution, which is not the majority of the Chilean population. This theme touches on the inequality within our country (Author Interview with Truan, January 30, 2017).

Although international travel is an option that many wealthy Chilean women use to obtain abortions, especially in cases where they have advanced pregnancies or pregnancies that would fall under the category of "therapeutic abortion," this option is severely restricted to a high socioeconomic class of women. This inequality in access is significant because it could allow some women to get potentially life-saving treatments by traveling to other countries, which is an option that even doctors, such as Dr. Truan, would recommend to their patients, while most Chilean women would be forced to access potentially unsafe methods to achieve the same result.

Conclusion

In this chapter, I responded to the questions: how does the black market for abortion function in Chile, who drives it, and how do women access it? In answering these questions, I outlined the three different parts of the black market: the “traditional market,” which is made up of both profit-driven figures and online websites that are operated on a more access-driven basis, the “parallel market,” which consists of international and local NGOs, such as Women on Web and Women Help Women, and the market for wealthy Chileans, made up of private clinics in Chile and international clinics in countries with less strict abortion laws, such as the United States, Mexico, and Colombia. In outlining these three different markets, I have laid out the different types of actors who are involved in each market, and the ways that they interact. In creating this descriptive chapter, which was necessary because previous literature does not contain a detailed outline of the nuances of the black market for Misoprostol, I have set the scene for the rest of this thesis, and the following chapters that discuss the regulation of this black market. Having outlined how this black market for abortion functions in Chile, in the next chapter I highlight how “full” regulation of each of these distinct elements of the black market could look, and argue that this regulation falls far short of “full” regulation.

CHAPTER 4: HOW DOES REGULATION OF THE BLACK MARKET FOR MEDICAL ABORTION FUNCTION?

The presence of the black market for abortion in Chile is widely acknowledged; however, there are few cases of prosecution of those who illegally perform abortions, or of those who sell abortion-producing drugs. Consequently, in this chapter I seek to respond to the question: does the regulation of the black market for abortion look different depending on the “type” of black market and the actors involved (sellers and providers of the medications or procedures versus the women who are their recipients)? In responding to this question, I hope to add to a literature about when and why black markets are regulated, and develop a theory to respond to a Chilean phenomenon that has of yet remained unexplained.

In this chapter, I first outline how we would expect the regulation of the three different types of black markets, the traditional, parallel, and private black markets, to look, and I examine the few cases where sellers or providers in this market have been charged. I then examine cases where women who have abortions and their “accomplices” in these abortions are prosecuted, as a point of contrast to the prosecution of the sellers of abortive medications. This chapter will be used to provide a description of the three different forms that the regulation of the black market for Misoprostol can take in Chile, as a way of demonstrating how this regulation falls short of “full regulation,” and to create a context for Chapter 5, which provides hypotheses for why this “full regulation” does not occur.

Charging Those Who Sell and Perform Abortions:

As was discussed in the previous chapter, the black market for abortion in Chile is made up of three sub-types of markets: the traditional black market, the parallel market, and the private

market. One of the important questions about the regulation of the black market for abortion in Chile is how one would expect the regulation of each of these three types of markets to take place, and how this regulation is actually being carried out. This comparison is important as a means of understanding where the discrepancies lie between “strong” and “weak” regulation of these different types of markets.

The traditional black market and the parallel black market

In chapter one, I created a working definition for how I understand regulation in terms of the black market for Misoprostol in Chile; regulation is the management of social risks that take place when individuals become involved in transactions with other individuals. I then outlined what I mean by “strong, formal regulation,” and “weak, formal regulation,” and provided examples of cases of strong and weak, formal regulation (see Figure 1). However, regulation does not only vary by level of formality of regulation, and level of strength, but also by the type of black market that is being regulated. Scholars have argued that regulation can look differently depending on the actors who are involved, and where the transactions are taking place.

In relation to the first type of black market, that I have categorized as “the traditional black market,” scholars make the claim that prosecution takes the form of police investigations, and prosecutions within the court. In this case, the main investigators are generally police officers. However, regulation of this market can also take the form of disruption of criminal operations, rather than prosecution, as there are “higher costs of gathering ‘evidence’ rather than ‘intelligence,’” and the outcome of prosecution is often unpredictable (Gill 2002, 535-536). The purpose of these market-disrupting actions is to raise the danger of involvement with this traditional black market, and to constrain the freedom of the actors within it (Karp 1994, 188). In

the case of the traditional black market for Misoprostol in Chile, the investigators are the police and the PDI, and “strong regulation” of this market would look like a high number of cases of prosecutions and investigations into venders of these medications.

A second area where scholars argue that regulation of black markets can take place is at countries’ borders. With countries’ increasing emphasis on free trade and open borders, borders become an important point of entry for goods, both licit and illicit. Academics argue that customs officials have some of the greatest capacity to regulate black markets, because they have the strongest legal authority for searching and inspecting people and goods (Flynn 2000, 58). In the case of both the traditional black market and the parallel market for Misoprostol in Chile, border officials play a very important role in the regulation of these markets, as they have the ability to intercept these goods before they reach the black market. In the case of this type of regulation, we would expect “strong regulation” to look like the prosecution at the border of a high number of cases of smuggling Misoprostol, particularly between Peru and Chile, and the postal service’s detection of a high number of cases of Misoprostol entering the country.

The model of “strong regulation” of the traditional and parallel black markets for medical abortion in Chile would look like regulation by the *aduanas* (border patrol), by the PDI, and more specifically, by the Cybercrime Brigade within the PDI, and by denouncements from the postal service. In the case of the traditional black market for Misoprostol, there are three places where the prosecution of the actors in this market could occur: at the border (by *aduanas*), online (through the Cybercrime Brigade), or through the postal service (as sellers send Misoprostol through Chile Express (Western Union) to women who live in regions that are inaccessible to the sellers (Author Interview with Erpel, January 25, 2017).

As the majority of the abortion medications that enter Chile come from sellers bringing it across the border from places like Peru and Bolivia, regulation of this market could look like border officials searching travelers for these medications, and charging the sellers with the possession of a banned drug. The possession of Misoprostol without a prescription is not considered a *delito* (crime) but is categorized as a *falta* (misdemeanor). If someone commits a *falta*, they generally only have to pay a fine, or may be subject to a short period of time in prison; whereas if they commit a *delito*, they will likely be imprisoned for longer periods of time. The sale of Misoprostol is categorized a “*falta*” in Chile’s *Código Sanitario* (Sanitary Code) because the sale of the medication isn’t necessarily associated with abortions, as the drug can also be used to prevent ulcers. Consequently, if a person were caught with Misoprostol, they would be charged with being in possession of an illegal medication, rather than with the crime of committing an abortion (Aborto Express 2016).

The regulation of the traditional black market for Misoprostol by the Cybercrime Brigade would look like the Cybercrime Brigade tracking down people with websites such as “vendomistrol.com,” or acting like a woman who is seeking the drug, and intercepting the sale in a metro station. In an interview with the Chilean magazine *Paula*, Bárbara León, sub-inspector of the Cybercrime Brigade commented that: “Generally, the seller and the buyer get in contact through email. We find the address where the emails are coming from and we find the person that sent them” (Aborto Express 2016).

As the emails and websites of the sellers of Misoprostol are readily available, one would assume that it would be relatively easy for the Cybercrime Brigade to crack down on this part of the traditional black market; however, in the interview Bárbara León added that “...we only act when there is a complaint” (Aborto Express 2016). Consequently, although the Cybercrime

Brigade may have the resources to regulate the sale of Misoprostol online, it only acts when they are informed about a case of the sale of Misoprostol, instead of investigating the online market themselves. Furthermore, Nicolas Perry argues that:

...the problem is that for there to exist the procedure there would need to be a denouncement. And the denouncements that are taken seriously and generate investigations are from government departments like the Ministry of Health...instead of from a citizen with little evidence (Author Interview with Perry, January 18, 2017).

As a result, there are very few cases of denouncements of the sale of Misoprostol, despite the fact that there are a large number of sellers. Between 2004 and 2006, the Cybercrime Brigade only investigated five cases of the sale of Misoprostol, and it is unknown if any of these cases were convicted (Aborto Express 2016). In fact, the documentary *La Línea de Aborto* shows an interview with one seller of Misoprostol in Concepción, Chile:

I'm not a drug trafficker. I don't sell coke or marijuana, only Misoprostol. Seven years ago, I was summoned to court. I was told that I was committing an infraction of the Sanitary Code, and that they couldn't accuse me because I didn't practice abortions, I was just selling drugs outside of established places. I went to a Bureau with my lawyer, and in ten minutes he closed the case, and nothing happened to me (Rist and Chartier & Lopez Escrivá, 2016).

From these interviews, it appears that the Cybercrime Brigade does not view the online sale of Misoprostol as a top priority, and that it only uses its resources to investigate the sale of Misoprostol in select cases. One of the most recent cases of the prosecution of a seller of Misoprostol was on November 17, 2015 in Rancagua, Chile. In this case, a man was charged for selling Misoprostol and violating article 314 of Chile's Penal Code. However, this man was only charged because the women to whom he sold Misoprostol arrived at the hospital with abortion-related complications, and the remains of Misoprostol were found in her vagina. In this case, the

Brigada de Delitos Sexuales y Menores (The Brigade of Minor and Sexual Crimes) arrived and prosecuted both the woman and the seller (at a latter point in time) (Detienen a una mujer...2015). Article 314 of Chile's Penal Code states:

Anyone who, in any capacity, sells substances dangerous to health, other than those indicated in the previous article, in contravention of the legal or regulatory provisions established in consideration of the dangerousness of said substances, shall be punished with lesser imprisonment in its minimum to medium, and a fine of six to twenty monthly tax units (Código Penal Artículo 314 Chile).

If a person is charged with violating article 314 of the Penal Code, they can be subject to a fine or lesser punishment, which means from sixty-one days to five years of imprisonment. However, it is clear that there are few cases where police actually enact this article and prosecute sellers of Misoprostol in the traditional black market.

In regards to the second area where one could image regulation of the traditional black market for Misoprostol, at Chile's border, there are also few recorded cases of the detection and prosecution of sellers bringing the drug across the border. One of the most recent cases occurred on July 18, 2015, and entailed two people being detained at the Chilean-Argentine border crossing, Pino Hachado. These sellers carried 21,000 abortion pills with them, which were valued at more than one million dollars. The main reason why these sellers were detained was that authorities thought the pills were methamphetamines (Millonario contraband a Chile...2015). From this case, it appears that the border patrol is more focused on prosecuting cases of the trafficking of drugs, rather than the smuggling of illegal medications. Furthermore, the Argentine border is better equipped than the Peruvian or the Bolivian border, where it would be much easier for someone to bring Misoprostol across the border, which is where the majority of Misoprostol that enters Chile originates (Author Interview with Perry, January 18, 2017).

In regards to the last area where one could image that regulation of the traditional black market could take place, through denouncements to the PDI by the postal service, there do not appear to be many prosecutions of sellers through this venue. This last area of regulation is also how one would expect the regulation of the parallel market for Misoprostol to take place. This parallel market is dominated by international organizations, such as Women Help Women and Women on Web, who send the medications through the mail to Chilean women. However, neither Women Help Women nor Women on Web have ever had problems with the Chilean PDI or postal service denouncing their organizations or shipments (Author Interview with Anonymous, February 14, 2017). The only country that has been able to stop, or has attempted to disrupt Women on Web's efforts is Brazil:

In 2015, the Pan-American health organization issued an alert for Zika, so the NGO had many requests for the drug. So the government became interested in this NGO, as the pills were illegal in Brazil.... One-hundred pills a day were being sent to Brazil. So the government tried to stop the NGOs' entrance to Brazil (Author Interview with Perry, January 18, 2017).

Women on Web was providing free abortions to women in countries that were affected with Zika; however, as abortion is only allowed for therapeutic purposes in Brazil, customs officials were stopping all packages from Women on Web. Consequently, Women on Web has stopped sending the medications to Brazil, and issued the statement: "Unfortunately the Brazilian government stops all packages that contain medical abortions. Women on Web "calls upon the Brazilian government and Anvisa to suspend the interception of packages with medical abortions at least for the duration of the Zika epidemic" (<https://www.womenonweb.org/> 2017). However, the Chilean government has not made efforts to stop these NGOs from sending packages to

Chile, and both the domestic and international mailing of Misoprostol appears to occur with little interception or investigation.

The private black market

A final area where scholars argue that regulation of abortion can take place is by prosecuting doctors or midwives who illegally perform abortions. In the past, in the context of abortion-related complications, doctors have encouraged women to name the healthcare professional who provided them with the abortion, so that they could give the police this information, and the healthcare professional could be prosecuted. For example, when abortion was made illegal in Chicago from 1867 to 1940, in most cases involving abortion the state prosecuted the healthcare professionals who provided women with their abortions, often from the evidence from women's dying declarations related to their illegal abortions. In order to obtain evidence, the state needed the cooperation of doctors, as prosecutors would have difficulty enforcing abortion laws without this collaboration. Furthermore, this practice was characterized by inequality, as wealthy women avoided investigations, while poor women were often forced to use more dangerous methods to abort, that were detected when they sought care for their complications (Reagan 1991, 1240-1246). Similarly, the private black market for abortion in Chile is characterized by inequality, and regulation of the medical professionals that provide abortions within private clinics requires the cooperation of doctors and hospital administration.

The private black market is distinct from the traditional and parallel black markets for abortion in the sense that these two markets provide drugs to women who abort at home, while in the private black market, women are assisted in their abortions in hospitals. The private black market for Misoprostol would likely be the easiest of the three types of markets to regulate,

because this activity is more visible than the other two forms of black markets. The regulation of this private black market would most likely look like hospital administration creating guidelines to ensure that doctors are not lying and performing “appendicitis surgeries.” If a doctor violated these guidelines, regulation would then take place through hospital administration reporting the transgression to the police officer stationed at the hospital, or through the PDI investigating private clinics or doctors who they believe may be engaging in this activity. Doctors, such as Dominique Truan, have reported that increased strictness in hospital guidelines has ensured that doctors perform fewer abortions; however, Truan also noted that “private clinics protect their clients and doctors,” and consequently, that the majority of denouncements occur in public, rather than private hospitals (Author Interview with Truan, January 30, 2017).

Charging Women Who Had Abortions and Their “Accomplices”

Traditionally, many of the cases surrounding the black market for abortion in Chile that are prosecuted are of the women who have taken abortive drugs, rather than the sellers who provide them with these medications. Between 1977 and 1995, a study conducted by Lydia Casas Beccera found that within Santiago’s Women’s Prison, there were 132 files of men and women who had been charged with abortion-related crimes. These included eighty women who had received abortions, forty abortion providers (thirty-nine who were women, none of whom were doctors, and all who provided these women with high-risk procedures), and twelve accomplices who either helped the women locate the provider, or went with the women to the hospital for abortion-related complications (Women Behind Bars 1998, 54-55). However, this profile of prosecutions has begun to change with the introduction of Misoprostol, as women are less likely to seek these high-risk abortion providers, and instead, abort at home. A recent study

that investigated cases through the *Defensoría Penal Pública* (Public Penal Defense) found that between 2010 and 2014, there were 271 crimes associated with abortion. This study found that the majority of people prosecuted for abortion-related crimes were women; 182 women were prosecuted, while only 89 men were charged for a similar crime (Salud Sexual, Salud Reproductiva 2016, 121).

Furthermore, the majority of denouncements of women occur through hospitals. A study conducted by the Center for Reproductive Law and Policy and the Open Forum on Reproductive Health and Rights found that from 1983-1984 and 1990-1991, 92% of institutional reports of abortion came from hospitals (See Figure 4). These high rates of reporting and prosecutions are a legacy of the Pinochet-era policies that criminalized abortion, and encouraged the prosecution of women engaging in this practice. In this study, all of the hospitals that reported women were public, and there was not one instance of a private hospital reporting women who had performed abortions. Furthermore, each medical institution has its own reporting process for abortion-related cases. Most hospitals report cases of abortion through calling the police officer assigned to their hospital, although some hospitals have sent lists of patients who have “confessed” to the crime of abortion, and oftentimes these confessions are obtained through coercion (Women Behind Bars 1998, 54-55). In the documentary *La Línea del Aborto*, there is an interview with Hernán Medel, the sub-commissioner of the PDI. In relation to the reporting process, Medel comments that:

Even without the fetus, a doctor could have enough evidence to say that this woman was pregnant, and can say she had an abortion. We then coordinate with the hospital and the doctors, and interview them. And if the women don't confess, we interview other people to see if they committed the crime or not (Rist and Chartier & Lopez Escrivá, 2016).

Figure 4: Reports Against Women Who Had Abortions, Classified by Origin of Report (Total 1983-84 and 1990-91)	
Hospital	127
Police	7
Intelligence Police	3
Other	1
Partner	8
Family Member	9
Stranger	1
Herself	3
Total	159
Source: 1998. Women Behind Bars. <i>The Center for Reproductive Law and Policy and the Open Forum on Reproductive Health and Rights</i> . New York, NY, 49.	

Sometimes it is not obvious if women arrive with abortion-related complications, or if they have had a miscarriage, following their use of Misoprostol. If women take Misoprostol orally, doctors are unable to detect it within their system, and they present with the same symptoms as if they had simply had a miscarriage. However, many women receive inaccurate information from sellers, and end up using Misoprostol vaginally. In this way, when women arrive at hospitals with these complications, they are often prosecuted due to the remains of the medications that doctors find in their vaginas (Línea Aborto Chile: El Manual 2012).

However, doctors are not required to report their patients who arrive with abortion-related complications. Doctors may be confused about their reporting obligations in relation to abortions, because on one hand, they are required to report any crimes that they are presented with in the hospital (and within the Sanitary Code, abortion is illegal); however, on the other hand, doctors have the obligation to protect patient confidentiality. Consequently, many doctors that do not know about their rights, or are scared about being prosecuted themselves, may report women unintentionally (Author Interview with Truan, January 30, 2017). Article 19 of the Chilean Constitution guarantees “respect for the protection of the private and public life of an

individual and his or her reputation and that of his or her family,” and article 10 of the Chilean Medical Professional Association establishes that maintaining patient confidentiality is a doctor’s duty (Women Behind Bars 1998, 49). Furthermore, in 2009, the Ministry of Health issued a directive to directors of health services stating that: “Medical attention should be unconditional, and any confession obtained in the described context is completely illegal” (Ord A15 Número 1404, 2014).

This directive asserted that it is illegal for doctors to obtain confessions from women about if they have committed an abortion, as the use of coercion to obtain these confessions can be defined as torture. Furthermore, on May 2, 2014, the Ministry of Health issued a second ordinance, A14 number 1403, that re-enforced the importance of doctor-patient confidentiality in cases of abortions (Ord A15 Número 1675, 2009). As a result, public officials from the Ministry of Health have visited hospitals, particularly those that have denounced women for having abortions, and told doctors and administrators about their duties related to patient confidentiality (Author Interview with Soto, January 25, 2017).

Many doctors don’t know about laws related to patient confidentiality, and make denouncements. But we, as the Ministry of Health, have gone to these places that have shown up in the press, and meet with the team, and tell them about confidentiality and human rights... We’ve worked a lot with themes of confidentiality, so that women aren’t denounced. Many doctors know this, and don’t make the denouncement. But some new doctors do, because they fear something could happen to them, and they think that they have to denounce it... They immediately denounce it to the police, and in every hospital, there is a policeman... And when this happens, they are in the press, so we can quickly intervene (Author Interview with Soto, January 25, 2017).

From these interviews, it appears that the Ministry of Health is opposed to denouncements against women who have had abortions, and arrive at hospitals seeking help. Furthermore, the Ministry of Health is also actively working to stop hospitals from making these

types of denouncements. However, the Chilean government also appears to be more willing to prosecute women who have had abortions, than sellers of abortive medications or healthcare providers who perform abortions, although this practice of high levels of denouncements of these women may decline with the Ministry of Health's current efforts.

Conclusion:

In this chapter, I responded to the questions: what are the forms that the regulation of the black market for Misoprostol could take, who would be the actors in the regulation of this market, and how does the regulation of the black market fail to meet a model of “strong regulation?” In answering these questions, I examined how “strong regulation” would look in each of the three different types of black markets, as a means of comparing this model of regulation to the true level of regulation in each case, to demonstrate the ways in which it falls short. I also analyzed cases where women who have had abortions, and their “accomplices” have been charged, to demonstrate the areas of the black market where government officials prioritize regulation. The purpose of this chapter was to outline how regulation looks different for each type of black market, and how within each market, government officials do not engage in strong, formal regulation. This chapter creates a context for Chapter 5, which examines the motivations behind the reasons why government officials do not engage in full regulation of the black market. Chapter 5 offers three hypotheses to explain why government officials might decide to pursue a policy of weak regulation of the black market for Misoprostol, in the efforts to answer the question: why has the government been unable or unwilling to regulate the black market for abortion in Chile?

CHAPTER 5: WHY HAS THE GOVERNMENT BEEN UNABLE OR UNWILLING TO REGULATE THE BLACK MARKET FOR ABORTION IN CHILE?

Chapter 4 demonstrated how the regulation of the black market for Misoprostol in Chile falls short of “full regulation.” This chapter will build off Chapter 5, and seeks to answer the question: why has the Chilean government been unable or unwilling to regulate the black market for Misoprostol in Chile? In answering this question, this chapter outlines three hypotheses for why there are low levels of regulation of the black market. The first hypothesis that this chapter investigates is that there are differing levels of regulation based on the different types of actors involved in the market. The second hypothesis is that levels of regulation do not depend on the type of actor; instead, weak regulation is due to bureaucrats’ desires to uphold the norms of their positions and to protect their interests through the two mechanisms of a drop in maternal mortality rates/complications related to abortions, and a reduction in hospital costs. The third hypothesis (the alternative hypothesis) presented in this chapter is that low rates of regulation are caused by a lack of information about the black market, and a lack of government capacity. The purpose of this chapter is to seek to explain the phenomenon of weak regulation of the black market for Misoprostol in Chile, and to extend theories about regulation and bureaucrats’ motivations.

Hypothesis 1: Differing Levels of Regulation Based on Type of Actor

The first hypothesis that I investigate is that there are differing levels of enforcement based on the type of actor. In this scenario, one could imagine that the PDI would be more willing to prosecute the traditional black market, than the parallel or private market for abortion. This would be the case because the traditional black market is run in a manner more associated

with typical “criminals,” who are involved in drug trafficking, than the parallel market, made up of international NGOs, which are well-known and respected, or the private market for abortions, which are conducted in private clinics by doctors who are also well-respected in Chilean society.

Some scholars have argued that bureaucrats and public officials are most motivated by self-interest. Lane and Kivisto applied the principal-agent model to politics, arguing that politicians are principals and bureaucrats are agents (Lane and Kivisto 2008, 176). Within this argument, these actors share different interests, but each of these interests are due to the fact that both actors are “rational utility maximizers.” In this scenario, politicians have an interest in engaging in policies that will get them re-elected, and benefit their constituents, shirking any activities that could be against these interests, and bureaucrats seek to maximize budgets (Lane and Kivisto 2008, 176). Within this theory, public officials are not motivated by norms, values, or ideas; rather, they only focus on themselves. This theory could apply to hypothesis 1, because in this scenario, one would imagine that politicians or government officials would be less willing to encourage the prosecution of international NGOs or doctors because of the potential political costs, while allowing the prosecution of the traditional market, where sellers are viewed as “criminals,” and their prosecution would be applauded by conservative constituents. Consequently, these officials would not be as focused on potential norms of justice or equal prosecution and, instead, would be motivated by their self-interested desire of maintaining positive public opinion, and not upsetting influential actors in society.

During my interviews with multiple Chilean public officials, they echoed the sentiment that the government allows private clinics to exist because the majority of government officials have some relationship to someone who has used these services to abort, or because they do not

view the people who attempt to access this method of aborting (or who provide abortions) as typical “criminals.” Ministry of Health official, Paulina Troncoso, stated:

This is a country of double standards. I’m sure their children have taken pills for abortion, but publically they display different opinions...since there is a very conservative discourse in Chile (Author Interview with Troncoso, January 26, 2017).

Yanira Zuniga, a lawyer and professor at la Universidad Austral de Chile, expressed similar opinions to Troncoso and commented:

There is a duplicity of public-private discourse about abortion. Often abortions in private clinics are committed by women who belong to the same political families that turn around and denounce abortions. This is similar to what happened with divorce. Parliamentarians would be publically against, but would annul their marriages (Author Interview with Zuniga, January 17, 2017).

There is a widely-shared view that neither politicians nor bureaucrats would support the prosecution of private clinics, because either people in their families or their friends have had to utilize these resources, and therefore that they do not view prosecution of these areas as politically within their interests. What is surprising is that there are also low rates of prosecution of the traditional black market for Misoprostol, where one would expect to see the highest levels of prosecution, due to the market’s more obviously “illicit” status. Although there are a few cases of people getting stopped at the border for trying to smuggle Misoprostol into the country, these cases are infrequent in relation to the size of the traditional black market, and the number of women who are aborting using Misoprostol. Furthermore, in cases of the online sale of Misoprostol, which also makes up the traditional black market, as highlighted above, the PDI only investigates cases of sellers of Misoprostol when there has been a denouncement. Although this traditional black market is the most visible of the three, as there are at least twenty websites

with the sellers' email addresses and phone numbers, the PDI does not appear to be more invested in prosecuting this market than the other two forms of the black market (Author Interview with José, January 12, 2017)

From case studies, it appears that the police and PDI are most focused on charging women who have undergone abortions, rather than those who have sold them abortion-causing drugs. In response to the question “what is the government doing to prosecute the black market for abortion in Chile?” María Jose, employee of Con las Amigas y en la Casa, responded:

The government isn't doing anything, or very little. There were a few cases from the press...but those who are most condemned are the women. It's not the men who are selling the drugs...which is why it's important to work for the depenalization of therapeutic abortion, to take away the culpability (Author Interview with José, January 12, 2017).

Consequently, the main reason why there are low levels of regulation of the black market for abortion in Chile does not appear to be because government officials favor regulation of the more “criminalized” part of the black market over regulation of the parallel and private markets, which consist of actors who have a higher status in society and who officials might not want to anger. Although this reasoning could be a partial factor in why there are even fewer prosecutions of private clinics and international NGOs than actors in the traditional black market for Misoprostol, it is unable to provide an explanation for why regulation of this black market as a whole is so shockingly low. As a result, I will move on to discussing the second hypothesis: that levels of regulation do not depend on type of actor, and instead, that weak regulation is due to bureaucrats' desires to uphold professional norms, and protect their interests.

Hypothesis 2: Levels of Regulation do not Depend on Type of Actor; Rather, Regulation is Dependent on Bureaucrats Upholding Norms and Protecting their Interests

The second hypothesis for why there are low levels of regulation of the black market for abortion in Chile is that bureaucrats feel that it is more important to uphold the norms of their position and maintain their interests, than pushing for the prosecution of the black market. In this case, there are two reasons why bureaucrats would act in this way. There is a broad scholarly debate about bureaucratic norms, and the motivations that bureaucrats face. Abers writes that this debate initially assumed that bureaucrats were essentially rule-followers, and were only forced to make decisions about which rules they should apply (Abers 2016, 5). However, other scholars argue that bureaucrats are actually governed by the principal-agent theory, and that they are “self-interested utility maximizers” that are only motivated by activities that further their self-interest (Lane and Kivisto 2008, 152).

Finally, a third theory about bureaucrats’ motivations is that “actors can be moved by values, ideologies or political projects, not just rules and incentives” (Abers 2016, 5). For example, Tumers found that in the case of Dutch public healthcare professionals and policymakers’ willingness to implement a new insurance model, this willingness was more dependent on their view of the value that this policy added for society, rather than their own influence on creating the policy, or their view of the positive impacts that this policy could have for them (Tumers 2011, 576) Consequently, these lower level bureaucrats were more influenced by the professional norms of their position as healthcare professionals than their self-interest or rule-following. Abers also found that in the case of the Green Grants Program (an environmental cause in Brazil), that public officials were motivated by bureaucratic activism to pursue this environmental cause, even in the face of opposition from their superiors. These bureaucratic

actors were motivated by the ideas and concepts that they believed in, and therefore, were surprisingly willing to go against their interests to stand up for this policy (Abers 2016, 1).

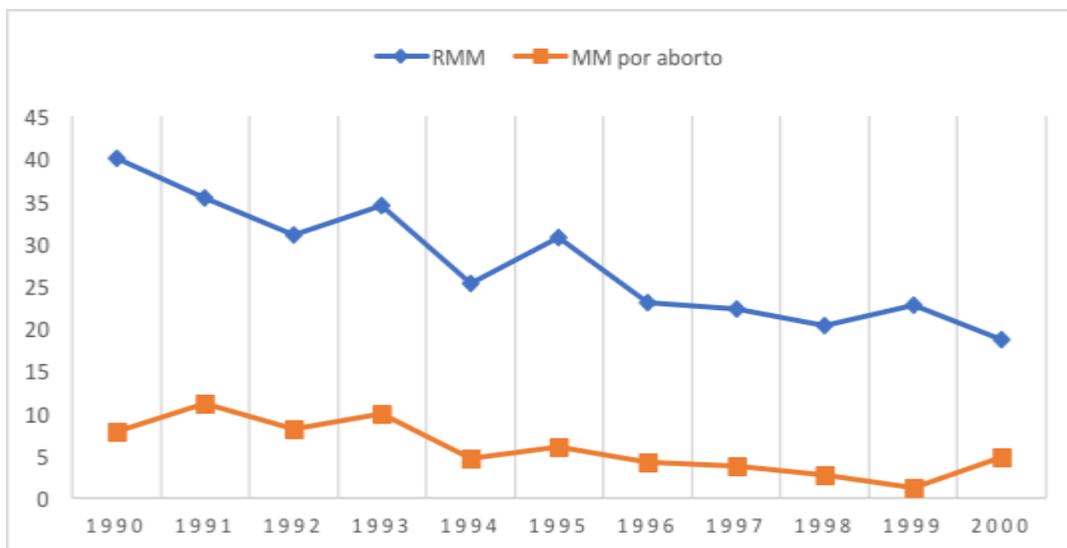
Consequently, this hypothesis furthers Tumers' and Abers' arguments by proposing that Chilean bureaucrats, particularly within the Ministry of Health, are also motivated by their norms as healthcare professionals to pursue a policy of not encouraging the regulation of the black market for Misoprostol in Chile, due to the societal benefits of its presence. Although this policy did maximize their immediate self-interest, it did provide important societal benefits. The first societal benefit of the presence of the black market for Misoprostol in Chile is that the introduction of Misoprostol is associated with a reduction in the maternal mortality rate in Chile (and around the world), and furthermore, is associated with a decrease in abortion related-complications. As a result, prosecuting the black market for Misoprostol in Chile, which has clearly led to many beneficial outcomes, would go against officials' norms of acting as "public servants" who seek to improve circumstances for the population, rather than make them worse. Furthermore, the government has been attempting for many years, and has invested a lot of money into trying to decrease the maternal mortality rate in Chile; it would not make sense for them to attempt to prosecute those who have helped them to achieve their goals.

The second reason why officials would not attempt to prosecute this market is that it has led to a reduction in septic units in hospitals, for abortion-related complications, which saves both hospitals and the government money. As a result, it would go against both these public officials' norms and interests to prosecute a practice that is helping to save them lives and money.

Mechanism 1: Decreased complications and a reduction in the maternal mortality rate

The first reason why bureaucrats may decide to pursue a policy of low levels of regulation of the black market for Misoprostol in Chile, based on their desire to follow bureaucratic norms, is that Misoprostol has led to a reduction in abortion-related complications and to a decrease in Chile's (previously high) mortality rate. In comparison to many other Latin American countries, Chile currently has a fairly low maternal mortality rate. Between 1990 and 2003, the maternal mortality rate decreased from 40 deaths per 100,000 live births to 12 deaths per 100,000 live births. This reduction was largely caused by the government's promotion of contraceptives, as in the 1960s, more than one-third of maternal deaths were caused by abortions (Salud Sexual, Salud Reproductiva 2016, 121). With the introduction of contraceptives, there has been a decrease in maternal mortality rates, birth rates, and deaths caused by abortions (see Figure 5).

Figure 5: Maternal Mortality Rates and Maternal Mortality Rates for Abortion (1990-2000)



Source: Troncoso and Soto: Maternal Mortality and Morbidity from Abortion in Chile: Critical Analysis of National Statistics.

Although the introduction of contraceptives has been very important in creating the drop in Chile's mortality rate, Misoprostol has also been essential in contributing to this decline, and especially to the drop in rates of complications related to abortions. Studies and reports, including one written by bureaucrats from the Ministry of Health, Paulina Troncoso and Eduardo Soto, have found that Misoprostol plays a role in reducing the number of insecure abortions, and therefore, in reducing the number of hospitalizations and deaths that they cause (Troncoso and Soto, 8). Studies have shown that the substantial decline in abortion rates that was observed between 1995 and 2003 has slowed, and that the proportion of unsafe abortions performed worldwide has increased since 1995. For example, in 2008, half of all abortions worldwide were unsafe. Furthermore, strict abortion laws (like those seen in Chile) are not associated with lower abortion rates, and in fact more liberal abortion laws are associated with declines in rates of unsafe abortions (Sedgh et al. 2012, 630-631). When women are unable to access safe and legal abortions, they resort to the use of other methods, such as herbs, which often lead to infections and hospitalizations (Miller et al. 2005, 1291). Moreover, medical abortion has been found to be safe and effective in developing countries (if used properly), as its efficacy is 88-96% for first-trimester abortions (Harper et al. 2007, 67).

There are few studies on the effectiveness of Misoprostol in less controlled settings (such as when women abort at home), but studies in the Dominican Republic and Brazil have found that the use of Misoprostol is associated with fewer infections and abortion-related complications. In one Brazilian city where Misoprostol was restricted, there were increased rates of abortion-related morbidity, and a tripling of the maternal mortality rate (Miller et al. 2005, 1219). Moreover, a study conducted in the Dominican Republic found that with the introduction of Misoprostol, abortion-related complications decreased from 11.7% in 1986 to 1.7% in 2001

(although they commented that their study had limitations) (Miller et al. 2005, 1219). One study, using a modeling approach with high and low mortality rates in Africa, Asia, and Latin America, found that under conditions of high mortality rates, there is a 15% reduction in mortality rates if 20% of the procedures are Misoprostol-induced, and a 45% reduction if 60% are Misoprostol-induced. Even in Latin American countries with low mortality rates, such as Chile, the study found that with 40% of abortions being Misoprostol-induced, there would be a 26% reduction in maternal death (Harper et al. 2007, 67-8).

Although few studies have been conducted in Chile on the effect of the introduction of Misoprostol on the maternal mortality rate, it is clear that bureaucrats and public officials from the Ministry of Health recognize that its introduction, and the creation of the black market in Chile, have contributed to a drop in these rates, and therefore, that its presence is important. In fact, Paulina Troncoso commented that:

The existence of Misoprostol helps in a way with public health. It's like I see it, but I don't want to see it. So, there aren't denouncements, and I don't think the government is going to do anything. Because the government is full of contradictions, the government has very progressive and conservative sectors, but the government isn't so conservative that they are going to prosecute it knowing that there are women who use it and that its their only access, since the wealthy can go to other countries (Author Interview with Troncoso, January 26, 2017).

From this comment, and the numerous studies showing the benefits of Misoprostol on reducing the maternal mortality rate in Chile, it seems that one of the main reasons for the lack of government regulation of Misoprostol is that government officials realize that it would not be in their interests to prosecute an illegal activity that has been effective in decreasing Chile's maternal mortality rate. Although illegal, this activity is helping to solve a problem that used to be a high priority for the Ministry of Health to solve. Ministry of Health officials, Eduardo Soto

and Paulina Troncoso, made it clear that one of their priorities was to ensure that hospitals do not denounce women who enter with abortion complications. Although having an abortion breaks the law, these officials view part of their professional duty as working to ensure the health and well-being of their population; they consequently weigh ensuring women get the treatment that they need over prosecuting their engagement in an illegal activity. Moreover, by choosing to enforce the ban on Misoprostol in Chile, it is possible that Chile could experience the same phenomenon that happened in the Brazilian city when Misoprostol was restricted, and Chile's maternal mortality rate could again rise steeply. Furthermore, many of the bureaucrats in the Ministry of Health are doctors or midwives, and are dedicated to saving lives. As a result, the norms of their position would indicate that they would not choose to take actions that would have negative consequences on Chilean women's health, and on the country as a whole. Although government agencies are not heterogeneous, and different officials within the Chilean government may be motivated by different norms, this theory is important because it suggests that some Chilean bureaucrats are influenced by these bureaucratic norms, and therefore, may act in ways that appear to be contrary to official government policy.

Mechanism 2: Decreased costs for clinics

The second reason why government officials would be opposed to regulating the black market for Misoprostol is that the introduction of the medication has helped to save them and the hospitals money. In Chile, hospitals used to have expensive septic units to treat complications and infections caused by abortions. However, with the introduction of Misoprostol, these expensive septic units have essentially disappeared. Dr. Ramiro Molina, a gynecologist and professor at la Universidad de Chile, related how this change took place:

I was the director of obstetrician and gynecology services in the hospital at the University of Chile... In 1984, one of the units in the new building was a “*unidad septica*” (septic unit) to attend to infected abortions, abortion complications. There were 17 or 18 beds in the septic unit... All septic abortion units in public and private hospitals that had always existed, and were very important, disappeared with the introduction of Misoprostol. Abortion didn’t disappear, septic abortions did in all of Latin America. Abortions continued in the same amount and as important as before... Intensive care units are very expensive, with septic shock you need technology, and now they don’t exist (Author Interview with Molina, January 13, 2017).

From Molina’s response, it appears that Misoprostol has been important in saving hospitals and the government money, as maintaining intensive care units is expensive, and the introduction of Misoprostol essentially eliminated the need for an entire unit in all Chilean hospitals. This sentiment, that the introduction of Misoprostol has essentially wiped out all of the septic units that used to exist in Chile, was echoed by many of the doctors that I interviewed, both pro-life and pro-choice. This drop in septic abortions is so stark because in the past, there used to be “*aborteros*,” or professionals who would perform clandestine abortions, but in generally unsanitary conditions and using unsafe methods (Author Interview with Molina, January 13, 2017). Consequently, Misoprostol has come to replace *aborteros*. Furthermore, with the introduction of Misoprostol:

There was a notable change in the maternal mortality rate... In the past, Chile had one of the highest rates in Latin America, due to abortion complications, septic abortions... Then with the introduction of Misoprostol, the maternal mortality rate from abortion complications dropped greatly, and the use of Misoprostol has saved many lives (Author Interview with Truan, January 30, 2017).

As a result, if the government decided to prosecute the black market for medical abortion in Chile, it is likely that the rate of septic abortions would again rise, which could re-open these costly septic units throughout Chile. Therefore, it would be against the government’s interests to pursue sellers of Misoprostol. Ramiro Molina further described why this situation occurs:

If the Ministry of Health gets into a fight against Misoprostol they are “cutting the neck.” It’s a political theme. That’s why there are twenty webpages and they all function well. They have always known about them. There is a double standard, we’re cynics, hypocrites, liars, we know what’s the reality. If we apply the law and arrest those who use and sell...they would fill the jails. And it’s a legal problem. Leave it, don’t touch it. If it’s not published, nobody wants to show what’s happening, that we have a double standard. Obviously they are not going to do anything in relation to Misoprostol because it saves a tremendous amount of money (Author Interview with Molina, January 13, 2017).

For government officials, attempting to prosecute the black market would be “cutting the neck,” because Misoprostol has been very influential in reducing Chile’s significant maternal mortality rate, decreasing cases of abortion-related complications, and saving the government money by shutting down septic care units. To prosecute the sellers of this black market, thereby reducing the supply and presence of these medications, would be contrary to both government bureaucrats’ professional norms, and their interests.

Hypothesis 3 (alternative hypothesis): Lack of Regulation Based on a Lack of Information About the Market, and a Lack of Resources to Address it

The final (and alternative) hypothesis for why there is a lack of regulation of the black market for abortion in Chile is that the government and the PDI lack the capacity to address this problem. Scholars argue that the relationship between informal and black markets is always in inevitable conflict, as the purpose of a state is to assume a monopoly of authority within a territory, while the purpose of informal or black markets is to avoid or undermine the state’s authority. Although the relationship between state strength and capacity is complex, in general, “the weaker the state, the greater the likelihood of an economy being able to escape its grasp” (Centeno and Portes 2006, 29).

In the scenario of the regulation of the black market for Misoprostol in Chile, a lack of state capacity would look like the PDI not having the information or the resources to investigate the presence of the three types of black markets. With the traditional black market, there could be difficulty in regulating the sellers because the government either does not have the resources or the information to do so. However, although there is some asymmetry in information within this black market, everyone knows how to access it, and who to call or email to get this information, which assumes that a specialized agency like the Cybercrime Brigade would be able to do so as well if they chose to act. In regards to this claim, Dr. Dominique Truan commented:

There are few prosecutions of Misoprostol. It's very available and it's very easy to buy because there are a lot of phone numbers. And it's not very prosecuted for the people who sell it... Maybe the government is more interested in stopping drugs. But I have the opinion that because it's so easy to get, that there isn't much prosecution (Author Interview with Truan, January 30, 2017).

Although it may be difficult to investigate this black market, there is a significant amount of visibility of the transactions that take place within it. From Bárbara León's comments that the Cybercrime Brigade only acts when they receive a denouncement, it appears that the government may have the capacity to intervene and regulate this market, but that it chooses to allow it to exist in some capacity (Aborto Express 2016).

In regards to the parallel black market for Misoprostol in Chile, it is possible that the Chilean government could have difficulties in stopping the entrance of these packages of Misoprostol, sent from organizations such as Women on Web and Women Help Women, if the postal service were not looking for them. Nicolas Perry stated:

You could send it from Holland and it wouldn't be detected unless border patrol was looking for it. People could buy boxes in a foreign country and bring it in without any

problem...So it's hard to regulate it if you don't know where it's coming from, who is buying it (Author Interview with Perry, January 18, 2017).

However, in the case of Women on Web in Brazil, the Brazilian government called for customs officials to investigate all packages from Women on Web, and these agents were able to stop their entrance into Brazil, leading Women on Web to cease sending them altogether (<https://www.womenonweb.org/> 2017). As in general, Chile's government is considered to have a greater capacity than Brazil's, one would expect that if the Chilean government decided to act, it would be able to suspend the entrance of packages from these organizations as well. Consequently, one would conclude that a lack of capacity is not the main reason for why there are low levels of regulation of the black market.

In regards to the third type of black market, as stated above, it would be difficult to regulate the private market for abortions in Chile. However, there also appears to be a norm that it would be unexpected for a doctor in these hospitals to be prosecuted for providing an abortion, which is described by social worker, Luis Rodriguez: "They say that it's a crime, and that it has to be punished like a crime, but here there is an absolute idea that it would be unlikely for a doctor to be punished or jailed for an abortion... Everyone knows that there's this reality, like corruption" (Author Interview with Rodriguez, January 12, 2017).

Although a lack of capacity or interest may play a role in why there are low levels of regulation of the black market for abortion in Chile, there are clearly areas of the market where the government does have the capacity and the information to intervene, but chooses instead to wait for someone else to denounce these sellers, or to ignore the problem entirely. In relation to this phenomenon, Perry comments:

Nobody wants to ask about it or take charge. Because to ask and find it generates a responsibility that's big. To find the problem and the source and confront it isn't hard, but I don't think the government wants to take the responsibility to regulate it (Author Interview with Perry, January 18, 2017).

This comment exemplifies the “*política del avestruz*,” because it acknowledges that government officials do not want to see the problem of the black market, because it would require action and confrontation, which is partially against their political interests. As a result, the alternative hypothesis of a lack of capacity to regulate the black market for medical abortion in Chile may be able to explain part of the reason why there are lower levels of government regulation than one would expect, but it is not the only reason why there is almost complete impunity for this black market. In order to fully explain these low levels of regulation, the hypothesis of bureaucratic norms must also be entertained, as it plays an important role in explaining this Chilean phenomenon.

Conclusion:

In this chapter, I responded to the questions: why has the government been unable or unwilling to regulate the black market for abortion in Chile, and what motivates government officials to engage in a policy of weak regulation of the black market? In answering these questions, I examined three different hypotheses for why there is weak, government regulation of the black market, and provided evidence for the claim that this low level of regulation is based on the contributions that the presence of the market has made towards women's health. This hypothesis adds to theories and literature about the reasons why governments choose to not stop illegal activity when they have the opportunity to do so, which could potentially extend beyond the area of the black market for medical abortion, and provide theories for why governments do

not regulate other types of markets or illegal activities. In the next chapter, I seek to answer another important question related to Chile's black market for medical abortion: In a situation where there is a lack of formal, government regulation of an illegal activity, how do other actors step in to informally regulate this practice, and how has this informal regulation occurred in the case of the black market for abortion in Chile?

CHAPTER 6: THE INFORMAL REGULATION OF THE BLACK MARKET FOR MEDICAL ABORTION IN CHILE

The past few chapters have described how the black market for abortion in Chile is characterized by a lack of formal, governmental regulation. Although there is little formal regulation of this market, to fill this vacuum, a variety of NGOs have emerged with the mission of providing a form of informal regulation. Because the government is unable to take on the role of “regulator” of this illegal space, and because the existence of an illegal space is also frequently characterized by potential dangers to those that seek to access it, these NGOs have taken on the role of informal regulators through a variety of different mechanisms. In this scenario, I define informal regulation as the interference of non-state actors within a market, through a variety of different mechanisms, with the efforts of trying to make this market function more safely and effectively for the people who try to access it.

In this chapter, I seek to answer the questions: how do NGOs informally regulate the black market, why did NGOs decide to take on the role of informally regulating the black market for Misoprostol in Chile, and how does this informal regulation function? In answering these questions, I first outline the dangers of an unregulated black market for Misoprostol in Chile, which prompted NGOs to form or expand their missions to seek to regulate these unregulated spaces. I next analyze literature about informal regulation, and the mechanisms that NGOs can use to influence behavior, in the efforts of situating the informal regulation of the black market for Misoprostol within this wider body of knowledge. I then use the literature about NGOs’ resources to describe the three mechanisms that Chilean NGOs have used to attempt to provide an informal regulation of this market: regulation through scientific information, regulation through exposure of sellers, doctors, and clinics, and regulation through price reduction of the

medication. Within this analysis, I also highlight the work of two NGOs, Línea Aborto Libre and Con las Amigas y en la Casa, that actively attempt to influence the black market by using these mechanisms. The purpose of this chapter is to add complexity to our understanding about how black markets function in the face of a lack of formal regulation, and to our knowledge about the circumstances under which non-governmental actors move in to provide informal regulation. This chapter also seeks to add new insights to theories about informal regulation, as abortion is generally not studied within this context.

Dangers of an Unregulated Black Market in Chile

Although the black market for Misoprostol in Chile has served to provide many women with access to this medication, there are many dangerous aspects of an unregulated market that are defined by asymmetries in information. There are four main risks of an unregulated black market for abortion in Chile: the presence of fake pills, the proliferation of false information about the use of the drug, the existence of unsafe spaces where women may experience violence, and the inflation of the cost of Misoprostol. In the following sections, I will address how informal regulation is used to mitigate each of these dangers.

The first danger caused by a lack of regulation is the presence of fake pills in the black market. As there are a large number of online websites that sell Misoprostol, it is very difficult to control for the quality of the medication. Women are forced to pay a high price for this medication on the black market for a quality that is not guaranteed. Angel Erpel of the feminist organization Línea Aborto Libre comments on this danger:

The fake pills are the first danger of the black market. This happens a lot, and it's awful. That's a woman's biggest fear. Because there are many offers, but women are afraid that they are fake (Author Interview with Erpel, January 25, 2017).

Línea Aborto Libre's manual, *Línea Aborto Chile: El Manual*, details the use of Misoprostol for inducing abortions, and recounts women's experiences with the black market. In the case of the first danger of the black market, women are often sold pills that are not actually Misoprostol, and instead are other drugs like aspirin. In other cases, women may request the medication through the mail, but either receive an empty box, or pay for the medication but never receive it. One testimony from *Línea Aborto Libre: El Manual* recounts: "I bought them through the Internet and they tricked me, they were fake" (Línea Aborto Chile: El Manual 2012).

Apart from losing money and having to contact another supplier for the medication, the danger of receiving fake pills is that it may extend the amount of time that a woman is forced to wait before she can abort. Misoprostol is safest and most effective when used up to the first twelve weeks of pregnancy. After twelve weeks, the risk of complications increases greatly, and the dosage of Misoprostol may need to be increased (Gómez 2015, 5). Consequently, it is recommended that after twelve weeks, women should only use Misoprostol for abortion in the presence of medical professionals (Línea Aborto Libre Manual). However, if a woman is sent fake pills, she may need to wait for weeks until a new supply arrives, which could put her life in danger. Casas and Vivaldi recounted a case where one woman was sold fake pills and had to wait for four weeks until a new box of pills arrived, pushing her pregnancy to fifteen weeks. As this case was a later pregnancy, the supplier sold her a dosage that was much too high, and after consulting a doctor, she was told that the dosage could have killed her (Casas and Vivaldi 2014, 74).

The second danger of the black market is that within this market there is a proliferation of incorrect information and instructions about the use of Misoprostol. One of the elements of incorrect information is that some sellers tell women that they either need to use too many or too

few pills to abort. FLAGSOG reports that nine out of ten women successfully abort using twelve pills (which is the recommended dosage and does not require medical attention afterwards). However, many vendors sell women four to eight pills, informing them that this is the correct dosage. In reality, a dose of four pills is considered by experts as an “unsafe abortion,” as it is unlikely that a woman will fully abort through this small number of pills, and a dose of eight pills often requires medical attention following the abortion (subjecting women to legal dangers), as the abortions are often not fully complete (Línea Aborto Chile: El Manual 2012). On the other hand, if a woman is given too high a dosage of Misoprostol, this can also put her life in danger. In relation to the danger of inaccurate information about the correct dosage of Misoprostol, Angela Erpel commented: “In our manual, we have cases of women who had abortions and didn’t know how to do it. They were informed by the seller to take two pills, to take it vaginally, and to lift their legs” (Author Interview with Erpel, January 25, 2017).

There are many cases of Misoprostol sellers telling women absurd instructions about physical actions that they need to do after taking Misoprostol to attain an abortion, such as lifting their legs above their head, not eating, or doing a variety of different exercises (Author Interview with Anonymous, February 14, 2017). However, the bigger danger for Chilean women (in terms of future repercussions) is when they are instructed to take the medication vaginally instead of orally. Although this method is equally as effective as the oral method, if a woman has taken Misoprostol vaginally and needs to go to the hospital for abortion-related complications within four days of taking the pills, the remains of the medication will still be detectable, and she could be prosecuted. In contrast, it is not possible to detect Misoprostol if it has been taken orally (Manual Línea Aborto Libre, 23). Consequently, Línea Aborto Libre only instructs women on

taking Misoprostol orally, in the efforts to mitigate the legal risk of denouncement (Author Interview with Erpel, January 25, 2017).

The documentary, *La Línea del Aborto*, shows a clip of an employee from the hotline contacting a male seller of Misoprostol, and asking him about instructions for taking the drug. In the clip, the seller repeatedly tells her that four pills are the correct dosage, and that she should take the pills vaginally. When the employee asks the seller about the possibility that doctors could discover the remains of the medication if she has abortion-related complications, he tells her that she should wait three days with the infection before going to the doctor- an answer that if followed would put a woman's life at risk (Rist and Chartier & Lopez Escrivá, 2016). From these interviews and first-hand accounts, it is clear that in many cases, the sellers of Misoprostol on the traditional black market are ill-informed about the correct usage of the medication, thereby putting Chilean women's lives at risk.

The third danger of the black market for Misoprostol is the creation of unsafe spaces where women may be exposed to additional harm. As the sale of Misoprostol is an illegal transaction, women are put in a vulnerable position where their safety may be placed in jeopardy. I define these unsafe spaces as areas where women may be exposed to physical or psychological harm in relation to their purchase or use of Misoprostol. These unsafe spaces can include both the interactions between women and the sellers of Misoprostol within the black market, and the hospitals or clinics where they may seek care for abortion-related complications. In these hospitals, women may be exposed to physical or psychological danger, as they may be forced to testify against themselves before receiving care, or may be the target of psychological abuse from their nurses or doctors (which will be described in greater detail below). In relation to the

first unsafe space (within the black market itself), Maria Jose, member of the feminist collective, Con las Amigas y en la Casa, stated:

It's just a business, and with all of the risks that come with illegality. It's almost like the drug market. Women are very vulnerable and could receive sexual or psychological violence (Author Interview with José, January 12, 2017).

Casas and Vivaldi echoed this sentiment, and recounted how in one of their interviews with a Chilean healthcare provider who advises his patients about the use of Misoprostol, the provider told them that three of his patients had been asked for sex in exchange for receiving an abortion (Casas and Vivaldi 2014, 74). From these accounts, it appears that within the unregulated black market for abortion in Chile, women may experience damaging physical and psychological violence. Moreover, the illegality of Misoprostol creates a second unsafe space where women may experience this type of violence: within the hospitals and clinics where they seek treatment for abortion-related complications.

Although under Article 342 of Chile's Penal Code it is illegal for a doctor to force women, who arrive at a hospital seeking care for abortion-related complications, to confess to inducing their abortions, there are still many cases where healthcare providers have forced women to confess, or tricked them into confessing because these women did not know their rights (Ord A15 Número 1404, 2014). *Women Behind Bars'* report on abortion prosecutions found that in their court statements, many women complained about being badly treated by healthcare professionals. Furthermore, this report found that these complaints were not isolated cases, and in fact, were made in all of the Chilean cities where they conducted their research: Santiago, Arica, Valparaíso, and Temuco. In these cases, healthcare professionals played a variety of roles in this physiological ill-treatment of these women, from forcing women to

confess and telling them that they would not receive treatment until they did, to chastising and shaming them for their abortions, to arguing vehemently that their patients had abortions as opposed to miscarriages (although all of these actions violate doctor-patient confidentiality) (Women Behind Bars 1998, 54-55). In one extreme case, two women in Santiago were beaten by a healthcare professional to force their confessions (Casas-Becerra 1997, 34).

The consequences of this ill-treatment and abuse are not only the physical and psychological damage that these women receive, but also the delay in treatment that results from women's fear of mistreatment and prosecution within hospital settings. *Women Behind Bars* reports that this fear can cause a variety of dangerous and life-threatening behaviors from delays in treatment, to flight from hospitals, to suicide (Women Behind Bars 1998, 53). Furthermore, this danger of the black market also highlights the inequality intrinsic to access to abortion in Chile, as in both the Casas-Becerra study and the *Women Behind Bars* study, all of the denouncements came from public hospitals, and all of the women who were reported were poor, and largely could not or did not know how to defend their rights (Women Behind Bars 1998, 52; Casas Becerra 1997, 33). Therefore, the creation of unsafe spaces, and the harms that this produces, is a third danger and by-product of the black market for abortion, and the illegality of this practice in Chile.

The final danger of an unregulated black market for abortion in Chile is the exorbitant price of abortions. Casas and Vivaldi report that Chile's abortion ban has fueled a demand in the market for abortions, which healthcare professionals and black market sellers have moved in to fill. Due to this large demand, these actors are able to charge large sums of money for abortions, in some cases up to five thousand dollars. In one case, a doctor forced a woman to pay extra money for her abortion after learning that she was the daughter of a wealthy public figure. As

abortion is illegal, women are unable to report abuse by healthcare providers or medical professionals, exacerbating their state of vulnerability. Casas and Vivaldi argue that in this sense “illegality makes for good business” (Casas and Vivaldi 2014, 73). This illegality makes the black market for abortion a very attractive market for the male sellers who dominate it, as they can earn around 500% profit by charging a high price for the medications that are oftentimes fake, or are not a complete dosage (Rist and Chartier & Lopez Escrivá, 2016). The higher the price of Misoprostol, the more inaccessible abortion is for poor Chilean women, leading to an increased risk that they will resort to dangerous and life-threatening methods to induce their abortions.

Having described the four main dangers of an unregulated market for abortion in Chile, I will now conduct a literature review of informal regulation, and the mechanisms that NGOs use to influence behavior. This literature review will provide theories about NGOs’ tools, which will be incorporated into the next section about the mechanisms that Chilean NGOs have used to respond to the dangers that exist within the black market for medical abortion in Chile.

Literature Review of NGOs’ Mechanisms of Influence

NGOs have a variety of mechanisms that they use to influence behavior. The two main mechanisms that scholars argue NGOs use to impact behavior are issue framing and agenda setting, and information provision. In the case of the black market for medical abortion, although Chilean NGOs do not use issue framing or agenda setting to influence behaviors in the black market, they do engage in a process of information provision. Furthermore, these NGOs also use a third mechanism, which is generally not viewed as part of NGOs’ resources, which is the manipulation of the market through flooding it with Misoprostol, thereby reducing the cost of the

drug. This activity can be viewed as another form of information provision because it changes the signals within the market about the price of the medication, thereby encouraging sellers to reduce their price as well. This section will outline the literary debate about NGOs' mechanisms of influencing behaviors, highlighting current theories about the three mechanisms that will be described in greater detail below.

The first mechanism that scholars argue NGOs use to impact behavior is issue framing and agenda setting. Issue framing is the process whereby actors "render events or occurrences meaningful," thereby strategically interpreting events to gain support for a particular issue (Snow et al. 1986, 464). NGOs use framing to mobilize a broad base of support for a movement or objective, and attempt to package an issue in a way that resonates with a large sector of the population (Jutta 2007, 22). For example, in the case of the antipersonnel landmine ban within the UN, NGOs were able to take the military issue of antipersonnel landmines (APLs), and publicize the issue with a humanitarian focus, thereby inciting outrage within the international community about the human toll of these weapons (Rutherford 2000, 80). NGOs are also often able to use issue framing to influence agenda setting. Schattschneider argues that "some issues are organized into politics, while others are organized out," meaning that one of NGOs' mechanisms of influence is through putting an issue on the political agenda, which normally would not be included (Schattschneider 1960, 8). For example, in the case of APLs, NGOs were able to publicize this issue, gaining attention from the public, thereby putting the issue of APLs on the international agenda (Rutherford 2000, 79).

However, although issue framing and agenda setting are important mechanisms that NGOs use to guide behaviors, these resources were not used by Chilean NGOs in the case of the informal regulation of the black market for abortion in Chile. The mechanisms of issue framing

and agenda setting are more often used to influence political debate and the behaviors of politicians, whereas Chilean NGOs were attempting to influence the behaviors of non-state actors within the black market for Misoprostol. Consequently, the mechanisms that these NGOs used in this informal regulation fall under the second category of NGOs' resources: information provision. NGOs are often able to engage in information provision because they can provide expertise on a particular topic, and can take on the role of informal monitor of a certain actor's behaviors. Scholars have argued that "the ultimate innate resource of NGOs is their expertise" (Joachim 2007, 36). NGOs can provide a variety of different information about issues, such as scientific knowledge, which is viewed as credible and reliable, as a way of holding actors accountable (Joachim 2007, 36). NGOs can also take on a form of information provision which involves "naming and shaming," whereby they "informally" regulate actors through providing information to the public through public disclosures of these actors' behaviors (Kathura 2006, 404).

For example, in the case of polluting industries in India, NGOs and the press have acted as "informal regulators" in cases where formal regulation is weak or non-existent, through a variety of forms such as information provision. Kathuria found that in India, the press successfully acted as an informal regulator of pollution by publishing articles about polluters' emission levels and public interest cases, thereby providing the public with information about their activities, in the efforts to hold them accountable (Kathura 2006, 404). NGOs in Chile have also used this form of information provision as a way of informally regulating the black market for Misoprostol. Chilean NGOs use the mechanisms of first providing women with information about the correct use of Misoprostol, and second, encouraging women to "name and shame" vendors, doctors, and hospitals that have treated them badly. However, Chilean NGOs use this

method of information provision as informal regulation differently than the cases described above, as their goal is to make an activity safer and more effective for the women who attempt to access it, whereas NGOs typically use information provision to influence industries or policymakers to change their behaviors.

The third type of mechanism of information provision that is not described in literature about the resources that NGOs use to influence behavior, but is an important tool of Chilean NGOs, is flooding the market with Misoprostol to reduce the price of the medication. This third mechanism, which will be described in greater detail below, is influential within the scholarly debate about the ways in which NGOs can have an impact on behaviors because it assumes a different, more active type of role for NGOs. This third type of mechanism could also be present in other circumstances outside of the ones described in this thesis. Having engaged in the scholarly debate about NGOs' mechanisms for shaping behaviors, this thesis will next describe and analyze the three types of mechanisms of information provision that NGOs have used to informally regulate the black market for Misoprostol in Chile: regulation through information, exposure, and price reduction.

NGOs' Three Mechanisms of Informal Regulation

From the four dangers of an unregulated market described above, it is clear that women who attempt to access this black market may be exposed to a variety of harms due to the illegal status of this exchange. As seen in the last chapter, the Chilean government is unable and unwilling to regulate this market, or mitigate the asymmetries of information and dangers that characterize its presence in Chile. Consequently, NGOs have developed three mechanisms,

which can all be characterized as “information provision,” in the efforts to mitigate some of the dangers of this black market, and make it function in a manner that is more effective and secure.

Regulating the market through scientific information

The first mechanism that NGOs use to informally regulate the black market is the provision of accurate, scientific information to women who wish to access this market. In the case of the second danger, the prevalence of incorrect information and instructions about the use of Misoprostol, and the medication’s illegal status, mean that it is unlikely that the Ministry of Health would formally regulate this market by proliferating information to the Chilean population about how and when to take Misoprostol, and what to do if complications arise. As a result, two Chilean NGOs, Línea Aborto Libre and Con las Amigas y en la Casa, formed with the mission of accompanying women who want to abort using Misoprostol. These NGOs function by providing women with advice and scientific information throughout the process of aborting.

Although Línea Aborto Libre and Con las Amigas y en la Casa are the main NGOs that provide the service of informally regulating through information sharing, Women Help Women, Women on Web, and a variety of smaller organizations and campaigns such as Miso para Todas and Yo Decido also act as informal regulators of the black market by providing accurate and safe information about the use of Misoprostol to induce abortion.

Línea Aborto Libre was founded as an organization in 2012, and works through the collective *Lesbianas y Feministas* (Lesbians and Feminists). Línea Aborto Libre uses a variety of strategies to informally regulate the black market by providing accurate information to women who seek it: through their hotline, their creation and distribution of the Manual *Línea Aborto Chile: El Manual*, their social media presence (website, Facebook page, and twitter), and their

workshops (<http://infoabortochile.org/>, 2007). In 2012, Línea Aborto Libre emerged from Línea Aborto Chile, which began in 2009 in Concepción. Once Línea Aborto Libre separated from Línea Aborto Chile, it moved its headquarters to Santiago, although it also has an office in Iquique and a variety of “*compañeras*” in Valparaíso and Valdivia. Línea Aborto Libre functions through funding from the Safe Abortion Access Fund, although its employees are essentially volunteers (Author Interview with Erpel, January 25, 2017).

The first method that Línea Aborto Libre uses to informally regulate the black market for Misoprostol, through the provision of scientific information, is through their hotline. As Línea Aborto Libre’s employees and volunteers are part-time, its hotline functions from 8pm to 11pm, from Monday to Friday. One of Línea Aborto Libre’s future goals is to create an automatic answering system that would function twenty-four hours a day, so that women would be able to receive constant information and help (<http://infoabortochile.org/>, 2007). On average, the hotline receives 10-15 calls a day from women who want information about using Misoprostol, in addition to the numerous requests for information that they receive from email and Facebook. Additionally, Línea Aborto Libre also provides in-person meetings for more complicated cases. Línea Aborto Libre’s hotline helps to solve the second danger of the black market, the high amounts of fake information and lack of safe instructions about the use of Misoprostol, by providing women with personal care and answers to their questions throughout their abortion process as a form of accompaniment. In order for this NGO to be able to function legally, it does not provide women with Misoprostol or any other abortion-inducing medications (Author Interview with Erpel, January 25, 2017). Rather, Línea Aborto Libre follows a strict protocol, and only shares information with women above the age of eighteen: “We don’t say, ‘Sophia you

have to do this...' we say, 'women have aborted in the following ways...'" (Author Interview with Erpel, January 25, 2017).

The second way that Línea Aborto Libre helps to mitigate the second danger of the black market is through their manual, *Línea Aborto Chile: El Manual*. Línea Aborto Libre released their manual in 2012, basing it off of an Argentine NGO's (Lesbianas y Feministas por la Descriminalización del Aborto en Argentina) manual, *Todo lo que querés saber sobre cómo hacerse un aborto con pastillas* (Everything that you want to know about how to do an abortion with pills), but adapting it to Chile's political and cultural context (Línea Aborto Chile: El Manual 2012, 2). Línea Aborto Libre initially printed 1,000 copies of their manual, and made it available for free through their website. The manual includes four chapters: the legality of abortion in Chile, how to abort using Misoprostol, testimonies from women who have aborted using Misoprostol, and the depenalization of abortion in Chile. Línea Aborto Libre's goal in creating this manual was: "To bring information to those women that don't have easy access to the internet, many times don't have enough money to make a phone call, or that require more detailed information about how to abort with pills" (Línea Aborto Chile: El Manual 2012, 6).

In creating this manual, Línea Aborto Libre has taken a step in informally regulating the black market by providing clear, scientific information about how Misoprostol should be used, and what the pills should look like, thereby correcting many of the misunderstandings and falsehoods that surround this illegal context. This action is a form of informal regulation because it attempts to make the black market for Misoprostol function more effectively by providing women with the necessary information to be able to determine that the products that they are receiving are not fake. This black market is characterized by asymmetries in information, which Línea Aborto Libre attempts to correct by ensuring that women are more informed.

The final way that Línea Aborto Libre provides information to Chilean women is through their social media presence and workshops. Línea Aborto Libre manages a Facebook page, website, and twitter where it keeps women updated about its workshops, provides them with accurate information about how to access the NGO, posts articles and updates about the decriminalization of therapeutic abortion in Chile, and provides a space for women to directly contact them to ask for advice or help. In 2014, Línea Aborto Libre also began a public workshop series in a variety of cities throughout Chile, with topics such as “sexual health and safe abortions.” These workshops are another way that Línea Aborto Libre provides information about Misoprostol and about women’s interactions with the black market to the general public, as a way of combatting the black market’s spread of false information (<http://infoabortochile.org/>, 2007). Through their hotline, manual, and media presence, Línea Aborto Libre is able to informally regulate the black market for Misoprostol by mitigating the danger of false information.

The second Chilean NGO that works to informally regulate the black market through information is Con las Amigas y en la Casa. Con las Amigas y en la Casa is a feminist network that functions through email and Facebook, and accompanies women who want to abort using Misoprostol. María Jose, an employee of Con las Amigas y en la Casa stated: “We provide information about how to conduct abortions safely and freely...this network emerged in a context where abortion is prohibited in all circumstances, and with the need to face the illegal market for Misoprostol, and to provide information and accompaniment for women who decide to abort” (Author Interview with José, January 12, 2017).

This NGO formed as a way of combatting the dangers of the black market for Misoprostol through providing accurate information to women about the use of Misoprostol.

There are twenty women who work for Con las Amigas y en la Casa. They receive about twenty emails a day, and between September and January, they completed around 1,000 abortion accompaniments (Author Interview with José, January 12, 2017). Con las Amigas y en la Casa also runs an active Facebook page where they post about their work. Additionally, in March, they held the “*Escuela para mujeres acompañantes de abortos con pastillas*” (School for female accompaniments of abortions with pills), for women throughout Chile who wanted to learn how to help other women abort using Misoprostol, or who wanted to start their own feminist collectives, as a way of spreading knowledge about how to safely abort with medications (Facebook page Con las amigas y en la Casa, 2017). Through their accompaniment and “school,” they are able to disseminate information to women about the correct use of Misoprostol, thereby informally regulating and monitoring the information that emerges from the black market.

There are a few smaller Chilean websites and campaigns, such as yo decido (I decide) that also work to inform women about the correct use of Misoprostol. Additionally, international NGOs, like Women Help Women and Women on Web, have websites that contain similar instructions, testimonies, and FAQs.

Basically, we provide information and we accompany women. What we do is difficult especially with the parallel market, as women write us with questions because the seller gave them fake instructions or fake drugs. Or if the drugs were real, they gave bad information so the drug didn't work (Author Interview with Anonymous, February 14, 2017).

As a whole, this group of Chilean NGOs, Chilean websites, and international organizations are able to work together to reduce the black market's risks, through the mechanisms of the provision of accurate, scientific information about the use of Misoprostol. These collectives provide a role and service that would be unattainable for the Chilean

government to deliver, and through information are able to improve the safety and effectiveness of this activity.

Regulating the market through exposure

The second mechanism that Chilean NGOs use to act as informal regulators of the black market for Misoprostol through information provision is by encouraging women to expose sellers and doctors who have mistreated them. In this way, these NGOs are able to tackle two other dangers of the black market: the existence of false pills, and the presence of unsafe spaces where women who seek Misoprostol or treatment may be exposed to physical or psychological harm. Línea Aborto Libre is the main NGO that does this work of publishing lists of places where women have been treated badly, as one of its employee describes: “On our webpage, we tell women to denounce all of the fake sellers and clinics that treat them badly, where they were discriminated against, or where they were denounced... We also tell women through the webpage to publish fake advertisements” (Author Interview with Erpel, January 25, 2017).

Through using social media, (their webpage and Facebook account), Línea Aborto Libre creates an online space where women can share their experiences with the black market, and with seeking care for abortion-related complications. Through this space, women can warn other women about clinics and doctors who have either treated them badly, or denounced them to the police, which is one of Chilean women’s largest fears when they seek care. In one case, the documentary *La Línea del Aborto* recounted a situation where a woman was told by a seller to take Misoprostol vaginally, and experienced complications:

My pregnancy was also advanced, so it was complicated. I was bleeding, I had a fever, and I was alone. And I went to a hospital and the doctor asked me a lot of questions.

Before giving me pills or saving my life they called the police and I was arrested (Rist and Chartier & Lopez Escrivá, 2016).

Through the creation of a forum that exposes hospitals and doctors, such as the one described above, Línea Aborto Libre helps to ensure that women get the care that they need, and feel comfortable seeking help when their lives are at risk. To further ensure that women are not ill-treated if they go to a hospital, Línea Aborto Libre's manual has a chapter dedicated to detailing a woman's rights to care, highlighting activities that are classified as "medical violence," such as forcing a woman to confess if she has had an abortion, refusing to provide care to a sick woman, or insulting her, and instructing women on how to expose medical violence (Línea Aborto Chile: El Manual 2012, 25). In this way, women can be more informed about their rights when they visit a hospital, and will be more able to protect themselves from ill-treatment or denouncements in situations of emergency.

Línea Aborto Libre's online website and Facebook page also allow them to address the danger of the presence of fake medications and fake websites. As Misoprostol has become a more lucrative medication, there has been a proliferation of websites, some of them real, some not, claiming to sell the medication. As the use of Misoprostol for aborting is time-sensitive, it can be dangerous if a woman is sent fake pills, because she may have to wait two to three weeks to receive a new shipment, which may push her pregnancy past the twelve-week period where the use of Misoprostol is considered safest and most effective. To combat this risk, Línea Aborto Libre encourages women to expose fake webpages and sellers of fake medications:

It's called a *funa* when many people get together and denounce a person. When there is a fake seller we publish it on Facebook and on the webpage, it's the most that we can do. We tell women that they are the ones that have to do it, we can't expect the government to do anything (Author Interview with Erpel, January 25, 2017).

Through their “*funa*,” Línea Aborto Libre provides a space to warn other women about abuses that they have experienced, which is a service that would be difficult for the government to deliver. Although government agencies, such as the Ministry of Health, are able to instruct doctors and hospitals about their obligations to respect doctor-patient confidentiality, and encourage them not to report women who have aborted, it is unlikely that the Ministry of Health would publish a list of clinics that have denounced women or treated women badly who have aborted, as in many cases, they may not know or have proof that medical violence was perpetrated. Furthermore, as the sale of Misoprostol is illegal, it is even less likely that the government would know about or publish a list of sellers who sold women fake drugs (as women are legally unable to report these cases to the government without being charged for abortion). Consequently, the only way to regulate this market is through these informal forums provided by NGOs, such as Línea Aborto Libre, which act as sites of information provision by warning women about dangerous spaces that exist within the market.

Regulating the market through price reduction

Chilean NGOs’ final mechanism for informally regulating the black market for Misoprostol in Chile, through information provision, is through flooding the market to reduce the cost of the medication. The final danger of the black market for Misoprostol is the high price that sellers are able to charge because they are part of an illicit activity. As Maria Jose, employee of Con las Amigas y en La Casa stated:

It’s a very attractive market, run by men. Most that have no responsibility for selling the medications, they just do it to make money. So, they speculate with the prices of the medications. We’ve had cases where women have paid 400,000 pesos for a dose... for an abortion that isn’t even guaranteed because the sellers make no promises, so there are many cases of fake medications (Author Interview with José, January 12, 2017).

There are cases where men have charged 50,000 Chilean pesos (about \$80) for four pills of Misoprostol, which is only a third of the recommended dosage (Rist and Chartier & Lopez Escrivá, 2016). This price inflation can be dangerous for women who seek Misoprostol because for many Chileans, the black market is their only way to access the medication, and if they are unable to pay, they may be forced to resort to riskier methods of aborting. Angela Erpel of Línea Aborto Libre commented:

Access right now is the main barrier because now there is more information. The main risks are internet scams and the price. In some cases, it's very high. You can get Miso for \$30, and on the internet sometimes they sell it for \$500, which is a huge difference (Author Interview with Erpel, January 25, 2017).

As price inflation is one of the main risks of the black market for Misoprostol, international NGOs, such as Women Help Women and a few Chilean NGOs, have banded together to reduce the price of the medication on the black market. By providing Misoprostol to women for a fraction of the cost on the black market (Women on Web encourages women to pay from 70-90 euros for a complete dosage, although they provide the pills for free or for a reduced price if women are unable to pay), this action has forced sellers in the black market to reduce the price of their medications in response (<https://www.womenonweb.org/> 2017). Angela Erpel explains this phenomenon:

Now there are more offers through the internet, and there are many offers through feminist networks. Thanks to the feminist networks, the price of Misoprostol dropped. Before it was a minimum of two salaries, like \$500 for a dose, and it's not worth this, it's much cheaper. And before it was only men who sold it. So, the feminists mobilized because the medication is cheap in other Latin American countries with a prescription, and one can get it easily (Author Interview with Erpel, January 25, 2017).

By mobilizing to provide women with a greater access to this medication, national and international NGOs have successfully reduced the high price of the drug, thereby informally regulating the price on the black market, and ensuring that a larger portion of Chilean women can access medical abortions. By flooding the market with Misoprostol, NGOs use a form of information provision by changing the signals about the price of the drug. Through this final mechanism, these NGOs manipulate the black market in a way that is completely unavailable to government officials, thereby providing an informal service to the Chilean population.

Conclusion

In this chapter, I investigated the four main dangers of the presence of an unregulated black market in Chile, and I examined the three mechanisms that NGOs use to informally regulate this market: through providing scientific information about the market, creating a space for exposures, and reducing the price of the medication. In describing the work of these NGOs, I highlighted how each of these areas of informal regulation are services that the Chilean government is unable to provide to its population, based on the illegal characteristics of the black market, and how each of these services is essential to mitigating the risks of the black market for Misoprostol. Having described the ways in which NGOs' involvement in the black market for medical abortion in Chile can be understood as a type of informal regulation, in the face of the government's inability and disinterest in regulating this market, in the next chapter I conclude by describing how this thesis can be understood in relation to a broader literature about black markets, decisions to regulate or not regulate illegal activity, and theories about informal regulation of illegal spaces and activities. In this final chapter, I also provide a short overview of

the current status of the therapeutic abortion bill in Chile, and how if this bill were passed, it could affect the black market for Misoprostol and the regulation of this market.

CHAPTER 7: CONCLUSION

In this thesis, I have attempted to analyze the multidimensional aspects of the regulation of the black market for abortion in Chile. In making the argument that this black market exists in a space of formal and informal regulation, I have attempted to highlight the complexities within this market, and demonstrate that in this case, non-governmental actors have emerged to take on many of the roles that the government is either unable or unwilling to assume. To create a context for this argument, in Chapter 2, I described the history of abortion and abortion law in Latin America and the Caribbean, and in Chile. In Chapter 3, I outlined the structure of the black market for Misoprostol in Chile, and the functioning of this market. Having created a context for analyzing the regulation of this market, Chapter 4 examined the ways that the regulation of this black market actually occurs, and Chapter 5 created an argument for why the government is unable and unwilling to regulate the black market; this market saves the government lives and money. Finally, in Chapter 6, I examined the emergence of a variety of non-governmental actors that assume regulatory roles that are unavailable to the government, in the efforts to make this market function better (and more safely).

In this final, concluding chapter, I first seek to situate this thesis within a larger body of literature on informal regulation and government regulation to highlight the theoretical implications of my findings. I argue that this thesis contributes to academic discussions about these concepts, as the topic of the regulation of the black market for medical abortion is a little-studied phenomenon, which could provide insight into the functioning and regulation of other illegal markets, adding to pre-existing theories. I next describe the ways in which this thesis could be extended, areas of future research in this area, and potential limitations of this thesis. Finally, I highlight two other important aspects of reproductive health in Chile that are currently

being discussed within the government, and could have implications for the black market for abortion: the *Ley de Tres Causales* (therapeutic abortion bill), and sexual education reform.

Theoretical Implications

There are three main theoretical implications of this thesis: implications for theories about black markets, theories about government regulation, and theories about informal regulation. There is a large amount of research dedicated to the study of black markets, and to the reasons why these black markets form. Authors such as Portes and Castellanos and Yashar write about the emergence of black markets as being linked to economic crises and industrialization, and about the negative effects of these markets, such as the creation of gangs (Portes and Castellanos 1989; Yasar 2013). However, the black market for Misoprostol is a very different type of black market than the market for illegal drugs or unlicensed taxi drivers, as it involves a different variety of actors and motivations.

The government regulation of the black market for Misoprostol is different than the regulation of most illegal markets because in most cases, actors like governmental figures or NGOs would not want to make the illegal market more accessible for the people who attempt to access it. In the majority of cases of illegal activity, such as the sale of illegal drugs, there is the assumption that these markets are bad, or at least neutral. In contrast, although there is a strong divide surrounding opinions about the issue of abortion, there are also government officials who believe that the existence of the black market for Misoprostol serves an important, positive purpose, which essentially no bureaucrats would say about the market for cocaine or heroin. Although in some cases, government officials may become co-opted into illegal activity, allowing it to exist with little regulation, these officials would still not believe that the presence

of this illegal market had a positive effect on society. As a result, this illegal market takes on a distinct role in society from the role of most illegal markets, and therefore does not fit within the majority of literature about the influences of black markets on society, and the reasons why government officials may be unable or unwilling to regulate them. Because there is little in-depth research on this type of black market, this thesis works to expand our understanding of black markets, and our conception of the circumstances under which they emerge.

The second theoretical implication of this thesis is for theories about weak government regulation. Dominant theories, such as those proposed by Gill, argue that deficiencies in the regulation of black markets result from a lack of state capacity (Gill 2002). However, as I have argued, this situation is not the explanation for the Chilean case. The arguments in this thesis are closest to those proposed by Holland's theory of forbearance, as they also argue that government actors are responding to outside motivations when they purposefully decide to not regulate illegal activity. However, the arguments made in this thesis about bureaucratic incentives are also distinct from Holland's argument of forbearance, because she focuses on how bureaucrats decide to ignore illegal activity as a means of economic redistribution, with the purpose of gaining electoral support from poor populations (Holland 2016, 233-4).

However, in the case of the regulation of the black market for Misoprostol in Chile, there does not appear to be an electoral motivation for the lack of regulation, as neither Chilean women nor sellers in this black market have made the connection that this lack of regulation is a purposeful electoral tool, and therefore do not vote for politicians based on this factor.

Furthermore, in the case of the black market for Misoprostol, bureaucrats' incentives and motivations for not regulating this market are distinct from the bureaucrats' motivations within Holland's theory of forbearance. In the case of the black market for Misoprostol, bureaucrats are

influenced by both their bureaucratic norms and monetary incentives (reduced hospital costs) to not enforce regulatory policies, which are clearly different incentives than those presented within Holland's model. This thesis adds new insights to theories, such as Holland's, because it demonstrates how government officials may also act in response to monetary incentives, and in accordance with their bureaucratic norms, in their decisions to not regulate black markets. It is possible that these theories could also apply to other cases where government actors purposefully decide that not upholding a law is in their interest.

The final theoretical implication of this thesis is in the area of theories about informal regulation and NGOs' resources. As described in Chapter 6, the majority of the research on informal regulation focuses on cases of environmental regulation, and does not investigate the possibility of informal regulation in the instance of black markets. Consequently, this thesis can greatly add to literature about when, how, why, and by whom informal regulation takes place. Moreover, this thesis extends theories about NGOs' resources in influencing policies, particularly in the area of using NGOs' resources to flood the market for illegal medications, thereby reducing their price.

The majority of literature about the resources that NGOs have available to them focuses on their ability to use shaming, frame development and agenda setting, and transnational networks to influence policymakers or to act as informal regulators. However, the resource of flooding the market, as a type of information provision, is an activity that is generally viewed as part of the state's or suppliers' domain. In this case, we have seen that NGOs used this tool to influence vendors to reduce the price of their medications, thereby making it more accessible to poor women. This theory therefore adds a new type of resource to NGOs' arsenal, and it would be interesting to study if NGOs have used this resource in other situations as a means of

influence. Having described the theoretical implications of this thesis, I will now discuss potential areas for future research in this topic.

Areas of Future Research

As this topic, in the context of Chile, has largely been unstudied, there are many areas where this thesis could be extended, or other aspects of the black market that could be investigated, which was not possible given my limited month-long fieldwork and year-long thesis experience. The first area for future research of this topic would be in seeing if the arguments and theories expressed within this thesis could be extended to other countries and contexts in the world, to determine in what ways the Chilean case is similar and different to these other environments. In future research, it would be important to determine if this lack of government regulation of the black market is unique to Chile, or if it is a worldwide phenomenon, as one would assume that the introduction of Misoprostol in almost any country where abortion is restricted would lead to lower abortion-related complications and mortality rates. It would also be interesting to determine if informal regulation has emerged in other countries in response to strict abortion laws, although the Chilean case is likely one of the most extreme cases since abortion is not permitted under any circumstances. It is possible that the groups that act as informal regulators could also look different depending on the country where they are located and the history of that country, as Chile currently exists with relatively weak feminist networks and civil society organizations, following the Pinochet dictatorship. An interesting point of comparison could be examining the roles that NGOs are able to assume as regulators in countries, such as Chile, that have experienced harsh dictatorships. It would also be interesting to extend these theories to other types of black markets, potentially for other types of

medications, drugs, or illegal activities, to determine under what contexts governments are most strict on enforcing regulations, and in what circumstances NGOs tend to emerge to act as informal regulators of these markets.

Additionally, there are other aspects of the black market for Misoprostol in Chile that could be interesting to investigate, or further examine, for which my limited time in Chile did not allow. One of these aspects, which could be more of an anthropology-focused study, would be investigating more about how Misoprostol enters Chile through the black market, and about the types of actors who engage in these activities. Although there are a few interviews with Chilean men who bring Misoprostol into Chile from neighboring countries (such as in the documentary *La Línea del Aborto*), within the academic world, there is an overall lack of knowledge and uncertainty surrounding how Misoprostol enters Chile, and the process that interactions within this black market take. An interesting study could be to spend time in border cities, such as Talca, Peru, where a large portion of the Misoprostol that enters Chile comes from, and to conduct fieldwork among the people who run this black market. The purpose of this study would be to answer questions about how these transactions occur, how similar or different they are to other types of drug trading, and how these individuals conduct their operations, as a way of developing a better understanding of the culture surrounding this market, and the actors who are involved in this trade.

A second, more in-depth examination of the regulation of the black market could also occur within one of the NGOs that act as informal regulators of this market. It would be interesting to conduct fieldwork within one of these NGOs to learn more about the specifics of how they conduct informal regulation, the networks of NGOs to which they belong, and how their roles have evolved in response to the passage of different laws relating to reproductive

rights in Chile. As there are few in-depth studies of this kind about the black market, these investigations could serve to further shed light on this taboo topic, and influence policy to make the market safer for women who attempt to access it.

A final area of this topic that deserves future research involves some of the limitations of this thesis in studying the black market. Due to the short length of my fieldwork, there are many important actors that I was unable to interview. Two interviews that would have contributed greatly to my thesis were with Claudia Dides, the director of MILES Chile, an NGO that works to provide information and research about sexual and reproductive health in Chile and create legislative change (they have been particularly active in the debate over *la Ley de Tres Causales*), and with Anita Román Morra, the president of *el Colegio de Matronas de Chile* (the school of midwives in Chile). Many of my informants told me that these two actors were very important in Chile's reproductive health scene, and that they could provide different insights into the functioning of the black market, and the roles of different actors within this market.

The final limitation of this thesis was that I was unable to interview anyone from the PDI, such as from the Cybercrime Brigade or border patrol. Because I was unable to interview these actors, my thesis ended up shifting focus from investigating the exact mechanisms by which these actors attempted to regulate the market (and at what specific places the implementation of this regulation was more lax than one would expect), to the reasons why there is less regulation than expected and to informal actors' roles in this market. However, another study could trace out these mechanisms and interview these actors to better understand how this regulation (or lack thereof) functions, and how different governmental actors work together in attempting to regulate the black market. Having described the theoretical implications of this study, and areas for future research, I will now highlight how two initiatives that the government

is currently discussing could affect the black market for abortion in Chile: *la Ley de Tres Causales* and sexual education reform.

Future Abortion-Related Government Initiatives

La Ley de Tres Causales

There is currently a bill pending in the Chilean Senate called *la Ley de Tres Causales* that would seek to decriminalize abortion for therapeutic purposes. These therapeutic purposes include providing an abortion to save a woman's life, if the fetus is inviable (due to malformations that are incompatible with life), or if a woman has been raped (but only up to twelve weeks of pregnancy for women above the age of fourteen, and up to fourteen weeks for women below the age of fourteen) (YoApoyo3Causales Website, 2017). There are many advocates both for and against this bill. Surprisingly, some of the opponents of the bill include both pro-life and pro-choice advocates. Pro-life opponents argue that for the first cause, a doctor will always save a woman's life so it is unnecessary to put this cause into law, for the second, that doctors can make diagnostic errors and inaccurately proclaim a fetus to be inviable, and for the third, that rape is not enough of an excuse for an abortion, and that this cause could "open the door" to unrestricted abortions (Author Interview with Figueroa, January 19, 2017).

In contrast, pro-choice opponents cite very different reasons; they argue that the bill does not go far enough and that abortion should be allowed in all cases, and that the bill contains limitations that restrict a woman's ability to access necessary care. For the first cause, the phrase "present and future danger to a woman's health" was eliminated and replaced with only "present danger," meaning that doctors could still wait too long to provide women with necessary care. Furthermore, opponents argue that the third cause's gestational limitations could inhibit pregnant

adolescents from receiving care, because many women who are raped in Chile are below the age of eighteen, and do not realize that they are pregnant until it would be too late (legally) to get an abortion (Author Interview with Truan, January 30, 2017).

However, overall in Chile there is widespread support for the *Ley de Tres Causales*, as a survey found that 69% of the Chilean population supported this bill (with 5% registering no opinion), and that 87% of young Chileans were in favor of this project (Lezaeta and Marín, 2016). It is clear that there is a large amount of debate in Chile surrounding this controversial bill. However, the passage of this bill could not only affect women's access to reproductive healthcare, but it could also have implications for the black market for abortion as well: the topic of abortion could become less taboo, increasing the amount of information available about the black market, there could be improvements within the healthcare system for abortion care, updating care for black market-related abortion complications, and there could be lower levels of government regulation of the black market.

In Chile, up until recently the topic of reproductive health, and more specifically abortion, was infrequently discussed and was viewed as taboo. This societal view is evidenced by the fact that between 1990 and 2014, twenty projects were created with the purpose of decriminalizing therapeutic abortion, but none of these projects gained widespread support (Author Interview with Soto, January 25, 2017). However, with the generational shift, more young people are in support of reproductive health initiatives, allowing for the current initiative to gain traction. In a self-perpetuating cycle, the press surrounding the *Ley de Tres Causales* allows for a further de-stigmatization of abortion, and a democratization of information relating to abortion. Two women from the Ministry of Women and Gender Equity who helped to create the *Ley de Tres Causales* emphasized this point:

Ten years ago, abortion was taboo... there's a social evolution, with the governmental and presidential support from Bachelet. The form that it was presented and the discourse that was used has allowed us to have a conversation. We presented this law, knowing it was polemic, and we started by discussing people's fear and our own cultural reality, which has allowed us to have a discussion. It has created an opening, and a place where people can have a discussion (Author Interview with Anonymous, Ministry of Women and Gender Equity, January 26, 2017).

Consequently, as the law allows for more discussion about the topic of abortion, it also serves to create more information about processes related to abortion, including information about Misoprostol and the black market. As the presence of the law in the media has spurred more discussions about abortions, more women are beginning to ask about the black market, and about the use of Misoprostol. Dr. Ramiro describes the effect of these discussions:

Now there is more information about the quality of abortion. And I think the idea of Misoprostol and the depenalization of abortion have been democratized, and knowledge about reproductive health as well (Author Interview with Molina, January 13, 2017).

As a result, by democratizing information about abortion, the creation of the law has acted alongside some of the NGOs that provide informal regulation of the black market, by providing information about the presence and accessibility of Misoprostol. Even if this law does not pass, it has already affected the black market for Misoprostol by allowing the spread of information about abortions, and if the law does pass, this process will continue to increase the accessibility of information about abortion and the black market.

The second impact of the therapeutic abortion bill on the black market for abortion in Chile is that it may allow for an increase in the quality of care related to abortions, and abortion-related complications, although it is unlikely to increase the quantity of abortions performed in Chile. Although there are few therapeutic abortions currently performed in Chile, in relation to

the number of overall abortions that take place, the real impact of the law will be in forcing hospitals to update their techniques and improve their abortion-related care (Author Interview with Soto, January 25, 2017). Dr. Dominique Truan comments on some of the changes that would be made if this initiative were to pass:

There's a lot of work to do, because there are many concepts we're not accustomed to that will have to be implemented...there will be changes in techniques as the doctors aren't taught about performing abortions with forceps or aspiration. The theme of education will be very important (Author Interview with Truan, January 30, 2017).

There is an overall view in Chile that hospitals are very behind in abortion-related technique education, because medical schools have not been training doctors in these practices. Ministry of Health official, Eduardo Soto, argues that “we are behind thirty years because we still use D&C” and that there would need to be many improvements in hospitals if the law were passed, including education about the use of aspiration for abortions, the implementation of the use of Misoprostol in hospitals, and the use of accompaniment and advice-provision before abortions, which currently are not part of abortion care within the Chilean healthcare system (Author Interview with Soto, January 25, 2017). The Ministry of Health has been partnering with the Ministry of Women and Gender Equity on the technical aspects of the therapeutic abortion law, and in case the law passes, they are already planning for its implementation in 2018 (Author Interview with Soto, January 25, 2017).

Consequently, if this law passes, it would vastly improve the care that women can receive if they suffer from abortion-related complications from the black market, and it would have the secondary effect of further increasing the information about abortions that is available to doctors and to the general public. The passage of this law could also make the aspect of the black market, which is based on performing abortions illegally in private hospitals, safer, as women would be

provided with new, up to date medical care for their abortions. Finally, this law could also help to democratize the information that doctors are able to provide to their patients (even those who are not seeking abortion for therapeutic purposes) about obtaining abortions through some aspect of the black market, because this topic has become less taboo for both doctors and their patients to discuss.

The final potential impact of the passage of the therapeutic abortion law could be on the level of government regulation of the black market for abortion in Chile. Some doctors in Chile believe that the passage of the *Ley de Tres Causales* could lead to even less government regulation than beforehand. This phenomenon would be because the legalization of the use of Misoprostol in certain cases could normalize the medication, and make the PDI view the sale of this drug as less harmful; whereas currently there is still a view of uncertainty about the safety of the drug (although these views are not founded in research). Dr. Dominique Truan comments on this possible consequence of the law:

I think that Miso will still be used for non-therapeutic cases. The cases of rape maybe will go to the black market, and the first two will be treated in hospitals. Miso will keep being sold as “aborto libre.” I think they’ll prosecute even less the sellers, because it will be legal, there could be taxes but it wouldn’t be formally penalized (Author Interview with Truan, January 30, 2017).

The passage of the *Ley de Tres Causales* would have a limited impact on the number of abortions that are performed through the black market each year, but it could (and already has) impacted the amount of information that is provided about abortions, Misoprostol, and the black market, the level of treatment that women receive for abortions and abortion-related complications, and potentially, the amount of government regulation of the black market for Misoprostol. Although this government initiative may not have a large impact numbers-wise on

the black market for medical abortion, one initiative that could create important changes in this area is a law calling for increased sexual education in Chile.

Sexual education reform

Chile is highly lacking in the area of sexual education, as it is the last country in Latin America to incorporate a law on sexual education (UCh lanza primer curso de Educación Sexual...2017). This deficiency leads to increased rates of adolescent pregnancies, sexually transmitted diseases, domestic violence, child abuse, and school drop-out rates. Adolescent pregnancy is an emerging problem in Chile, and unwanted pregnancies are becoming a large issue, primarily due to adolescents' lack of knowledge about sexual and reproductive health. In the last five years, the number of adolescent abortions has significantly increased, and around one in every ten women who is hospitalized for abortion-related complications is under the age of twenty (Montenegro 2000).

During the 1970s, Chile institutionalized a sexual education program for the first time, but during the military dictatorship, this program was censored and removed from school curriculums. Following the return to democracy, the Ministry of Health attempted to implement a variety of other sexual education programs, such as Jornadas de Conversación sobre Afectividad y Seuxalidad (JOCAS). However, due to pressure from the Catholic Church and the conservative right, this initiative failed, as they felt that increased sexual education could lead to increased sexual promiscuity. In 2010, the government created law number 20.418, which established that “all people have the right to receive education, information, and orientation in the matters of the regulation of fertility in a clear, comprehensible, and in some cases, confidential form” and that all middle schools were required to provide sexual education (Salas

2016). However, a law detailing the implementation of law number 20.418, was not created until 2014. Furthermore, these laws have been largely ineffective because the creation and implementation of sexual education courses are the responsibility of the schools, not the government, and many teachers lack the capacity to create these courses. Moreover, schools oftentimes do not follow-through on this implementation (Salas 2016).

The main place where adolescents learn about sexual education is when they go to hospitals to get contraceptives. Dr. Dominique Truan comments on problems related to sexual education in Chile that:

The young kids are learning about sexuality and sex from porn. I'm a gynecologist and I work with adolescent girls and I've seen that nobody teaches them, and the parents know less than the kids. When there is sexual education in schools it's about sexual anatomy, and maybe about preventing sexual diseases and pregnancy. But about sexuality there is nothing (Author Interview with Truan, January 30, 2017).

Furthermore, in 2016, the Municipality of Santiago published a book called *100 Preguntas Sobre Sexualidad Adolescente* (100 Questions About Adolescent Sexuality). This book answered a variety of questions about sexual and reproductive health, including anal sex, contraceptives, and the morning after pill. However, conservative sectors of society were very opposed to this book, and a mayor from Santiago took the book out of circulation because he argued that anal sex did not exist (Author Interview with Troncoso, January 26, 2017).

However, there currently are a variety of initiatives that are attempting to address this disparity in sexual education in Chile. Doctor Ramiro Molina, a professor at la Universidad de Chile, is trying to allow Chileans to have greater access to sexual education by launching Chile's first, free, online sexual education course. One aspect of this program is a three-month course for students and the general public, and the other aspect is a five-month course for primary and

secondary school educators to teach them about sexual health, and about teaching sexual education to their students (UCh lanza primer curso de Educación Sexual...2017). The Ministry of Health is also working with the Ministry of Education to improve sexual education in Chile, and Ministry of Health officials, such as Dr. Paulina Troncoso, hope that the *Ley de Tres Causales* will create greater awareness about sexual education, and a higher societal demand for this right (Author Interview with Troncoso, January 26, 2017). If there were better sexual education courses in Chile, it is likely that the black market for medical abortion would not be as large as it is currently, and would be less-used as a last resort for women and adolescents.

Conclusion

Through this thesis, I have sought to illuminate the nuances of the black market for abortion in Chile, and the regulation of this market, which many Chileans and academics have purposefully ignored. The situation surrounding the regulation of this market is truly “la política del avestruz” because like ostriches, some Chilean officials purposefully bury their heads in the sand to ignore the presence of this market, and the harms that it may cause. Consequently, feminist NGOs have emerged to try and mitigate some of the dangers of this unregulated space, while acknowledging the many benefits that it can provide to women who are left without options. Hopefully, the government’s *Ley de Tres Causales* and sexual education courses will come to fruition and reduce the necessity for women’s reliance on the black market and feminist NGOs’ informal regulation. In Chile, there are many areas of sexual and reproductive health that either are biased against the poor, or simply are too inadequate to provide women with their basic rights to health. However, the Ministry of Health and Ministry of Women and Gender Equity are working to provide women with greater access to these services, and until all women

have access to affordable reproductive care in Chile, the black market for abortion will continue to exist as an alternative, under the watchful gaze of domestic and international NGOs.

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