Abortion Access in Colombia

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Bridge Sisters and Vitala Global

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EXECUTIVE SUMMARY

This analysis reviews the context and legal framework of abortion access in Colombia to understand its evolution, challenges, and current implementation status. The document starts by defining the demographics of young individuals, women, and other people who can become pregnant as the population of interest for this analysis. It first provides the current political, economic, and sociocultural context in which reproductive, and particularly, abortion rights have unfolded over the last three decades. Furthermore, it discusses how the political and economic situation of the country have created different barriers to digital literacy and internet access which is practically non-existent in rural areas.

Later, this document reviews the legal framework in which abortion was initially decriminalized in three circumstances by Constitutional Court Order C-355 in 2006 and later fully legalized by ruling C-055 in February, 2022. Furthermore, this section provides context on how the healthcare system works and how healthcare regulations have impacted women's ability to access services even when abortion is technically legal.

Additionally, the analysis takes into account the broader abortion rights movement in Latin America and its impact on the success of the national *Causa Justa's* campaign to remove abortion as a crime from the penal code.

This review has a special focus on five areas of interest (Bogotá, Cúcuta, Mitú, Popayán, and Soledad) where different stakeholders, including health providers and accompanists, were interviewed. This analysis is informed by their experiences and perspectives which shine a light on the gaps to achieve full access to the reproductive rights granted in the law.

CONTEXTUAL FRAMEWORK

The following chapter offers the contextual framework of Colombia. The first section provides relevant demographics that include specific data about women and other people who can become pregnant, young individuals, and ethnic groups. A second section, reviews the political context of this country, highlighting relevant aspects of the sexual and reproductive policies. A third section explores the economic context providing information on socioeconomic gaps and inequalities. Then, a sociocultural context of Colombia adds to the understanding of social practices, like religion and other conservative views on abortion and sexuality. Finally, the context of digital gaps in Colombia offers the state of internet access and other communication services.

Relevant Demographics

Colombia is a country in northwestern South America that borders the Caribbean Sea and Panama to the north, Venezuela and Brazil to the east, Ecuador and Peru to the south, and the Pacific Ocean to the west. It has a population of approximately 51.3 million, of which 7'149.540 live in its capital (Departamento Administrativo Nacional de Estadística 2018), Bogota (Knoema n.d.). For the purpose of this report, the following population groups are of interest:

Women and other people who can become pregnant: In Colombia, 51.2% of people identify as women. According to DANE , there are 23.3 million women in the country (Departamento Administrativo Nacional de Estadística n.d.). Unfortunately, official demographic data available on other people who can

become pregnant (such as transgender, nonbinary, and/or gender queer individuals) is limited. Despite current efforts to generate gender-sensitive studies of the LGTBIQ+ population, the Colombian national census does not include genders other than male and female (Cubillos Álzate, et al.2020a). The report "Situación de las personas trans en Colombia" (Situation of trans people in Colombia) explains the difficulty of gathering demographic information for the trans community, but estimates that transgender people represent approximately 0.05% of the country's total population (Dirección de Desarrollo Social, Subdirección de Género, Departamento Nacional de Planeación 2021).

According to the World Health Organization (WHO), the typical reproductive age for women is between 15 and 49 years, with several exceptions of girls who have been pregnant at the age of 10 (Herrera-Cuenca 2018). About 30.5% of Colombians who identify as women fall within this age range (Cubillos Álzate, et al. 2020a).

Young people in Colombia: According to the 2018 census, 18.5 million people in Colombia are between the ages of 10 and 29, making up 36% of the total population. Of that total, 2.2 million (11%) are Afro-descendant and 735,890 (3.9%) are Indigenous.

In addition, a substantial percentage of Venezuelans living in Colombia are under 18 years old. The Migration Venezuela Project of Semana S.A. published the "Migrant Childhood Report," which states that approximately 38% of the 1.7 million Venezuelan migrants in the country are under 18 years old. (Semana S.A. n.d.).

Finally, there are 12.7 million people between 14 and 28 years of age living in rural areas, of which 6.3 million are women. In other words, 24% of the total population of the country is a young person residing in a rural area (Departamento Administrativo Nacional de Estadística 2020).

Individuals living in rural areas: The National Administrative Department of Statistics (DANE) follows Law 731 of 2002 in defining "rural women" as women "who without distinction of any nature and regardless of where they live, their productive activity is directly related to the rural sector, even if such activity is not recognized by the State's information and measurement systems or is not remunerated" (Lara and García Rojas 2020). In short, the rural population's economy depends on agricultural work, meaning they typically live in geographically sparsely populated areas far from cities.

With 24% of the Colombian population living in rural areas, there can be significant social and economic gaps between urban and rural opportunities (Mohorte 2016). In Colombia, 12 million people live in remote areas with limited or no access to comprehensive healthcare, formal education, and digital technology. Of the rural population, 5.8 million (48.1%) are women. Also, according to the population pyramid in rural areas, more than a third of both women and men are under 20 years of age. This population group is mostly made up of children from 0 to 4 years of age, who represent 9.7% of the rural population (Lara and García Rojas 2020).

Illiterate population: It is also important to note that 5.4% of the total Colombian population is illiterate. This statistic highlights the social inequalities and economic disparities that underlie Colombia's severe digital gaps, which will be explained

later in the report (Matera 2021). For 2018, the rate of illiteracy among women was higher than that of men. In addition, the illiteracy rate between the ages of 5 and 14 was 93% and between 15 and 24 was 97.7% (Departamento Administrativo Nacional de Estadística 2020).

Population by culture and ethnicity: Colombia is a multi-ethnic country. Despite the genocide of the Colonial Era, 115 Indigenous groups resisted and remain in the territory. Today, they are still fighting for their lives, defending their territories, and protecting the nature around them. As of 2020, 4.4% of the Colombian population identifies as Indigenous (Valencia Otava and Obispo González 2020).

According to the DANE 2018 census, the self-recognized Indigenous population is 1'905,617, of which 50.1% are women, adolescents, and girls (Cubillos Álzate, et al. 2020b). The departments with the largest Indigenous presence are La Guajira, Cauca, and Nariño.

In addition, Afro-Colombians represent about 11% of the country's total population: according to DANE, 4'671,160 people self-identify as Afro-Colombian, of which 51.2% are women, adolescents, and girls (Kanem 2020) The departments with the largest Afro-Colombian population are Valle del Cauca, Choco, Bolivar, Antioquia, and Cauca (Instituto Caro y Cuervo 2019).

Valle del Cauca and Quibdo have the largest Afro-descendant populations in the country. For example, Cali is the city with the second largest number of Afro-descendants in Latin America, after Salvador de Bahia in Brazil. In the capital of Valle del Cauca lives 27% of the total black population of Colombia, which is also 52% of the total population of Cali (CIDAF - UCM 2018).

To this day, Indigenous and Afro-Colombian communities continue to resist the violence and discrimination resulting from systemic racism, the legacy of colonial violence, and over 60 years of internal armed conflict which has caused land dispossession; forced migration; displacement; and genocide perpetrated by right-wing paramilitary groups, guerrillas, and the Colombian government (Villa 2005).

This impact is reflected, among other areas, in the rates of access to education and employment. For example, only 14.3% of Afro-Colombians have been able to access university and 1.8% have completed postgraduate studies. Similarly, among Afro-Colombians the unemployment rate is 6.3%; the rate of forced displacement is 6.3%; the illiteracy rate is 11.7%. In contrast, the corresponding rates for people who do not identify as Afro-descendants are unemployment at 3.4%; displacement at 3.4%, and illiteracy at 7.0% (Granja Escobar 2021).

In the labor market, inequality is also evident, as Afro-Colombians make on average 71% of what those who are not Afro-Colombian earn. Only 2.2% of salaried people identify as Afro-descendants (Noticias Elempleo 2013).

Of course, these economic gaps are even larger for Afro-Colombian women than men. Despite the lack of available data, it is clear that the conditions of discrimination by gender, race, and class are extreme. For example, 80% of domestic service workers are Afro-Colombian or Indigenous. Domestic service is usually a labor sector representative of economic poverty, made up of primarily Black women in informal employment agreements with neither contracts nor services like social security (Posso 2008).

Furthermore, in the territorial war between the state and illegal groups, Indigenous and Afro-Colombian women's bodies have been used as weapons. The sexual violence against women of these communities has caused high rates of unwanted pregnancy, with poor or virtually no access to comprehensive sexual and reproductive healthcare (Comisión Interamericana de Derechos Humanos 2006).

Political Context

Countless armed conflicts due to the political confrontation between right-wing and left-wing factions have marked Colombia's history. The 19th century saw many civil wars, and gradual polarization generated irremediable conflict over the land, which is extremely fertile even for illicit drug trafficking.

Since its formation as an independent republic, Colombia has had right-winged administrations with conservative agendas since its formation as an independent republic, and high levels of corruption have also been constant ever since. In 1948 political leader Jorge Eliecer Gaitan's assassination ignited the Bogotazo, a social revolt that spread throughout the country and still impacts society. Today, armed groups enlisted in leftist guerrillas or ultra-right-wing paramilitary groups continue their violent confrontations. The people have undergone a historical and systematic violation of human rights by illegal armed groups as well as the national military forces, local police, and other law enforcement institutions.

Colombia is undergoing a high-stakes electoral process for the Presidential and Congress in which candidates from the left have a high chance of winning. The C-055 of 2022 ruling is extremely relevant for this particular election because the

new elected officials in Congress as well as the president and their administration will have to "implement an integral public policy on the matter" (Lizarazo Ocampo and Rojas Ríos 2022).

Such future policies should provide information on the options available to the pregnant person during and after pregnancy; remove all barriers to access to all reproductive rights recognized in the ruling; formulate strategies for increasing contraception access and preventing unintended pregnancy; create educational programs on sexuality and reproduction; develop support systems, including alternatives to adoption, for pregnant people; guarantee the rights for the children of people who wanted to have an abortion but decided to continue with their pregnancy (Lizarazo Ocampo and Rojas Ríos 2022).

The Constitutional Court has required Congress to develop legislation to guarantee abortion access to all women and other people with gestational capacity. Furthermore, it mandated the development of policies to guarantee sexual and reproductive rights to all. However, many elected officials, including the current administration, and other right-wing candidates are using the ruling to advance their political agenda to restrict the bodily autonomy of women and people of other marginalized genders (France24 2022). In political discourse, abortion is rarely discussed as a medical procedure or a matter of human rights. Instead, public debates often refer to it as a moral issue. Elected officials from almost every political party have chosen to ignore the court's mandate and avoid prioritizing public policies. However, some left-wing parties such as Colombia Humana, Alianza Verde, Polo Democratico Alternativo, and Unión Patriotica have shown support and proposed initiatives for effective implementation.

Congressional elections took place on Sunday, March 13, 2022, and resulted in a drastic shift in Colombia's political atmosphere, with progressive parties gaining unprecedented representation in both the Senate and House. A coalition of parties supporting the left's presidential candidate, Gustavo Petro, took important seats traditionally held by conservative extremists. Recent polling data foreshadows a similar trend for the upcoming presidential election in May 2022. This political swing would increase the chances of the advancing legislation and public policies to implement the court's ruling on abortion and guarantee sexual and reproductive rights.

Economic Context

Given the tremendous economic gaps and social inequalities that the government has failed to address, decriminalizing abortion up to 24 weeks has complex implications in the economic sphere.

In Colombia, the current legal minimum monthly wage is 1 million COP (approximately 266 USD). However, 45.2% of the working population earns less than that. Furthermore, unemployment rates are significantly higher for Colombian women than men. In 2019, 16.9% of Colombian women were unemployed, while the rate for men was 9.8% (Dinero 2019, para.1). In 2020, the situation for women in the labor force worsened. According to the National Administrative Department of Statistics (DANE), COVID-019 has eviscerated 65% of female worker-supported industries such as hospitality, tourism, and retail (DANE 2020). In a recent article, Colombian Vice President Martha Lucia Ramirez, said that "during the pandemic and the resulting confinement measures, in the quarter May-July of 2020, female

unemployment increased to 25.5%, the highest figure in the last decade" (Ramirez 2020).

Because abortion access impacts women and people of other marginalized genders, these numbers matter. Economic inequalities resulting from gender-based discriminatory practices impact people's health — and vice versa. Therefore, one of the government's main challenges to guaranteeing abortion as a fundamental human right, as required by the Constitutional Court, is building a healthcare system that can offer the procedure in a timely and affordable manner for everyone, particularly the marginalized and impoverished.

For this to be a reality, the next government must write laws to prevent gender-based and sexual violence in all forms; build educational strategies on contraception, autonomy, and alternatives such as adoption; strengthen the capacity of health services in terms of infrastructure and medical staff; remove all existing obstacles to accessing abortion; and ensure that reproductive rights can be guaranteed throughout the country (Lizarazo Ocampo and Rojas Ríos 2022).

Today, several institutions that offer IVE services have differential rates. Ideally, the EPS would cover the procedure's cost with a co-pay set according to the patient's income level. However, medical attention through this system is slow, and many agencies are resistant to providing abortion services despite the court's mandates. Unfortunately, when institutions refuse to provide care, people in need of the procedure must file a *tutela,* to seek enforcement of the ruling. That process takes time, information, finances, and resources that many lack.

Alternatively, private organizations, such as Oriéntame and Profamilia, provide abortion care on a sliding scale based on the patient's income. These

organizations offer special rates for adolescents, Indigenous people, and individuals who have been forcibly displaced as a result of armed violence. The procedure's cost also depends on the gestational age and the type of abortion performed. Despite these cost adjustments, private rates remain unaffordable for many impoverished and marginalized individuals.

Furthermore, these institutions have limited capacity and are mostly located in urban areas. Moving from the rural side of the country to the cities can be difficult not only because of the cost of transportation but also poor road infrastructure. Additionally, gender stereotypes limit women's mobility: Cultural beliefs rooted in traditional, binary gender roles dictate that women by nature must assume caregiving and domestic responsibilities while men provide economic stability. This is why Colombian women perform almost four times more unpaid domestic work than men (Oviedo 2019). These gender stereotypes also make women "much more likely than men to experience family-related career interruptions" (Pew Research Center 2013, paragraph 8). As a significant number of women provide full-time care for their children and other family members, securing childcare to be able to go to the doctor is often neither affordable nor possible.

Before the landmark court decision C-055 of 2022, only people who had the financial means to pay for the procedure could access a safe abortion. However, given the described gaps and long waiting periods within the EPS system, abortion still remains unaffordable for most people. In private or IPS clinics, the cost of an abortion ranges from 360,000 COP to 655,000 COP, or100 to 180 USD (Oriéntame, n.d.). This means that people making minimum wage would have to spend 38% of their salary at minimum to pay for the procedure, without considering aftercare expenses and other associated costs.

The reality is that the economic disparities exacerbated by gender-based discrimination still make safe abortion inaccessible for most people in Colombia. Therefore, marginalized and impoverished people often seek clandestine clinics and methods that put their lives at risk. In the wake of decriminalization, it is urgent that the right to free and safe abortion be guaranteed.

According to a report by Women's Link Worldwide (2021), between 2010 and 2017, 97% of people who were reported to the police for illegal abortions were from rural areas, and 75% were between 10 and 24 years of age.

Clandestine clinics are also an unavoidable reality that will not cease to exist until the stigmatization of abortion is eradicated through educational campaigns with effective outreach and engagement. Information on rates of clandestine abortion as well as the number of clinics that practice these unsafe procedures are very difficult to find.

Sociocultural Context

Criminalization also has a social component marked by religion and conservative social norms. Although Colombia does not have an official religion, most Colombians identify as Catholic (69%) or evangelical (16.4%) (Romero 2022). The court's decision was highly controversial among people of faith because of the Catholic church's stance on abortion, Colombian bishops' remarks against the decision, and even the pope referring to abortion as "murder" (Catholic Review 2022). The current president, Ivan Duque, identifies as a Catholic and uses his religious beliefs to support his conservative political agenda, which includes

restricting sexual and reproductive freedom. He has also made public statements against the Constitutional Court and its ruling, stating that he has always believed that life starts at conception (Torrado 2022). These statements have only increased stigma and exacerbated the social and cultural barriers that limit people's ability to make informed decisions about their health.

Over the past few years, religious leaders from right-wing evangelical churches have gained a concerning amount of political power and influence. In the 2018 elections, right-wing evangelicals gained 10 congressional seats and strengthened their political alliance. Evangelicalism's growing role in the political sphere has had a significant impact on the way people perceive the separation of church and state. Furthermore, the rise in right-wing evangelical power has a direct impact on the advancement of reproductive rights because their ultra-conservative positions influence the development of restrictive anti-rights laws (Naranjo Salazar 2021).

People who have had, or are considering having, an abortion face judgment, social condemnation, and spiritual violence from friends, family, and religious leaders who question their decisions. For many people, abortion remains a sin and a crime regardless of what the law says.

Profamilia's website provides a salient example of the tremendous stigma around abortion when describing the difference between abortion and IVE:

> Abortion and Voluntary Interruption of Pregnancy (IVE) may seem, in principle, to be the same thing. However, it must be taken into account that behind the word abortion there are a series of imaginaries related to illegality, fear and, in the worst cases, crime. The expression IVE, which stands for Voluntary Interruption of Pregnancy in Spanish, allows us to analyze a reality from the field of ethics, freedom and women's autonomy and enables a decision from

> the perspective of sexual and reproductive rights, which, above all, are human rights (Profamilia n.d.).

The truth is that abortion and IVE are the same thing. They refer to the same medical procedure. The term IVE is common among institutions and the reproductive rights movement. But in their daily lives, people use the word "abortion."

Digital Gaps in Colombia

In rural areas, internet access is practically non-existent. Likewise, computers and cell phones are extremely expensive for the vast majority of people in the country. Nationwide, 39.3% of households have computers or tablets; in rural areas, that number is only 10.3%. It is difficult to find information on digital illiteracy figures, as rural regions are often beyond the reach of the state (Orduz 2021). Policies to close the gap have been derailed by corruption that has severely affected projects meant to bring internet to schools in remote and rural areas of the country.

Karen Abudinen, the former head of the Ministry of Information and Communication Technologies, resigned on September 9, 2021, after Congress issued a motion of no confidence (or motion of censure) against her for allegedly funneling approximately 70 billion COP (about 19 million USD) paid under a contract to provide free internet access in rural areas (Portafolio 2021). The national and international pressure forced Minister Abudinen to resign, and the case remains under investigation.

Because of the high rates of digital illiteracy in the country, such scandals are significant. Social media, streaming videos and playing music account for 70% of the country's internet usage, and only 10% is used for educational and other productive apps. In urban areas, middle- and upper-class individuals and families have more easily adopted the internet and digital technologies.

Although it is difficult to find official studies on this digital illiteracy, the digital gaps and inequality in rural areas of the country are evident. This means that comprehensive access to health information is extremely limited for the impoverished, racialized, and marginalized people living in the countryside and the peripheries of the cities (Carvajal 2021). Connectivity and internet coverage are unequal and correspond to the economic gap. Therefore, educational programs and policies must incorporate a technological component, so that knowledge of sexuality, reproduction, and health is within the reach of all people.

LEGAL FRAMEWORK

This chapter, which overviews Colombia's laws and political processes, is divided into five sections. First, this section reviews the basic legal and political systems of government. The second section explains the role of the Constitutional Court. A third section details the legal framework for abortion rights, including the recent decriminalization of abortion in all cases up to the 24th week of gestation. The fourth section of this chapter addresses the healthcare system, specifically the healthcare laws for migrants and undocumented individuals. The final section presents the implementation challenges of these laws.

Legal System And Political Powers

Colombia is a civil law country, meaning that its legal system relies on codified statutes. Unlike in common law countries, the Colombian courts' decisions lack legal binding beyond the parties involved in the case. Typically, legal decisions only serve as the basis for other judges to rule in different cases. Nonetheless, high courts' decisions, and particularly those resolving matters of constitutionality and fundamental rights, can be relevant and binding for the entire population. Therefore, in Colombia, the Constitutional Court's interpretation of the law is just as important as codified laws and regulations (Ramírez 2007).

The 1991 Colombian Constitution (Colombian Constituent Assembly of 1991) established the organization of political power in three branches: executive, legislative, and judicial (Colombia 1991 [Rev. 2015] Constitution - Constitute).

- The *Legislative Branch* serves as the voice of the people, making laws that govern the entire nation. It also oversees the political control of the executive branch and its administration. Legislative power is vested in Congress which is elected by popular vote and has two chambers: the Senate and the Chamber of Representatives.
- The *Executive Branch* includes the President of the Republic as well as Colombia's governorates, municipalities, and ministries.
- The *Judicial Branch* encompasses the State of Council (the highest court for administrative jurisdiction), the Constitutional Court (the highest court for constitutional jurisdiction), and the Supreme Court of Justice (the highest court for ordinary jurisdiction). Other relevant jurisdictions and judicial institutions include the Superior Council of Judiciary (the highest authority for disciplinary jurisdiction), Special and Peace Jurisdictions, and the General Prosecutor's Office ("Rama Judicial" n.d.).

In addition, autonomous public agencies such as the National Comptroller, the General Prosecutor's Office, the National Electoral Council, and the Bank of the Republic keep other government entities accountable.

In this power structure, the Constitutional Court interprets and enforces the Political Constitution of 1991.

The Role of the Constitutional Court

The Constitutional Court has issued crucial rulings that guarantee the fundamental human rights of all Colombians, particularly the most marginalized

and those living in rural areas whom the government has failed to protect. The court's rulings have proved essential to protect safe and legal abortion access — particularly as it relates to the constitutional right to life, healthcare, integrity, dignity, autonomy, and privacy for all women and people who can become pregnant.

In the 1991 constitution, Article 86 establishes an injunction called *tutela* as a unique legal mechanism for individuals (whether they are Colombian citizens or other residents, including undocumented Venezuelan migrants) to request immediate protection when any public authority violates or threatens to violate their fundamental human rights (Colombia 1991 [Rev. 2015] Constitution - Constitute). This legal mechanism is unique in that it must be solved within 10 days, contrasting other legal proceedings that can take years. Many people whose sexual and reproductive rights were violated filed *tutela* lawsuits that were later elevated to the Constitutional Court.

Contending that the Penal Code violated fundamental rights by criminalizing abortion, several *tutelas* filed by individuals and a *tutela* filed by Women's Link, La Mesa por la Vida, and other organizations resulted in Ruling C-355 of 2006. In this decision, the Constitutional Court legalized abortion in only three situations. After this groundbreaking decision, a battle to ensure compliance ensued, in which citizens and pro-abortion organizations filed numerous *tutelas* asking that abortion access be protected based on human dignity, autonomy, the right to life, and the right to healthcare.

The court responded with more than 23 rulings to ensure that healthcare institutions perform the abortion procedure without moral obstacles (particularly

because the conscientious objection is only permitted for individuals rather than healthcare institutions), recognize mental health afflictions as life-threatening, provide truthful information to all patients, and more. Thus, by 2008, the court had identified 46 institutional and social barriers to guaranteeing abortion rights (Casa Editorial El Tiempo 2018). *La Mesa por la Vida y la Salud de las Mujeres* created a compilation of the 23 rulings issued since 2006, along with the keywords needed to make an analytical summary of each ruling's content: History of the rulings and the tutelas that prompted them. These cases, along with other constitutional challenges filed by individuals, activists, and organizations, strengthened the Constitutional Court's regulatory framework around abortion, ultimately leading to the monumental decision to decriminalize abortion on February 21, 2022.

Although the *tutela* has been crucial to abortion access in Colombia, it is not accessible to everybody. Those who are from rural areas, impoverished, and/or from other vulnerable groups rarely know about this legal mechanism. After being denied an abortion, if they are lucky enough to become aware of *tuletas* or gather the tools to file one, it is generally because they have been struggling for weeks or months under the EPS to access the service, prompting a human rights organization or activist group's involvement. By that time, the pregnancy is most likely in an advanced stage, making the legal process more traumatizing and difficult for the person needing the service.

Colombia's journey to legal and safe abortion has been long riddled with obstacles — and it's not yet complete. Abortion remains a crime under Colombia's Penal Code. Congress has yet to remove this law, despite the Constitutional Court's

decision requiring them to do so as well as create public policies that align with its mandate.

Legal Framework for Abortion Rights

Abortion, which is commonly known in Colombia as Voluntary Interruption of Pregnancy (IVE), was first decriminalized by Constitutional Court Order C-355 of 2006 in three specific circumstances (Corte Constitucional de la República de Colombia 2006):

> (i) When the continuation of the pregnancy constitutes a danger to the life or health of the woman, certified by a physician;
>
> (ii) When there is a serious malformation of the fetus that makes its life outside of the woman impossible, certified by a physician; and
>
> (iii) When the pregnancy is the result of conduct, duly reported, constituting carnal access or sexual act without consent, abusive or non-consensual artificial insemination or transfer of a fertilized ovum, or incest (idem.).
>
> A medical certificate confirming the applicability of these circumstances issued by the professional from the healthcare institution handling the abortion request is required, and if the circumstance is rape, a legal certificate is necessary, that is, the patient should bring a copy of a criminal complaint properly filed.

The court's decision complemented Article 122 of the Penal Code, which stipulates the punishable conduct related to abortion in Colombia (Congreso de Colombia 2000). However, abortion remained a crime in cases outside the three delineated circumstances.

Subsequently, the court issued more than 20 rulings that confirmed abortion as a fundamental and constitutional right for women and people with gestational capacity provided that they met the three special circumstances. *La Mesa por la Vida y la Salud de las Mujeres* provides case summaries of these rulings for further information (La Mesa por la Vida y la Salud de las Mujeres n.d.).

These rulings resulted from several *tutelas* filed by people who faced great difficulty accessing timely services to terminate pregnancies, including those that threatened their lives or in which the fetus was nonviable.

La Mesa por la Vida y la Salud de las Mujeres outlines the court's arguments to legalize abortion under three circumstances in the ruling C-355 of 2006 as follows (La Mesa por la Vida y la Salud de las Mujeres 2019):

- IVE is ratified as a fundamental human right. In this sense, the state has the responsibility to offer timely, sufficient, and adequate information. In addition, it must guarantee service throughout the entire national territory regardless of the complexity or stage of pregnancy.

- The right to privacy and confidentiality is also granted to abortion providers and others involved in the care pathway. In addition, prior to the procedure, the person must receive a timely and comprehensive diagnosis of their health and the state of the pregnancy; thus, the abortion must be performed within five days of the request. The requirements for the procedure are specified in Ruling 355 of 2006, and all medical personnel must be familiar with them to avoid unnecessary delays and requests outside this regulatory framework.

- There is no age limit to access an IVE. Even minors have full autonomy to choose and receive the service, with or without the consent of their family and/or primary caregiver. In the case of a pregnancy resulting from sexual abuse, an IVE will be considered a medical emergency.

- The issuance of a medical certificate to practice the procedure must be immediate to activate the IVE route when abortion is requested based on a threat to the person's life and/or health, or when there is a serious malformation of the fetus. The abortion must be performed within five days after it is requested. Because mental health is considered part of the integral health of a person, a licensed psychologist can also issue a certificate when the abortion is requested based on a risk to the person's life and/or health, and in case of rape. Informed consent is guaranteed through clear communication of the abortion's risks.

- The conscientious objection cannot prevent abortion in any case and can only be made by individual members of the medical staff rather than an institution. Healthcare providers must provide abortion services in a timely and safe manner. If a doctor or any other healthcare provider directly related to the medical procedure claims conscientious objection, they must guarantee the patient their right to access the procedure and refer to another professional willing to perform it. Administrative, pre-care, and post-care staff cannot claim conscientious objection.

- The *nasciturus* (embryo or fetus) is not considered a human person. Therefore, it does not claim a right to life since it is only in the process of gestation. Accordingly, priority is given to the life and integrity of the woman or pregnant person requesting the medical procedure.

- Health Promoting Entities (EPS) must maintain a defined list of Health Provider Institutions (IPS) that perform IVE. This corresponds to the state's responsibility to provide timely, sufficient, and adequate information about resources to access the procedure. Additionally, the Ministry of Health must ensure that no entity refuses to comply with this ruling. If an entity refuses to provide the service without any valid legal justification, it can face a monetary sanction by the Health Superintendence. Furthermore, there can be no discrimination against those who request or those who provide abortion services.

This framework preceded the more recent ruling of the Constitutional Court **C-055 of 2022** that decriminalized abortion in all cases up to the 24th week of gestation, as well as at any gestation under the three circumstances previously permitted (Lizarazo Ocampo and Rojas Ríos 2022). Handed down on February 21, 2022, this decision includes the following guidelines:

- **Up to the 24 weeks of gestation, abortion is no longer a crime.** IVE can and should be performed legally and freely during this period, without the requirement for justification of special circumstances or a medical or psychological certification. Furthermore, there will be neither charges nor criminal prosecution for abortion patients and providers. The court based its decision on the concept of "extrauterine autonomous life," meaning that after week 24 of gestation the fetus has a higher probability of surviving outside the womb. The court based this decision solely on scientific arguments.
- **After 24 weeks of gestation, the three circumstances established in ruling C-355 of 2006 will continue to apply.** This means that a person can end

their pregnancy after week 24 when (i) the pregnancy constitutes a risk to the life or health of the woman; (ii) a serious fetal malformation makes life outside the womb impossible; and (iii) the pregnancy resulted from rape, incest, or forced insemination.

- **The request should be processed within five days** and the patient should be referred to a healthcare institution with the capacity to provide a safe and timely service.
- **Criminalizing abortion is considered gender-based violence following the recommendations of the CEDAW Committee and the current interpretations of international treaties.** The court also recognized two groups of people who had been excluded from prior legal analysis' of abortion access: undocumented migrants living in Colombia and all gender diverse people that do not identify with the category "woman."
- **The National Government and Congress must create a comprehensive public policy.** This policy should include administrative and legislative measures to guarantee access to abortion for all women and pregnant people to protect their dignity and human rights.
- The court's decision is effective immediately and does not depend on the public policy's creation.

The Healthcare System

In compliance with Law 100 of 1993, the Ministry of Health and Social Protection regulates the national health and social security systems. The legislation created two health insurance programs: the subsidized regime, which is free and covers 47% of the population, and the contributory regime, which covers 48%. Both

regimes must offer comprehensive coverage with access to medicines, surgical procedures, and medical services. The remaining 5% corresponds to those unaffiliated with the general social security and healthcare system and those for whom no information is available (Hilarión Gaitán et al. 2019).

EPS programs implement the Ministry of Health's decisions, guidelines, and protocols through a network of services distributed among hospitals, clinics, and IPS facilities, which are direct health providers. Employers, independent contractors, and salaried workers, as well as the state, privately finance this system.

Colombia has a stratification system that sorts neighborhoods into six categories, with strata 6 as the richest and strata 1 as the poorest (Jessel 2017). Deficiencies in the health system disproportionately affect individuals classified under socioeconomic strata 1 and 2, who qualify for social programs (Sisbén) and therefore belong to the subsidized regime. This subsidized regime also covers victims of forced displacement, Indigenous communities, elderly people in state-run care centers, people in the witness protection program, street dwellers, and Romani people.

Despite these regulations, the healthcare system is not comprehensive for everyone and therefore is highly inequitable. The social and economic gaps in the country are extreme, affecting the most impoverished and marginalized communities who are often at higher risk of facing illness and lack access to the care they need. There are many barriers to accessing basic health services. The public sector's infrastructure is weak and less desirable than that of the private sector. The costs of transportation, medicine, and medical exams, as well as the lack of availability of healthcare facilities in rural or remote areas, contribute to

this inequity. Thus, the healthcare system faces significant obstacles, with lengthy and consistently delayed waiting periods to receive any type of medical attention.

In addition, private medical insurance providers offer prepaid medicine plans, which can be accessed voluntarily by people with the disposable income to pay for them. These plans aim to speed up waiting periods while providing easy access to healthcare services and wider hospital networks. In other words, privately insured medical care is immediate, unlike the services offered by the EPS, for which waiting periods can last several months.

People who cannot access a prepaid healthcare plan generally have limited care in precarious conditions. Securing an appointment with a general physician can take weeks, and with a specialist, it can take several months depending on the EPS institution (Así vamos en salud 2020; Supersalud 2016). Many people in need of costly treatments have died waiting for a response from healthcare entities (Duva Ruiz 2020; Gossaín 2014).

Healthcare for Non-Citizens, Migrants, and Undocumented Individuals

According to Colombian law, migrants have the right to fully access the social security and healthcare systems. Therefore, migrants should be able to access abortion care regardless of their immigration status. For Colombian and foreign citizens, healthcare is a fundamental civil right established by Constitutional Court orders T-298-19 (Corte Constitucional de la República de Colombia 2019a) and T-452-19 (Corte Constitucional de la República de Colombia 2019b). However, local reproductive justice organizations have found that Venezuelan women in Colombia encounter more obstacles when seeking abortion services precisely

because of their migration status (La Mesa por la Vida y la Salud de las Mujeres 2019b). For example, Venezuelan women have described unlawful discriminatory practices from healthcare institutions denying them or obstructing the access to abortion services, such as: denial of the services based on their undocumented status, the requirement of a residence permit to provide the service, leaving them at the back of the line for attention due to their nationality, etc.

Implementation Challenges

Many prior court rulings on abortion paved the way for the implementation of C-055, the monumental 2022 ruling that decriminalized abortion in all cases. The decision is recent, and so far governmental as well as private institutions and some medical practitioners have resisted its implementation. However, based on the court's decision, all three branches of the state (executive, legislative, and judicial) will be required to adopt strategies and concrete public policies to guarantee sexual and reproductive rights for all. This process will include country-wide education to communicate that abortion is a decision that belongs only to the pregnant person. In the meantime, a network of independent organizations and feminist collectives are working to ensure compliance and monitoring individual cases to safeguard unencumbered access to abortion services.

Recent cases of people seeking abortion care have already exemplified some of these challenges. On March 28, 2022, just weeks after the C-055-22 ruling, a *tutela* was granted against EPS Sánitas for denying a woman's request for an abortion procedure after three weeks of delaying the response. In this case, the

social worker had misdiagnosed the woman with hormonal sensitivity to disregard her expressed desire to interrupt her pregnancy. Her gynecologist and psychologist both told her that abortion was murder and, the EPS Sánitas informed her that given that the ruling had not gone into effect, they could not perform the procedure because her request did not fall under one of the three circumstances. Looking for legal aid and support, the woman turned to the feminist organization Somos Jacarandas. They were able to help her file a *tutela* requesting the protection of her fundamental human rights as ruled by the court order C-055 of 2022. The judge ruled in her favor and ordered the EPS to carry out the procedure without delay.

Current implementation challenges include but are not limited to (Cocomá Ricaurte et al. 2021):

- Lack of access to healthcare facilities for impoverished and marginalized individuals living in neglected areas.
- Poor healthcare infrastructure and limited coverage in rural areas.
- Digital gaps that prevent people from accessing information about reproductive health.
- Failures in the health system due to socioeconomic gaps that affect the quality of the service based on the applicable regime.
- Religious beliefs of a highly Catholic and evangelical population with significant representation in all branches of government.
- Stigmatization of abortion patients and providers.
- Moral conflicts at the social level that result, for example, in doctors' conscientious objection.

The most relevant obstacles to C-055-22's implementation are related to the political, economic, and social context in Colombia.

ABORTION MOVEMENT IN LATIN AMERICA

Undoubtedly, the feminist movement is gaining more and more strength in the world, and Latin America is a diverse region scenario where the feminist movement has strong roots that are generating transcendental changes (Sardiña 2021).

Thus, the Marea Verde, or green wave in English, has inspired many under an initiative whose symbol is the green handkerchief. Increasing numbers of South American countries have joined the jurisprudential trend to decriminalize abortion, especially since the United Nations Organization (UNO) praised the decriminalization of abortion in Argentina, urging other South American countries to soften the laws that condemn abortion as a crime (Becerrica 2020). In addition, the World Health Organization (WHO) recognizes that abortion is an essential and often lifesaving healthcare service for women (Organización Mundial de la Salud 2021).

December 2020 was the date on which the Argentinean green wave celebrated the decriminalization of abortion up to 14 weeks. Since then, Latin America has eight Latin American countries that have decriminalized abortion: Cuba, Uruguay, French Guiana, Guyana, Puerto Rico, México, Argentina, and Colombia.

In Chile, Perú, Ecuador, Bolivia, Paraguay, and Brazil abortion is legal under certain circumstances. Many feminist organizations are fighting for complete decriminalization, declaring that the system based on special circumstances is insufficient, since continues to consider abortion as a crime. The following are reasons for which abortion is permitted in each country:

- Venezuela, Guatemala, Paraguay: risk to the life of the pregnant person with gestational capacity.

- Costa Rica and Peru: when physical health is at risk.
- Panama, Ecuador, Brazil, and Chile: rape, incest, threat to the life, physical or mental health of the woman.
- Bolivia: also contemplates all of the above and incest.
- Belize: includes socioeconomic factors among the causes.

Despite the efforts of activists and international human rights organizations, Haiti, Nicaragua, Honduras, El Salvador, and the Dominican Republic continue to criminalize abortion completely.

National Organizations that Support Abortion Rights

In Colombia, a robust collection of organizations has spent decades promoting the fight for free, safe, and legal abortion. They have created national coalitions, forged powerful alliances with international initiatives, and been crucial to the advancement of abortion rights in Colombia by prompting groundbreaking legal, political, and social groundbreaking changes, including the pivotal court decision. These organizations and movements are formed by feminist activists, social leaders, healthcare personnel, lawyers, religious groups, nonprofits, agencies, medical institutions, and others. The following organizations and movements are the most visible and influential:

Causa Justa Por el Aborto

Translating to "Abortion is a Just Cause," this movement is promoted by the organization La Mesa por la Vida y la Salud de las Mujeres and supported by

other organizations such as Católicas por el Derecho a Decidir, Grupo Médico por el Derecho a Decidir, Women's Link Worldwide, Centro de Derechos Reproductivos, and more than 90 feminist human rights organizations and activists. Its goal is to achieve reproductive freedom, bodily autonomy, and gender equality. They have been at the forefront of the fight to remove abortion from the Colombian Penal Code and end the social stigma. They call it the fight for social and legal decriminalization.

Since 2020, the Causa Justa movement has led a strong campaign to educate people on abortion rights and eliminate stigmatization and criminalization through different outlets such as lawsuits, institutional complaints, social media campaigns on Twitter and Instagram, press conferences, virtual and in-person events, workshops with grassroots organizations, lobbying, and more. They have been trans-inclusive and have shown awareness for all diverse populations with the capacity to gestate. Their most influential action was filing the lawsuit to declare Article 122's unconstitutionality and the educational campaign around the legal arguments, which resulted in the monumental ruling C-055 in 2022. Because of this movement, almost every person in Colombia knows that abortion is a right, regardless of whether they agree.

La Mesa por la Vida y la Salud de las Mujeres

Founded in 1998 by a group of feminist organizations and activists, La Mesa por la Vida y la Salud de las Mujeres support sexual and reproductive rights, including free and safe abortion, for women and gender-nonconforming people at any stage of their lives. Currently, the organization's most visible leader is one of its

founders, Dr. Ana Cristina Gonzalez Velez. The organization has four areas of work (La Mesa por la Vida y la Salud de las Mujeres 2022):

1) *Legal and political advocacy* with pro-bono legal support for folks facing any type of barrier that prevents access to abortion. They also work on constructing regulatory frameworks that guarantee the right to abortion and follow up on bills and litigation in the courts to review cases in which fundamental rights have been violated.
2) *Implementation of Ruling C-355 of 2006 and C-055 of 2022* by collecting expert knowledge and information regarding the health sector to encourage compliance with the court's order. For example, La Mesa provides training to healthcare providers, officials of the judicial and executive branches, in charge of monitoring abortion services.
3) *Communication strategies* provide accurate information to eliminate the social stigma surrounding abortion. Through social media campaigns, perception surveys, and a transmedia artistic campaign called Mujeres Imparables (Unstoppable Women), the organization makes visible some of the experiences that have taken place around abortion.
4) *Regional work* generates territorial alliances with feminist organizations to build local strategies to guarantee the implementation of a regulatory framework for abortion access.

La Mesa's work led to the creation of the Causa Justa movement, which promoted the decriminalization of abortion before 24 weeks. Its objective is the total elimination of such criminalization.

Although La Mesa's headquarters are in Bogotá, the organization oversees cases and provides support across the country through its strong network of allies. La

Mesa hosts a wide range of resources on their website, including a documentation center with a research library, academic material, and legal archive.

Grupo Médico por el Derecho a Decidir

Operating as part of Global Doctors for Choice, Grupo Médico por el Derecho a Decidir is a network of doctors fighting for timely access to all sexual and reproductive health services, including abortion. As defenders of human rights, these physicians use their expertise in health to influence the creation of laws and public policies for equal access to health services at national and local levels. Led by Dr. Laura Gil, they use scientific knowledge and evidence to generate alliances and educate others (Grupo Médico por el Derecho a Decidir n.d.).

> In Colombia, Grupo Médico por el Derecho a Decidir have achieved the following:
>
> 1. Expanded the organization with professionals from cities across the country.
> 2. Established itself as a voice of authority before different governmental and judicial decision-making entities.
> 3. Joined the public debate on the decriminalization and implementation of safe and legal abortion.
> 4. Built alliances with human rights groups.
> 5. Contribute to the development of regulatory frameworks issued by national and local health authorities in the area of sexual and reproductive rights.

Grupo Médico por el Derecho a Decidir has been fundamental, as it has contributed scientific information to the abortion debate since 2010, particularly in the health sector. The organization has also proved essential for regulating

conscientious objection. They have been a crucial part of the Causa Justa movement.

Centro de Derechos Reproductivos

A legal defense fund with its branch for Latin America and the Caribbean headquartered in Bogotá, el Centro de Derechos Reproductivos is a global organization operating on all five continents. The organization fights for reproductive rights to be recognized as human rights and monitors governments to ensure that they guarantee equal access to justice and have reparation policies in cases of gender-based violence.

The organization advocates for strategic public policy and laws that reduce sexual violence; strengthen access to sexual and reproductive health education and services; decriminalize abortion; defend people who have unjustly received punitive measures for having an abortion; improve access to maternal healthcare, emergency contraception, and other services; and guarantee reproductive rights in transitional justice contexts.

In Colombia, el Centro de Derechos Reproductivos has also worked with the Causa Justa movement as the legal backbone of the lawsuit that prompted the 24-week court decision, directed by human rights lawyer Catalina Martínez Coral.

Red Nacional de Mujeres

Red Nacional de Mujeres is a network of independent, feminist, and social organizations with chapters in Barranquilla, Bogotá, Bolívar, Cauca, Chocó, Manizales, Magdalena Medio, Medellín, Pasto, Puerto Colombia, Risaralda, San Andrés and Providencia, Santander, Tolima, and Valle del Cauca.

For thirty years, Red Nacional de Mujeres has worked to strengthen women's political participation in order to create public policies that support their needs. In territorial peace-building scenarios, the network has also promoted women's access to the restorative justice program resulting from the Colombian peace accord: Justice, Truth, Reparation, and Non-Repetition System.

As part of La Mesa por la Vida y la Salud de las Mujeres and Causa Justa, the organization also focuses on ensuring full access to sexual and reproductive education as a fundamental right.

Women's Link Worldwide

Founded in 2001, Women's Link Worldwide is an international nonprofit organization that defends the rights of women, girls, and adolescents — especially those living in vulnerable conditions. The organization works to protect human rights using an intersectional and gender-based approach. It has regional offices that focus on legal support in Colombia and Spain.

With respect to sexual and reproductive rights, Women's Link Worldwide seeks to ensure that there is neither social nor state discrimination of any kind interfering with integral health in all sexual and reproductive areas: abortion, safe and freely

chosen parenthood, sexual education, access to contraceptives and assisted reproduction methods and more.
Women's Link has joined the Causa Justa Movement with the representation of attorney Mariana Ardila.

Oriéntame

Since 1977, Oriéntame — which is registered as an IPS — has promoted sexual and reproductive health and rights through provision and support. The organization offers medical and psychosocial care as well as comprehensive training and education programs. It seeks to both prevent unplanned pregnancies and support people who experience them. After Ruling C-355 of 2006, the foundation became a model for other institutions implementing of legal abortion services.

Oriéntame offers three types of abortion services: at-home medication abortion, in-clinic medication abortion, and in-clinic procedural abortion. In the event of an unplanned pregnancy, Oriéntame also provides adoption counseling and support for pregnant women without a support network who decide to continue with their pregnancy.

The organization also has several options for contraceptive services, including counseling and laboratory tests for sexually transmitted infections, gynecological consultations, free pregnancy tests, and the morning-after pill free of charge.

The price of Oriéntame's services ranges from approximately 300,000 COP to 1,000,000 COP (80 to 266 USD) depending on the income of the person that requires the service and/or the complexity of the procedure. The organization also

has agreements with certain EPS institutions to provide abortion services to their referrals. Oriéntame also has limited special grants that support abortion for people from marginalized communities.

In the Causa Justa movement, Orientame has been promoted as a leading organization. One of the pioneers of the movement and a member of La Mesa por la Vida, Cristina Villareal, previously served as Orientame's director.

Católicas por el Derecho a Decidir

Católicas por el Derecho a Decidir is an autonomous organization of Catholic feminists that works for the protection of human rights with a gender-based focus on reproductive and sexual rights and for the eradication of gender-based violence and discrimination. It seeks equity, women's civic participation, and social justice, all through feminist theology and secularism. Católicas por el Derecho a Decidir also fights for the right to legal, safe, and free abortion based on the Catholic values of social justice and following one's conscience in matters of sexuality and reproduction.

Although this organization has a religious affiliation, it advocates for a secular state that legislates fairly for diverse faiths, particularly when it comes to sexual and reproductive rights. In Colombia, they are leaders in the fight for abortion rights because they focus on promoting awareness and eliminating the stigma around abortion from a moral and religious standpoint.

They joined the Causa Justa movement under the leadership of their director and magister in political studies and international relations, Sandra Mazo.

Profamilia - Mía

Profamilia is a private, nonprofit organization with locations in 31 regions of the country. Like Oriéntame, it is an authorized IPS.

Profamilia provides abortion care; family planning resources, contraceptive methods, and pregnancy tests; prevention and treatment for sexually transmitted infections; gynecology, urology, sexology, psychology, vaccinations, and general medicine; sterilization and fertility treatments; and diagnostic imaging and laboratory tests.

It is one of the few organizations in Colombia that openly offers safe abortion for women and people who can become pregnant on all its platforms. The organization has declared itself discrimination-free, so its stated mission seems to acknowledge diversity in gender identity and sexual orientation.

Also fitting with their anti-discrimination ethos, Profamilia's services are offered with a price calculated considering the income of the person that requires the abortion and/or the complexity of the procedure. They also perform abortions referred by EPS institutions. However, so far Profamilia has not been part of the Causa Justa Movement.

Other Local Organizations that Support Abortion Rights

Small movements at the regional level provide education and awareness-raising campaigns for bodily autonomy in decision-making; accompaniment for at-home abortions; contraception, sexually transmitted infection prevention, and more. In other words, education in sexual and reproductive rights goes beyond these organizations — it has also become a micro-political movement in homes, cultural centers, schools, and other alternative spaces.

For example, Causa Justa lists 57 feminist collectives as part of its coalition. Activist groups that seek to guarantee abortion as a fundamental right are proliferating in every territory. Although these groups are more popular in large cities, the initiative is gradually reaching remote areas through educational and social awareness campaigns with a clear focus on the advancement of abortion.

In Colombia, movements of popular resistance have become increasingly well-organized, active, and strengthened. The feminist movement is one area of popular resistance that has made historic achievements on many fronts. Today, Colombia is home to organizations of radical feminists and growing collectives of trans-inclusive feminists.

Among the many organizations gaining strength at the national level, the following are highly visible for their impact and their grassroots work both at the regional level and in the large cities: Las Parceras, Rhuda, Tamboras Insurrectas, Jacarandas, Las Viejas Verdes, Coalla colectiva llanera, Red Defensoras, Todos

somos una, Yapuranas, Dos Latinas, and La Manada Colectiva Feminista de Derechos Humanos.

Below are some organizations at the local level in the five cities of interest, that provide abortion services or provide information to access those services.

Bogotá: Las Viejas Verdes, Siete Polas, Imprudentes, Ruidosa Ruidosa, La Hoguera Feminista, Dos Latinas, ATAC - Alianza Trans Abortera de Colombia, and Las Parceras. Other institutions providing the services in the city include Oriéntame and Profamilia.

Cúcuta: Oriéntame — together with Corporación Mujer, Denuncia y Muévete, and Médicos del Mundo — worked to publish a report that denounces the obstacles for Venezuelans in the area trying to access abortion. Halú Foundation makes referrals for access to legal abortion in Colombia and works closely with migrant population. Other local organizations in Cúcuta are Las Morias, the Red de Movilización Feminista, OIM, Princesas Guerreras, ALU, International Rescue Committee, and Cosas de Mujeres.

Mitú*:* Profamilia and Grand Challenge Canada are conducting an investigation in Mitú to strengthen sexual and reproductive health and safe abortion services, as the barriers faced by their community are very high (Profamilia n.d.). Also, the Oficina de la Mujer y Equidad de Género provides sexual and reproductive informationn, and Mesa de Juventud.

Popayán: Colectivo Viraje is a feminist and queer space for training on issues of gender diversity, sexual orientation, and sexual and reproductive rights in relation to the rural territories of Cauca. Other organizations in Popayán are Las

Yesbateras, Insurrectas, Mujeres en Movimiento, Ácidas, Raíz Violeta, Furia Marica, La Colectiva, Comunitar Zully, Fundación Mujer On, and Profamilia.

Soledad: The collective Las Parceras has a nationwide presence and provides abortion counseling by telephone, digitally, and in person. It is a feminist hotline and network that proclaims that abortion should be free, affordable, and safe. Innovación Social offers sexual and reproductive education, including information for IVE. The Colectivo Emma Goldman offers sexual and reproductive education, although they do not offer accompaniment, they do provide information.

THE YOUTH AND OTHER MARGINALIZED COMMUNITIES: A MULTIPLE CASE STUDY

According to Ana Langer (2002), in Latin America and the Caribbean, the majority of unplanned pregnancies occur in adolescents or very young people with limited economic resources and low levels of education. Minors endure sexual abuse in their everyday environments, in family circles, for example. During puberty and adolescence, many people lack sufficient support, information, and

guidance regarding their autonomy, power over their bodies, and sexual and reproductive rights. Thus, the rate of unintended pregnancies at these ages is a public health problem, especially in rural and remote areas where the state is either absent or harmful in its presence 1) by action or omission, 2) by favoring certain groups, or 3) for economic and military purposes (Serje 2012). Rural areas, city peripheries, and semi-urban areas have serious problems with healthcare access, insufficient digital connectivity, poor road infrastructure, and the lack of educational institutions. This creates a huge gap between the development of urban and non-urban areas, which ultimately affects access to healthcare services related to sexual and reproductive rights, including abortion and family planning.

Research has shown that impoverished women and those from rural areas are more likely to have an abortion through a traditional midwife from their community or to perform a self-managed abortion through unsafe and life-threatening methods than to have an abortion in an equipped healthcare facility or a safe self-managed abortion with the proper accompaniment and medication. In addition, rural and impoverished women have the greatest health complications from badly performed abortions (53% vs. 24-44%) (Prada et al. 2011).

This multiple-case study describes risk factors such as deep economic inequalities, forced displacement, and drug trafficking in five regions of interest: Bogotá, Cúcuta, Mitú, Popayán, and Soledad. Throughout March and April 2022, the research team held 19 interviews with different key stakeholders of these regions to explore the barriers, challenges, and commonalities in their work with sexual and reproductive rights, sexual education, and abortion accompaniment. The data gathered provides a brief description of how they experience these contexts and

will add to the understanding of the socio-cultural and economic factors relevant to these regions. The following chapter provides a deeper analysis of these interviews.

It is key to note that in some of these areas, demographic data and academic research about abortion access, as well as information about organizations and activists, are difficult to find. The recent shift toward legalizing abortion access should encourage more research that will impact the defense of fundamental rights related to sexuality and reproduction in these locations.

Bogotá

With more than 7 million inhabitants, Bogotá is the country's capital. Bogota's population is 51% female and 27% women of reproductive age. Within the last two years, poverty rates have increased 35% mostly due to the pandemic and poor management by the national government, with 16% of Bogotá's population falling under the national poverty line. The unemployment rate is approximately 40% (Cámara de Comercio de Bogotá, n.d.). Bogotá is a large metropolitan area that has become home to a significant number of Colombians who have been forcibly displaced by violence, as well as Venezuelan and other migrants. In Colombia, 4.1% (352,000) of all the victims of armed conflict in the country, including the displaced population, live in Bogotá, making it the city with the second greatest number of victims. Of the displaced victims in Bogatá, 35% are between 18 and 28 years old, 50.9% are women, and 0.04% are part of the LGBTQIA community. They live mainly in five areas: Ciudad Bolívar, Bosa, Kennedy,

Suba, and San Cristobal. In the city, 9.3 % (32,000) of displaced victims identify as Afro-Colombian or Black, and 2.7% (9,000) have a disability (Barreto 2018).

By 2020, Bogotá was the Colombian city with the highest Venezuelan population, with 20% of Venezuelans in the country living in the city. Other cities with high Venezuelan populations include Barranquilla, Cúcuta, Medellín, and Cali (Migración. Ministerio de Relaciones Exteriores 2021).

As the country's capital, Bogotá is not necessarily affected by infrastructural issues and digital barriers, and it has a wide range of medical services. However, the density of Bogotá's population; the corruption and the socio-economic challenges derived from poor governmental management, and the xenophobic, racist, colonialist, and patriarchal social forces, represent a huge threat to the population, which needs special protection to access healthcare services, including abortion.

For the purposes of this study, one Bogotá-based stakeholder was interviewed. Because this was the only interview made in Bogotá, the data might not reflect the realities that others experience in this context. Nevertheless, the interviewed organization is a transfeminist group that provides abortion accompaniment to trans men, transmasculine people, nonbinary trans folks, and cisgender women. The group members discussed their work with people of these diverse gender identities, and they highlighted that these identities tend to experience invisibility more often than trans women. That is, when cisgender people and media talk about transsexuality, they often think of trans women and their disadvantages before trans men, nonbinary trans people, and their specific needs. The group's representatives also mentioned how medical institutions perpetuate a binary discourse that does not align with nonbinary identities. For the interviewed group,

this is a particular problem when accessing gender-affirming treatments in the city. For example, trans people are forced or firmly persuaded to have hysterectomies without a chance to contemplate other options.

Cúcuta

As the capital of the Department of Norte de Santander, Cúcuta has a total population of 776,106 inhabitants according to the latest census. In Cúcuta, 51% (405,595) of the population are women, with 13,940 women (48.9%) living in the rural area and 391,655 (51.6%) in the urban area. Most of the female population is within the age range of 20 to 34 years old ("Presidencia de La Republica" n.d.). It is located on the border with Venezuela, which is why in recent years it has received a large migrant population from the neighboring country. It is the third city in Colombia with the third-largest population of Venezuelan migrants (94,847) (Migración. Ministerio de Relaciones Exteriores 2021).

Cúcuta has a complicated socio-political, economic, and territorial dynamic because of its interdependence with the Venezuela border and the armed conflict in the Catatumbo area, one of the greatest rural conflicts related to the expansion of illegal drug cultivation and trafficking. The territorial war for expansion has extended its impact from the Catatumbo region to the rural and metropolitan areas of Cúcuta (OCHA and Humanitarian Response n.d.). The main actors in this war are criminal groups; paramilitaries; National Liberation Army Guerrillas (ELN); and drug cartels such as Clan del Golfo, Los Rastrojos, and La Línea that seek to control the land for illegal activities such as drug trafficking, smuggling, and illegal mining.

Despite the land's substantial business potential, 45% of the population lives in poverty, 10% live under extreme poverty conditions, and 72% of the population's main activity is related to informal employment (Zambrano Miranda 2021). This economic context prevents the overall population, including undocumented migrants, from accessing comprehensive and timely healthcare. The prevalence of immigration also leads to other abortion-related barriers despite the Constitutional Court's decision on access to IVE (La Mesa por la Vida y la Salud de las Mujeres 2019b). For example, hospitals require Venezuelans to obtain a Special Stay Permit, and they do not recognize any sexual abuse complaints filed in Venezuela.

For the municipality of Cúcuta, the research team interviewed seven actors. They serve the whole Department of Norte de Santander as well as settlements near the border like La Fortaleza. Groups that access their services include Venezuelan migrant women; refugee host communities; female migrants who have returned to Colombia; young people ages 14-25; LGBTQIA communities; and victims of sexual violence, including victims of armed groups during armed conflict.

The interviewed actors from Cúcuta identified men from these armed groups as sexual predators, especially on the weekends when they often use threats to force women to have intercourse, even when these men have severe STIs. They also mentioned cases of gang rape by the Revolutionary Armed Forces of Colombia (FARC).

Mitú

Located on the border with Brazil in southeastern Colombia, Mitú is the capital of the Department of Vaupes. The territory has been plagued by armed conflict and suffered from state abandonment.

Located in the Amazon region, Mitú had 16,980 inhabitants by 2021. The majority (87%) of its territory has been declared an Indigenous reservation. Since it does not have an administrative political division recognized by the state, the national government's presence is null or practically nonexistent, which has made Mitú a territory with a strong presence of illegal armed groups using the land as a corridor to Brazil. This dynamic has also led to the forced military recruitment of children and adolescents, cases of sexual violence, rampant forced displacement, and mobility problems due to lack of proper means of transportation or unlawful territorial controls. These issues have resulted in the absence of the media, government institutions, and humanitarian organizations. Additionally, there is strong exploitation of natural resources and areas for illegal businesses: soil exploitation, smuggling, narcotics cultivation, trafficking, robberies, and illegal roadblocks. The armed state presence in Indigenous communities has made them a military target and has led to rampant sexual abuse. Gender-based violence has also become established and naturalized due to the lack of state protection, which prevents complaints because people lack knowledge of safe routes and distrust the institutions.

"Early pregnancies are frequent throughout the department, and in some areas, there are still forced and child marriages. ... girls and adolescents are victims of commercial sexual exploitation, temporarily handed over by relatives to settlers

with links to armed groups and drug traffickers" (Consejo Noruego para Refugiados 2021).

In the case of Mitú, four actors were interviewed. They seek to serve children, people between the ages of 14 and 28, Indigenous groups, and the LGBTQIA community. They focus on reproductive and sexual education; gender equity; public policy; institutional programs for education, employment, and entrepreneurship; and restoration of women's and children's rights in contexts of domestic violence. Interviewed actors highlighted one of the common problems of Mitú: high rates of suicide among the young population, particularly among women. Although academic research has yet to confirm it, the interviewed advocates pointed toward alcoholism, cultural shock, socio-economic disparities, and domestic violence as the leading causes of suicide. Alcoholism is a pervasive health problem in the area, particularly the consumption of *chicha*, a homemade liquor. Since this substance suppresses the nervous system, it can increase the likelihood of depression. In addition, interviewed actors said that one main source of mental health problems is the profound socio-economic differences in Mitú, especially for the Indigenous communities that arrive in the city and see themselves as different from the *mestizo* population. Differences in clothing, for example, can lead to harassment based on class and, therefore, frustration and depression for the victims of this form of violence. For the interviewed actors, another problem common to this area is the consumption of psychoactive substances by the young population.

In addition, the Indigenous population of Mitú has spiritual beliefs that provide explanations for health and social problems. For example, the community believes that a *payé*, a sort of shaman, caused the prevalence of suicide. These *payés* are

also in charge of abortion procedures and other health remedies, which presents problems around access to safe health services.

Popayán

Capital of the Department of Cauca, Popayan is a city in southwestern Colombia. The physical and social geography of the department is very complex. It is ethnically diverse, with many Indigenous reservations resisting the ruthless advancement of industrialization and 17,000 hectares of illicit crops, and towards the Pacific coast, Popayán is inhabited by several Afro-descendant communities.

In contrast, the city of Popayán has no significant industrial activity. Geographically, its topography is rugged, with a large part of the Colombian massif, from which the Cauca and Patía rivers rise (the former to the north between the Central and Western Cordilleras, and the latter to the west, flowing into the Pacific Ocean after breaking through the Western Cordillera).

In general, Popayán has an extremely conservative and religious society that constantly clashes with Indigenous resistance. In addition, the state leaves many gaps in terms of education, health, justice, and security, which allow for a strong presence of drug trafficking: Popayán is the department with the third-largest area planted with coca, and it has strategically located corridors to transport cocaine to the Pacific for export. This serious problem also generates the presence of several armed groups throughout the territory, especially in the 80 coca-growing municipalities (Moreno Montalvo 2019). Dozens of social and

environmental leaders have been killed for defending the territory and their communities.

All these factors account for the deep social gaps that affect the rural populations surrounding Popayán. The economic vulnerability in certain sectors of the population is undeniable, and this has serious repercussions on impoverished girls and adolescents, as well as Indigenous, Afro-descendant, young, female-headed households.

With respect to sexual and reproductive health, in 2018 Popayán was home to 27 sexual and reproductive healthcare providers, but a study by Profamilia (Royo [Dir.] 2020) indicates an alarming amount of ignorance about the legal framework on abortion. Clearly, education does not aim to provide comprehensive information on sexual and reproductive health. Even though Popayán is the capital of a department, its social and economic inequalities affect people of all ages and ethnicities who can bear children.

In Popayán, the research team interviewed four actors. They work in Popayán; Cali; Pasto; Santander de Quilichao; and the Comuna 6, where Popayán's most violent neighborhoods are located. Their work focuses on diverse areas such as trans-*marica* (queer) narratives; abortion, accompaniment; *escrache*, which is the practice of publicly denouncing aggressors through protest; and sexual and reproductive education. According to the interviewed actors, Popayán is also affected by the armed conflict and is highly conservative and religious.

Soledad

Located in the metropolitan sub-region of the Department of Atlántico, Soledad has 535,639 inhabitants: 443 identify as Indigenous and 6,909 as Afro-descendants.

Due to the number of streams throughout the department, the territory is constantly at risk from flash floods, windstorms, fires, and landslides. Several of these natural disasters have generated a strong social impact and great material losses for the affected population (Álvarez [Dir.] 2012).

The Department of Atlantico is characterized by its rapid population growth. Soledad has seen high rates of unplanned pregnancy and serious cases of mortality due to clandestine and unsafe abortions (Marroquín Ortega 2018).

The territory is home to the community feminist organization *Innovación Social*, which works for women's sexual and reproductive rights, as well as *Oriéntame,* which is located in nearby Barranquilla.

The three actors interviewed in Soledad work with young people, especially young women ages 13 to 24, migrant women, and female sex workers. These actors described Soledad as a region where sexuality is taboo, particularly in familial conversation which creates a significant information gap for adolescents. In addition, these interviews highlight the region's extremely high levels of teenage pregnancy. Therefore, the interviewed actors focus on menstrual care, IVE procedures, sexual and reproductive rights, and life planning.

INTERVIEW FINDINGS:

BARRIERS AND KEY STAKEHOLDERS' COMMONALITIES

The following constitutes the analysis of 19 interviews with key stakeholders from the five regions of interest in Colombia: Bogotá, Cúcuta, Mitú, Popayán, and Soledad. The interviews were carried out throughout March and April 2022.

The interviewed actors were:

a) **From *Bogotá***: Alienhadas.
b) **From *Cúcuta***: Las Mijas, Aquelarre Violeta, Fundación Frida Kalho, Corporación Mujer Denuncia y Muévete, Irene from Ensororadas, Andrea and Kelly from Moiras, and Karen from Frontera Morada.
c) **From *Mitú***: Comisaría de Familia, Paola from Oficina de la Mujer Gobernación, Gilma from Instituto Colombiano de Bienestar Familiar (ICBF), and Leydy from ICBF.
d) **From *Popayán***: Colectivo Viraje, Comunitar Zully, Insurrectas, and Jennifer Flores.
e) **From *Soledad***: Innovación Social, Colectivo Rosa Violeta, and Jennifer from Colectivo Emma Goldman.

To show common factors identified during the analysis of the 19 interviews, the following word cloud shows the most mentioned topics. These common topics

included women, abortion, accompaniment, health, access, process, people, rights, networks, violence, trans, pregnancy, talking, education, IVE, and more.

Access Barriers and Challenges

Below are the access barriers and challenges identified for these regions of interest based on those common factors.

Young Population Barriers

One of the many barriers young people face is the lack of sexual and reproductive education and access to contraception. The interviewed actors said that in many

cases doctors deny contraceptive methods to young women because they are perceived to be too young to have an active sexual life. At the same time, rape culture is a severe problem in these places, given the high child and teenage pregnancy levels. Interviewed actors emphasized this issue by frequently mentioning girls 14 and younger:

> *"One of the girls told me, 'Teacher, but I went to the doctor once … at the health post he told me, no, that what was wrong with me, that I was very sassy and too young to start having sexual relations and no, no, I did not manage to get that [contraceptive] method. … That cannot be permitted. If they are minors, they are minors, but they also have the right to access to these methods, then we should not judge because at least they are doing it well, because they are preventing those pregnancies that later become torture for them, because in my school, you see pregnancies of girls of 12, 13, 14 years" (CUC-A2 2022).*

For girls 14 and under, pregnancy is particularly complicated because they often do not yet know their bodies well, so there is a lot of confusion and misinformation around sexuality and pregnancy. Oftentimes, there is even abuse. Interviewed actors questioned whether it is possible to access a medical procedure alone at a young age. They expressed the importance of educating girls on accessing services without their parents' consent.

Data show that many young migrant women end up working as sex workers, often resulting from deception. It is important to consider the difference between sex trafficking networks and sex work, with the latter being "a willing engagement in commercial sex" while sex trafficking uses "force, coercion, or deceit" (Human

Trafficking Search 2017). Sometimes, underage women do not know what they are about to face when beginning sex work. Only later do they realize what it means to be trapped in a sex trafficking network. Interviewed actors noted that procurers or pimps create cultural imagery falsely implying that sex workers have "an easy life," suggesting that these women's situation in their country is already highly precarious:

> *"What happens is that the youngest [victims of sex trafficking] are even minors, and they have faced abuse or are in some very determining risk factors that make them suddenly lean or allow or let even be cheated or taken. For example, a girl told me, 'Doctor, I knew what was coming. I knew what was coming because they brought me from Venezuela and took me to Tibú, and I knew I was going to be in prostitution, but what happened is that we have always heard that women in prostitution are those of the easy life, only that generating that money is not easy.' Then those are cultural imaginaries that these pimps or these exploiters create in this population to capture them. Then the women say, 'I have a difficult economic situation, I have my children, I prefer this because with that I do not harm anyone, but if I win it supposedly easy, it turns out that I won it easy only at the beginning.' That is the issue. This has a background, and she told me crying, 'Now I have AIDS, and my life has been damaged'" (CUC-A2 2022).*

Even young women around 14 years old who are not involved in sex trafficking can be exposed to teenage pregnancy through their older sisters. Sometimes, the mother in a family with a pregnant teenager forces their younger children to use hormone implants at that early age to prevent unplanned pregnancy. Although this practice can prevent teenage pregnancy, the interview participants called

such situations problematic because these mothers control these young women's bodies without their consent.

When discussing young migrant men from Venezuela, the interviewed actors mentioned that many are described as *ninis*, meaning that they neither work nor study. When they do have jobs, young migrants often face precarious economic situations. Many have informal jobs with wages around 1.22 USD per workday. This situation results from the access barriers to education due to their legal status in Colombia. Also, many immigrant parents migrate to other countries like Perú, Ecuador, and Chile, leaving their young children with other family members, sometimes resulting in dysfunctional family relations.

For some of these young men, drug consumption is also a problem. The actors interviewed mentioned the consumption of controlled drugs like clonazepam — a benzodiazepine used to prevent and treat seizures, anxiety, and panic disorders — which is also known to create high levels of dependence. While the actors interviewed try to manage addiction with psychological counseling or admittance into mental health institutions, they realize addiction is out of their organizations' expertise.

When discussing how to approach different social groups, the interviewed actors emphasized recognizing Colombian ethnic groups, including Black or Afro-Colombian and Indigenous people, according to their specific experiences and needs. For example, interview participants mentioned that it is not the same to talk about sexuality and the body with the Indigenous *Nasa* community as it is with Afro women, particularly because Black and Afro-Colombian women

experience hypersexualization. Interviewed actors added that although many Black and Afro-Colombian women speak freely about sexuality and have an understanding of pleasure, even though it is primarily considered a subject for men. On the other hand, Indigenous communities tend to be more conservative, so women are not used to discussing these subjects even when they are interested in learning.

> *"With Afro women, we have more conversations [than with Indigenous women about sexuality], because it goes through a cultural lens, but these conversations also show the effect that all the hypersexualization of Afro women has on their lives. So, yes, there we saw that if, let's say, they speak more calmly about sexuality, it is a sexuality that is more mediated by generating pleasure for men, that is, in the end, [women's] pleasure is not in the center " (POPA3 2022).*

> *"We said, 'What are we going to do with the Indigenous* compañeras*?' Because it is one thing to work with urban women, and another thing to work with Afro-descendants, and another thing to work with Indigenous women. With the Indigenous population, there is also a very complex issue. You have to be very precise because when it comes to reproductive rights, there is a whole case there. For example, the issue of abortion. So we discuss it very carefully, not emphasizing too much, beyond mentioning the Court's decision. The same goes with Indigenous communities who are supposed to have their particular laws. Still, we find that women, if they are concerned, if they want to know ... They also do it carefully. That is, they don't do it publicly, because they know that within their communities there is a lot of resistance, so it's difficult" (POPA3 2022).*

The interviewed actors did not mention specific barriers faced by lesbians or bisexual women. Nevertheless, the situation of trans men, transmasculine people, nonbinary folks, or people assigned female at birth by doctors (known as AMAN, *Asignadas Mujer Al Nacer*, especially in Perú) is relevant. Considering that this is a social group that suffers transphobia in their communities and by medical personnel, the interviewed actors mentioned that it is essential to educate doctors and healthcare institutions about diversity in gender perspective.

> *"Very high percentages of trans people have felt transphobic violence in medical settings they entered, so that is another gigantic barrier that makes them scared to go there, not only because of the violence of being trans but because of the violence that can be received for the sexual practices that they have. Then there is homophobia. If there are trans men who are gay or who have relationships with trans women and can get pregnant, there is homophobia, and there is transphobia also regarding the sexual practices of trans people. It is another barrier" (BOGAI 2022).*

> *"Forced sterilizations and forced mutilation of trans people that we feel are disguised as a health and sanitation discourse are actually trans hate, transphobia, and an attempt to ensure that there is no trans reproduction too. If they talk about trans, they talk about them not gestating, you know? It's like a social, cultural, and medical sterilization. We feel that" (BOGAI 2022).*

Finally, the interviewed actors mentioned that young people often seek information about healthcare services using social media platforms, even when internet access is scarce. This population group uses Instagram and Tik Tok

primarily, and Facebook to a lesser extent. Interview participants noted that Twitter is the platform least used by young people.

All these interviews reflect the urgency of establishing easy access to abortion and sexual and reproductive care, particularly since many young women and girls in rural communities do not even know they can access abortion. Interviewed actors also emphasized the barriers created by a transphobic culture. In addition, many young women and girls lack access to quality education, which translates to limited access to information.

Economic Barriers

Overall, interviewed actors agreed that Colombia is a country with high poverty levels. For them, the lack of economic resources has a negative impact on the infrastructure of communities, which results in a lack of access for women, trans men, and nonbinary people to services such as transportation, communication technologies, health services, education opportunities, and sometimes even basic needs like food.

> *"When you talk to me about difficulties, well, in Colombia, poverty is very high, and I am always going to focus on the rural areas because I come from a rural area. So it is very difficult — education, that is. There, seriously, they are stuck learning the alphabet" (POPA2 2022).*

> *"Colombia is not a country with access for all, internet access for all. It is a country where many people still do not have access to the internet … that is,*

Colombia is neither a rich country nor middle class. Colombia is still a poor country" (CUC-A3 2022).

"Look, I think that one of the things is when we begin to measure economic indices, one of the most important financial indexes is the Gini index, which places us, Colombia, I believe that we are in the third most unequal country in the world. And then, to that Gini index, you add an index called the multidimensional poverty index, and in that multidimensional poverty index, you realize that there are abysmal differences between living in a city and ... a person in a dispersed rural area, [because they] receive a more precarious education, in general. Sometimes they have to make life decisions such as study or work because if they don't work, they won't eat, or their family won't eat" (POPA4 2022).

Cost is a common concern for people who want to access abortion and/or family planning services. For young people, there are particular financial pressures because they are dependent on their parents or caregivers most of the time, and may not want to disclose their situation.

Rural Areas

According to the interview participants, people in rural areas experience greater poverty. As mentioned, these areas are especially challenging to reach on an infrastructural level because they are sometimes far from the cities, and transportation to and from these areas is difficult. Also, rural areas tend to have insufficient or sometimes deficient health services. These areas are also related to

poor access to general education and sexual education specifically and high levels of teenage pregnancy.

> *"What happens in many departments here, in terms of service, is that they are places where there is only one health post and they do not provide the service. And transportation there is very complicated, so women have to move, let's say a day of travel away, but many of the people who live there do not have the resources to travel. So with that, well, there are almost no health services there" (CUC-AI 2022).*

> *"There is no connectivity, so what happens is that, for example, to reach a community by river or by plane, the costs are high, and there are only a few distant communities that have healthcare institutions. And I tell you that it is not only because that community is remote, but the cost of the tickets, that is, the transportation, and even paying commission to the professional [provider]. Well, when it's by a river, let's say that the issue of gasoline, Mitú sometimes runs out of gasoline, did you know? Here sometimes we run out of gasoline for three or four days, and it's three or four days in which there is no transportation of any kind, because there is no gasoline, for example. So, we are an area of difficult access" (MIT-4 2022).*

Overall, rural communities are very diverse, and their socio-economic conditions vary, creating one more challenge of working in these areas.

Furthermore, interview participants indicated that cultural views on sexuality and women's roles in society are critical since prejudice and stigma often harm women

with active sex lives or interest in sexual education. This discrimination worsens for women who decide to end their pregnancy.

> *"Well, first, as a feminist, I feel that there is an importance to thinking about care, about mutual well-being, about a judgment-free accompaniment. There is concern around caring for the other person, which in some way generates trust. And with the institution, well, knowing that there are some barriers; or that you are going to meet super prejudiced people who will judge you, people who are going to point the finger at you, that there is no confidentiality, that you will enter a process of violence through language, through the way they treat you, and it will be as if you have to justify your decision all the time. Institutions are already super violent. So meeting a peer, whoever it is, but especially a feminist, generates confidence and gives you peace of mind" (POPAI 2022).*

Some interviewed actors, like Colectivo Viraje, mentioned their work's focus on the experiences of the *marica* (queer) community in rural areas.

> *"In Viraje, the main question is how sexual and gender dissidence is experienced in rural places as well, and this question about rurality crosses over our own identities ... how to be queer in the rural areas" (POPAI 2022).*

Multiculturality

The interviewed actors mentioned this is a multicultural and multiethnic context. Therefore, messaging delivery is difficult since not all groups share the same views on sexual and reproductive health, family planning, sexual abuse, domestic violence, and more. For example, interview participants indicated that for some

Indigenous men, women wanting to access contraception can be a sign of infidelity.

> *"It would be very good to carry out prevention campaigns, to prevent pregnancies, to teach [Indigenous women] the methods of planning so that they do not see it as a taboo, planning. Because they, for the man ... if the woman plans, it is because she is going to be unfaithful" (MIT-A5 2022).*

> *"I don't know, talking about methods, contraceptive methods in Indigenous communities is complex ... Because Indigenous peoples, they say, are disappearing, and reproduction is the way to guarantee that these Indigenous peoples endure over time. So it is quite complex to address the issue, even when Indigenous women decide to access family planning, because it is conflicting" (MIT-A3 2022).*

For some, physical violence is a natural way of relating to their partner or family members rather than a form of gender violence. Therefore, it is a challenge to create information that all groups can accept and understand.

Insufficient Access to Technologies

Since most women living in rural areas are impoverished, it is difficult to access communication technology such as the internet or smartphones, particularly for those who are migrants. For example, actors said that some families have only one device at home that the male partner controls, making it difficult for women to communicate. Other times, women must rely on a friend to use a phone, or the phone they have only allows them to make calls and send SMS messages.

"Because they don't have anything to eat, they don't have a device that allows them to access a platform. Something like that is fundamental, and this [healthcare] platform should not be, cannot be exclusively digital; instead, it has to be a network of actions" (CUC-A6 2022).

"We have to take into account that in Colombia, not all the people, or the majority of people who fall into our range of interest, have internet. They have neither a cell phone nor computer" (POPA2 2022).

"Well, obviously, many of [the people we serve] don't have technological tools. Many of the girls who contact us are migrants or from rural areas, and they don't even have telephones — the telephone is held by their husbands, or they have a friend with one. And it has happened to us many times that they have one of those phones called flechitas *[burner phones], which don't have WhatsApp" (CUC-A1 2022).*

However, the interviews also showed that apps like WhatsApp and Facebook are often used in rural areas because they are included in data plans. Instagram, on the other hand, is less popular because it consumes data that comes with an extra cost.

"I think that WhatsApp continues to be the most important app ... because also, right now, it is a little more democratized, a little more spread, because, well, it comes with data plans. It is easier to access than other networks that have paid plans ... Facebook and WhatsApp are the ones that come with phone plans ... Yes, in rural areas, these are the most used" (POPA1 2022).

In addition, because of the restrictions on technology access in rural areas, according to the interviewed actors, many women will never learn about self-managed abortion apps. This is particularly true because people in rural areas, migrants, and other impoverished people may only have access to low-end smartphones.

> " *[App creators] have to articulate themselves with the neighborhood organizations to expand and think about forming women leaders, of care, of different spaces. From there, it will begin to connect with the platform, with what it offers. But that offer will never, that is, these girls will never find out about that platform if it is spread only through digital means. So that platform has to reach the neighborhood" (CUC-A6 2022).*

Machismo

The interviewed actors talked about *machismo* in Colombian society as one of the most challenging obstacles to overcome when working with sexual and reproductive health and rights. As mentioned, the collective idea of women's roles in society is inextricably attached to a patriarchal system that determines traditions and costumes.

> *"The issue of* machismo*, that the woman is the one who stays at home cooking and all this, all that happens there [in the rural area of Zubia], but in an incredible way" (CUC-A2 2022).*

> *"I think that it has also been difficult. It has not been easy, but I think that seeing it, let's say, from a national perspective, I believe that there are cities that have it worse, such as the Caribbean coast, where* machismo *is very profoundly rooted … I'm not saying that Cúcuta is not a* machista *city. It is* machista. *All of Latin America is* machista, *a lot, but there are places where* machismo *is even more concentrated. It is more concentrated, and it hasn't been easy, but I think [Cúcuta] is a city that has been cooperating little by little, little by little. There is still a long way to go, and there are still many challenges, but it has been cooperating. There are very radical cities" (CUC-A3 2022).*

Therefore, sexual violence against women, and particularly rape culture, is constant in these communities.

> *"One day at a training, [a physician] stopped and told me, 'That's enabling it. Women come here who've had five or six abortions.' Then I told him, 'See, doctor, why do those women come here with five and six abortions? Because your grace only sees the abortion and does not see the woman in her context and her history. Ask that woman if her husband rapes her, because husbands also rape … Many women do this because they are not allowed to plan. I have women who have died of cervical cancer in the territory because her husband never let her go to get a cytology because only he could see her vagina. And I'm telling you that from a study that I have here — not from outside, but in the territory of Cauca. So her reality is totally different from the context of other people, from the worldview, from the belief system, from everything, and you have to understand that this complexity is what you treat. You do not treat abortion; you treat a woman with all her complexities" (POPA4 2022).*

"Many of the people who live in these peripheral areas and human settlements are migrants and are constantly on the move, and some of the paths they use the most often are illegal routes. And over there, you either pay or they rape you. So many end up in a situation where they don't have money and need to pass or their families, and it's the only option. The only option they have is to pass through those routes" (CUC-AI 2022).

"We have a patriarchal culture, a misogynistic culture … To say women at this moment are autonomous, that we are free to decide, is a lie. I mean, that's false … So why do we deal with the problem of women ending pregnancies but not the underlying problem? What is causing women to make those decisions … The important thing is that they know that when they are raped, they can end the pregnancy here … Because, of course, society stigmatizes, and society is horrified that women are accessing it, but society does not want to understand that women are being sexually violated" (CUC-A5 2022).

The interviews show that male-oriented sexual education is vital, since currently mostly women and girls are interested in learning about sexuality and reproduction, which is understandable because women must face the possibility of becoming pregnant. However, hegemonic masculinity damages young and adult men's health. For example, when engaging in unprotected sexual activities, men are exposed to STIs just as much as their partners. In addition, men risk untreated prostate problems or cancer when they refuse examination, often because of the belief that prostate exams must be performed through the rectum. According to the interviewed actors, this machista-homophobic culture prevents men from getting treatment.

"Sexual education, which includes not only a breast exam for women, but also a prostate exam for men ... Where can I get it within the local [area]? What is it? What it is for? Why it is so good to do? I must have that knowledge. Many men do not receive their prostate exams [due to their machismo*] because they fear it will be rectal. So it is also good to say that the exam no longer needs to be rectal, because there is also a blood test" (CUC-A3 2022).*

Lack of Comprehensive Reproductive & Sexual Education

The interviews also show that a lack of comprehensive sexual education is one of the key barriers to abortion care and sexual and reproductive health services in general. As noted, the lack of education on this topic contributes to higher rates of teenage pregnancy and a lack of knowledge about one's body in general. In the case of cisgender women, the interviewed actors highlighted menstruation as a topic of concern. They promote the dignification of and education about menstruation because many cisgender women do not understand how their cycle works. Others either do not know how to deal with menstrual pain or experience the effects of taboo around it, making it hard for them to discuss it and personally perceive it as a natural part of their anatomy.

"Since in many places, menstruation is still a taboo, something that belongs to the privacy of women, it is not considered a necessity, that [people]must have rights and that [menstruation]must be, that it must be responded to with actual public policies, starting from there ... In other words, it is not an issue. Menstruation is not [understood as] a public health

issue, but rather a women's thing, which is also embarrassing" (CUC-A6 2022).

"Regarding menstrual health, we also recognize a significant economic expense. Menstruating with dignity implies access to information and more and access to resources. For example, in some communities, there are women who continue to use rags, which are not very clean to retain blood. And there are women who do not have the means to buy sanitary pads or who are utterly unaware of the power in recognizing our cycle as part of us and not just as something that bothers us and annoys us, like a relationship with the body that is so contemptuous and distant. It also has to do, for example, with unplanned pregnancies — not knowing our menstruation, not knowing our body, is intimately linked to not knowing and not having power over the prevention of pregnancies at specific times" (CUC-A6 2022).

"Look, it would be important not only to explain the menstrual cycle to[women] but also that they can keep their calendar and that they have a period. 'How long did [the cycle]take you? How about your bleeding?' Because we need that — to know if your blood was very dark, if it was lighter, or if it suddenly had a different smell. To talk about whether it arrived — or what if it didn't? To see that it is not only a pregnancy that can cause a delayed period [amenorrhea] but also other situations in your body that can generate that change in your menstrual cycle. We need to also explain all that to them" (SOLEDADUI 2022).

The interviewed actors also reflected on the need to educate people about trans men's pregnancy and menstruation, considering that amenorrhea is not an indicator of pregnancy when under hormone treatment. Interview participants also

mentioned the importance of educating transmasculine and nonbinary folks on managing menstruation from their own gender identities, that is, working with menstruation beyond its traditional gender association.

> *"In talking about menstruation or the menstruation scenarios that we knew before … [advocates] didn't even give themselves the opportunity to think that not just [cisgender] women menstruate. And when we approached them to talk about menstruation, we were visibly the first trans organization that talked about trans menstruation. It was hard, and not only with women's organizations. They were like, 'Not you. Wait'… But this is not just for you, biological women, oh well. And on the other hand, there is an internal clash within transmasculine people because these are not discussed topics. Many boys are afraid of being able to express that they still menstruate or that they have a conflict with their genitals. There are a lot of feelings around that and zero space to talk about it. So [the program]* 'monstruación' *[monstruation] emerges as that possibility of initial dialogue that later turns into a scenario of healing and creation of tools … with questions such as 'What can we use to manage menstruation and menstrual cramps?' Because, in the case of trans people undergoing hormone replacement therapy, even though the menstruation stops, the cramps continue. Many things are managed differently, such as the use of the cup or recognizing that sanitary napkins or cloth pads don't work on men's boxers. So what do we think of now to wear? What can we wear? So, it's going through that experience of menstruating" (BOGAI 2022).*

Migration Barriers

The situation for migrants, particularly Venezuelan migrants, is challenging and complex. The interviews show that many migrant women are victims of at least one type of violence, and many are fleeing from a situation of domestic or sexual violence in their own country. Others were deceived with false promises of a better future and ended up caught in sex trafficking and prostitution networks and other forms of "modern" slavery.

> *"There are no guarantees, because these women are exposed. It has been proved that there is sometimes trafficking behind [their situation]. The conditions in which they live are violent because they can be murdered. They are experiencing systematic sexual violence, being coerced because there are armed groups … but we are with them. And also, there is a stigma against that because they say we re-victimize them, but we do not. We don't tell them, 'You are victims.' We simply clearly identify that woman because she is there, and if we approach her to understand why she migrated, and if we sit down with each one and say, 'How did you get here? If you are in need, do you want to be here? Are you okay with what you are doing?' And they give us an answer, which we analyze, and it indicates to us that, look, it is trafficking. They deceived her. She is here because of this situation. [And] many of them have, well, unwanted pregnancies. And suppose you ask me who among my population group are the ones who access [abortion]. In that case, I'll tell you about women in exploitation or prostitution, girls and women, products of systematic sexual violence who live in these conditions" (CUC-A5 2022).*

Hence, undocumented women and girls have many obstacles to accessing reproductive and sexual health services. Many of them cannot use EPS since they lack the required official document, forcing them to search for private services.

However, the precarious economic situation of most undocumented women makes it almost impossible to afford private care. Therefore, the interviewed actors mentioned that migrant women tend to turn to unsafe abortions. This constitutes a high risk to their physical and mental health, especially when using methods such as punching oneself in the stomach, falling from stairs, taking herbal remedies, or inserting dangerous objects through the cervix, which can lead to hemorrhage, infection, and sometimes death.

> *"From my experiences with women in Venezuela, many arrive in conditions where they tell me … 'I threw myself from the second floor. My friends hit me.' They even do it themselves. They hit themselves, mistreat themselves, insert things. They do a lot of things. Or they come here. There are many clandestine places here. In La Parada there are many clandestine places. [La Parada is] the entrance to Villa del Rosario because the women do not know here, and they come looking for a termination [of pregnancy] at any cost" (CUC-A5 2022).*

The fact that people turn to these abortion methods shows the lack of access to information regarding the safety of self-managed abortion with pills, which can also be done with support from a medical provider.

Law Implementation

The interview participants also expressed concern over the implementation of laws around abortion access and other human rights. Actors indicated that while it is important to have a law on paper, it is entirely different to have a law that is functional, respected, and guaranteed to all.

"The phrase 'change of law' sounds enormous. We have to be aware that as the legal mechanisms change, it is much easier for us to be able to inform and be able to accompany people. However, culture will be a problem because we, as feminist groups, not only fight against the mechanisms that we have or do not have, but notice how people accept or deny those mechanisms, and how those mechanisms are engaged. For example, the law is protected under I256, and I257 is the most ignored law in the universe. So we have to say, well, it is good for it to be done, for it to be already in the Constitution or on paper waiting to be signed, but it is a much bigger problem [to implement it]" (POPA2 2022).

"Many people need to have something, a written piece of paper, a legal basis that tells them that this is fine to consider something correct. So I feel that this [law] advances us toward social decriminalization. I feel that it is of great help because particularly young women were being criminalized, as well as those from rural areas and migrants who lacked knowledge and were in situations of vulnerability. So the fact that a legal process is not initiated against them and that they are not threatened with imprisonment helps a lot. But I feel that there is more than a challenge now because, as I told you, since 2006, there was already a decision that allowed people[to have an abortion] legally under certain grounds. But to date, women have not had clarity on those grounds. Although [the government]mainly described the grounds as [termination for] health, [women]did not know that. And so many years have passed. So I feel that it will be hard work to raise awareness so the same thing does not happen again. So many years, and women still did not understand the scope of that law in terms of reproductive decisions" (CUC-AI 2022).

> *"Implementation is the most difficult thing to achieve. I think that to carry out a law is one of the main challenges because there will always be barriers to being able to access rights. There are many rights in the Constitution that are violated as we speak even though they are within the Constitution. How do we ensure that women have these rights, that they can access these sexual and reproductive rights?" (CUC-A2 2022).*

Without this, the women most vulnerable to criminalization are those living in the margins, such as young people, those living in rural areas, and migrants.

Commonalities

The following factors are commonalities identified for the regions analyzed in this report.

Telemedicine

According to the interviewed actors, it would be more feasible for women to go to the city for medical attention than to wait for services to reach their communities. But, as mentioned before, rural communities have many barriers, including infrastructure and economic ones, that make travel difficult. For this reason, interview participants praised telemedicine as an excellent tool for receiving medical attention. In addition, telemedicine saves patients from explaining their whereabouts to their families and protects patient privacy in cases where the community's only doctor is a family member.

Nevertheless, many interview participants also think of telemedicine as a service that only a few can use because of the economic barriers and insufficient access to communication technologies, particularly in rural areas. Likewise, interview participants mentioned that people might be reluctant toward telehealth, which is a relatively new form of healthcare. For this reason, the interviewed actors recommend a subtle approach to telehealth in conservative communities. Along these lines, some actors mentioned that people are more likely to trust telehealth when organizations or *colectivas* recommend this approach.

> *"Telemedicine has helped a lot, more than anything in Norte de Santander, where many places are difficult to access. Some girls are not in Cúcuta and come to us. They might also be from a small town, where there is less opportunity to access [healthcare], where there are not so many private clinics, and everything has to be through public services. And [telehealth] has made it much easier for them, especially to avoid traveling, because they would have the expense of tickets, they would also have to give explanations to the people they live with asking what they are going to do to Cúcuta … it hasn't been easy … in that sense because apparently many do not have the technology" (CUC-AI 2022).*

For the interviewed actors, communication with the patient is also essential. These advocates believe that empathy and confidentiality are crucial in their line of work. They also said that when using telemedicine, patients must be able to speak to a person and not just a bot. That is especially important for the early stage of contact, when patients thinking about ending their pregnancy have questions and doubts about it or when they experience anxiety or are emotionally unwell.

> *"You have to have empathy and know how to say things … In this process, you have to know how to talk to them … because they don't know the wild effects of these processes. No, it's not that you want to be happy overnight because you had an abortion, no … And some women don't feel these hormonal and moral shocks too badly. Still, others do, some are more sensitive. There are some women we must be more careful with than others … And that is only known through communication" (POPA2 2022).*

In addition, the interviewed actors emphasized that communication between providers and patients must be free of stigma, blame, and moral prejudice. Therefore, it is essential to remember that these interactions happen in a moment of extreme vulnerability for the person who needs the service. Interview participants were aware that in a patriarchal society where power is always present in social interactions, providers must receive training on gender and feminist perspectives.

Lack of Trust in the Institutional Services

The interviews showed that women and migrants often distrust institutional health services and therefore reach out to advocacy organizations for guidance. For example, the interview participants said that women prefer to contact the actors' groups or *colectivas* for information on having a self-managed abortion at home instead of going to a hospital. The interviewed actors attribute this trend to the *machista* culture expressed in obstetric violence, the lack of personal care in healthcare institutions, long waiting periods, and secrecy around abortion and family planning services resulting from the lack of promotion by state health institutions. In addition, underage women can have issues with institutional

services because doctors may believe they are too young for sexual activity, making them vulnerable to being refused contraception methods.

> *"I believe that there is a deep distrust towards institutions, so that was never an option [before legalization]. Now, perhaps Profamilia, Oriéntame, well, right now, they appear relevant. But at that time, we were resigned to clandestine abortion in conditions that were very, very, very, very complicated" (POPAI 2022).*

In the case of migrants, the interviewed actors report that legal statuses can complicate any access to health services. Therefore, even if migrants can receive medical attention, they experience lengthy waiting periods.

Accompaniment

According to the interviewed actors, healthcare institutions have many issues, including accessibility, equipment, quality of gender-based care, discrimination, and reproducing stigma around sexual and reproductive health and rights. Additionally, even when the law permits abortion, there are several barriers to accessing reproductive services, particularly in rural communities. Likewise, young women and girls face special harsh situations of sexual violence, misinformation, and denial of planning services.

Thus, whether for abortion services like self-managed abortion at home, psychological treatment, gender affirming care, *escrache*, or legal processes, all interviewed actors considered accompanying people through their experiences

one of the crucial and most relevant parts of their work with women and girls, trans men, and nonbinary people.

> *"And to understand how to accompany, we don't approach saying that we know how to accompany. Instead, we analyze the situation to understand how to accompany people, and the tools are born. They are co-created" (BOGAI 2022).*

> *"I think we have to have a lot of empathy, not just like, 'Oh yes, look, call this number and get in touch there, go there, and they'll do something to you.' No, because they are people, and we, in addition to being an organization in defense of human rights, we are an organization in which all the volunteers and professionals. We have a person-first attitude, so that women feel comfortable. Until all their questions are resolved … we accompany them" (POPA2 2022).*

For them, accompaniment is more than giving information to the person in need during their process. This form of activism exercises company, empathy, patience, education, and love. Interviewed actors explained particular examples of the ways their work saves and changes lives in ways that institutions do not.

Transparency of the Abortion Process

For the interviewed actors, it is crucial to offer patients as much information as possible about the self-managed abortion experience they will undergo.

> *"It seems to me that this image of the happy woman who just had an abortion is very romanticized. It hurts. That's it, and it's ok. We will not*

necessarily be traumatized for life, but we still have to be very serious. It is not sunny either. We need a more grounded look at the services and what can happen. Because if not, it could be like, 'Maybe they didn't lie to me, but they said that it would hurt like a menstrual cramp, and it wasn't a menstrual cramp. It was a powerful thing that made me go to bed for half a day, and I bled, and I was scared.' I mean, contemplating those moments of anguish that can be represented" (POPAI 2022).

Advocates seek to do the following around self-medication abortion:

a) To give a cautious and friendly explanation of why people should not do it alone, and if they do and explain why they should have someone online or on the phone with them.
b) To offer a friendly recommendation to be near a hospital when doing it.
c) To explain how, when, and why they must take the pills.
d) To ask for an allergy test to prevent any reactions if using misoprostol.
e) To describe all the possible secondary effects and the safest possible response.
f) To offer an empathetic, cautious, and clear recognition that abortion is not a painless procedure and explain the possible physical discomforts or pain.
g) To offer a clear description of what will come out of the uterus depending on the pregnancy's gestation to demystify the imagery that anti-abortion advertisements may have generated. For example, because of anti-abortion messaging, the patient could expect the expulsion of a wholly formed fetus when they will only see blood clots.

By following the above guidelines, advocates could ensure that patients understand that they have performed their self-managed abortion correctly.

Accessibility

In addition, the interviewed actors discussed the importance of accessible information. They declared it necessary to consider class as a category that defines how people will experience their pregnancy decisions. For example, class privilege is reflected in people's educational levels, indicating it is more challenging for underprivileged people to understand instructions written in a stilted language. For this reason, educational information must be easy to find and phrased in accessible ways.

These accessibility concerns multiply when considering the different age ranges of potential users. The interviewed actors mentioned that the COVID-19 pandemic had a somewhat positive impact on elderly groups, because it forced them to use communication technologies with which they were once unfamiliar. Therefore, in addition to language phrasing, technological interfaces must be as friendly and intuitive for the user as possible.

The interviewed actors also recommended a territorial approach, meaning that advocates must take into account languages other than Spanish, like English and Indigenous languages. Inclusiveness is crucial, and videos with sign language are equally necessary. Likewise, interview participants recommend a pedagogical approach that demystifies antiquated notions on sexuality and abortion. For this, interviewed actors insisted that talking without taboos or censorship is crucial.

"Well, I think that here in the territory, [apps] must have a territorial focus, in terms of women and migrants, that not all of them can access Profamilia in the same way as we Colombians do, for example, then certainly they must provide a language, either with institutions or cooperation, that can work more directly with migrants. It is something they must have" (CUC-A6 2022).

The following are specificities that actors mentioned any accompaniment of abortion app should have:

- Step-by-step instructions.
- Pedagogy to demystify patriarchal ideas.
- Question boxes.
- Educational information for individuals and organizations interested in working with abortion accompaniment or sexual and reproductive education.
- Juvenile and adolescent-focused language.
- Cartoon format.
- Peer-to-peer video capsules (such as adolescents to adolescents or kids to kids).
- Information on pregnancy and the body ("Know your body").
- Parenting material (such as "What to do when" and "How to approach these subjects").
- Color schemes not traditionally associated with the gender binary (such as pink/blue).
- Contraception information that targets both women and men.

- Trans inclusivity ("What happens with trans men's pregnancy/menstruation").
- Information on menstrual health.
- Vasectomy education.
- Lists of active telephone numbers/websites.
- Messages of encouragement.
- Practices that prioritize confidentiality and anonymity.

CONCLUSIONS

The objective of this report has been to account for the situation of sexual and reproductive rights in Colombia, particularly in relation to access to safe abortion. Through a multiple-case study, it was possible to know the situation of five regions of interest: Bogotá, Popayán, Cúcuta, Mitú, and Soledad as representatives of the national territory. The results obtained allow us to point out that although abortion is currently legal in Colombia, there are significant barriers and implementation challenges that continue to limit access for young women, and other people who can become pregnant, particularly girls under 14 years old and those living in rural areas or in contexts where armed conflict is still an existing problem.

After reviewing the national political, economic, and sociocultural context as well as the local conditions of the five areas of interest and the experiences of health providers, accompaniments, and patients we identify the following barriers as the most pressing ones to guaranteeing abortion access in Colombia:

- Technology gaps, including access to internet service and devices.
- Lack of infrastructure in rural areas, including access to the communities, transportation services, and healthcare institutions.
- Multidimensional poverty
- Insufficient education or the lack of it.
- Multiculturality and traditions. Colombia is a country with a large Indigenous population. These communities have their own views on abortion and sexuality. Also, the country is predominantly conservative which leads to stigma and taboo over sexual and reproductive matters.

Finally, the decision **C-055 of 2022** which fully decriminalizes abortion up to 24 weeks of gestation is recent, and so far governmental as well as private institutions and some medical practitioners have resisted its implementation. However, based on the court's decision, all three branches of the state (executive, legislative, and judicial) will be required to adopt strategies and concrete public policies to guarantee sexual and reproductive rights for all. This process will include country-wide education to communicate that abortion is a decision that belongs only to the pregnant person. In the meantime, a network of independent organizations and feminist collectives are working to ensure compliance and

monitoring individual cases to safeguard unencumbered access to abortion services.

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