Co-design of a digital solution for abortion self-care

Profamilia

VITALA

Global Care
The Global consortium for Abortion and Reproductive Self-care.

Executive Management
Marta Royo, Executive Director
Lina Castaño, Social Senior Manager
Paola Montenegro, Research Director
Diana Carolina Moreno, Advocacy Director

Global Care Consortium
Larisa Caruso, Coordinator of Global Care Secretariat

Research Team
Paola Montenegro (Profamilia's Research Director)
Marcela Sánchez (Profamilia's Research Coordinator)
María de los Ángeles Balaguera (Profamilia's Partnerships and Funding Analyst)
Diana Marcela Zambrano (Quantative Research Analyst)
Roopan Gill (Vitala Global Foundation's Executive Director)
Genevieve Tam (Vitala Global Foundation's Project Director)
Bianca Maria Stifani (Vitala Global Foundation's Quantitative Researcher)
Silvia Barragán (Vitala Global Foundation's UX/UI Designer)
Ana Jiménez (Vitala Global Foundation's Researcher and Senior UX/UI Designer)

Data collection
María de los Ángeles Balaguera (Partnerships and Funding Analyst)

Writing staff
María de los Ángeles Balaguera (Profamilia's Partnerships and Funding Analyst)
Diana Marcela Zambrano (Profamilia's Quantitative Research Analyst)
Roopan Gill (Vitala Global Foundation's Executive Director)

Data transcription
Lida Muñoz
Helena Santa

Proofreading
Gloria Hoyos

Translation
Sergio Velásquez, Ingesonic Ltda.

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Contenido

List of tables

Índice de gráficas

Appendixes list

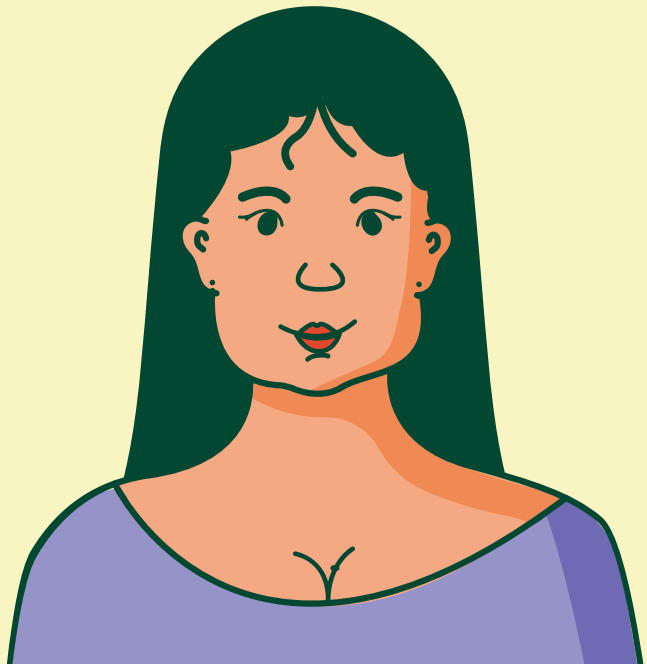
Presentation

Protecting and guaranteeing the right to abortion is one of the most urgent tasks to be fulfilled to strengthen the gender equality and sustainability agenda at local, regional, and global levels. In February 2022 Colombia took a historic step towards securing universal access to abortion with the ruling C-055 of 2022 that decriminalised abortion up to 24 weeks of pregnancy, and although it is not a challenge-free endeavour, it represents a milestone towards a more equitable and democratic country and brings us ever closer to realising the full exercise of the *right to decide*.

This maxim, which has been a guiding tenet in the fight to make abortion a legal and socially recognised right, free of stigma and barriers, can go beyond its legal confines and become a central principle for the design of healthcare technologies and services that are more attuned to the needs of those who have abortions. Especially in a scenario marked by unprecedented social, political, and economic disruptions due to the COVID-19 pandemic, the commitment to design better healthcare services that can be adapted to the identities, preferences, experiences, social contexts and possibilities of the user population is more necessary than ever. In this sense, the possibility of expanding access to services through telemedicine brings us closer to consider the role of healthcare models in transforming the way individuals and communities make autonomous, safe, and informed decisions about their health and well-being, reducing healthcare costs and waiting times, promoting autonomy and agency.

Built in these commitments, the Global Care Consortium created in 2021 with Profamilia as the host Secretariat played an essential part as technical

Protecting and guaranteeing the right to abortion is one of the most urgent tasks to be accomplished to strengthen the gender equity and sustainability agenda at the local, regional and global levels.



Secretariat and Associate Member of the Consortium, roles from which it develops the premises of this research. This global initiative aims to facilitate self-care abortion practices globally by developing person-centered and context-sensitive models of care and communication, and advocacy tools to assist key stakeholders at all levels (community, institutional, and political) in supporting and empowering women, men with trans life experience, and non-binary people assigned female at birth to make more strategic, autonomous and agency-based reproductive decisions. The Consortium's work has focused on the development of multiple action, articulation, and advocacy strategies, as well as the creation of support networks, the promotion of legal provisions, and the use of innovative technologies that create optimal environments to guarantee access to safe and high-quality self-managed abortion, all of which are also central premises for Profamilia in its mission to ensure the full exercise of sexual and reproductive rights.

Within the framework of these priorities, Profamilia developed this research in collaboration with Vitala Global Foundation with the goal of contributing to the evidence framework of abortion self-care in telemedicine contexts, highlighting the main needs, barriers, and opportunities that exist today in Colombia's legal abortion ecosystem, and emphasizing the opportunities that telemedicine abortion might create to facilitate access to information and quality services that can fill gaps of timely and inclusive access, in conditions of dignity and quality. This initiative will also highlight opportunities for advocacy, innovation, and the promotion of best practices for improving tele-abortion services in Colombia and Latin America.

We hope that these findings and analysis will not only serve as input to improve Profamilia's services but will also platform persistent needs in the sexual and reproductive health experiences of women, men with trans life experience, and non-binary people assigned female at birth, whose well-being and care will be part of our ongoing work.

Marta Royo

1. Introduction

In Colombia, there is a significant gap in access to sexual and reproductive health services, specifically safe abortion, which disproportionately affects the country's young population of limited resources who live in rural or suburban areas. These issues, accentuated by the effects of the COVID-19 pandemic, could be transformed into windows of opportunity considering the expansion of telemedicine services in the country and with the new provisions of Ruling C-055 of 2022 of The Constitutional Court of Colombia, which decriminalizes abortion up to 24 weeks of pregnancy. These advancements provide a key opportunity for healthcare providers such as Profamilia to identify routes and tools to facilitate access to abortion services in a context free of criminalization and, simultaneously, open possibilities for innovation in potential solutions to the obstacles identified in access to this right.

In this scenario, approaches from alternative fields, such as those offered by **medical abortion**[1] via telemedicine, could promote explorations that could accelerate the closure of the access gaps mentioned for the population in conditions of vulnerability. Telemedicine, a modality in which medical

1. **Medical Abortion:** also known as "non-surgical abortion" or " Medication abortion," refers to the practice of pregnancy termination that uses drugs such as misoprostol and mifepristone to perform the procedures. Although the most common practice refers to the use of misoprostol alone, combined treatment (incorporating mifepristone) has been proven to be more effective than misoprostol administration alone (Lete et al., 2015; Coll, Serrano, Doval, & Carbonell, 2015; World Health Organization, 2019, 2022a). In Colombia, medication for abortion procedures is authorized only up to 10 weeks of gestation (Ministry of Health and Social Protection, 2014).

Pharmacological abortion refers to the practice of pregnancy interruption that uses pills such as misoprostol and mifepristone to perform the procedures.

personnel uses information and communication technologies for diagnosis and treatment, has grown significantly in the last decade in parallel with the widespread use of mobile devices connected to the Internet (Doshi et al.; 2020). Its application in sexual health and reproductive health services (including medical abortion) has been endorsed by the World Health Organization's last two technical guidelines for abortion (2019; 2022a) and has been explored preliminarly in positive experiences in countries such as the United States, Australia, United Kingdom, Argentina, and Indonesia (Prandini and Larrea, 2020).

The World Health Organization (hereinafter WHO) guidelines and recommendations regarding abortion self-care and national policies regulating these services, as well as the guidelines provided by the Colombian Ministry of Health and Social Protection, currently support the coordinated provision of abortion services through clinical telemedicine (2014). According to the WHO, self-care abortion via telemedicine, that is, outside of the clinical context of hospitals or health centers, can be safe if people have access to adequate information and support services are available at all stages of the process (World Health Organization, 2022a). This research confirms that these provisions are critical in responding to and adapting sexual and reproductive health services, particularly among young people.

This perspective on health management recognizes the role of people who seek an abortion as autonomous agents who can make informed decisions about their health, while not necessarly implying that they bear complete responsibility for the safety of the practices. In this regard, it is critical to develop and adapt support services, care, and information delivery to reduce risks and adverse effects.

In the context of the pandemic by COVID-19, Profamilia created the **tele-abortion service mía** as part of a strategy to facilitate access to the right to abortion during mandatory confinement.

Profamilia established the *Mía* tele-abortion service (derived from the word autonomy in Spanish: autonomía) in 2020 as part of a strategy to facilitate access to the right to an abortion during mandatory confinement. Following the country's telemedicine regulations in effect at the time[2], the service provided (and continues to do so) medical assessment, prescription, and delivery of medicines to the user population via a Whatsapp line and direct telephone contact. The Mía Kit being delivered to the patient's home contains the following items: the prescribed doses of mifepristone and misoprostol, informative self-administration brochures that graphically support the care process, menstrual pads, and the contact number of Profamilia in the event of an emergency. Furthermore, the service includes the prescription of contraceptives, which are made available to the patients to begin after the procedure is completed. As a result, this research aims, among other things, to identify opportunities to improve the current service based on the testimonies, preferences and expectations of people who have used the Mía service or who may use it in the future. These efforts are consistent with the prospective that telemedicine abortion has the potential to become a strategic solution for the care of the young population.

This report is divided into seven (7) sections organized as follows: the first section discusses the background context of abortion in Colombia and frames the possible upcoming changes in narratives of abortion following the Constitutional Court's new ruling C-055. Also, this segment analyses the perceptions of stakeholders and interviewees about what opportunities exist for the socio-cultural transformation of abortion stigma and explores what barriers are perceived to persist. The second section presents data on the dynamics of abortion and access to sexual and reproductive health registred in the municipalities prioritized in this research. The third section analyses young people's narratives regarding access to sexual and reproductive health, as well as their accounts of where related information is found. Also, this section examines perspectives on the need for differential approaches needed in the provision of sexual and reproductive health care tailored to people with dissident identities and racialised ethnic groups. The fourth section delves into the participants' narratives about contraceptive use, their barriers and paradoxes, and their perception of their own autonomy in coercive contexts.

The fifth and sixth sections will address preferences and perceptions of acceptability of abortion self-care in telemedicine contexts and identify new elements for the design of the proposed digital solution in relation to

2. **See Appendix 1:** "List of regulatory policies and legal framework for the delivery of telemedicine abortion services in Profamilia"

the expectations and needs documented in the research. The seventh section will address the concepts of autonomy, care, and consent as guiding principles for the design of technologies in relation to sexual and reproductive health services, based on the centrality of these categories in the testimonies and surveys obtained in the context of the research. The document closes with final reflections, general recommendations for the prototype, and conclusions on the most significant findings.

Objectives and Methodology

This research consolidates the efforts and collaborations of Profamilia and Vitala Global Foundation for the creation of a prototype digital solution that seeks to facilitate self-care abortion among young people, while at the same time aiming to identify routes and strategies on how to contribute to strengthening the safe abortion ecosystem in the country. Linked to these goals are the following specific objectives:

- To explore the abortion self-care needs of young people assigned female at birth (women, non-binary people, and men with transmasculine life experience) living in Colombia who had or had not accessed abortion services.

- To understand the content and design preferences for a digital solution that can provide abortion self-care via the Mía platform.

- To identify the perceived risks and benefits of using digital platforms for abortion care and support.

- To comprehend the perspectives of key stakeholders of preferences and needs to integrate into the digital solution to provide abortion care and support.

This exploratory and formative research represents the first of two consecutive phases and serves as the diagnostic stage of the prototyping, allowing for the identification of the population's needs and preferences. Phase two of implementation, aimed at incorporating the findings into the creation of the prototype. At the core of this venture, we strategically integrated Human-Centred Design (as a methodological and creative approach) and an intersectional and human rights-based approach to health (as lenses for the design and analysis of the information collected). The articulation of these frameworks allowed, on one hand, to align and standardize the research instruments based on the characteristics and identities of the research subjects and, on the other, to contribute to the interdisciplinary convergence of knowledge and expertise of both the organizational teams

and the groups interviewed and surveyed. In addition, they made it possible to focus all points of contact with key stakeholders to be based on empathy and attentive listening.

> **Human-Centered Design** refers to an iterative design methodology that prioritizes the needs and characteristics of the people who use a product or service in all phases of an intervention. This approach prioritizes understanding problems from people's perspectives, incorporating their needs into the design, and including measurements of their experiences in all progress and implementation reports are all part of this (Fakoya et al., 2022).
>
> From its intersectional edge, **the intersectional and human rights-based approach** to health proposes considering the simultaneous interrelationships between different aspects of subjects' social identities in their contexts and how these derive from qualitatively different experiences of exclusion and/or privilege situated in the encounter of their social characteristics. From the perspective of human rights and health, this approach recognizes the universality, inalienability, and interdependence of the human rights that all people possess, empowering their holders to demand them and the guarantors to comply with their obligations (OHCHR, 2016).

In addition to incorporating these frameworks and approaches, the research combined qualitative and quantitative methods organized into four key activities:

1. **Literature review and context analysis of abortion in Colombia.** Secondary sources were reviewed, including published studies, legal statutes, medical guidelines, and Colombian policies on telemedicine and

In the heart of this bet, the **Person-Centered Design** and an **intersectional and a human rights-based approach to health** were strategically integrated.

safe abortion. This provided information on the legal, political, economic, and social context for telemedicine approaches to abortion, sexual health, and reproductive health services.

2. **Qualitative semi-structured interviews in prioritized municipalities.** Interviews were conducted with assigned women at birth between the ages of 13 and 28 who have or have not had induced abortions (including non-binary people, cisgender women, and men with transmasculine life experiences) to inquire about barriers, opportunities, and perspectives framed in experiences and narratives on abortion, sexual health, and reproductive issues, as well as design preferences and the content of potential digital platforms that address these issues and services. Priority was given to the participation of historically marginalized groups such as people from the LGTBIQA+ community, migrants, indigenous people, afro-Colombians, and campesino people (peasants and farmers). A total of twenty-four (24) interviews were conducted with users or potential users of abortion services in five (5) municipalities across the country chosen for their demographic and cultural characteristics, as well as their media visibility due to reported cases of abortion in these contexts.

3. **Interviews with key stakeholders in the prioritized municipalities and at the national level.** We identified the map of institutional and community stakeholders, feminist support groups, community-based organizations, and humanitarian organizations working on gender equity, sexual and reproductive rights, and, more specifically, abortion. Twenty-one (21) interviews were conducted with local stakeholders and three (3) with national stakeholders to inquire about actions, perspectives, and proposals regarding the context of abortion in Colombia and the use of digital media for its access (telemedicine).

4. **Virtual survey distributed nationwide.** The survey enquired about how women, men with transmasculine life experiences, and non-binary people assigned female at birth (between the ages of 13 and 28) use their mobile devices to access information and healthcare services related to sexual and reproductive health, as well as abortion. The survey was disseminated through Profamilia platforms (the organization's social media and Mia/Profamilia websites) and ad campaigns with third parties (allies and/or other strategic stakeholders), accompanied by a communications strategy validated with Profamilia Youth Network members. The survey collected a total of 5,733 responses.

The survey and the semi-structured interviews with users and key stakeholders addressed the following themes:

- Sociodemographic information
- Types of electronic communication devices that individuals use and have access to
- Purposes of use cell phones
- Family dynamics
- Acceptable information to include in a digital intervention on abortion self-care
- Optimal mobile strategies for abortion, sexual health, and reproductive health interventions
- Information preferences about health, sexual health, and reproductive health
- Design qualities for the digital solution
- Privacy and security
- Perceptions and realities of sexual health and reproductive health, specifically around contexts that restrict abortion
- Digital health/mobile health (mHealth) solutions in the current Colombian context
- The complexity of the humanitarian crisis and its impact on services (migrants and refugees)
- Acceptability of a digital solution that provides care and support for safe abortion services
- Ease of use of technological solutions
- Inclusiveness and digital literacy

Profamilia's Research Ethics Committee approved this study on March 8, 2022. The interviews were conducted in person in the municipalities with the exception of six (6) cases where video calls were chosen as an alternative due to health and mobility issues. Data collection lasted six (6) weeks between March 22, 2022, and April 30, 2022. Before the start of each interview, participants signed informed consent forms that provided information

on the objectives, topics to be addressed, duration of the activity, the voluntary nature of their participation, and the confidentiality of the information collected, as well as the option to leave the interview at any point. The interviews were recorded with prior consent and transcribed in Word documents for qualitative data analysis. The processing and systematization were completed using NVivo12. The creation of categories and subcategories was based on the thematic axes, as well as being in accordance with the objectives and issues brought up in the research[3].

The online survey was created on the SurveyMonkey® platform. A non-probabilistic sample was used. It was distributed via social media and was previously calibrated with feedback from the Profamilia's Youth Network. The results of the quantitative data were analysed using SPSS Statistics 25.

Finally, for the development of the analyses presented here, we implemented a **triangulation method**, which refers to the practice of using, cross-referencing and contrasting multiple data sources and approaches to consolidate more cohesive arguments that can make use of the qualitative and quantitative information obtained. In addition to this triangulation, a literature review was conducted on abortion, telemedicine, sexual health, and reproductive health, using academic articles and reports published locally, regionally, and globally in open access indexed databases. The categories of analysis used in the systematisation of qualitative information correspond to the central thematic axes mentioned, as well as to some emerging categories in the interviews that correspond to personal life trajectories and territorialised visions of abortion narratives. The conclusions and recommendations contained in this research report are the result of several iterations with the Global Care team, Vitala Global Foundation and the different Profamilia teams involved.

Limitations of the study

The limitations of this research are related to the limits of the methodologies chosen to guarantee the representativeness of the objective population in both the quantitative and qualitative exercises. The virtual survey, for example, faced limitations mainly derived from the low participation of people without mobile devices, low participation of people from ethnic minority groups, and low participation of people living in rural areas of the country where there is scarce digital connectivity. In addition, for the question modules asking about favourability of using mobile devices to

3. **See Appendix 2.** List of nodes and categories used during the processing of semi-structured interviews.

manage health-related services and concerns, it should be noted that the majority of respondents own at least one device that connects frequently to the internet and follows content related to Profamilia's services, so there may be biases in the characteristics and practices of the respondents.

In the semi-structured interviews, the limitations were mainly related to the challenge of including and representing the heterogeneity of abortion experiences that may exist in Colombia and the task of converting subjectivities into concrete measurable characteristics. There were difficulties in convening people with dissident identities in abortion contexts, as well as ethnic groups such as Raizal, Afro, Black and Campesino due to operational limitations. Considering these blind spots, it is possible that there are particularities of abortion experiences that were omitted from this research but which it is hoped to expand on in future opportunities.

2. Research Results

Twenty-four (24) semi-structured interviews were conducted with people assigned female at birth, of these, nineteen (19) were cisgender women, three (3) were non-binary people assigned female at birth and two (2) men with transmasculine life experience. Only three (3) people self-identified as indigenous, the rest of respondants did not belong to any ethnic group. The average age of the respondents was 24 years. Seven (7) of the twenty-four (24) people interviewed have had abortion experiences, five (5) of them with Profamilia's Mía platform, one (1) using the general health system, and one of them (1) acquired the pills clandestinely. Twenty-four (24) interviews were conducted with key actors, twenty-one (21) with local actors in the prioritised municipalities and three (3) with national stakeholders.

The online survey collected a total of 5,733 responses from women, men with transmasculine life experiences, and non-binary persons assigned female at birth between the ages of 13 and 28. According to their socio-demographic characteristics (Table 1), 98.5% of participants are cisgender women, 0.1% are men with transmasculine life experiences, 0.9% are non-binary persons assigned female at birth, and 0.5% are people with another gender identity. According to age groups, the highest percentage of participants is between 20 and 24 years old (46.4%) and 95% of the participants live in the urban area. In relation to their affiliation status to the General Social Security Health System (SGSSS Spanish acronym), 81.5% of the participants are affiliated to the contributory regime, 11.3% are affiliated to the subsidised regime, 2.7% are affiliated to the special regime and 4.6% are not affiliated.

Data of ethnic groups shows that 93.8% of participants do not identify with any ethnic group, 4.9% identify as Black, Afro-descendant, Raizal or Palenquero; 1.2% as indigenous, and at least 0.1% as Gypsy/Roma. Regarding educational levels, the highest percentage of participants who responded the survey are studying or have completed their bachelor studies (48.5%), 25.6% are studying or have completed high school, and 23.4% are studying or have completed their technical/technological studies. Survey respondents' income levels reveal that 27.3% have no income, 42% earn between zero and one legal minimum wage, 17.2% earn between one and two minimum wages, and 14.3% earn more than two minimum wages.

Table 1. Sociodemographic characteristics of online survey respondents

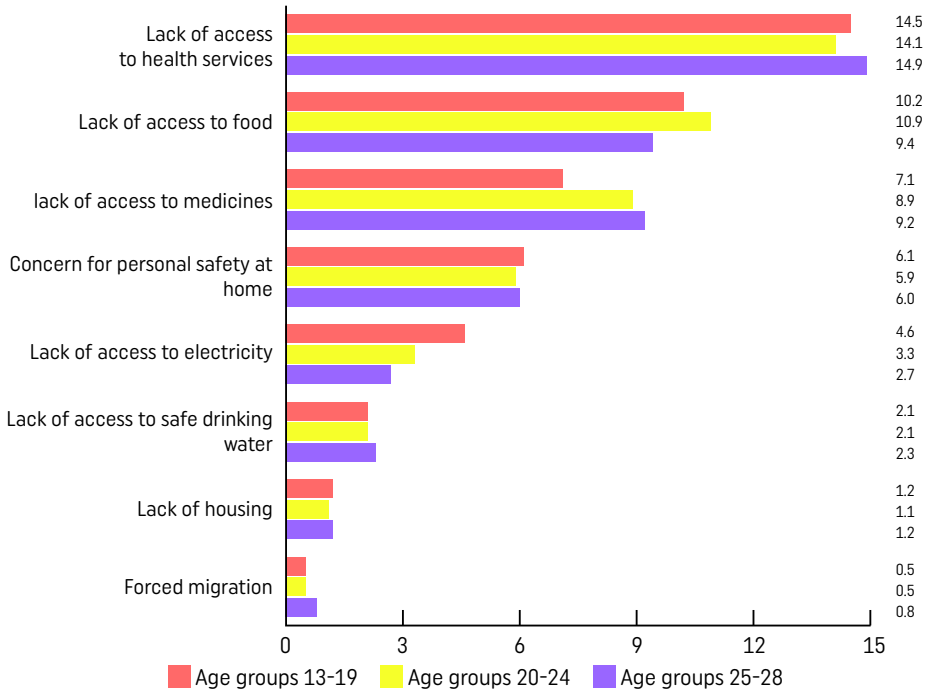
Variable	Category	Percentage (%)
Gender Identity	Female (cisgender women)	98.5
	Trans, Non-binary or Other	1.5
Age Groups	13-19	23.9
	20-24	46.4
	25-28	29.7
Area of Residence	Urban	95.0
	Rural	5.0
Ethnicity	None	93.8
	Raizal, Palenquera, Black, Mulata or Afro	4.9
	Indigenous	1.2
	Gypsy/Roma person	0.1
Education Level	Completed elementary school	0.3
	High school (complete or incomplete)	26.1
	Bachelor (complete or incomplete)	48.5
	Technical/technological (complete or incomplete)	23.4
	Master's/Doctorate	1.7
SGSSS Affiliation	Contributory	81.5
	Subsidized	11.3
	Exception or Special	2.7
	Not registered / Do not know	4.6
Employment Status	Students	45.1
	Employed or Self-Employed	36.9
	Unemployed*	15.8
	Other	2.3
Income Level	No income	27.3
	0 - $500,000 COP	26.0
	$500,001 - $1,000,000 COP	15.2
	$1,000,001 - 2,000,000 COP	17.2
	$2,000,001 or more COP	14.3
Total Cases		**5,733**

Source: Own elaboration based on the data collected from the virtual survey.
* The Unemployed category includes people who are not studying and not working; unemployed people who are either not looking for work or are unable to work.

The survey made it possible to identify some situations of vulnerability that the participants have experienced in the last year. Even though approximately 80% of participants are registered in the contributory system, 14.4% (n=827) identified a lack of access to health services as the most difficult challenge. According to age groups this lack of access was reported in similar rates: 14.5% of participants between the ages of 13 to 19 experienced

this barrier, 14.4% in ages 20 to 24, and 14.9% between the ages of 25 to 29 faced obstacles in accessing health services. The identification of this issue as one of the main barriers may be related to the public health situation caused by the COVID-19 pandemic since 2020, a year in which the percentage of people registered in the national health system increased from 92.8% to 93.2% (DANE, 2020), but whose effective access may have been hampered by the prioritization of healthcare related to the COVID-19 pandemic (See Figure 1)

Figure 1. Situations experienced by survey participants by age group.



Source: Own elaboration based on the data collected from the virtual survey.

Furthermore, situations such as lack of access to food (10.3%) and lack of access to medicines (7.5%) are also the second and third most significant problems faced in the last year. Worryingly, it is evident that young people between 20 and 24 years of age were the ones who mainly indicated having faced barriers in accessing food (10.9%) and participants between 25 and 28 years of age were the ones who had the most difficulties in accessing medicines (9.2%).

3. Colombian abortion context: perceptions of needs and opportunities following the decriminalisation of abortion

Colombia's abortion context is currently undergoing legal, institutional, social, and cultural transformations. The Constitutional Court of Colombia ruled in favor of the Causa Justa Movement's lawsuit in February 2022, through sentence C-055 of 2022, decriminalizing abortion in all instances up to 24 weeks of gestation and maintaining the model of three grounds defined in sentence C-355 of 2006 for the subsequent weeks; outside of these conditions, abortion remains punishable under the Penal Code. Far from being a novel effort, this partial transition from crime to right was the result of significant changes in the national and international legal landscapes, as well as the positioning of a feminist and human rights agenda based on principles of autonomy and dignity that began to take hold in Colombia in the 1970s (with the First National Meeting of Women convened by the Socialist Bloc in Medellin in 1978) and that continues to catapult several social movements that fight for universal decriminalization and the guarantee of quality services for the entire population (La Mesa por la Vida y la Salud de las Mujeres, 2009).

The criminal nature of induced abortion was first established in the Colombian Penal Code in 19364, mantained in the 1980 update, and was again ratified in Article 122 of Law 599 of 20005 in light of Article 11 of the Colombian Constitution of 1991 and item 4.1 of the American Convention on Human Rights, which states that "The right to life is inviolable" and "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception" respectively. Under these provisions, induced abortion practices were threatened with possible prison sentences for "the woman who causes her abortion or allows another to cause it," as well as for "whoever, with the woman's consent, performs the procedure" (Constitutional Court of Colombia, 2022).

4. In effect until 1980.

5. It should be noted that as these updates were made, significant differences between consensual abortion and the inclusion of specific circumstances related to sexual abuse that provided nuances to the interpretation of the crime were documented

With this ruling, Colombia took the lead in Latin America in terms of reproductive autonomy6 by becoming the country with the highest number of weeks allowed for free abortion in the region, however, at the same time, it witnessed the unveiling (or continuation) of significant questions regarding the implementation of this decision and how to combat the major barriers that persist. With this ruling, Colombia took the lead in Latin America in terms of reproductive autonomy by becoming the country with the highest number of weeks allowed for free abortion in the region, however, at the same time, it witnessed the unveiling (or continuation) of significant questions regarding the implementation of this decision and how to combat the major barriers that have remained. Proof of this were the numerous articles in the media that appeared in the weeks following the ruling, covering a reactivated debate among stakeholders in the abortion ecosystem (which includes: service providers, users, regulators, legal and governmental entities, feminist collectives and grassroots organisations, as well as in the social media, feminist collectives and even detractor anti-rights groups) about how this decision would translate into adaptations in health services and procedural protections, while also questioning how this opportunity for reinvention will reinforce or diminish barriers to effective and safe access to abortion.

Against this backdrop, different positions emerged with varying degrees of acceptance of the ruling. On one hand, numerous feminist organisations and pro-choice advocates celebrated the decision, arguing that it was an opportunity to reduce social stigma and strengthen the guarantees for its enforceability in health care providers. They mention in interviews:

In the context of the Court's decision, these provisions could be countered in the 2022 ruling through reasoning such as: the recognition of the right to health as an autonomous fundamental right; how the 2006 ruling disregards the right to equality and recognizes the disproportionate affectation and configuration of a barrier for women in vulnerable situations and irregular migratory situations; the existence of international documents (of different normative value), which, unlike in 2006, have defended the decriminalization of abortion beyond the three grounds defined in Ruling C-355 of 2006 and, therefore, allow to advance in a new constitutional understanding of the phenomenon, in line with this, for example, the Inter-American Court of

6. In comparison to other countries such as Mexico, where decriminalization is in effect until the 12th week, Chile, which is based on the three grounds model, and Argentina, where decriminalization is in effect until the 14th week in all cases and without a time limit in cases of rape and risk to the mother's life or health. The situations in Uruguay, Guyana, and Cuba are comparable.

Human Rights recognized that although life is a legal right that is protected at all stages of its development, it is not protected with the same intensity. Thus, prenatal life is not exempted from being recognized as a legal right to be protected. Still, it recognizes that the fetus is not a subject of rights and has a legal personality different from the pregnant person, who is a subject of rights. Reasons such as "recognition of how the criminalization of abortion violates the obligations to respect the right to health and reproductive rights of women, girls, and pregnant women" were also added.

The criminalization of the conduct is based on a suspicious criterion of discrimination: sex. Additionally, the decision acknowledges that the norm under consideration permits punishing and judging someone who chooses to act following their moral judgments or personal convictions. This strongly affects the aforementioned freedom because it results in the imposition of a particular course of action, which in this case implies having to assume maternity -the ultimate purpose intended by the criminal offense-even against one's own will, an aspect that strongly affects the freedom of conscience of women, girls, and pregnant women" (Constitutional Court of Colombia, 2022).

> "This already gives us a legal basis, because beyond what we knew about autonomy and so on, many people need to have something, a written paper, a legal basis that tells them that this is right, so that they consider it correct, so I feel that this is an advance towards social decriminalisation, I feel that it is a great step forward because the women who were being criminalised were precisely the young women, those from rural areas and migrants who did not have the know-how [about safe and legal abortion access]. Most of the were in vulnerable situations, and the fact that they will not being prosecuted or threatened with imprisonment is very helpful. "(Local stakeholder 1 in Cúcuta, personal communication, 4 April 2022).

With Judgement C-055 of 2022 **Colombia took the lead** in Latin América in terms of reproductive autonomy by becoming the country with the highest number of weeks allowed for free abortion in the region.

Additionally, some narratives emerge in this position of favourability and positive outcomes stemming from the ruling that links abortion with desired motherhood and potential positive effects on parenting practices. As a result, this legal change broadens the scope of its impact to include other cultural spheres, such as affection, coexistence, parenting, and violence reduction.

> "[...] We hope that everything will change, because this is a historical decision that we did not expect and what, well, I am not going to elaborate too much on the subject, but [...] it changes the regulations. We will be in a different position regarding unintended pregnancies simply because women have the option to freely and voluntarily end their pregnancies up until the 24th week. In other words, what we hope will change is that from now on, the pregnancies we will have here in Colombia will be desired pregnancies, so for me, the most significant accomplishment is that no woman will be pushed to have forced motherhood because we know that when a woman is pregnant and does not want to have it, she will have the chance to abort it as soon as possible. So, in ideal normative terms, pregnancies will be desired, women will not be forced to have children, and this will be subject to the right to choose. But we also know that what follows is extremely hard in terms of barriers, institutional barriers, and state barriers. For instance, this nation will undoubtedly face legislative bills and a legal and legislative offensive of detractors." (National actor, personal communication, April 18, 2022))

These testimonies are interesting considering the high rates of single motherhood in Colombia that outnumbers those in the other countries of Latin America (UN Women, 2019), and opens an interesting question about the possibility of this change in sentencing impacting these statistics on the demographic and family structure in the country in the long term.

These narratives, which place a high value on the transformative nature of this type of rulings in the Constitutional Court, do not rule out acknowledging the paradox that arises between the law (in defense of human rights) and its effective enjoyment. In other words, these narratives do not deny that abortion barriers have vanished or have been significantly weakened, but rather believe that this shift allows for a social reinterpretation of the socio-cultural sanction assigned to abortion and sets essential foundations for the construction of new social meanings. According to Lemaitre (2009), this optimistic phenomenon in jurisprudential changes is called "legal fetishism", an in her analysis she recommends that it must be balanced with "studying the generating role of social meanings and the emotions involved in legal reforms because these stakeholders largely explain the relationship between violence and the abundance of rights and their defense"

(Lemaitre, 2009, 28). Some of these barriers were acknowledged by the people and stakeholders interviewed, they mentioned:

> "I think we need to review it, that is, for us to be able to know the updates, maybe it [the ruling] changes a lot of issues, maybe not so much, because we were already dealing with abortion as an autonomous decision, we were already talking about it, not outside of the three grounds as something illegal, but as something that was thought of more from a legal perspective. [...] We were obviously in favour of it and felt it was necessary to frame the debate from that point of view, not denying it, not making it clandestine, but as an autonomous decision. [...] Well, considering that if the past ruling [C-355 of 2006] has only been in force for 14 years and still has enormous barriers, I think this one will have even more challenges [...] And even beyond that, the main concern we have is related to its applicability, because it will be embedded in a very lacking health system. So, it's like, because you know that they don't even prioritize normal services, you know beforehand you will have to go through a horrible "filter" to get to be admitted. We already know that the EPS [private healthcare] don't work, that they have technical limitations, that they lack supplies, that they have problems, problems, and more problems..., ¡especially in rural areas! so this will have to be adapted to this dead and very poor system." (Local stakeholder 1 in Popayán, personal communication, March 22, 2022)

> "in the end... the norm, the norm does not change behavioral or cultural patterns, it is an important advance, but it will not change it, so, if it continues to happen, as it is now, we will continue to have women who abort in solitude, and who are exposed to suffer pain in silence, and facing complications with scant information. And in the scenario of having to go the hospital, they are going to be mistreated and psychologically abused and so on" (Local stakeholder 2 in Popayán, personal communication, March 24, 2022)

Analysing the triumph of the partial decriminalisation of abortion in the country implies recognising the transcendental role played by Colombian and Latin American feminist social mobilisations in achieving this achievement in the Constitutional Court. This same fight to decriminalize abortion was waged in the National Congress in the past, with at least 39 bill projects (Dalén, 2011) (El Tiempo, 2022) filed between 1975 and 2020 that were not resolved in favour of this cause. In addition, as it was a case pertaining to constitutional articles and with a legal precedent in the Penal Code, the Court became the appropriate platform for resolving this tension. This, combined with other instances of social mobilization in favour of decriminalization of abortion, provided the country with an opportunity to explore

how these groups can become vigilant communities that work to ensure the full implementation of laws (Castañeda, 2022). Later sections of this study will take a closer look at the role of feminist organizations, community-based organizations, and support groups in the abortion ecosystem, particularly regarding their strategies to facilitate access to sexual and reproductive health specially to historically marginalized groups and people living in poverty.

A significant group of stakeholders and users interviewed stated that despite all the positive implications of this transformation of the normative framework, the barriers in dignified and timely access to health services and the non-explicit inclusion of trans and non-binary populations in the ruling make up a panorama of complex challenges that are not fully resolved in the Court's document. Regarding this explicit absence, trans and non-binary interviewees argued:

> "What happens if I [when discussing abortion] state it like "trans people and pregnant women"? They would feel attacked and diminished! [...] It is so essential to name all categories, even if it takes more time: we need to mention women, transmasculine people and non-binary people in these discussions... even if it takes more time to do so! because they cannot recognize [women's] identities and put the others in the shadow of another person who also aborts. I abort as a trans MAN [...] The entire healthcare system must be reinvented entirely, and people must stop believing that the binary is the only way of thinking that exist. [According to this] The rest of us have to settle to live in the borders of diversity and narratives of supposedly differential approaches.". (Personal communications, Local Actor 1 Bogotá, March 30, 2022).

Currently, ruling C-055 of 2022 explicitly mentions "women, girls, and pregnant persons," the latter being the category that the Court uses in a legal document of these proportions for the first time to include non-binary people and men with transmasculine life experience to whom access is extended. However, in the months following to the ruling outcome, the National Ministry of Health and Social Protection issued the Resolution 051 of 2023 that restates and protects explicitly the right of trans men and non-binary people to interrupt their pregnancy affirming their sexual and reproductive rights.

This debate surrounding the concept of pregnancy and trans people and the abstraction of the concept of pregnant person (also expressed *as gestating body or with the capacity to gestate*) first became widely debated in Latin American academic spaces in 2014, with the conference "Males and Abortion: Their Decision, Everyone's Conquest" organized by the Colectivo

de Varones Antipatriarcales CABA and the Grupo de Estudios sobre Sexualidades (GES) of the Instituto de Investigación Gino Germani at the University of Buenos Aires, and since then, it has sparked numerous discussions about how institutional stakeholders and community collectives have strategically used the idea to make trans masculinities and non-binary people visible and invisible as well as to reduce people to their reproductive capacity (Actuall, 2022) (Michael Powell, 2022). It is important to note that these debates occur in the same context that creates barriers for trans people to access healthcare in to accessing abortion often appear simultaneously interlinked and collude in qualitatively different ways in different contexts, but are particularly more complex and difficult to navigate in the experiences of trans and non-binary people.

The main perceived barriers to accessing abortion frequently appear linked to one another and conspire in qualitatively different ways in different contexts, as will be further explained in later sections. These barriers are especially complex and challenging for trans men and non-binary people. This fact is related to the cross-cutting experience of sexual and reproductive health, which alters service accessibility and quality following user identities and contexts.

3.1. Key data on the abortion context in Popayán, Cúcuta, Bogotá, Soledad, and Mitú

Abortion experiences in Colombia are defined by territorial and socio-cultural dynamics, as well as social determinants such as economic resources, access to information, and the availability of service providers, among others. Exploring territorial differences in access to abortion makes it possible to highlight the needs that different population groups have in terms of possibilities and barriers in their immediate context. This section aims to address precisely these differences, based on the exploratory qualitative findings of semi-structured interviews carried out in five (5) municipalities in the country chosen for their historical, cultural and social relevance to the abortion context in the country. The criteria used for the prioritizing of the municipalities considered dynamics such as that data could be collected from remote areas affected by the armed conflict and where there is low capacity in health centers to provide abortion care (which is precisely why Mitú (Vaupés) was included); that it was possible o include at least one border city with high numbers of Venezuelan migrants and predominantly informal labor dynamics (for which Cúcuta (Norte de Santander) was prioritized), as well as a municipality with high rates of criminalization of abortion practices in Colombia among young people (for which Soledad (Atlántico) was included). Likewise, we sought to include at least one municipality with cultural and intercultural conflicts based on religious beliefs and identity

of the population (Popayán (Cauca) was selected as one of the relevant municipalities due to its demographic characteristics and considering the media attention of publicly disputed abortion cases in the municipality). Finally, we sought to include a municipality in which it was possible to explore a high proportion of service providers but whose context is characterized by exclusionary dynamics, especially affecting the population living in poverty (here, Bogotá D.C. was the prioritized municipality). The main findings of each municipality are detailed below:

Popayán, Cauca

It is the capital of the Department of Cauca in southwestern Colombia, with 318.059 inhabitants according to the latest National Census conducted in 2018, 51.498 of its inhabitants (14%) live in rural areas, and 266.561 (86%) live in the municipal capital. Regarding population composition by sex, according to the 2018 Census, 52% of the municipality's inhabitants are women, and 84% of this group lives in the urban area.

Despite making up only 2% of the department's surface area, Popayán, the departmental capital, has a high population density per square kilometer, which accounts for 22% of the department's total population (Alcaldía de Popayán, 2020). As a municipality that represents a center of power in the territory, it concentrates the provision of health services in the department, with 27 entities providing sexual and reproductive health services (Profamilia, 2020).

The municipality is the scene of multicultural encounters between ethnic groups, conservative economic elites, complex rural dynamics, armed conflict stakeholders, and a colonial historical heritage associated with the Catholic Church. In this context, stakeholders and users interviewed claimed that abortion and sexual and reproductive health experiences are permeated by dynamics associated with this territory, some of which are briefly listed below:

- Popayán is the Department's administrative and political center, it receives daily floating population, migrants, and displaced populations from other municipalities who travel to access services, carry out administrative procedures and even get cellular and internet signal (very limited in other areas of the department). In this flow, these trips are frequently made in search of attention to health needs that still need to be met in other municipalities of the department, which, due to their rural characteristics, are unattended and disconnected from the service infrastructure.

- Popayán, like the rest of the department, has a long and complex history of social organization and mobilization, which plays a critical role in the promotion of human rights and the possibility of articulating agendas for gender equity, reproductive justice, and autonomy. "Cauca, precisely because of its social complexity, is also like a boiling pot of the social movement, and sometimes you do not feel it until you are outside," a local actor says" (Local actor 1 in Popayán, personal communication, March 22, 2022)

- One of the main barriers identified by those interviewed is the social weight of Catholic dogma in sexuality and reproduction decisions. The physical presence of monuments and churches in the city also creates a tense scenario that emphasizes the Catholic Church's central role as an actor in the local abortion ecosystem.

  > "here in Popayán, since it is a Catholic city and most of the schools are Catholic, they still see sexual and reproductive rights as taboo; talking about condoms in a school is "like invoking the devil," so I think that is one of the biggest, like, barriers that exist, the fact that many people do not have easy access to contraceptives or they are very expensive, or they do not use them because they do not know about them." (Local actor 1 in Popayán, personal communication, March 22, 2022)

- Similar to what will be described in the other prioritized municipalities, information on the logistics of abortion services in the municipality is in the hands of three types of stakeholders: service providers, pharmacies, and feminist support groups. The latter have started to position themselves on social media as alternatives to abortion services that accompany the cases through constant calls, messages on social media, sending the pills for the procedures (sometimes), paying maintenance

Exploring **territorial differences in access to abortion** makes possible to visualize the needs of different population groups according to the possibilities and barriers of their immediate context.

for those who have traveled, accompanying the procedures on-site, and even providing accommodation at their homes. These support groups are significant in Cauca's small municipalities because of the possibility of confidentiality they provide and the potential reduction of travel costs to the municipality's capital.

- The presence of armed stakeholders and illegal groups controlling territories in Cauca creates particular barriers to access procedures. For some, these circumstances force them to travel to Popayán in search of places to access procedures, which significantly raises the cost of care because it also entails food, accommodation, and transportation costs, which get increased by waiting times at medical centers. Others are discouraged from seeking these options in the first place, forcing them to rely on clandestine alternatives in their home:

> "Everything happens in Cauca, peace occurs here, war happens here in a particular way, and the absence and precariousness of the State too. So well, there are many fstakeholders, so of course, we know that there are many places where the termination of pregnancy is something that women do on their own; they do it on their own because it is a society that, I mean, it is not, and the armed conflict makes it more challenging to access these spaces, also because in many cases we find sexual violence, that is, in the context of the armed conflict, and from there also the concern about abortion, or about how to access their rights, to sexual health, and everything stays there; Then, there are still many more restrictions because women are kept quiet, they receive care at home, and you already know that there is no possibility of privacy in rural areas. I recall that at the time, they told us, but I cannot remember in which municipality, and it was terrible because they did those campaigns they do, only campaigns they do for women, that cytologies, that I do not know what, and that they did the cytologies, they adapted a place, not even a private place. And many women find it difficult to go for a pap smear, even if the service is available, because they are embarrassed. So, I think that of course, the armed conflict prevents the full exercise of women's rights" (Local actor 2 in Popayán, personal communication, March 24, 2022)

- Notably, among the clandestine abortion practices in the municipality, the mention of experiences of sexual abuse at the hands of people who work in local pharmacies and provide abortion pills is noted with concern:

> "One person told me about a pharmacist who illegally placed the pills here, [...] he told them that the only way to introduce them was by penetrating them, imagine, women in the middle of their VTP experienced a rape, so tell me what part of that story you want to tell, I mean, what gives

> them the right to manipulate women's bodies like that, I mean, VTP is a necessity, especially in territories like this one, and it is a necessity that must be discussed." (Local actor 3 in Popayán, personal communication, March 24, 2022)

> "I know of two cases, not as closely, but I have been told that the pharmacists tell them, "yes, I can sell it to you," I'm not sure what, "but for it to work, the pill has to be inserted vaginally high enough and for it to be high enough, I have to push it in with my penis because it is the only way," so they rape them at the moment they sell them the medicine, I mean, the misoprostol, but who knows if it is misoprostol, or if it is something else". (Non-binary person 3 in Popayán, Personal Communications, March 23, 2022)

The lack of confidentiality as a barrier in all municipalities will be explored in greater detail in subsequent sections; however, preliminarily, we highlight the constant mention of these situations in the interviews, which confirms that it is a factor present in the context of abortion in the municipality.

Bogotá, D.C.

It is the Republic of Colombia's capital and the country's political, economic, administrative, industrial, cultural, sporting, and tourist epicenter. It has the highest number of inhabitants in the country, accounting for 17% of the country's total population, or 7,181,469 people, of whom 49% are men and 52% are women, according to DANE (DANE, 2018). Since 2015, it has established itself as one of the main receiving territories for Venezuelan migrant flows (Ministry of Health and Social Protection, 2021), to which are also added national migrant groups and displaced persons seeking job opportunities and access to justice. It is noted that 35% of the victims of displacement in the municipality are between the ages of 18 and 28, 50% are women, and 0.04% are members of the LGTBIQA community (Conexión Capital, 2018). Regarding the level of criminalization of abortion, it is the city in Colombia with the most investigated incidents (1,008), according to the study "The Criminalization of Abortion in Colombia" by the Mesa por la Vida y la Salud de las Mujeres (La Mesa por la Vida y la Salud de las Mujeres, 2021).

Some context-specificities are highlighted below concerning the results on opportunities and challenges for access to abortion and other sexual and reproductive health services:

- The capital concentrates a large and diverse proportion of health services and providers of sexual and reproductive health services. Unlike the other municipalities examined, the main barrier identified in the testimonies collected in Bogotá was not the lack of providers but the cost of the procedures and the limited information on how to access them; these elements operate in tandem, creating economic barriers for the capital's population and demonstrating that this is a social inequality problem. In 2020 alone, it was estimated that one in every two young people lived in a poor household, a figure exacerbated by the employment and education indicators that were severely impacted during the first year of the pandemic (El Quindiano, 2021).

- It was the only municipality where no testimonies about barriers to abortion access related to institutional confidentiality emerged. It is perceived that the size of the city and population density dissolve these concerns. Instead, there were more testimonies about delays and waiting periods for procedure authorization.

- The digital gap and the possession of mobile devices for internet access were not as noticeable in the municipality's testimonies. Stakeholders and interviewees agreed that it would not be a current barrier for people in the capital; however, it was mentioned that some limitations related to poverty situations specifically affect people with trans and non-binary life experiences:

> "But it is a reality [...], not everyone has the peace of mind to say, "I want a safe abortion at home," because they do not have a home, and it is something that will not be solved here, but we must recognize it there, because the home or the house for women, as well as for trans people from another experience, is not always a safe place, right? Then other places where people end up having an abortion [medical] appear, such as friends' houses, in other scenarios, how to activate the networks, but definitely there are people who do not have a safe abortion place. That occurs, and it is also for us to consider how to accompany from our possibilities.". (Local actor 1 in Bogotá, personal communication, March 30, 2022)

Cúcuta, Norte de Santander

It is the capital of the Department of Norte de Santander, located in the country's northwest near the border with Venezuela. According to data from the DANE's National Population and Housing Census in 2018, it has an estimated population of 776,106 people, of which 51% are women (405,595), and 25% are men. According to the Ministry of Foreign Affairs (2021), it

is the third city in the country with the highest presence of Venezuelan migrants, so encounters marked by exchange dynamics and multiculturalism are configured on its territory. Additionally, due to its proximity to the Catatumbo Region - a rural sub-region characterized by armed conflict dynamics and the presence of drug traffickers -the municipality is the site of several territorial control tensions.

Despite the municipality's significant commercial potential, 45% of the population is poor, 10% is extremely poor, and 72% of the population's primary activity is related to informal employment (La Republica, 2021). This economic environment makes it difficult for the general population, including undocumented migrants, to obtain comprehensive and timely health care. There are abortion-related barriers in the migrant population that are specific to their citizenship status (La Mesa por la Vida y la Salud de las Mujeres 2019). For example, hospitals conditioned services for Venezuelans on special residency permits. And they refused to recognize sexual abuse complaints filed in Venezuela to benefit from the protection of grounds in sentence C-355 of 2006 (This prior to ruling C-055 of 2022).

Some elements that stand out as being particular to the context of abortion, and sexual and reproductive health in the municipality are as follows:

- Numerous humanitarian agencies and non-governmental organizations (NGOs) provide health services to the migrant population in neighborhoods and settlements. This aims to close the gap in timely access, but it falls short of meeting the needs of local stakeholders working with this population, either due to a lack of healthcare spaces or a lack of available agenda. Furthermore, there are logistical challenges in contacting the beneficiaries of this care due to the scarcity of mobile equipment, their limited access to the internet, and the limited time they have available for medical care due to inflexible and informal working conditions:

> "Well, it happens to us with the migrant women who come; they usually have an old phone or don't have [money] to [pay for data simcards]. In the case of [those] who are older, the telephone is not theirs; it is their husband's; or there is [only] one telephone in the house; many adult women who do not have a phone communicate through their husband's one [...] In these situations, the information is very erratic. For example, she calls me today, I look up the information, and I give it to her the following day. I then must wait for her at night when she calls again, and so on. Obviously, this process takes longer, but it is the way to do it. Maybe the friend has, or the neighbor has a telephone or a leader in certain areas, so she can communicate using the phone she was lent" (Local actor 1 in Cúcuta, personal communication, April 4, 2022).

Local stakeholders describe that access to abortion pills in the municipality through covert channels is not complicated. Thus, the alternative of waiting in the formal health system for public or private suppliers is counterbalanced by more immediate and logistically accessible options such as pharmacies in the neighborhoods or local providers contacted by the internet, which creates a potential element of danger for abortion in the municipality:

> "Well, they go to drugstores because it is really not that difficult to get a pill. They go to a drugstore, and they buy them. I mean, drugstores sell them as doses. However, I know that the doses are incorrect because many of these girls have not had a test and have miscalculated their estimated number of weeks. So, based on that miscalculation, pills are sold, and women take them vaginally, and so on. It is very easy to get the drugs in an unsafe way, and even when it is not supposed to be legally allowed, it is effortless to get them"." (Local actor 1 in Cúcuta, personal communication, April 4, 2022).

Soledad, Atlántico

Soledad is a municipality in Colombia's Atlántico department that is part of the Barranquilla metropolitan area. It is the eighth most populous city in Colombia and the third most populous city in the Caribbean region, after Barranquilla and Cartagena de Indias. According to the 2018 National Population and Housing Census, it has a total population of 683,486 people, with 51% women and 48% men. According to the National Demographic and Health Survey (2015), it stands out as one of the municipalities in Colombia with the highest population growth. The fertility rate for women between the ages of 15 and 49 is 2.5, while the national average is 2.0. (ENDS, 2015), which contrasts with the compositions of households since 14% of them contain six or more people.

One of the main concerns expressed by people in abortion situations and accompanying stakeholders in the municipality is the lack of confidentiality in sexual and reproductive health procedures, with a particular emphasis on abortion. In general, there is a narrative of hypervigilance toward the bodies and sexuality of people assigned female at birth that frames the stigma and judgment of self-determination actions such as contraception, abortion, and sterilization procedures as socially sanctioned actions that remain in the collective memory of the community. This seems to act as a sexuality control device, which appears to be more related to asymmetrical power dynamics between genders than preventing unintended pregnancy.

> "So it's like I know that if you go here to have an abortion [here in Soledad], first absolutely all of the staff who are there, the entire staff at the health center finds out first, they look at you horribly, they cross you out, they don't accompany you, I know it's like that, I have... my sister-in-law is a doctor here in Soledad, so as she tells me, all of this is experienced in the health centers by women. Even [she says] they have asked her 3,483 times [who goes to them]. "Are you sure?" and [they answer] "Yes, I am sure, I am here to have an abortion; I am here because I am sure." So, it's like there's a lot of judgment, and I believe there is still a lack of understanding that this is a right for all." (CIS woman 1 in Soledad, personal communication, April 19, 2022).

Other recurring concerns are the risk of lawsuits, potential deliberate barriers implemented by municipal officials, and social stigmatization, all of which deter people from using the already scarce pool of institutional suppliers with lengthy wait times. To expedite services or even provide them independently, feminist support organizations have depended on other organizations like Las Parceras or other abortion services suppliers.

Mitú, Vaupés

Mitú, the capital of the Vaupés department, is situated on the banks of the Vaupés River and is surrounded by freshwater streams and the Amazon rainforest. According to the 2018 Census, it has a population of 29,850, with 48% women and 52% men. Of the total population, 55% identify with one of the municipality's 18 indigenous groups, 2% are Afro, and 0.01% are ROM. According to the DNP, only 19% of the population has access to health care, with 76% living in poverty (DANE, 2018). On November 1, 1998, the municipality was the site of a violent guerrilla takeover by the FARC; because of this event, 61 people died, 11 of whom were civilians.

Today, the Ombudsman's Office has reason to believe that there is a reactivation of the conflict in this area, particularly due to the presence of drug traffickers who use young people and children to transport illicit crops. According to the latest report, "Since November 2021, non-state armed groups (GANE) present on the river routes that connect the department of Vaupés are responsible for at least six cases and two attempts of forced recruitment of minors, as well as one (1) case of suicide to avoid recruitment in the municipalities of Mitú and Carurú". Because the affected families fear retaliation from the GANE, only one of these cases has been reported to the corresponding authorities. Additionally, cases have been identified of the use of minors in activities related to transporting illicit crops" (Ombudsman's Office, Vaupés region and Norwegian Refugee Council, 2022

In contrast to the other municipalities explored, Mitú is geographically and infrastructurally isolated from the rest of the country. People and goods can only enter via the river or the airport, making transit and cultural exchange with neighboring towns difficult.

According to the most recent data available from the Gender Observatory in 2020, the municipality has high rates of gender violence, with 44 cases of sexual violence and 76 cases of domestic violence (Observatorio Colombiano de las Mujeres, 2018). Added to this is an alarming panorama of suicides, which have increased significantly in the last decade and that reached their peak between 2020 and 2021, with a total of 26 people dying between 2016 and 2021. From 2010 to 2019, the overall suicide rate in Colombia ranged between 4 and 5.7 per 100,000 inhabitants, while it ranged between 2.6 and 3.5 among children, adolescents, and young people aged 5 to 19. (ICBF, 2020). Furthermore, the testimonies speak of atypical data to be confirmed on the higher proportion of women and girls who commit suicide than men.

Some of the municipality's particularities in terms of sociocultural context, abortion narratives, sexual health, and reproductive health are listed below.:

- According to the people and organizations interviewed, the Departmental Hospital San Antonio de Mitú is the only actor providing services and information on sexual and reproductive health. One of the hospital nurses interviewed explains the implications of this fact:

> "The other part is regarding the service provider network, which is very precarious here, I mean, in the rural areas, it is very precarious; the only centers, the only hospital here is the ESE Hospital San Antonio de Mitú, which has two health centers, Carurú and Taraira, which are the only places where care is provided beyond primary health care, where births are attended, implants are placed and so on. In the rural area, there are primary health care units, but these units attend, for example, a child who goes because he/she has diarrhea, very, very basic things. And there is no permanent staff, there are not always the tools. But more than anything, the rural area is impacted in the sexual and reproductive health area to ensure the delivery of services, unfortunately only when the strengthening contracts are signed, which are agreements that the department makes with the hospital, then those strengthening contracts are made every year, they hire personnel, who go to the area, and nurses make visits to deal with the whole issue of implants and so on. But until then, until this process of hiring begins, there is no permanence of personnel". (CIS woman 4 in Mitú, personal communication, April 29, 2022)

According to the 2018 DANE Census, only 9,358 (31%) of the municipality's 29,850 residents live in the municipal capital. Internet access is 11% in this area and 1% in rural areas (DANE, 2018). Because the telecommunications signal is weak throughout the municipality, especially in the rural area, communication alternatives with riverside communities are highly complex, and healthcare experiences are fragmented. This means that abortion practices in the municipality may be underreported due to intercultural barriers with indigenous groups and their conceptions of reproduction and contraception (these will be addressed in later sections in more detail). They are also explained by the lack of medical personnel reporting cases.

> "The communities' access to health posts, where professionals can give them implants and injections, is sometimes difficult because it is different from other places, where you take a cab or a bus, and it takes you there. Not here, where people live, sometimes in places two or three hours' walk away, and where gasoline is extremely expensive [...] Imagine those people from the communities who do not have a stable economy, and practically everything they farm is for their consumption; getting that money to buy gasoline to go get an implant, that isn't easy. And how can they stop using that money if they have it to get things to eat rather than to get an implant [..] There is a phone system [radiophone] that functions similarly to a satellite system, but it is not available in all communities; instead, it is available at specific points, and the people [health personnel] who are present try to gather as much information as possible from the surrounding communities and notify them. [...] It is information we cannot know, with certainty, the number of abortions that occur in communities because the information arrives very little and does not arrive on time, I mean, I can go to a community now and find out about fetal deaths or abortions that occurred last year. Still, since last year, since December [2021], when there were health personnel, there have been no abortions" (CIS woman 4 in Mitú, personal communication, April 29, 2022)

- Parallel to the health practices in the municipal medical centers, the indigenous population preserves ancestral medicine practices with payes (traditional doctors) and uses treatments based on medicinal plants and their spiritual practices for the care and protection of the body, as well as for the management of reproduction. There are no indigenous peoples' testimonies about these practices; interviews with local stakeholders will be used as an approximation:

> "Well, this is another complex issue in the communities because it is known that, in general, indigenous people do not use much planning methods; they say that they take care of themselves through their prayers; some

say that having more children, having more reproduction, is much better for them because there would be many more to help the family with farming and all that on the land. [...] First and foremost, I am aware of a woman who already had four children and, because she did not want any more, went to pray and became pregnant again. So, these are beliefs that, well, do not help much because, let's say, if she was 45 years old, she did not want to have more children, and instead of going, and she is from here, from the urban area, instead of going to the medical center, to have access to a planning method and that, she goes to a Payé to have a prayer. So, she realizes that, in reality, it did not help her at all; well, then, it is complex. Well, indeed, some herbs are used to cause miscarriages and so on, and they use them, but they also have prayers to help them become more fertile and so on. When they have babies, they also pray so that no evil enters them; as they say, they do everything through prayers". (Local actor 1, person 1 in Mitú, personal communication, April 26, 2022.)

4. Young people's health narratives: crosscutting sexual, reproductive, and mental health

Understanding the adaptation needs of a platform that incorporates a self-care model for abortion is based on framing the designs, processes, and interventions in a comprehensive understanding of the social representations of health as a right, a service, and a set of care that guarantee the well-being of the body. It is in this framework that abortion finds meaning in its most pragmatic dimension, and many of the barriers to accessing procedures through institutional channels can be made visible, which are not only related to the stigmatization of pregnancy termination but also to how it is treated, how other elements of health care are articulated, and what information is provided in this regard.

In its legal context, health in Colombia is both a fundamental constitutional right and a state-managed service. Despite this, there are systematic and ongoing violations in service delivery by both public and private institutions (Hilarión-Gaitán, L., Díaz-Jiménez, D., Cotes-Cantillo, K., & Castañeda-Orjuela, C., 2019). Because of its nature as a right, it is frequently possible to effectively seek its protection and guarantee in dignified conditions through lawsuits and tutelas. In this scenario, the interviews revealed a deep distrust in the health system, which is primarily explained by experiences of waiting and delaying procedures, high costs associated with specialized medical care (especially in contexts where it is urgent), a lack of health insurance (particularly for people in rural areas, trans and non-binary people, and migrants), a lack of knowledge of non-binary and trans people's gender identity in procedures, lack of humanized and warm care, perceptions of pathologizing and overmedicating bodies (this is especially relevant in sexual and reproductive health), experiences of coercion and violence in medical scenarios, and finally the hyper-technified language in information about diagnoses and associated treatments (this element will be especially relevant in how people approach - or not - sexual and reproductive health).

> "I believe that the medical system is also very violent; it's as if they're going to do something to you, and you're terrified and don't know what to ask, and that's it. "Move out of the way, undress, get in'", you see? it's like [...] I mean, how they treat you... And well, if you are in the middle of a process about which you have little information, about which you believe that when you go there, they are doing you a favor in some way because that is sometimes the attitude of the doctors, it is as if you feel you do not deserve enough care, not only medical care in professional terms but also human care" (Local actor 1 in Popayán, personal communication, March 22, 2022)

In addition to these ideas, there is a recurring theme in the interviews about how the health system fragments the concept of the body, addressing what happens to it in different dimensions of care that, in the opinion of the people interviewed, do not end up communicating with each other. This is seen as the source of decontextualized interpretations of people's needs, which are incompatible with the comprehensive, interconnected, and simultaneous health experiences mentioned by young people in their testimonies. The interviews revealed, in particular, that there is a concept of a profound interrelationship and correspondence between sexual health, reproductive health, and mental health, which is especially evident in the care and accompaniment of abortions, which is most likely (but not exclusively) derived from the fact that in the C-355 ruling of 2006, one of the three grounds accepted for abortion practices in medical institutions was related to the risk to the mental or physical health of the pregnant person:

> "That, at least for me, was a significant doubt I had, and I sought during the process, psychological support. I believe it is something fundamental because I always say it out loud; I mean, I never regret my choice. Still, maybe, when it comes to talking and not keeping it quiet, and how to not feel guilty, not even for the act, or for hiding, that is something that weighed on me; for example, I get along well with my sister, but I have never told her about it. So, it is the weight of saying that there is nothing wrong; I mean, it is not something from another world, like you don't have to keep quiet about it, like you don't have to feel like you are doing something illegal, against the law, or wrong, it is more naturalized, without so much taboo. I think it could be like that accompaniment, maybe." (Local actor 4 in Cúcuta, personal communication, April 7, 2022).

> "I believe that the state should make or have these guarantees, or at the very least address the entire issue of health and mental health care. Mental health is critical for this process; I mean, even if the woman is seven or eight weeks pregnant, the fact that she is pregnant creates an expectation of, I don't know, everything "(Personal communication, April 7, 2022, local actor 7 in Cúcuta)

> "In addition, there is a need for mental health follow-up with trans masculinities; we [the collective] do it, but we know that we are not the only ones who accompany and many [trans men] put aside their identity to access an abortion, and it is tough" (Local actor 1 in Bogotá, personal communication, March 30, 2022)

These testimonies suggest that the user population calls for an integral and comprehensive approach to designing sexual and reproductive health services. This recommendation should be linked to a careful interpretation of the call for an integral and holistic view of health and the body, particularly in specific care relating to sexual and reproductive health and mental health. The relationship between post-procedure and mental health effects in the abortion context has been extensively studied globally over the last 50 years through numerous clinical and cross-disciplinary studies. The results of these investigations have not yielded conclusive results about a causal relationship between abortion and adverse mental health effects due to recognized methodological and ethical limitations, as well as difficulties in assessing the subjective multidimensionality of individuals' reproductive autonomy in abortion contexts (Wiebe, Littman, & Kaczorowski, 2015) (Reardon, 2018) (Rocca, Samari, Foster, Gould, & Kimport, 2019)On the contrary, research has begun to show that fstakeholders such as cultural stigma, the possibility of legal persecution, criminalization, and limited health insurance have a direct relationship between mental health impairment and the abortion experience (Biggs, Brown, & Greene Foster, 2020) (Biggs, Kaller, & Ralph, 2020).

Similarly, mental health has historically been a contentious area where the pathologization of gender identities and expressions that differ from those socially assigned at birth has predominated, particularly concerning the transitions of people with trans-life experiences framed in sexual health and reproductive health. This medical model (still predominant globally) has been gradually refuted by strategic human rights documents[7] within the human rights framework, as it employs discriminatory conceptualizations, unethical clinical practices, ethnocentric biases and excludes academic knowledge produced by people with experiences of trans lives who have addressed these concerns.

With these considerations in mind, the call is made to develop comprehensive care processes that incorporate a mental health care component—not because people's reproductive choices directly threaten mental health, but rather because mental health care offers an opportunity to combine practices of care, listening, and dignified attention that can mitigate the effects of the risk contexts in which people live.

7. Some documents are mentioned, such as the Yogyakarta Principles (2010), the Yogyakarta Principles Plus (2018), and the Council of Europe and United Nations recommendations and resolutions issued between 2011 and 2018 on discriminatory practices against trans people in Europe concerning their human rights, gender identity, and sexual orientation.

4.1. Where is the sexual and reproductive health information?

One of the central research questions focused on the sources of sexual and reproductive health information that young people interact with, the reliability characteristics of these references, and perceptions of the accessibility of this information that might have an impact on the design of the envisioned digital solution.

The survey's findings show that young people are more likely to use the internet (66.9%) and rely on their friendship circles to find information about sexual and reproductive health or make decisions related to sexuality (34%), a situation that, due to the epidemic, has come to be seen as a method for addressing the needs in these areas (The PMNCH, WHO, PAHO WHO and Asociación Profamilia, 2020). However, they do not ignore the significance of the healthcare providers—clinics, hospitals, and healthcare centers—as the leading sources of knowledge (56,8%). The primary source of information for young people in all age groups and income levels regarding sexual and reproductive health continues to be the internet; however, the gap in providers' priority as primary sources of information over friends is starting to widen among those between the ages of 25 and 28. On the other hand, evidence suggests a rising trend in people's confidence in the information-gathering system as income levels rise.

The **technical language barrier** to talk about sexual and reproductive health was mentioned as an opportunity to transform the ways in which information is delivered on these topics.

Table 2. Sources of consultation for sexual and reproductive health issues among survey respondents.

Consulted sources	Age group			Approximate monthly income					Total
SRH Concern	13-19	20-24	25-28	No Income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2,000,001 or more	
Searching online using a search engine	68.2	68.0	64.0	70.7	65.8	63.3	64.9	67.6	66.9
Request a medical appointment at a clinic, hospital, or medical center	45.6	57.5	64.7	49.7	55.6	59.3	63.8	61.1	56.8
Ask friends	41.2	35.0	28.1	38.6	36.6	28.4	30.6	33.4	34.4
Attend a Profamilia clinic	30.8	33.4	35.2	29.2	32.3	32.6	36.9	39.5	33.3
Make an appointment at a private clinic	10.8	15.3	22.3	11.6	12.5	16.2	18.5	29.6	16.3
Consultation in social networks	20.7	12.6	7.4	17.4	14.3	10.4	9.3	9.3	13.0
Ask family members	17.1	12.1	10.4	15.7	13.5	13.2	10.4	8.4	12.8
Go to a pharmacist	8.8	9.9	9.4	8.6	11.9	12.9	8.0	4.9	9.5
Go to a traditional doctor	4.7	9.7	12.6	7.0	8.6	12.0	10.9	10.5	9.4
Go to the hospital immediately	6.9	8.8	10.6	8.6	7.8	10.8	10.2	7.8	8.9
Contacting a community-based organization	4.9	3.3	2.0	3.8	4.3	2.4	2.6	2.1	3.3
Support from a WhatsApp group I'm a member of	3.1	1.8	2.3	1.9	3.0	2.4	1.8	1.8	2.3
Other	1.0	0.9	0.8	0.8	0.7	1.1	0.8	1.2	0.9
Total Cases	**1,368**	**2,661**	**1,704**	**1,564**	**1,488**	**873**	**987**	**821**	**5,733**

Source: own elaboration based on the data collected in the virtual survey.

These results include the narrative interpretations stated by the stakeholders and people interviewed. The following are some of the key findings:

- Stakeholders and interviewees acknowledge that information on sexuality, reproduction, health, and rights is not only found in one place. And that the most prevalent information at the social level tends to reinforce gender stereotypes that seek to naturalize the biological reproductive destinies of bodies. The interviews and surveys revealed that the sum of related knowledge was derived from interactions with family members as they grew up, friendships at school and university, personal experiences, internet pages and blogs, social networks, and, in some

cases, cultural representations in the media (among which news channels, movies, documentaries, and pornography stood out as some of the most significant sources). This has been identified as a barrier to access to abortion and other reproductive rights, as it allows the circulation of inaccurate, unverified, and rapidly disseminated information.

> It is emphasized that social networks and internet forums play a significant role as mechanisms for exploring and constructing identity and community for interviewees with non-hegemonic gender and sexuality identities, as they provide access to information about other perspectives on non-hegemonic identities.
>
> "There was also a lot of taboo around bodies, so adults never told you what to do with your sexuality or gave you any advice about it. Instead, young people were [orienting] themselves with one another, there was not much to say there, there was [...] a lot of social pressure to start a sexual life in my adolescence, a lot [...]. I began using the internet around the age of 17-18, but not at home; instead, I had to leave my browsing history at an internet cafe. So, obviously, I discovered a lot of things [for example], that bisexual people were always confused, things like that, a lot of false information, but I also came across a group of bisexual activists, and at this point... I mean, I was lucky because they were discussing an internet campaign on Tumblr about how bisexual women can be mothers because they have sex with men at the time. So I said, "OK, I'm going to get informed about bisexuality and motherhood." I ended up getting into [the topic] [...] about my personal experience as a poor girl, I mean, zero, so for me, it was clear when my friends started talking about their sexual relationships, when they had the confidence to do it, I started to notice like, "Hey, it's not like that" or "it's not only that he has to come outside, there are other possibilities of getting pregnant without ejaculating." (Trans man 1 in Bogotá, personal communication, March 28, 2022).

- Public and private health institutions providing sexual and reproductive health services are perceived to have the capacity to deliver accurate and reliable information (this perception is especially strong in small and rural municipalities). Still, there are barriers of cost, hyper-technified language, and a lack of differentiated approaches for young, rural, migrant, and dissident populations. The "language" barrier was frequently mentioned and raised as an opportunity for the digital solution to transform how information is delivered:

> "because they speak very technical; I mean, sometimes they get lost in the technicalities, and the communities are like this, like looking at them, like [yes] and nodding their heads, not knowing anything, because they

are embarrassed, "oh no, you must think I'm a dumb guy," and it's not that I'm dumb, it's that they are not speaking the same language and anyone who does not speak to me in the same language, obviously I will not understand, because you come here talking to me in English, and I do not speak English, how am I going to understand you?" (CIS woman 1 in Cúcuta, personal communication, April 4, 2022)

"because medical language is also a white, privileged, hegemonic language that nobody understands [...] I think I have to take that pill, but I didn't understand anything, so let's try to use simple and straightforward language. We can redirect the person to texts, documents, videos, or other alternatives instead of just texts because some cell phone users struggle to read or have visual impairments. In that case, we can have other options in the App to adjust it to people with functional diversities and with differences in access to education" Local actor 1 in Bogotá, personal communication, March 30, 2022)

- Testimonies affirm that low levels of empowerment in sexual and reproductive health and rights are strongly related to the gap in sex education in schools.

"Well, in fact, I came from studying in Villavicencio, and there they talk about it, a regular topic. I arrived here and here [Mitú], in the schools, they don't give like, like that orientation, and my mom was embarrassed, and my dad didn't talk about it with me either. It was something that I had already seen, more or less, in other places. [...] Well, I would have liked to have had some kind of awareness-raising at school, and I believe that if my classmates and I had had that, we would have lost our embarrassment in talking about those issues, because I know there were a lot of questions at the time, and we still have a lot of questions" (CIS woman 1 in Mitú, personal communication, April 25, 2022).

- They add that when Profamilia or Nosotras product brand visited schools, it was one of the few opportunities for this type of conversation:

"No, they didn't [talk to me about it] at school; when they went to school, [...] only when they brought Nosotras' towels did they put [information], but only about the period; otherwise, almost nothing else." (CIS woman 2 in Popayán, personal communication, March 24, 2022)

"Well, I believe that educational institutions should be a pillar in this discussion; schools should provide spaces that are in line with and realistic about this situation; I think that not only Profamilia or Nosotras (because Nosotras also carries out these campaigns) should be in charge of taking

them to the schools, I believe that when you are 28, you already have a vision about many things, but not when you are an adolescent. When you are an adolescent, you are influenced by what your school and family say because you do not have a... I mean, like the institutions you were a part of at the time." (CIS woman 1 in Soledad, personal communication, April 19, 2022)

- In municipalities with high concentrations of community organizations, feminist groups, and collectives, these groups are beginning to position themselves in the testimonies as sources of specialized information and rooted in legal attention channels that support the enforceability of rights. They have also made it possible to advance the normalization of conversations on sexual education and to develop more profound debates on rights and collective advocacy due to their efforts to make feminist causes visible.

"One of our bets on issues like health or well-being is to recognize that safety does not always occur within health institutions and that being a safe scenario does not always imply legal or institutional aspects; instead, we understand it from this place of accompaniment, of a trans sorority, of brotherhood, and that accompaniment should be based on personal life experiences." (Local actor 1 in Bogotá, personal communication, March 30, 2022)

"I believe that talking about it... has become normalized in women's circles. I'm not sure about things that happen during sex, or [for example, that] everyone has had a vaginal infection, or that something has happened to all of us with our periods at some point, or even very esthetic things about depilation and why some women prefer to depilate while other women do not. I feel that this has changed a lot; there are things that I no longer feel embarrassed to ask and things that I no longer feel embarrassed to say even without being asked, like being with friends and saying: "ouch! I got my period, and it has been hard because I have a lot of blood flow". It used to be super embarrassing; I mean, I was taught that when I had my period, I was sick because women used to say: "you are sick this week." So, I believe that this has changed significantly; I think that as time passes, conversations about sex become much calmer, especially when they are between peers, as in my case, and so on. I went to the gynecologist for the second time in my life last year. Years of feminism hadn't prepared me for the moment I opened my legs in front of the gynecologist." (CIS woman 3 in Bogota, personal communication, March 29, 2022)

4.2. Differential approaches and urgent transformations: dissident identities and interculturality in sexual health and reproductive health services.

One of the most concerning findings from the research's testimonies and surveys is the significant gap in access to quality sexual and reproductive health care for populations whose identities are considered outside of racial and gender norms. These obstacles were strongly associated with clandestine abortion practices, which are not always necessarily synonymous with unsafe actions. Instead, they are seen as alternatives that take on significance when it is acknowledged that they are used when systems of support, care, and attention are insufficient for their needs and contexts. The intercultural dilemmas and the differential approach to dissident identities will be discussed separately in the following sections, but this does not imply that the experiences of racialized people with non-normative gender identities do not exist or are invisible; on the contrary, it emphasizes that it is precisely these experiences that are marked by double discrimination.

The lack of coverage by the General Social Security Health System (SGSSS), the denial of care - where they experience various forms of violence, stigma, and discrimination -the design and implementation of plans, policies, programs, budgets, and models of health care without prior consultation, or at least research that generates evidence about their needs, expectations, and outcomes, are just a few of the obstacles that people with trans life experiences face daily. These significant barriers have a negative impact on the lives and health of transgender people, who are frequently forced to make their transitions "artisanally," that is, without the assistance of a health professional or access to quality information, raising the risks and exposing them to extreme vulnerability" (Profamilia, 2019). In one of his testimonies, a man with transmasculine life experiences claims:

> "Actually, my treatment has been quite exhausting; I am on a hormone replacement treatment, so it was chaotic because I was starting, [and] the pandemic broke out. They didn't want to assist me, which was clearly understood by the safety protocol. If it was not something crucial or COVID-related, it was not attended. But it was the most important thing for me. I don't have any health issues, but it's essential for me to have periodic check-ups with the endocrinologist. So, it wasn't easy [...]. Well, because of the hormone, the fact that the majority of trans people lack access to it, or because the healthcare system causes unnecessary delays, people get bored. I also became bored and began without medical authorization; that is, I purchased the hormone on a friend's advice, which was incorrect. However, he told me that if I did it that way, the pathways would be activated faster because it would become a priority. If I am undergoing hormone replacement treatment on my own, it is a priority that they see

> me to check how my system is inside and how I am functioning. [...] Well, another thing is that I also started with a collective that at that time was only a support network, so, in that group, there were only four people, and one of those [people] [...] [...] had been on hormones for about five years, [...], and he has already had surgery and everything, so he was like our only source of knowledge, what had to be done, how everything moved around, like [he would tell me] "Look, you have to do this, go to the doctor's office, super... go in a serious mood, dress this way, answer this way", because even answering incorrectly makes the doctors not attend us in an ideal way. For example, when I went to the internist for the first time, he told me, "no, that cannot be done" [...] and if [...] X had not told me, that would have been the end of the process, without a doubt." (Trans man 5 in Soledad, personal communication, April 21, 2022)

It is worth mentioning that this barrier to care is explained not only by the stigmas associated with these identities but also by the precarious and impoverished conditions into which people with dissident identities[8] are forced due to the abandonment of their family core and support networks, as well as frequent unemployment or informality. One of the interviewed collectives accompanying abortions of people with transgender life experiences in Bogota emphasizes this argument:

> "I mean, the economic aspect is the main barrier, but there is one factor that never ceases to amaze us, and that is that when we accompany cis women, most of them have already taken a test, and they [tell us] "I'm sure I'm pregnant." When the kids call us, many have yet to be tested because they don't have the money for a test that costs $10,000 or $16,000 [...] it's challenging. Many boys are already pregnant when they find out, [...], because it is obvious that they are pregnant, and it's like, "oh, I'm pregnant!" And it's also very complicated because it's not... I mean, many things can be identified in this type of case, but it's not like "They just wanted to wait or didn't feel like it," or these ridiculous ideas about late pregnancies, which are mostly delayed due to an economic situation [or] a lack of access to information" (Local actor 1 in Bogota, personal communication, March 30, 2022.)

8. The terms "dissident" and "non-hegemonic" identities will be used throughout the report to refer to identities that are framed in non-heteronormative manifestations of sexuality and gender, that is, outside the heteronormative-cis gender framework and the heterosexual matrix (Rubino, 2018). These concepts emerge as a political bet of enunciation from the field of queer studies, alluding to how these identities are "positions outside or beyond the norm" of masculine/feminine binarism.

In addition, another issue raised during the research is the healthcare system's bureaucratic red tape and long wait times, which disproportionately affect this group:

> "The situation of trans people in the health system is precarious, so there is no set follow-up. If we are told to meet at the endocrinologist in four months, the next day, you must request an appointment to see if there will be one in four months. [In addition,] trans men who change the sex component on their identity card [...] do not have access to gynecology. [...] or obstetrics. Because the EPSs say that this is a service "for women," and since we changed our sex on our identity card, we are no longer women for the State or the health system." (Trans man 1 in Bogotá, personal communication, March 28, 2022.)

Given this scenario, the call for the development of a digital solution is to avoid reinforcing these barriers.:

> "It must be an environment in which the person's gender identity is created; it must be attention that is not focused on the sex distinction, that is, sex-gender, in which it is assumed that you are a woman, that you have a uterus, and that these are your services, because I can be a man but have a uterus and require these services. And because I stated that I am a man, I am diverted to another line of attention that has nothing to do with what I require. So, I do not have to pretend to be someone I'm not just to use a different service, do you get what I mean? In other words, if a female user [says that] she needs urology, it is because she is a female user who needs urology; regardless of what you think a woman is, she is a woman who needs urology, and I need gynecology. Nobody cares if I am a man or a woman, what I need... I have a bodily situation that makes me need gynecology; why do I have to differentiate myself by a sex-gender system to access or not to [...] health? (Trans man 1 in Bogota, personal communication, March 28, 2022)

Regarding the needs and perceptions of sexual health and reproductive health of indigenous, Rom, and Afro-Colombian populations, this research does not seek to propose generalizations because few data could be collected in the interviews and surveys; however, as an issue that emerged recurrently in the interviews (especially in Popayán and Mitu), some gaps in information, access, and provision of differential services were preliminarily identified. The following is a summary of some of the tensions and opportunities discussed:

Colombia recognizes itself as a multicultural and multiethnic nation in its 1991 Constitution and through adopting International Labor Organization

Convention 169 on indigenous peoples in independent countries. Several binding documents protect indigenous peoples' self-determination over their health, reproduction, and sexuality within this framework. Indigenous peoples face various problems of inequality and security as social groups, including forced displacement, armed conflict, food insecurity, impoverishment, and state neglect, which have resulted in the disappearance of some ethnic groups and a decline in welfare indicators. Through Resolution A004, the Constitutional Court ordered the State in 2009 to take measures to protect ethnic groups at risk of "being culturally or physically exterminated" (Colombian Constitutional Court, 2009). As a result, some indigenous groups regard reproduction as a sacred act that has also become a mechanism of resistance and survival (Profamilia, 2016, 77). As a result, the authorities of these groups frequently reject contraception and abortion because they conflict with their beliefs. In this regard, an abortion case of an indigenous person interviewed in Popayán reveals some of these tensions and how users deal with them:

> "I went through the entire process alone, so it was satisfying to find someone who could help you because going through the process with the EPS... [...] our EPS is also indigenous, so they have specific routes [for abortion care] in which the information is not linked to you, so [...] they [the health service providers] begin to evaluate the decisions with the authorities or with the community [...] to be able to make the decision, while in other places, I'm not sure, peasants and others, I know that the EPS contacts the woman directly and that [she] is the one who makes the decision after going through the necessary procedures like medical appointments, cytology, and other things. In contrast, over there, there is always a third party or more... [who] knows this information. I am respectful and very participative [...] of all the things that involve or maintain the communities, but I believe it is my right to choose what I want and do not want for my life, future, and other things. So, I decided not to continue the route [with the indigenous authority] because I felt the need that, firstly, they would know information [...] that is very personal, and secondly, because it would not be my decision. I would have to accept what they decided. I searched, and let me tell you, I searched for many [places] and could not find anything. I even went directly to the facilities of Profamilia, but the attention was negligent [...]. The first thing I thought was that I knew the route of the IPS, so I said no because if I did it with the IPS they would tell the authority, there would be assemblies, assemblies with the entire community, and they would want to decide for me, and no, I said no, it would be chaos." (CIS woman 1 in Popayán, personal communication, March 23, 2022)

This conflict was particularly visible for healthcare providers in Mitú. The interviews revealed two limitations: on the one hand, health promotion

programs attempted to integrate a differential approach in population attention, but with few elements studied in these contexts to propose negotiations or adjusted programs. On the other hand, there is public opposition to allowing these programs to be implemented in communities for reasons that may be more complex than those presented in the following testimonies:

> "They have told me, for example, when they [the health personnel] arrive and show up, that the captain of the communities [ethnic group authority] is in charge over there. Here we are, and he, of course, [says] "they can talk about everything except contraception and family planning," that is, he establishes the parameters for the topics they will discuss [...] So, you are aware that you cannot discuss abuse or anything similar because if they are unwilling to discuss contraceptives at this time, they will certainly be unwilling to discuss other subjects. Therefore, you have not yet begun, you are introducing yourself, and suddenly they inform you that these topics are not discussed here, and that is all. This is done to protect these communities and this specific population, so you are not allowed to enter and run over them, and start a conversation about anything [...] And if you suddenly go over the authority's head, which is him at the time, what will you do to make way for the others, the people who come behind us, the other groups that are going to support us there? They don't want to let them in, so you prefer to intervene even a little rather than not intervene at all.""
> (CIS Woman 2 in Mitú, personal communication, April 26, 2022)

An indigenous non-binary person was interviewed in Soledad and shared her perspective on this conflict.:

In interethnic health contexts, abortion should be studied with more depth. Because there is a tension of it being an **act of self-determination** but that is not fully approved by many ethnic group authorities.

> "Conception is a natural process for us; however, it is also a personal choice, even in religion, and I have attended many talks to try to assimilate what I think about it because it has been difficult for me to have an opinion, my own, that sticks with myself about what I think about abortion as such" (Non-binary person 4 in Soledad, personal communication, April 20, 2022).

It is also worth noting that, according to the interviews, medical spaces are frequently perceived as insecure and disconnected from individuals' physical, social, and identity realities in trans and non-binary life experiences. They often refer to them as places where binary gender ideas are reinforced, their transit is pathologized, and there is even coercion regarding how their bodily decisions are oriented:

> "the whole health system has to be completely reinvented and stop thinking that there is only the binary and that's it, the rest is on the outside, in the place of diversity and in the differential approach [...]. I believe it has to do with the lack of tools in these locations, as well as the obligatory pathologization imposed on us by the institution of medicine, such as "you are going this way", "eventually you will have surgery", "eventually you will not menstruate"", [...] "You're going to get your womb out." Like everything. And many of them didn't choose, they had that procedure done, and it was what they knew [Complete hysterectomy]. And more than advice, it's like... "a route." Yeah, a "masculinity route," [they tell you] "you need to get this out." That route is not written; it's an imposed route, more cultural, it's not that it's written that you have to take out your uterus, no, they're going to tell you "no", but when you get to a scenario like this, they tell you "What's the next step in your transit?" How is it that they have a "line" of transits? [Sometimes they "congratulate you," saying:] you are doing very well" [or] "you need to have this removed because it gives you cancer. Like where do they get that from? You don't know! Because there are no studies that show that hormone replacement therapy leads to this kind of damage. There aren't. [...] It's like, those forced sterilizations and mutilation of trans people that we feel [are] disguised as a discourse of health and sanitation: they are trans hatred, transphobia, and [they are] the place to make sure that there is no trans reproduction too, can you see what I mean? Like, trans people only talk about... when they speak about trans people, they talk about "not to gestate," you know? Like a social, cultural, and medical sterilization" (Trans man 1 in Bogota, personal communication, March 28, 2022)

Without resolving these conflicts directly, these testimonials allow us to reflect on opportunities for functional adjustments to both the design and the informational content to be included in the digital solution so that the platform can promote respectful, dignified, and inclusive interaction with all possible user identities concerning abortion self-care.

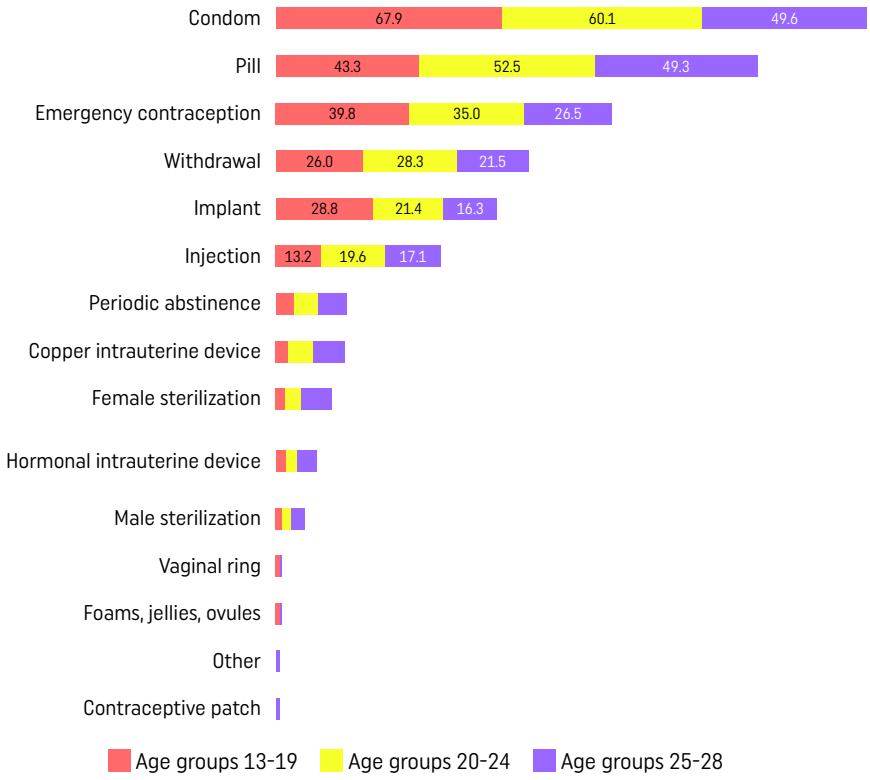
5. Contraceptives: narratives of medicalization and agency

Contraceptive methods play a fundamental role in preventing unintended pregnancies and protecting against sexually transmitted infections (STIs). Even though almost the entire population of reproductive age in the country is aware of contraception, there are barriers, practices, and complex notions about contraception that affect their desired mass use and effectiveness (ENDS, 2015). Next, we will explore some of the perceptions and practices discussed by the research participants concerning the use of contraceptives in their daily lives, narratives about side effects, and their implications in the preferences of use and type of methods chosen. Finally, we will address the paradox that users perceive in contraceptive use as acts of self-determination and examples of autonomy and agency, but which are limited by a lack of available information, difficulty in accessing specific preferred methods, and, in some cases, coercion experienced by physicians, partners, and family members.

According to the 2015 National Demographic and Health Survey, 81% of women and 83% of men aged 13 to 49 who lived in a consensual union used some form of contraception. Similarly, data from the survey used in this study revealed that women, men with transmasculine experiences, and non-binary people used contraception frequently in the last two years (85.8%). Condoms, contraceptive pills, the morning-after pill, and the method of interruption were the most commonly used contraceptive methods. Definitive contraceptive methods were the least used among young people; however, there was an increase in use at older ages. (See figure 2).

The contraceptive methods play a fundamental role in preventing unwanted pregnancies and in protecting people from sexually transmitted infections.

Figure 2. Use of contraceptive methods in the last two years by age group.



Source: own elaboration based on the data collected in the virtual survey.

Among the 14.2% of participants who indicated that they had not used contraceptives in the last two years, the four main barriers to access mentioned were: "Lack of knowledge about contraceptive methods and where to obtain information and/or access them (13.9%)", "Have had sex with people who have a vagina (10.2%)", "Cost of the contraceptive method (8.4%)" and "Difficulties in obtaining medical authorizations (7.6%)."

On the other hand, as can be seen in Table 3, among those who used methods, 41% of the participants had difficulties accessing them, including the lack of available supplies, the method's cost, and issues with scheduling appointments. This trend was present in all age groups and income levels.

These issues demonstrate the persistent systemic limitations in access for both users and non-users of contraceptive methods, which may be related to the fact that the provision of contraceptives is not universally guaranteed and is even more limited in situations where there are few trustworthy sources of information. Similarly, these findings are consistent with those obtained by similar studies, such as those of Amador (2017), which show that using contraceptive methods as a public policy strategy

through regulations that cover the costs of contraceptives has a positive effect on fertility decisions, as the choice of contraceptives is sensitive to changes in costs.

Table 3. Type of difficulties you experienced in accessing the contraceptive methods you currently use.

Difficulties	Age groups			Approximate monthly income					Total
	13-19	20-24	25-28	No Income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2,000,001 or more	
No supplies available	54.2	68.0	67.0	59.1	63.4	61.1	71.6	75.1	65.0
Cost of contraceptive method	54.9	50.1	42.6	55.4	53.1	48.6	43.8	35.7	48.9
Delay in scheduling medical appointments	32.9	25.4	26.0	25.0	28.5	34.8	25.6	20.6	27.0
Service supplier did not provide the method	8.4	13.0	14.6	11.1	11.8	12.9	12.9	15.9	12.5
Lack of service	11.9	10.7	9.1	9.7	10.7	14.7	10.1	6.9	10.5
Lack of knowledge	12.4	7.3	4.6	8.7	7.6	10.3	5.6	4.3	7.5
Cost of transportation	9.6	7.5	5.1	11.1	7.6	6.6	4.5	4.0	7.3
No youth-friendly services are available to me.	11.6	5.5	5.3	9.7	7.2	6.6	3.1	4.3	6.6
Lack of transportation	7.6	6.4	5.4	7.7	5.4	7.8	6.7	3.6	6.4
Required parental consent	16.7	3.4	0.7	10.3	5.4	3.8	1.7	1.8	5.2
Not enrolled in the social security health system	3.8	4.2	5.6	4.4	6.3	6.0	3.1	1.1	4.5
Other	3.5	4.2	5.4	2.8	5.6	3.1	5.3	5.1	4.4
Didn't know I was eligible	6.3	3.8	3.2	4.4	4.9	4.7	2.8	2.9	4.1
Prefer not to answer	1.0	1.3	0.0	1.8	1.2	0.3	0.0	0.4	0.9
Consent required from partner	0.5	0.7	0.9	0.8	1.1	0.3	0.8	0.0	0.7
Do not know	0.0	0.6	0.4	0.6	0.5	0.0	0.6	0.0	0.4
Total Cases	**395**	**1,060**	**570**	**504**	**569**	**319**	**356**	**277**	**2,025**

Source: own elaboration based on the data collected in the virtual survey.

These findings on barriers to contraceptive use are consistent with the testimonies in the interviews; excluding responses of sexual relations between people with vaginas, the three most common types of responses indicate

that deep problems related to a lack of economic resources, a lack of adequate information, and, in general, gaps in timely attention to sexual and reproductive health needs in the public health system.

In this sense, regarding the experiences of lack of information, the interviews point out that this is a generalized situation that begins in adolescence and whose gaps have repercussions on how people make decisions about their sexuality and reproduction. As discussed in the section on Narratives on sexual and reproductive health, there were omissions and systematic gaps in sexual education in schools and families that were filled by diverse, disconnected sources with different levels of reliability. Given this, the testimonies warn that the consequences translate into limitations in decision-making autonomy:

> "Many mistakes are possible. I believe that when you lack information, don't know how to act, or don't know where to turn, you may make a mistake [...] I think that, for example, what happened to me [abortion experience], you don't rely on a good source, on someone reliable, or truthful information, and then you rely on your friends, on your boyfriend, on another source that wouldn't know how to explain you, like... there is no information about sexual issues, and you rely on sources you should not, like your boyfriend or friends ...." (CIS woman 3 in Soledad, personal communication, April 20, 2022)

In addition to this information gap, there is the phenomenon of incomplete knowledge about how the methods work, as well as the prevalence of other social representations of contraception associated with trust, fidelity, and the couple's preferences, giving rise to limitations of autonomy framed in asymmetric erotic-affective relationships, primarily influenced by the convergence of several concurrent inequalities such as a lack of economic resources, limited access to information, particularly in rural areas, gender, race, and age inequalities, among other fstakeholders:

> "because I have friends from the countryside, they don't, I mean, they say, "no, we don't plan," because their husbands don't plan or let them plan, so they don't take care of themselves, but they don't want them to take care of themselves either. So it is still widespread in different places and municipalities, especially in Cauca, because I have friends in many municipalities and communities where it is not. And in schools, they do not guide them either, or they only tell them there is this method, and only with this one, they do not give them the option of choosing whether or not to take care of themselves and everything else related to this" (CIS woman 1 in Popayán, personal communication, March 23, 2022)

> "the woman inserts the implant or starts the process of her method, the use of her contraceptive method is with her husband's authorization, so, from there, you can imagine. [...] They think, well, what is regularly believed, is that when the woman starts to plan or use a contraceptive method, there is the issue of infidelity and all that, so there is also a kind of rejection" (CIS woman 4 in Mitú, personal communication, April 29, 2022

Finally, concerning the non-use of contraceptives, the participants described that another significant barrier lies in the current health system's neglect of their needs, either because they experience a lack of coverage in their territories or because during consultations, there is no concern for understanding the users' possibilities following their contexts, identities, and bodily particularities, or because there are no clear languages and routes.

> "[...] they deny service if you go to the health post and your date for the injection is [day] 2, how are you going to get it on the 15th, or [they tell you] "Oh no, whoever is taking care of so-and-so, she didn't come today." Because I used to hear it a lot when I [went], what I have agreed to is the general practitioner's control [...] at least in my IPS, at the cashier's office, they ask me, [and I said] "Oh, I am coming for the control, for the injection," [they answered me "oh no, that injection is not available, come next week, there is no such thing," like that, I mean, this is supposed to be something that should always be there, because it is a normal process. You go there every month, and they should have a supply of it, but they do not, but since I never had access to this service through IPS, I always paid for it privately, let's say that I did not have these difficulties" (CIS woman 2 in Cúcuta, personal communication, April 5, 2022).

> "For example, I do not use a family planning method because I have migraines with aura. On top of these migraines, I am very tight, so I would never use an intrauterine device, which is the only method I can use. And the third thing is that because of my obesity, I am not able to use any hormonal method either, there is no hormonal method that works for me because the methods work up to a body mass index of 30, and my body mass index is much higher. So, because of my obesity, I cannot plan with hormonal methods, so why am I going to take a drug that will not work for me? , so that is what I am telling you, that there is a significant lack of counseling, [...] with these characteristics in particular, I believe that a good orientation in family planning should be given. There should be another informed consent, in other words, she already gave me all the counseling, she wants to plan, yes or no, and with that, I am done [...] I do not want to influence her body anymore; it is her risk, and it is her life" (Local actor 3 in Popayán, personal communication, March 24, 2022)

People with transmasculine and non-binary life experiences interviewed join this group with significant barriers, and their limited use or non-use of contraception is explained by the limited information available that adjusts to their characteristics and body experiences, as well as the hostility of medical spaces with personnel who are not trained for care and orientation. They describe:

> "I believe there are things related to trans masculinities when we are on hormones. It is that the people who carry out these gynecological processes also understand that we have some differences due to our hormonal treatments, less humidity in the vaginal area, often less dilation, and usually less lubrication, so there are processes that, for some people, are very easy, but for others who do not lubricate as much, well... [...] trans men on hormones cannot have... we cannot use contraceptives because the hormones clash and literally damage the treatment, and it is an overload that, in other words, screws up the body; it is extremely dangerous, even a risk of thrombosis, I mean, it is very dangerous. [...] So, for example, those of us who are undergoing testosterone treatment are unable to use any other method than the copper T or condoms; I believe there is another one, but I can't recall which one it is; and there is another one that is not hormonal. And that is also why the issue of being able to get pregnant is so complex and dangerous for trans men because we cannot undergo any contraceptive treatment while we are on hormonal therapy, only the copper T and not all of us, I believe the vast majority of us do not have it, I do not have the copper T, and it is also a decision of yours, [...] And because it is not believed that we get pregnant, it is not believed that there is a problem. It turns out that we are among the people most vulnerable to pregnancy because we do not have the option of alternative contraception methods [...] because we have had to learn about our own bodies since no doctor gives us a solution, [does] not provide us with information" (Trans man 1 in Bogotá, personal communication, March 28, 2022.)

> "I haven't really been to the doctor, so I couldn't tell you if I have been discriminated against because I feel that I have fled from medical spaces precisely due to my gender identity [as a non-binary person] and because of the possibility of being discriminated against [...] that everything, having to tell the doctor: "no, look, that name that comes out is not mine," also everything, the simple fact of going to the restrooms, the simple fact of being called and being told the full name on the ID card, not just the last name, the full name, that is already extremely violent for a trans person. So, I feel that this distances me from the spaces, and concerning the medical spaces, this is what it is" (Non-binary person 7 in Bogotá, personal communication, March 31, 2022.)

It was evidenced that the reported barriers to non-use coincide with the difficulties of access for those who did use contraceptive methods in the previous two years, reinforcing the hypothesis that the obstacles are systematic in the young population in general.

On the other hand, in the interviews, the use of contraceptives showed a precedent of narratives regarding corporeality and autonomy. It was common to hear that they were associated with basic sexual education knowledge and that their use is strongly related to the ability to make decisions about the future and create what interviewees refer to as a "life project":

> "Because the idea isn't that people become afraid of having sex but want to have sex and have safe sex. For me, a girl should know how to protect her body, how to defend herself, and how to continue with her life project or her family project, and that the idea is not that if she does not want to have children, she is wrong; no, we are not women whose purpose is to be mothers; there are many other things for us to do. And what happens if you give them important basic information? The girls end up resigning themselves to live a life they do not want but have to live, and they assume it" (Local actor 2 in Soledad, personal communication, April 20, 2022).

These constructs about deciding in the present and influencing the future were repeated in abortion discussions. The "life project" materializes as a set of expectations, goals, and possibilities that a person seeks to pursue through daily actions, contributing to the consolidation of one's idea of oneself. It is, in their words, a map derived from will and self-discovery, with reproductive decisions viewed as determinants of success or failure along this path.

> "[It is] something born of dreams, something I aspire to be, and it takes the issue of contraception more seriously. For example, you are going to do it with your boyfriend, and then your boyfriend says: "no, honey, without a condom, well, it feels better" [...] But you have your hopes and dreams. [...] I dream of becoming a teacher; what happens if I get pregnant or get a disease? It clouds my dream, my career, what I want, and my life project. So, when you love yourself a little more and are passionate about what you want, you come to a halt and say, "no, if it isn't with this, I won't do it," and that is a fundamental part of your life project (CIS woman 1 in Cúcuta, personal communication, April 4, 2022.)

> "First of all, for me, it is not to see us as women and men but as individuals who can achieve the projects we set for ourselves. So at least talking about life projects is extremely important because they involve much more than simply saying, "I want to own a house," no. What is your life project? How do

you see yourself in your life on an emotional level? or an intellectual level? In other words, it is how you build yourself as an individual. I think it's very uncommon to discuss how you build yourself as an individual with young people. How do you build yourself as an individual? What are your desires? What are your goals? What are your passions? What do you hope to learn about yourself, and what do you expect to give to society? it's not like "you just see how to get your job and that's it", no. I believe that solving issues of this nature would be possible if young people were more motivated to contribute. If you see someone who is passionate and focused on something they enjoy and who contributes to society, things will happen; there will be a process of discovery; they will seek their well-being and refuse to accept the reality that they say has been given to them (Local actor 2 in Soledad, personal communication, April 20, 2022).

The interviews in this exercise of deciding for one's own well-being emphasized how, while contraceptives are one of the most important vehicles for reaffirming these decisions, there is apprehension about the effect of continued use on their bodies, which is why they usually speak from very embodied and subjective experiences generated by using contraceptives (especially hormonal contraceptives). Beyond coexisting with incomplete or uninformed perceptions about contraceptives and their medical implications, this demonstrates a capacity for critical analysis and agency in which decisions about methods are counterbalanced by the psychological, medical, and social effects that lead to practices of "protection" of health and the body with pendulum cycles of use/non-use:

"I also feel that many women who do not plan are afraid of the changes in their bodies. [...] It has happened to me, I mean, I am afraid, and I'll put it this way, I am afraid to introduce something in my body to plan, [...] but

The **"life project"** is materialized as the set of expectations, goals, and possibilities that a person seeks to pursue through the daily actions that contribute to the consolidation of the person's idea of him/herself.

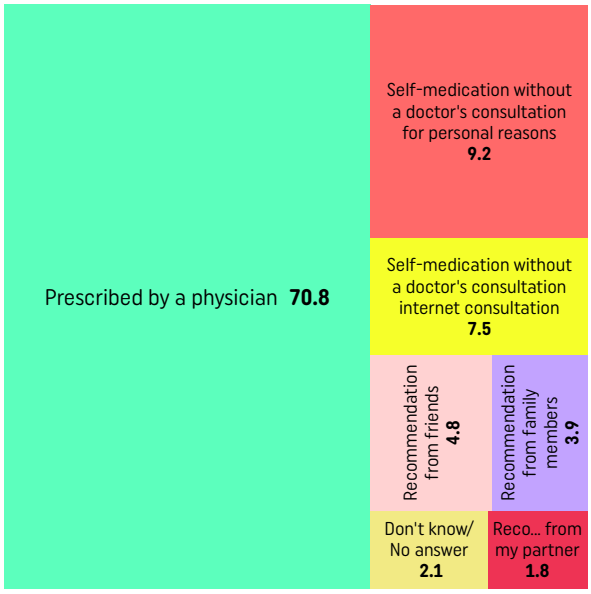
> for me to say that I want to use X or Y method, no, I am afraid because of the changes that may occur in my body or the problems that may occur in the future. For example, my cousin planned since she was very young, and when she was 13 years old, she started planning. She started with the T, but it didn't work; then she started with the Jadelle, and it didn't work, and then she started with the injection. It is like a transition, and now she has polycystic ovaries, so I have this image that planning for this issue is like not..., perhaps I will use barrier protection methods". (CIS woman 2 in Bogota, personal communication, March 29, 2022)

> "One can also read about how violent planning methods are with women, and I didn't want to; I was refusing to plan and saying things like... I had many friends tell me, "no, that made me fat, depression, outbreaks," and a variety of other things, and I said, "I can't believe I have to go through all of that to be able to enjoy my sexual life," why do things have to be this way? But then I got pregnant, and I was like, "No, my God," they may have whatever effects, but I don't want to go through this again." (CIS woman 4 in Bogota, personal communication, March 30, 2022)

These testimonies frequently highlighted the role of medical professionals in gynecological consultations as "translators" or "intermediaries" of the information related to the methods and their effects on the bodies, specifically in the face of the expectation of adverse effects of hormonal methods. And there were also expectations that, jointly (doctor-patient), a successful orientation could be reached for the assignment of "compatible" methods.

> "For me, it is essential that a person can identify which one best suits the body; it is important to know them, but, again, I refer to humanization; it is important to go to a professional who tells you, "well, for your body, this and that" because how am I supposed to know? For example, it has happened, or at least it has happened to me; there was a time when I planned with pills. I know how to plan because I understand the entire context; I know about the pills and that I have to take them every day; however, the pills hurt me because they caused my hormones to become out of control, resulting in pimples on my face. I still have traces of pimples, so it was crazy. So yes, it's very nice and everything to know, but that's when I go back. If it intervenes in me, I don't like it because there's no possibility of going to a gynecologist who tells me, "look," and does a study, and says, "look, the method that works for you is the injection, because, with the daily pills, it could be that the hormonal load..." whatever the reason is, so that would be the best way to do it" (CIS woman 1 in Cúcuta, personal communication, April 4, 2022)

Figure 3. Percentage of individuals consulted about contraceptive methods used in the last two years



Source: own elaboration based on the data collected in the virtual survey.

Part of this association between information and side effects may explain why, according to survey data (see Figure 3), the use of barrier methods and rhythm methods (associated by participants as "more natural") is frequently used and why informal alternatives to guide their administration such as self-medication without a doctor's consultation for personal reasons (9.2%), internet consultation (7.5%), and recommendations from friends or family members (4.8%), are often used (although not a majority)

Finally, regarding the idea of contraceptive use as an exercise of self-determination, some paradoxes were evidenced in the interviews with stakeholders who reported cases and experiences of coercion in the delivery of methods that occur in the family unit (under the argument that "early pregnancies would not be allowed at home") and in medical consultation spaces (especially in contexts with people in impoverished conditions such as irregular migrants and indigenous people). They stated that medical personnel frequently talk about methods strategically, omitting information on side effects or the bodily and economic costs associated with long-term use and that by doing so, they influence people's decisions to promote preference for certain methods. They also shared stories about cases involving the imposition of contraceptive use following abortion procedures, in which access to the termination procedure was contingent on the continued use of specific contraceptives. In these scenarios, these actions coerce and condition the freedom to choose and make it subject to medical approval, which is interpreted as a voice of authority.

> "For example, there was the case of a girl [in Cúcuta], and she was not the only one; before the abortion, they told her that she had to have the IUD inserted; that is, they did not offer her the route I mentioned, the [abortion] route [...] so she had an abortion and then [they inserted] the contraceptive method they choose for her. They told her that if she did not use that method, they would not perform the abortion, and then [...] they did not tell her after the abortion; instead, they told her before, so obviously she, in her desperation and without the knowledge, said yes, so that they would perform the abortion [...] [Also] In response to the migrant crisis, many NGOs distribute contraceptives; they kind of hand them out just to get them out of the way, so women go and are asked to choose. Supposedly she chose freely, but they tell her, "Look, we have this implant, we have this one for one year or this one that lasts five years, which one do you prefer?" obviously, she will say, "Oh well, the one that lasts five years," supposedly she made the decision. Still, she does not know all the effects that a long-term contraceptive method with such a hormonal load can have, especially if she has never used one, [...] that this is a strong hormonal change, all the implications that it can have. [...] Because many women go, they use the method, and we know that most want it. Still, because they do not know [about the side effects], they will want to take it out after three months, after a month, because they do not understand that these side effects are normal, or rather, expected side effects of the method. So, they will want to take it out immediately because many do not know, and they get stuck with it. I mean, the institution gave it to them for free, but they didn't realize they had to pay for the removal, and they had no idea what it could do to their body, so they don't want to have it anymore and they don't have a way to remove it" (Local actor 1 in Cúcuta, personal communication, April 4, 2022.)

The lesson from these testimonies is that the systematic persistence of barriers to contraceptive use among young people must be interpreted because their contexts, bodies, and interactions are constantly changing. This implies that because preferences and needs for use change frequently, preventing unintended pregnancies requires flexible and responsive strategies that must be underpinned by efforts to normalize, familiarize, and approximate information on sexual and reproductive health. It should also be noted that their preferences regarding contraceptive practices are not secondary or less important than medical advice; instead, they contain knowledge about the body and what they believe is essential to listen to in medical consultations.

6. Medical abortion self-care and telemedicine: opportunities and challenges

The WHO and the literature on telemedicine self-managed abortion[9] have documented the advancements and opportunities of this practice in the sexual and reproductive rights landscape by allowing pregnant women to exercise their right to health in a timely and private manner while also promoting bodily autonomy as a human right[10]. Numerous related global[11] and regional[12] studies have demonstrated that access to the right information and support systems makes it possible to maintain the success and safety rates of face-to-face procedures in non-clinical settings such as at home.

This section will discuss the findings of the qualitative and quantitative analyses regarding the experiences, preferences, and perceptions of the acceptability of this modality in people who used Profamilia's MIA tele-abortion service, people who had abortions inside and outside the social security health system, people assigned women at birth who have not had abortions. Importantly, it will also consider the contributions of the support groups interviewed, feminist and trans feminist collectives, and community-based organizations that work on gender equity in the prioritized municipalities. It is hoped that these data and testimonies will enable the identification of new elements for designing the digital solution for abortion self-care. These elements will be based on the needs and expectations of the user population regarding services, information, care, and support and will be examined through the lens of autonomy. This will open the possibility of enhancing the care given and increasing access to abortion, especially in contexts where there are geographical, sociocultural, and economic restrictions.

In 2019, the preface to WHO's (World Health Organization 2019) first consolidated guidance on self-care interventions for health notes that "people have been developing self-care practices for millennia" and that it has

9. Self-managed abortion is defined as the practice of self-administering medication for pregnancy termination outside of clinical settings (Wainwright et al., 2016).

10. See: (Bercu et al. 2022) (Larrea, Hidalgo, Jacques-Aviñó, Borrel, & Paléncia, 2022) (Kohn et al. 2021) (Wiebe et al. 2020) (Ehrenreich et al. (2019).

11. See (Endler et al. (2019), DeNicola et al. (2020), Kohn et al. (2019) and Fix et al. (2020).

12. See: (Zurbriggen, Vacarezza, Alonso, Grosso, & Trpin, 2019) (Moseson et al. (2020) (Zamberlin et al. (2012).

been the context of new technologies and scientific advancement in medicine that has allowed the expansion of these practices into new settings, expanding access to services and the range of possibilities for it to happen on its own terms. In abortion contexts, this vision entails self-administration of misoprostol and mifepristone to terminate pregnancies without direct medical supervision and has resulted in recognition of individuals as active agents in the management of their own health care and, in most cases, as complementary actions to health system services under safe conditions (World Health Organization, 2022a). This model of abortion self-care does not seek to transfer complete responsibility for care to the individual but instead recognizes the responsibility of institutions as suppliers of quality services who should anticipate the needs of their patients, particularly - according to the evidence gathered in this research - in terms of the emotional and psychological support they may require before, during, and after procedures.

6.1. About telemedicine

As a result of the COVID-19 pandemic's restrictions on face-to-face contact, health care via communication channels such as phone calls, video calls, and text messages expanded significantly. During this time, providing health care services through these channels was critical to facilitating access to health care in a context limited by isolation measures ordered by the national government to prevent contagion.

As a result of the health crisis, the use of digital environments accelerated in different spheres of daily life. According to survey data, there is a higher prevalence of access to smartphones and laptops in all age groups

The Health care through media outlets such as calls, text messages, and video calls, expanded significantly as a result of the limitations of face-to-face contact imposed by the COVID-19 pandemic.

and income levels when it comes to access to technological devices. Based on the responses obtained and taking into account the majority participation of people in urban areas, 83.46% of participants between the ages of 13 and 19, 79.8% between the ages of 20 and 24, and 75.9% between the ages of 25 and 28, stated that they had access to the Internet via their cell phones. On the other hand, the laptop is the second most popular device for browsing the Internet, with 85.7% of young people aged 13 to 19, 81% aged 20 to 24, and 78.9% aged 25 to 28 using it to access the Internet. It is worth noting that, although the percentage of computer use is increasing as age increases, the use of smartphones has become a plausible alternative for accessing information due to the versatility to make the most of the available content, but this does not represent a definitive solution.

Table 4. Percentage of people who agree with some statements while using their phone to obtain information about sexual and reproductive health services.

Variable	Category	I would be concerned about other people (partner, family, friends, others) reading the messages.	I would be concerned if the word Voluntary Termination of Pregnancy (VTP) was included in the messages.	I would be concerned if the word abortion was included in the messages.	I would be concerned if the word birth control or contraception were included in the message.	I would be concerned if the word sex or sexual health were included in the message.
Age groups	13-19	55.6	15.2	21.5	7.1	7.9
	20-24	50.9	19.0	27.7	5.6	6.5
	25-28	47.7	21.8	31.9	6.8	6.9
Income Level	No income	55.6	18.9	27.4	8.2	9.4
	0 - $500,000	51.3	18.4	25.9	6.9	6.3
	$500,001 - $1,000,000	48.0	20.3	26.8	6.4	6.4
	$1,000,001 - 2,000,000	46.4	16.9	27.0	5.0	5.5
	$2,000,001 or more	50.8	20.8	31.8	3.2	5.8
Total Cases		**2,928**	**1,085**	**1,575**	**362**	**399**

Source: Own elaboration based on the data collected in the virtual survey.

Despite its expansion in the last two years, telemedicine still poses some challenges due to the cultural imaginary that is held about the suitability of the doctor's presence to obtain adequate care and the conflict that it represents for people to discuss or receive sexual and reproductive health

services in spaces other than a doctor's office (Profamilia and MEXFAM, 2021). When asked about their level of confidence using mobile devices—defined as a cell phone, tablet, laptop, or desktop computer—as a proxy for how acceptable it is to use technology to access information about sexual and reproductive health services, young people between the ages of 13 and 19 are the most likely to express this concern (55.6%), followed by those between 20 and 24 (50.9%), and those between 25 and 28 (47.7%). This is also true at any income level, and it continues to be the situation with the most mentions. Furthermore, as shown in Table 4, participants indicated that mentioning a service such as abortion or VTP in the body of the message would be cause for concern when accessing services via mobile devices.

People interviewed, on the other hand, questioned the acceptability of this modality, both for the quality of care and for the systematic barriers that exclude the disconnected population or those with low levels of digital literacy. Several old questions about face-to-face health care are raised here, such as the perceived lack of empathy of medical staff, the difficulty of access for the impoverished population and in conditions of socioeconomic vulnerability, and the lack of differentiated approaches to address the contexts of people in rural contexts. Furthermore, the testimonies show a widespread distrust of digital media as a means for patients to effectively communicate and "show the evidence" of their bodily conditions, given the inability of medical personnel to conduct physical assessments.

> "I mean, I could have lied to him a lot, he didn't even realize it, and he prescribed me a lot of things based on what I told him, so of course, if what you say is not true, that is like calling any friend. Think about it, if there is mistrust in person, I mean (laughs). We are not very accustomed to this type of consultation, nor are there the conditions for a good tele-consultation. And I also believe that it derives from something that happens a lot here, where we usually have close physical contact; Indeed, we are very relationship oriented. So, one expects to be talked to; in other words, there is a need for a friendly treatment, and for it to be, I mean, kind of delicate... and the coldness, the very idea of imagining that already generates a barrier of "I'm not even going to try it." And if you do try it, it's like "no." I have not particularly lived in a place where telemedicine is the only alternative, so I believe that people prefer to go to other types of medicine, traditional ones, some more reliable than others" (Local actor 1 in Popayán, personal communication, March 22, 2022)

> "Well, I did have telemedicine, and the truth is that it was very... I mean, the fact that the doctor did not touch me, that he did not really know, I mean, I could tell him, I am dying, and he has to go with [my testimony:] "I am

> dying," because how is he going to determine whether it is true or not, or if it is something in my mind, I do not know, I mean, I feel that it is something very... I do not know. But besides, if one is very sincere with the doctor, I think it is possible to reach a diagnosis. But there may be many shortcomings because it is not the same, [...] I see that in the teleconsultation, we are like from the neck up, but [when it is in front of you] it turns out that I could see on your arm, I see that you have a spot, I can see this, and that, which is not the case in the teleconsultation because you are not in front of me, and the patient is also like in something else, they are as if they have different visions. On the other hand, when it is face-to-face, we have a whole perspective of the person, from the hair, the eyes, the brightness, I mean, whatever, the skin, the color of the skin, because the camera also distorts us a lot. So, I feel that no, personally, I don't think so". (CIS woman 1 in Cúcuta, personal communication, April 4, 2022)

When asked about the use of other services parallel to telemedicine, such as the use of chatbots to manage medical appointments and provide information, the responses showed a resounding and almost unanimous rejection, indicating that these platforms promote the "dehumanization" of care and that they rarely fulfill their purpose of channeling services:

> "They [chatbots] don't work that much. I think that in terms of health, there is nothing like sitting down with another human being, who understands that something is hurting, who understands that something is burning, who understands what is really bothering you, and who maybe has that empathy and that human sense" (CIS woman 2 in Mitú, personal communication, April 26, 2022)

> "Yeah, it's a bit time-consuming, it would be more efficient with the phone number and the call, and you talk to the person a little quicker, or the

As a result of the health crisis, the use of **digital environments** accelerated in different areas of everyday life.

conversation is much more fluid. Although, through the numbers, I think the conversation is not as personal." (CIS Woman 2 in Soledad, personal communication, April 20, 2022)

"But when I have been with a BOT, that is horrible; it is like they will make me waste 10 minutes of my time with that BOT, and then they refer me to a person. And once with the person, I can ask them, and that has happened to me in call centers, it is horrible" (Local Actor 1 in Popayán, personal communication, March 22, 2022)

Despite these resistances, some of the telemedicine>s advantages were highlighted, including the potential to personalize interactions and cut down on appointment assignment wait times.; this was especially significant for the population with trans-life experiences and non-binary people:

"For trans people, going to health services is a very hostile space. From the moment we walk in, they don't call us by our names, or they don't use our pronouns. If one has not changed or the system has not been renewed, they suddenly call you by those megaphones with the previous name or that the doctors use the name that is not because it is what the system says. Yeah, the issue of being in person is very complex, it is challenging, and it exposes you a lot, very much. But I know that at least if the doctor mistreats me because of my pronouns in a video call, I can close this video call; I can say that I want to see another doctor, turn off the computer, and be in a safe place. I am not in an office exposing myself to this person having another type of violence. (Trans man 1 in Bogotá, personal communication, March 28, 2022).

"In reality, there isn't much of a difference, even if you're used to going to the doctor and having the doctor check everything. I believe it works, and it is a great mechanism for prioritizing the things that truly require you to visit an EPS. So, I liked it, and I have used teleconsultation several times with no problems. In fact, there are several things, not just medicine, that save time. Yeah, sure, it has worked perfectly for me when I have done it."". (CIS woman 2 in Mitú, personal communication, April 26, 2022).

6.2. Abortion in digital spaces

With this context in mind, discussions about abortion, self-care,[13] and telemedicine revealed opposing points of view. Some people expressed skepticism that access to medical abortion via telemedicine could be approached safely, citing potential risk scenarios due to a lack of information or adverse outcomes that could endanger the person's life during the procedure, which was particularly prevalent in the testimonies of people who had only had in-person abortion procedures and those who had no abortion experience at all. This could be related to how medical abortion narratives in the country inherit the stigma that associates these procedures with dangerous and unsafe actions that take place in the shadows of pharmacies and underground clinics, as well as a lack of information about medical abortion and, more specifically, telemedicine:

> "Well, admiration and respect, I mean, it's a difficult choice. I feel that if it happened to me, I really do not know what I would do because it makes me feel like a lot of things, I don't know, it's weird, like in those movies that you see and sometimes they go wrong, so it's awful"." (CIS woman 5 in Bogotá, personal communication, April 1, 2022)

> "Look, the pandemic forced us to move forward a hundred years, but that was already used before, only it was forbidden. I do not know if you have heard before about pills called Cytotec,[14] which were used to induce abortions; they were called Cytotec. However, it was a means, and it was not used orally, but vaginally, and because of that [...] [the result of] so much bleeding. They were dangerous. People used it, but no, they were super, super risky, and that is why I am telling you about the bleeding. Also, that is why I am saying to be careful, make sure it's not dangerous. So, I mean, because I have not had the experience. [...] but we have friends who sometimes tell us, no, I don't want to have an abortion, because I'm going to

13. Self-care understood as "the ability of individuals, families, and communities to promote health, prevent illness, maintain health, and cope with illness and disability with or without the support of a health care worker. Thus, self-care encompasses health promotion, disease prevention and control, self-medication, service delivery for care-dependent individuals, seeking hospital/specialty/primary care as needed, and rehabilitation, including palliative care. It encompasses a variety of self-care practices and approaches " (World Health Organization, 2022b)

14. This drug has no sanitary registration in Colombia, and the INVIMA (National Institute for Drug and Food Control) has warned of its risks since 2016. In 2014, the laboratory that marketed it (Pfizer) permanently removed it from the Colombian market (El Espectador, 2020)

> bleed to death, I'm going to die, or I'm going to have a rehabilitation process [...] but if the application manages to arrive in a clarifying way and very... [to] calm the women down [...] Of course, and, I mean, it was something secret, something I learned about from my mother, [she told me] "don't take Cytotec," and I [asked myself] "what could that be? Then, they explained to me about Cytotec and how people used to order it over the Internet. You would Google Cytotec and see advertisements for all of that, which was extremely dangerous, and of course, women died like that. Could you Imagine? It was something crazy, what people were doing to protect their morality" Local actor 2 in Cúcuta, personal communication, April 5, 2022

In contrast, those who expressed positions close to feminism and reproductive justice discourses in the interviews were more likely to express favorability and acceptability for these types of bets and less stigmatizing views of abortion in general. This was explained in the numerous advantages these approaches were known to have as possible strategic alternatives to reduce some of the most significant barriers to abortion access, such as lack of confidentiality of the experiences, costs, waiting times, the agility that allowed the delivery of timely information, and the type of care that could be delivered during the procedures:

> "Well, I believe that anything that can be generated in favor of women, that they can have access to decent, autonomous, and respectful conditions, and that they can have access to terminate a pregnancy when they need it, for whatever reason, especially these days, is well... welcome. And I am confident it will be better received in other parts of the country. Here, because of these limitations, because of the access to the Internet, I believe that... there is a highly digital population here, and nowadays, young women are very motivated to think about and question all the restrictions they have,

According to the survey results, participants indicated that when they underwent an abortion procedure, **the accompaniment in the process** played a key role.

> and which socially have been placed on their bodies. In other places, it will undoubtedly be better and more accessible, but that does not mean it is unnecessary or cannot be used here in Cauca," (Local actor 2 in Popayán, personal communication, March 24, 2022)

In line with this favorability, which is not without questions given the recognized barriers to health and digital infrastructure, testimonies and surveys (see table 5) highlighted the significant role played by abortion support groups in the sexual and reproductive health ecosystem[15] by allowing access to health to people who are typically excluded from timely care through communication channels mediated by technology, and that their actions have created important precedents that contribute to the implementation of self-care models of abortion. This seems consistent with recent literature on abortion in contexts of stigma and criminalization, where community health models are informing new public health care policy stakes in other parts of the world (Braine, 2020).

According to the survey results, participants indicated that when they underwent an abortion procedure, accompaniment in the process represented a key role, whether from the partner, counselor, service provider, or friends. On the other hand, the role that feminist groups or collectives play during the process stands out. During the procedure, 7.3% of the participants received support from a feminist group, with the adolescent population between the ages of 13 and 19 receiving the most (10.5%). These collective groups operate at the community level, through networks that extend beyond local boundaries (there are connections with other national and international collectives or organizations), where they have established accompaniment routes and defined roles, allowing them to mitigate the risks of suffering prejudice or being victims of discrimination for the decision made, while also openly questioning the hegemony of medical knowledge and the need for accompaniment to have accompaniment for the performance of abortions when these are done early, as part of exercising the right to safe abortion (Profamilia, 2020).

15. The ecosystem concept is used throughout the paper based on IPAS conceptual propositions that define it as "a dynamic condition in which resilient local parties and systems are accountable and actively engaged in upholding abortion rights and being responsive to all people's abortion needs." (IPAS, 2022).

Table 5. People who helped you in your abortion procedure by percentage

Who helped you to have an abortion	Age groups			Approximate monthly income					Total
	13-19	20-24	25-28	No Income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2.000,001 or more	
Partner	31.6	29.8	32.4	26.3	30.5	34.6	33.7	29.4	31.0
Counselor	21.1	23.9	24.1	18.4	21.0	24.7	34.9	19.1	23.7
A private health care provider	7.9	21.0	22.9	14.5	15.2	19.8	27.7	27.9	20.6
Friends	21.1	22.9	14.1	17.1	18.1	19.8	21.7	19.1	19.1
No one	23.7	12.2	9.4	17.1	13.3	8.6	7.2	14.7	12.1
A public health care provider	7.9	10.2	14.7	5.3	11.4	11.1	16.9	14.7	11.9
Other	7.9	9.3	11.2	14.5	11.4	4.9	8.4	10.3	9.9
Feminist group (support group)	10.5	7.8	5.9	6.6	7.6	9.9	8.4	2.9	7.3
Family members	10.5	6.3	5.9	7.9	8.6	3.7	4.8	7.4	6.5
Online service (Hotline)	0.0	5.4	3.5	2.6	4.8	4.9	4.8	2.9	4.1
Community based organization	7.9	2.4	2.4	2.6	3.8	6.2	1.2	0.0	2.9
Prefer not to answer	2.6	4.4	0.6	5.3	4.8	1.2	1.2	0.0	2.7
An international organization	2.6	0.0	1.2	0.0	1.0	1.2	0.0	1.5	0.7
Total Cases	**38**	**205**	**173**	**76**	**106**	**82**	**84**	**68**	**416**

Source: Own elaboration based on the data collected in the virtual survey.

The interviews revealed significant differences between telemedicine abortion procedures performed in clinical settings and accompaniment provided by groups, collectives, and community-based organizations that use technology as a contact platform. Although both processes appear to follow similar steps in the delivery of medications and guidance for their use at first glance, they are viewed as mutually complementary but fundamentally different approaches at the core. Some of the differences mentioned, for example, have to do with how health and well-being are promoted in support groups through care and affection; the operational deployment of procedures based on principles of flexibility to start, accelerate, pause,

and stop processes (the latter conceived as an "impossible" action in formal medical consultations); the use of friendly and simple everyday language to guide the processes; the collective financing of initiatives and procedures for those who cannot afford it; the combination of "natural" health practices related to traditional medicine; the personalized and systematic follow-up of each case even after the procedure has been completed; just to mention a few.

> "For instance, no one can, I do not know, really take the time to listen to the emotions that each person experiences—not Profamilia, not private physicians, not the EPS, not anyone else. And that person wants to tell you that she has broken up with her ex a thousand times, that it is not the first time, that she is pregnant, that she has already done it, but yes, that her ex is a dog, and that when that happens, she has no idea what to do and is not with her. That is what that person wants, for you to listen. People trust you more as an activist to tell you these things, even if they have never met you, because they believe you are more willing to listen to them; on the other hand, if they go to a doctor's office, they do not feel like they can say to the doctor, "look, my ex is a dog." So, they believe there is a formality and a hierarchy of doctor versus patient, which prevents them from experiencing this emotionality. [...] It has also been important for me to have the moment when they say thank you. I don't know if it happened, but it is more difficult because of what I said about the doctor's hierarchy. It is not likely for them to say, "oh, I am going to tell the doctor in the chat thank you very much; it was very important for me that you were there" because it is the doctor; why the hell is he going to care? On the other hand, when they feel that it is someone else, perhaps even a little more with a psychologist, or for example, with me. I am a companion who understands, I am not being paid to do this, I am making time apart and all the rest of it; they are more likely to respond positively. They have the space here to say, "thank you, it's very nice, how nice to have met you, when I can help you with something..." so that's what's needed, that moment." (Non-binary person 3 in Popayán, Personal Communications, March 23, 2022)

> "Oh yes, Yerbateras did a project with Fondo Lunaria, and they created herbal kits to accompany abortions and gave us some packages here. So, when we knew of a case of a girl who was going to have an abortion at home, we sent the kits free of charge. They came with an implaste, an oil, a tea bag, a pillow, and a tincture. These are some of the elements that are taught and how care is provided. So, they sent the kit and accompanied it with the book. It was an effective method because it is an affectionate accompaniment. For example, it is important for us that it is from the care of the person rather than from the judgment that can occur because precisely if one feels judged or evaluated, then one simply will not go, and if

the person who provides me with this service is like that, then no, we must consider other options [...]I believe that is the feeling of self-managed abortion, and Las Parceras is one of the leading networks. It is one of the main networks, and it appears to be saturated; they do not appear to have the capacity for everything that is required throughout the country." (Local actor 1 in Popayán, personal communication, March 22, 2022.)

"I believe that [abortion providers] should learn a genuine, situated, and emotional process about what it means to care for someone during a process such as a pregnancy termination. It would be very beneficial, I mean, caring more than providing information, right? For example, knowing that violence from medical personnel can make a person give up. I feel that this is something they have to learn" (CIS woman 3 in Bogota, personal communication, March 29, 2022)

"Let's say it depends on how the person wants to do it; some people feel safer going to a place, but they don't want to go alone, so we accompany them [...] Then it is also necessary to understand that many of the abortion cases of transgender people are due to sexual violence, so other lags remain in the body, that require different types of support. Let's say that what would be great to have here is that for us, the process of abortion accompaniment is an accompaniment that goes beyond expulsion, right? In other words, this is not the center, it is just one more moment in the process, and many other things must be considered in the person's experience without re-victimizing, without over-complexing. It should not become the most complex and unattainable thing because it is neither, and it is extremely calm on many occasions. But we're thinking about many things with simple questions, like how can we help people without overwhelming them with information? [...] You must understand how to manage information because if you throw a lot of information at someone at the start, they will become scared and anxious. Something that helps a lot to have a calm abortion process and to talk to people is information. But besides this, with trans masculinities, there is a need for a mental health follow-up that is not done. We do it, but we know that we are not the only ones who accompany, and many put aside their identity to access an abortion, something challenging. So, it would be necessary, either with the social movement or with medical research, [to investigate the] adjustments concerning the physical body" (Local actor 1 in Bogota, personal communication, March 30, 2022.)

Based on the convergence of autonomy and accompaniment, these approaches to care can help guide the design of interactions and points of contact with users to improve the quality of care while actively contributing to their autonomy. Allowing them to choose the type of accompaniment

they want would be a simple and logical starting point in the framework of procedures and actions that would be implemented to help address the diverse needs of abortion users. Furthermore, there is a perceived need to incorporate guidelines and recommendations for possible safe, holistic practices that can be performed during abortion procedures, which, as rationalized in the testimonies, allow people to perceive more control over their bodies, the recovery to which they actively wish to contribute, and their recognized right to take charge of their own self-care.

7. Self-care abortion needs in hindsight: some design guidelines.

Examining the population's perceived needs to access the right to abortion is an exercise that must begin with a thorough examination of the barriers identified in the contexts and experiences of people who have had abortions. Thus, this section aims to delve into six major barriers identified in the research framework and against which the digital solution has the potential to contribute to their closure by designing actions, content, and tools aimed specifically at addressing, dealing with, and reducing them. For this purpose, the results of both the survey and the in-depth interviews will be used to provide elements that will help the analysis.

According to the survey results, 636 people (11%) had unintended pregnancies between 2020 and 2021, with 163 accessing an abortion procedure (induced with medication or by surgical methods).

The main barriers to accessing abortion services among these 163 people were: the cost of the procedure (59.5%), moral judgment on the part of health care providers (42.9%), a lack of access to information (33.1%), a lack of friendly services (22.7%), and a lack of medications (19%) (See Table 6). The cost of the procedure, moral judgment on the part of health care providers, which may be related to the social stigma that afflicts the country when faced with the decision to have an abortion, and lack of access to information were the three main difficulties for accessing abortion in the three age groups that comprised the survey sample. When considering the respondents' income levels, it became clear that, while the cost remains the main barrier, when the income level exceeds two minimum wages, the

The three main difficulties to abortion access were: the **cost** of the procedure, **moral judgment** by health-care providers, and lack of **access to information.**

prioritization shifts, and the moral judgments suffered by a person who undergoes an abortion by the service provider becomes the main obstacle.

Table 6. Main difficulties encountered in accessing medical and surgical abortion services

Type of difficulty	Age groups			Approximate monthly income					Total
	13-19	20-24	25-28	No income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2,000,001 or more	
Cost	80.0	65.3	47.1	70.0	55.6	66.7	66.7	33.3	59.5
I felt judged by the service providers.	50.0	42.7	41.2	45.0	40.0	44.4	44.4	41.7	42.9
I did not have the knowledge or information	35.0	41.3	23.5	35.0	33.3	29.6	37.0	29.2	33.1
No youth-friendly services available to me	35.0	22.7	19.1	22.5	28.9	22.2	18.5	16.7	22.7
No drugs available in pharmacies	25.0	17.3	19.1	15.0	22.2	11.1	37.0	8.3	19.0
The health care provider did not want to deliver the service	25.0	18.7	11.8	15.0	17.8	22.2	18.5	8.3	16.6
Lack of service in my city/town	25.0	12.0	13.2	10.0	22.2	11.1	14.8	8.3	14.1
Other	5.0	6.7	16.2	5.0	8.9	0.0	18.5	25.0	10.4
Transportation	5.0	16.0	4.4	10.0	15.6	3.7	14.8	0.0	9.8
Health care provider did not know how to deliver the service	15.0	8.0	10.3	10.0	8.9	11.1	11.1	8.3	9.8
It was too late, advance pregnancy	15.0	6.7	8.8	7.5	11.1	3.7	14.8	4.2	8.6
Don't Know/ Don't Respond	0.0	0.0	1.5	0.0	0.0	3.7	0.0	0.0	0.6
Total Cases	**20**	**75**	**68**	**40**	**45**	**27**	**27**	**24**	**163**

Source: Own elaboration based on the data collected in the virtual survey.

The stigma associated with abortion was acknowledged in both the interviews and the survey results as one of the major obstacles preventing women, men with transgender life experiences, and non-binary people assigned female at birth from accessing sexual and reproductive health services such as abortion due to a lack of confidence to discuss the subject or fear of judgment by some providers who still do not know the regulations or delay the procedures. This fear of judgment was especially prevalent in younger people aged 13-19 years (35%) and 20-24 years (41.3%), as well as across all income levels, which corresponds with the findings of the interviews, which show the central and decisive role played by medical opinion on bodily decisions, particularly those concerning reproductive health. At the same time, these findings highlight the perception of limited reproductive autonomy in these groups, particularly among those with lower incomes.

On the other hand, these findings show that another major barrier to access is a lack of friendly services, which posed a significant barrier to abortion procedures for 35% of young participants. This could be attributed to a lack of technical discussion spaces and encouragement of healthcare providers to promote the adaptation of sexual and reproductive health services, particularly abortion care, to the needs, identities, and circumstances of women, men with transmasculine life experiences, and non-binary people assigned female at birth, as well as a lack of dissemination of quality information on the availability of services at the national level, and where and how to find data in a clear and stigma-free manner (Profamilia 2020).

Below, we will delve into these, and other significant barriers identified as part of the abortion ecosystem and how the digital solution can help to close them by designing actions, content, and tools specifically aimed at addressing and reducing them:

1) Information

As explained in previous sections on how people seek and find information about sexual and reproductive health, access to safe abortion procedures is conditioned in many ways by the information one has about this practice, where and how it is performed, what legal support surrounds it, what it implies on a biological level, logistically what should be taken into account, and other questions that people with these experiences reported having before their procedures. This opinion is supported by the survey's findings, which showed that the third most frequently cited barrier across all age groups and income levels was a lack of information for about 33% of participants who had an abortion procedure within the previous two years. These results could be directly related to the need to continue implementing preventive and informative campaigns on comprehensive sexuality education,

but also to the need for effective dissemination of the regulations in effect following the decriminalization of abortion up to 24 weeks, as well as of the institutions providing services, to ensure access to safe abortion services.

In general, there are four fundamental needs in the narratives of the participants' experiences regarding access to information: I) the use of a language close to people's experiences, II) the ability to find all the information centralized, III) the reliability of the data included, and finally IV) the ability to have permanently open channels for the resolution of concerns.

> "I think the process [of abortion with MIA] was very cold, although, in itself, the process is cold because it consisted of two appointments and "take your pills." Although it was good because the process was quick, it was very cold and left you with the feeling that ouch! (laughs). One is left with the impression that it is a rather cold process; perhaps a more mutual accompaniment, a little more human, slightly more open to giving you more information or things of that nature, because, let's say, despite having the accompaniment of a person, a person close to me, I believe the process was very cold. They were very cold questions, and it is difficult to answer such a cold question at such a sensitive moment in your life." (CIS woman 2 in Bogota, personal communication, March 29, 2022

> "As a matter of fact, when my friend underwent the process, she knew it existed, but she had no idea what it was like, what they were going to do to her, how much it was going to hurt, or how she would feel afterward. They explained it to her when she was already there on the site, but it is not something you can read about telling you here we are going to do this and this and this. For example, in Profa, they explain it to you right when you get there. But there is no information on a web page that tells you, for example, "we are going to do this and put that," that information is given when you access the service as such. So, it would be beneficial if that information were available [before] so that people are aware and have clarity. I am not sure if knowing what is going to happen will make me feel calmer or more nervous, but at least I will know whether it's traumatic or not. But if you know ahead of time, you can kind of prepare yourself, thinking, "Well, this, this, and this is going to happen to me, so I'm going to do this.". Like the interview, I am going to ask you this and this, when you want, you can leave, but if I arrive, and then I feel like leaving [I do not know if I can]" (CIS woman 2 in Cúcuta, personal communication, April 5, 2022)

> "If, for example, there can be a suggestion that says: "if you need more information," or "if you do not understand something, call this number", or " let us know, and we will call you." I do not know, something like that, and try to make the people who answer the phones a little bit more... empathetic

> […]. I understand that receiving calls all the time can be exhausting or make one feel bad-tempered. Still, I believe that in the case of abortion issues, people should understand that it is a difficult process, that you can't talk to people in a rude tone because it will make them feel [bad], so you have to try to make people be a little bit more, like, how can I put it, that they have that little warmer attitude, that they transmit that little feeling of accompaniment through the phone call" (Local actor 4 in Popayán, personal communication, March 23, 2022)

The centrality of this barrier in the testimonies makes a lot of sense if one considers that, in fact, information is a central component in strengthening abortion self-care practices and is a key element in processes of autonomy. However, it is important not to overestimate its role in reducing unsafe practices or resolving all concerns in the context of abortion.

The WHO emphasizes this fact by clarifying in its guide on self-care in health emergency contexts that not all pregnant women require the same level of support in self-management processes. Hence, it is critical to consider that vulnerable populations may require more information and/or support to make informed decisions on the use and acceptance of these interventions to avoid increased vulnerabilities that are exacerbated by decisions made out of fear or lack of alternatives rather than autonomy (WHO, 2019, 5).

Even with these limitations, providing the population making the decision with appropriate information can help people understand the options they are entitled to and have available to them, create a common language with medical personnel for the discussion of procedures, and provide practical elements to combat coercion and misinformation. It can also help people better understand the effects of their sexual and reproductive decisions on their life projects, thereby promoting their right to decide.

2) Waiting time

This is one of the most frequently raised and prioritized concerns in documented abortion experiences. It was often rationalized as one of the deciding fstakeholders in the choice of health care provider sought by those seeking an abortion, sometimes even above cost (another closely related barrier) and was subsequently sometimes reduced to "who will answer first.".

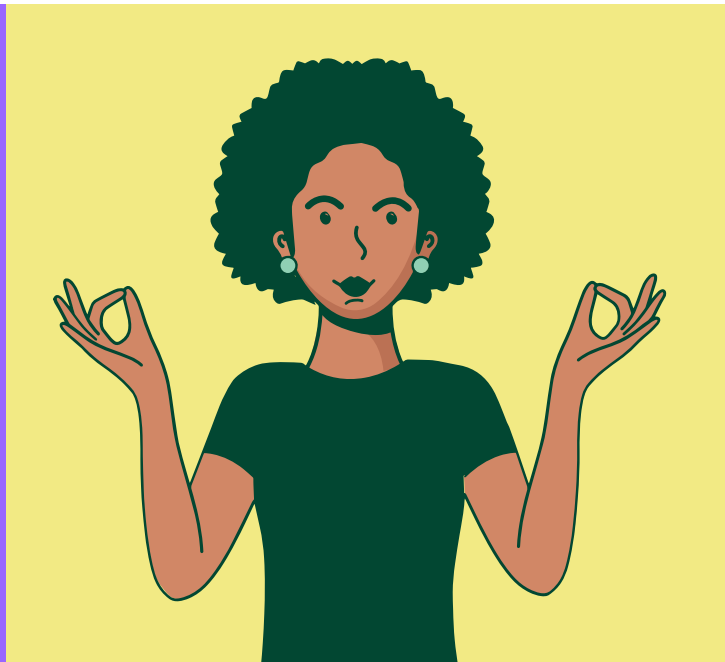
Due to the well-known lag of medical entities providing health services in terms of timely responses, the waiting time associated with the management of medical appointments and the approval of authorizations for procedures was often a factor that discouraged the activation of

institutional routes from accompanying these procedures, motivating people to seek expedited, clandestine, and local alternatives. It is in this type of context that abortion support groups are closing a significant gap in terms of access to safer procedures. Still, due to the high patient volume, they are forced to prioritize some services, diluting, or losing contact with some of the individuals who consult them during the process:

> "Many make the appointment [at Profamilia], but they get it after 15 days or more. So, they decide to get the pills somewhere else, fearing the weeks will advance because there is also the fact that up to a certain number of weeks it is possible [with pills] [...], so they decide to go elsewhere. And usually, the process tends to be slow, at least at the Cúcuta site. [...] Many write to us, and the next communication is in two weeks, and it is not only the communication issue, but I imagine the personal issue they are going through. So, it is with great patience, to be honest. We have to be aware of the conditions and find a way; if they cannot communicate with us" (Local actor 1 in Cúcuta, personal communication, April 4, 2022.)

> "Perhaps the speed of response. Many times, you arrive, and they put a channel, let's say, on Facebook. Then you write, and nobody responds, and then you are referred to another channel from that channel. In other words [there are gaps in] clarity in the points of contact because it has happened to me that I am looking for information that does not differ from one point to another. Let's say if I search on Facebook, or WhatsApp, I don't know, in whatever I search, if I search on Google, I want it to be the same information and that they attend to me as soon as possible. Because a day goes by, two days, I wonder if they will ever answer me. So, I don't know, it's like the speed of response, and from there on, it would be everything else" (Local actor 1 in Popayán, personal communication, March 22, 2022)

Waiting time is one of the most recurrent and priority concerns in documented abortion experiences.



> "They told me there were no appointments available at the time, and I wanted to get out of the situation as soon as possible because pregnancies cause me a lot of vomiting symptoms, and I didn't want anyone to notice at home because I now live with my mother again. I was a bit anxious and got desperate, so I said, "no, I am not going to wait" because they told me that there was no appointment, but after a week. I was still on time because I had not been pregnant for long, and I went to the... well, I went to that person, I bought the pills, and I took them; I was at home alone at night, so I took them at night, and I started with very light bleeding, not very serious. Then it increased, and I thought it was over, so I went through a process to... like they say that you take it, and after the bleeding, if you throw clots, you are supposed to have expelled everything. But no, about two weeks went by, and I still felt weird, I still felt pregnant, to tell you the truth. Then I said: "No, I am going to go to the EPS," so I went, and again I did not say that I had taken anything; I said that I had discovered that I was pregnant because doctors tend to judge a lot, in fact, when I said that I was pregnant they said "congratulations," they did not even let me finish explaining why I was going to the doctor. Then they did an exam and an ultrasound, and they realized that there was already damage and referred me to a clinic which was the worst experience of my life. It went badly, I was there, I went there at night, and the nurses ignored me. Then during the day, they told me to go the next day because there were no stretchers to do any procedure. I went early the next day, and I was waiting all day; I remember that I felt... then they gave you a medicine again, the same medication so that you dilate and throw everything out; they gave me the medicine, and I remember that I bled a lot, a lot, I had never bled so much in my life, the doctor came every so often and checked me, he put his fingers in me and at one point he put his fingers in me so hard that a lot of clots and blood came out, I filled the whole bed, [...]. So, it was... I mean, it was very traumatic because I felt that in that place I... I mean, all the people who were there, all the women, we were there for a curettage, they treated us as if we didn't matter, as if it wasn't urgent, as if [they told me] "well, it hurts, but it will pass, it's normal to feel that way." (CIS woman 3 in Soledad, personal communication, April 20, 2022)

In these contexts, considering the possibilities of expedited care offered by the telemedicine alternative for abortion self-care is not only strategic in the context of the pandemic but also an urgent response that can promote abortion care as a medical emergency and as a constitutional right. Additionally, this can be articulated as a potential response to the guidelines issued in the Ministry of Health and Social Protection's circular 044 of 2022 (Ministerio de Salud y Protección Social, 2022)(Ministerio de Salud y Protección Social, 2022).

3) Cost

The interviews and surveys mentioned the cost as the main obstacle to accessing procedures. All age groups and almost all income levels rated it as the most significant challenge, except those who reported making more than two minimum wages. The main challenge for this group was the prejudice of service providers. Table 6 reveals that this prioritization tends to decrease as age and income level increase, which would indicate that it is younger people who are in more vulnerable scenarios, who have less economic autonomy, and that this is an obstacle that can be circumvented in the groups insofar as they are able.

In the same way, it is a fundamental determinant that defines the quality of services to which population groups can have access and is deeply related to economic autonomy, which is why it was recognized in the new ruling of The Constitutional Court as an accepted argument that evidences the perverse inequalities that are configured for socioeconomically vulnerable groups.

It is especially unfavorable for young people who are studying and do not have their own resources, those who are informally employed or are the primary breadwinners in their households, and those who live in rural areas (where salaries are usually lower). It also has specific effects on the possibility of moving to other municipalities in search of more confidential and secure procedures. This is explained by the testimonies collected:

> "Well, one of the concerns that young people express to us is economic, because they always think it will have some cost and they are people who cannot support themselves. So, first of all, that is a barrier and one of the reasons why it is difficult for them to terminate, especially if we consider that their parents support them and so on, and obviously, they do not want them to know about it. And I think that class privileges also play a role, if you are poor or do not have enough money this month to carry out the procedure, So, one way to go to the service is as if it were charity or they give you undignified treatment, which takes away a lot. On the other hand, in a support network, it's more like "what do you need?" and "if there is no money, we will get it somehow, and we will take care of you anyway," which means that regardless of the circumstances, we will be in a network, which I believe is important. (Local actor 1 in Cúcuta, personal communication, April 4, 2022.)

Given this reasoning, the coordinated implementation of services to support abortion finds in telemedicine a promising modality that would significantly reduce numerous costs associated with the procedures; and,

while there is still a long way to go to ensure that these costs do not have a barrier effect on the user population, for the time being, it can consider agile solutions such as offering clear alternatives for the cost of the procedures, whether a person is enrolled in the contributory or subsidized health care system or outside both (in the case of migrants without documentation of regular status of permanent residency).

4) Privacy and confidentiality

Privacy is a constitutional right protected at the national level by Article 15 of the Political Constitution, which establishes that "all persons have the right to their personal and family privacy and to their good name, and the State must respect them and ensure that they are respected." Despite this, in social contexts where abortion still has a significant stigma, the confidentiality of the practices is a major problem that poses significant barriers for the young people interviewed.

Especially in small municipalities, there are severe social and symbolic sanctions for those who are publicly singled out for formally or covertly accessing procedures. This is due to the various interpretations of abortion as an action that reconfigures gender roles and challenges the concept of biological destiny in the bodies of people assigned female at birth. Such sanctions restrict the social collective's ability to regulate sexuality and reproduction. This is true for the cis-gender women, men with transmasculine life experience, and non-binary people interviewed. Still, it has different social manifestations depending on their gender identity, as it enters into dialogue and conflict with the socially assigned ideas of maternity-paternity and care.

There are tensions in these practices since, on the one hand, they appear in relation to the fear of violence that the disclosure of the experiences may bring. Still, on the other hand, they also mask possible feelings of shame associated with abortion, which underpin practices of silence in which the idea that abortion is a "transgression" that must be covered up and hidden is popularized.

> "Another one that surely has a lot to do is the fact of shame in the sense that many trans men have in their imagination that men do not get pregnant. So, if they live this, they live it in silence because they are ashamed to recognize that they have a reproductive capacity for fear of social rejection or the violence they may suffer. For example, I know this, and I have experienced it with my friends who have become pregnant and have had children; you say you are pregnant, and one: nobody believes you; two: you are a freak, they question your gender identity. Then you are told you're

"Not a man," "you're not a trans man because trans men don't get pregnant," and "you're a woman," and they deny your identity entirely. If I had an abortion situation, I would probably live it alone or with people very close to me because I am not interested in receiving such attacks; knowing that I can have an abortion in silence would prevent a lot of violence." (Trans man 1 in Bogotá, personal communication, March 28, 2022)

"The truth is that only my boyfriend knows, and we have not wanted to tell anyone else because I do not feel comfortable, and if I have prejudices about doing it, how will external people, men, react? I do not want men talking about the decisions I've made or the experiences I've had, so I don't want to expose myself to that kind of situation. [...] It happened to me that I had some flyers that said something like, "This is your guide to abortion," so if my mom finds one of those things, or if a person sees me with one of those things, she says, "Oh my God," well, they will find out, and I do not want them to know about it. So, it would be more like using a veiled vocabulary about what is being done. For example, there was another flyer that had the Mía package; it said: this is your Mía package, your pills, take them ta, ta, ta", but they didn't mention what it was for, they didn't mention anything, so it was quite discreet." (CIS woman 4 in Bogota, personal communication, March 30, 2022)

"The other issue is that [young people] are unsure about the EPS's or health care providers' confidentiality, so they avoid approaching an EPS as much as possible. Why? Because they are afraid that this will be recorded in the clinical history, that there will be a record of the fact that they did it [...] and then there is the barrier of the parents, who, once they find out, find it extremely difficult to agree, no matter how much one wants to interrupt. The fact that someone in the family knows will bring long-term problems for them. After they have it done, many of them even ask us

In social contexts where abortion is socially and culturally sanctioned, **lack of confidentiality** represents a very significant problem.

how to fake a miscarriage so that when the family finds out, they can claim it was an accident, and so on. And many of them have had to do this; after the procedure, they go to the public health service saying they had a hemorrhage or something to make it look like a spontaneous abortion and avoid problems with the family" (Personal communications, local actor in Cúcuta, April 2022)

"The child's godmother also already knew, she told me. The following month, she told me, "I found out about your pregnancy; someone told me, you know that in the hospital, they are very gossipy." And I said, " really, that's so weird." Then, I realized the one who was supposed to be my friend had told her, but I didn't want anyone to know. And sometimes I get, like, that little thing of telling my mom, I tell her practically everything, but how do I [tell her? [...] What happens is that we are in a small town, and that is the bad thing. Besides, in the hospital [in Vaupés], they are not very confidential, as they say, so sometimes you even think about going to the hospital. So, there is nothing wrong with the fact that they are from here, but they do not respect confidentiality because most of them don't do it [...] To this day, he doesn't know I did it; he thinks I lost the baby. However, at the hospital, an ex-girlfriend of his, who has never liked to see us together, told him. She is an auxiliary nurse and told him I had gone to the hospital to ask for the pills. Then he asked me when I first got here, he asked me, and I couldn't tell him the truth. [...] Well, I know it is a subject that will never be forgotten, but I would like to take it with calm and tranquility, not to beat myself up so much and say, it's my fault, my fault, it shouldn't have happened like this. To look my mother in the eyes and not have to see her with that look that says I'm hiding something from her. Or to look at my son and say, "It could have been him," so yes, I'd like to change all that" (CIS woman 1 in Mitú, personal communication, April 25, 2022.)

The possibility of keeping abortion experiences private is one of the top priorities mentioned by those interviewed, as it is a practice that provides alternatives to security and autonomy. Much remains to be done to destigmatize and naturalize abortion. Still, until then, the population interviewed sees the digital solution as a discreet alternative in which the desire for confidentiality can be maintained without giving up the possibility of safe practices.

5) Assistance before, during, and after the procedures

The interviews unanimously revealed that users and potential users of abortion services expect the digital solution to provide tools and information for self-management and to deploy a robust, warm, agile, and continuous system of care that will guarantee support and promote well-being.

Underlying the abortion narratives in the interviews is the idea that abortion is a practice surrounded by many symbolic burdens (positive and negative) and entails a biological change that can raise many questions. Because of this, they see the need for permanent points of contact to help navigate the procedures with all the concerns, feelings, and outcomes that can be anticipated, allowing the users to determine how far they want to take the contact process:

> "There was only one phone call [after the abortion with Mía] to see how it went. I don't remember what day it was, but they had already called me and given me recommendations for planning, and that was it. But I don't know if one is prepared or not to talk about the experience, although they didn't ask anything about how the process had been, nor if I had been alone; I mean, not really. They only asked if I had had any health difficulties, but nothing else. They did not ask if I had done it alone, if I had needed other things, medications, or anything like that, no, nothing. Maybe a follow-up psychology appointment would be good, it would be appropriate, wouldn't it, because it is hard... so you think that [it is important that there is] someone to listen to you, to talk to you, things like that if there had been a little bit more" (CIS woman 1 in Popayán, personal communication, March 23, 2022)

> "Yeah, maybe it would have been cool like... well, I didn't really need it so much, but I think a lot of girls might need a psychological accompaniment like "Ok, you didn't do anything wrong, it's ok, you don't have to carry that on your conscience as if I was a murderer killing someone." (CIS woman 4 in Bogota, personal communication, March 30, 2022)

> "I would have liked to have more psychological support during and before the process, not to feel that what I was doing was wrong. At least in the first procedure, I would have liked to have more information on how to.... a guide on making a good decision for my health. Fortunately, in both [abortions], I came out [well], nothing happened to me physically, but it could have happened because I did not know the origin of those drugs. I would have liked to have had more psychological support and, on the medical side, obviously better, humane, and dignified treatment. That is it, and the ease of access to this service" (CIS woman 3 in Soledad, personal communication, April 20, 2022)

> "At least for me, that was a huge doubt that I had, so I sought psychological support during the [abortion] process; I feel that it is something fundamental. I always say it openly, I never regret, I never regret my decision, but then perhaps, when it comes to talking about it, to keep it quiet and not feel guilty, not so much for the abortion, but for hiding it. That weighed on

me because I get along well with my sister and have never told her. So, it is the burden of saying that there is nothing wrong, that it is not something out of this world, you don't have to keep quiet about it, you don't have to feel that you did something illegal or that you are doing something illicit, or that you are doing something wrong. If it is more naturalized, without so much taboo, I feel it could be like that accompaniment, perhaps so.". (Local actor 4 in Cúcuta, personal communication, April 7, 2022)

In the survey, of the 636 participants who stated that they had had an unintended pregnancy in the last two years, about 416 people indicated that when they had undergone or attempted an abortion procedure, they were accompanied before, during, and after the procedure. As shown in Table 7, in terms of accompaniment actions, the results show that accompaniment is higher before and during the procedure and decreases relatively afterward, primarily among people aged 25 to 29 (47.9%) and those who report having no income (39.55%).

Table 7. Percentage of accompaniment provided to people who have undergone or attempted an abortion procedure.

Accompaniment	Age groups			Approximate monthly income					Total
	13-19	20-24	25-28	No income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2,000,001 or more	
Accompaniment before your abortion	65.8	56.7	49.1	44.7	61.0	57.0	56.6	49.3	54.4
Accompaniment during your abortion	52.6	60.6	56.2	51.3	58.1	59.5	61.4	59.7	58.0
Accompaniment after your abortion	55.3	55.7	47.9	39.5	54.3	51.9	59.0	56.7	52.4
None of the above	28.9	23.6	29.0	34.2	23.8	25.3	20.5	29.9	26.3
Total casos	**38**	**205**	**173**	**76**	**106**	**82**	**84**	**68**	**416**

Source: Own elaboration based on the data collected in the virtual survey.

This accompaniment can play a critical role in transforming the narratives of guilt and insecurity associated with abortion because it allows users to reinterpret this framework of actions previously read from misinformation or stigma, provides users with emotional and subjective resources for

decision-making, can increase the perception of safety associated with the practices, and is a strategic channel for the delivery of essential information for the person to take control of decisions during the procedure.

6) Role of third-party companions

In recognition of the narrative of self-care as a bet that restores agency to those who are going to live the medical experience and determine how they want to carry out the processes, a recurring request emerged in the testimonies regarding the creation of easy tools to guide with information the accompaniment that couples, mothers, family, and friends provide during the abortion process.

> "Well, I don't know, maybe also care in case of a crisis because everyone reacts differently. Perhaps some basic psychological first aid so that these people can take protective measures. Because I know girls who do not have a network of accompaniment, but they have already gone through it, and they are the ones who help to orient, but as friends. But they don't know how to do the management, like those self-care measures and so on. So yeah, self-care measures for companions to provide a good orientation. What to do in case they face barriers, making sure that this information is there" (Local actor 1 in Cúcuta, personal communication, April 4, 2022)

It is worth noting that, according to the survey results (Table 5), in addition to health care providers, those who underwent an abortion procedure received support and accompaniment from their partner (31%), friends (19%), feminist groups (7.3%), and family members (6.5%), confirming that there may be more stakeholders involved in home procedures, people who could be provided with important information on how to make the procedure a safer and more dignified experience and to influence contexts that transcend what is individua.

Accompaniment can play a very important role in allowing the transformation of narratives of guilt and insecurity associated with abortion.

8. Autonomy, care, and consent: guiding principles for abortion self-care and the design of sexual and reproductive health technologies

The self-care approach to abortion puts health management in the hands of the patients based on their needs and preferences. Moving away from paternalistic healthcare models in which only medical personnel "know what is best for the patient" allows for greater self-determination and may improve health outcomes in the future (Gawron & Watson, 2016). Technology can play a critical role in these contexts by facilitating means and platforms for information delivery, integrating tools for symptom monitoring and medication management, and creating a personalized channel for secure and confidential care experiences.

With this in mind, this section will address some preferences mentioned in the surveys and interviews regarding the design, content, and tools the prototype is expected to include. It will also explore how these priorities align with abortion self-care needs by being oriented around autonomy promotion, care, and consent.

Design

This dimension of the prototype was primarily concerned with information visualization, ease of navigation, and visual representations of people to be included in these procedures. Expectations can be summed up as follows:

- Clear visualization of information when Browsing on the platform is expected, presenting information in a multimedia balance that is close to how young people currently consume information on digital media (strongly associated with social networks such as TikTok, Instagram, and Facebook and the use of text, video, illustrations, and audios). They emphasize the importance of accessibility in content browsing, recommending the inclusion of customization tools for increasing and decreasing font size, making content available in indigenous languages, and having read-aloud support for those with audio-visual impairments.

- Some comments about the images and body representations commonly seen in sexual and reproductive health advertising emphasized the importance of diversifying the image of "happy white women." They hoped to balance the presence of diverse bodies in the illustration accompanying the prototype, including CIS-gendered people, ethnically diverse groups, and other dissenting gender identities, without

necessarily expecting graphic and explicit content about abortion procedures to be included.

Table 8. Percentage of respondents who would be comfortable using social networks and electronic media to access sexual and reproductive health information on a mobile device.

Social networks and electronic media	Age groups			Approximate monthly income					Total
	13-19	20-24	25-28	No income	0 - $500,000	$500,001 - $1,000,000	$1,000,001 - 2,000,000	$2,000,001 or more	
Other media	92.9	91.0	90.6	94.7	83.8	90.7	94.0	93.8	91.2
Personal e-mail	86.5	88.8	91.3	86.6	89.0	88.7	91.0	91.6	89.0
WhatsApp messages	84.5	87.2	86.4	84.8	87.3	85.0	87.8	87.0	86.3
Instagram Chatbots	74.7	74.5	71.2	72.0	74.0	71.5	75.5	75.7	73.6
Instagram	75.8	71.3	68.6	72.3	72.5	68.9	70.4	72.7	71.6
Text messaging	70.2	69.4	66.9	68.4	68.9	71.5	69.7	65.7	68.8
Other mobile applications	65.9	63.7	60.6	61.7	63.8	63.5	65.5	62.5	63.3
Chatbots	61.6	63.2	61.6	58.3	61.7	62.3	66.9	65.8	62.3
Tik Tok	70.3	60.0	52.0	62.2	63.3	58.2	58.0	54.6	60.1
Facebook Messenger	52.9	50.4	49.6	49.1	54.2	52.0	52.0	45.0	50.8
Twitter	51.9	49.1	47.1	47.8	50.0	47.8	52.0	48.5	49.2
Snapchat	34.9	30.2	30.7	29.5	32.1	35.3	32.5	28.9	31.5
Total Cases	**1,368**	**2,661**	**1704**	**1,564**	**1488**	**873**	**987**	**821**	**5,733**

Source: Own elaboration based on the data collected in the virtual survey.

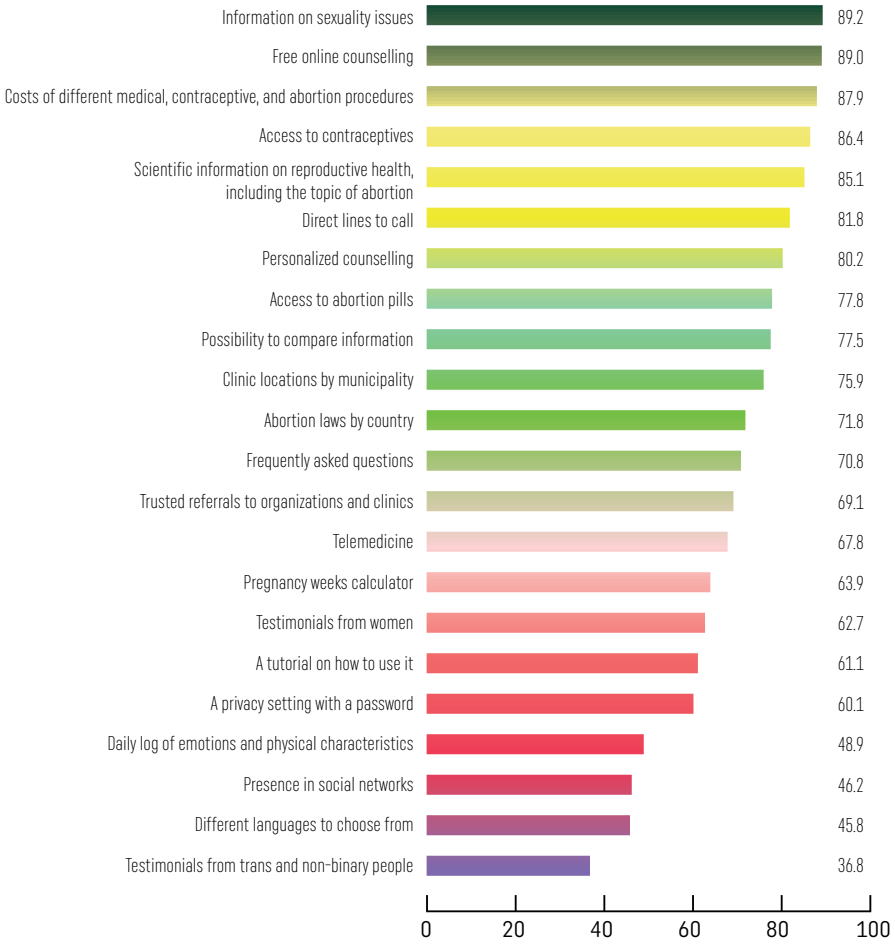
When inquiring about the media through which young people would feel comfortable obtaining information on sexual health and reproductive health (Table 8), the preponderance of social networks such as Instagram (71.6%) or Tiktok (60.1%) highlights the opportunity to disseminate truthful information through these, with Instagram being the most widely used in all age and income groups. Additionally, participants across all age groups and income levels indicated that personal email (89%) and WhatsApp messages (86.3%) would be their preferred methods for receiving information.

However, the use of chatbots through WhatsApp (73.6%) or official websites (62.3%) to access information on sexual and reproductive health stands out.

Content

In terms of the number of opinions expressed by participants, this was the densest category. There are high expectations concerning the previous sections' discussion of the lack of platforms centralizing accurate, safe, and accessible information on sexual and reproductive health. Some of the topics most frequently suggested and considered important by the participants are listed below.

Figure 4. Functionalities that people expect to find in a sexual health and reproductive health application.



Source: Own elaboration based on the data collected in the virtual survey.

In the survey applied, the top five functionalities that people expected to find were (See Figure 4): Information on sexuality issues (89.2%); Free online counseling (89%); Costs of different medical, contraceptive, and abortion

procedures (87.9%); Access to contraceptives (86.4%) and Scientific information on reproductive health, including the topic of abortion (85.1%).

Meanwhile, the survey responses are aligned in the qualitative exercise, and content proposals related to the following are added:

- Contraception and STI protection (in both female-assigned bodies at birth and male-assigned bodies at birth, emphasizing and addressing side effects, costs, delivery sites, and percentage of effectiveness).
- Legal framework to protect the right to abortion.
- Before, during, and after the procedure, psychological first aid capsules.
- Holistic abortion care practices (lessons on the use of natural products for self-care and nourishment in these contexts).
- Pleasure and self-awareness of one's own body.
- Micro-stories, personal experiences, and testimonies about abortion and contraception.
- Legal tools to address barriers to health access (downloadable tutelas, especially).
- Myths and frequently asked questions about sexuality and reproduction.
- Assistance routes for gender-based violence, violence in contexts of migration, and violence in the context of the armed conflict.
- Blog posts on destigmatizing abortion and sexuality.
- Basic glossary on dissident identities, sexual orientation, and diversity.
- Trans masculinity and trans femininity in sexual health and reproductive health.
- Reflections on religion and abortion.

Tools

Participants mentioned some of the following ideas concerning functionalities to facilitate interaction and promote continued use of the prototype:

- A platform that allows user, profile, and password creation but is not a mandatory step for information content navigation.

- Free hotline and chat for medical abortion-related consultations ("let us call you back" buttons).

- Integrating cybersecurity measures such as PIN, pattern or facial recognition, which is particularly useful and a priority during an abortion procedure.

- An anonymous discussion forum for people who have undergone medical abortion procedures.

- A territorialized directory of organizations and collectives accompanying abortion procedures and other community processes related to reproductive justice and gender equity.

- Menstrual and pregnancy tracking tool (that also considers the particularities of people with trans and non-binary life experience).

- Directory of specialized medical personnel for access to sexual health and reproductive health consultations.

- Support messages and notifications regarding customizable procedures (based on the frequency chosen by the user).

- A directory of all Profamilia offices in the country.

- Customizable app icon.

- Emergency exit button from the app or the displayed content.

8.1. Central principles for the design

The testimonies and statistical data about the expectations that the user and potential user population have in relation to the prototype digital solution were articulated to these preferences throughout the research in a cross-cutting manner. They showed a natural coherence between the platform's infrastructure design principles and the agenda of promoting autonomy, consent, and self-care in abortion settings. This means that the platform's functionalities, contents, care, procedures, and other components should reflect the stated needs and gaps in access to abortion and other sexual and reproductive health services, actively contributing to the

empowerment of processes through technology as a catalytic component. In this narrative, based on the three principles, the prototype can recognize fundamental elements to guide the design as it is shown next:

Autonomy and agency

Autonomy can be understood as a capacity associated with self-determination and self-governance that enables people to critically assess their needs and desires and act on them (Walker, 2018). In the abortion literature, this concept has made it visible how the multiple barriers to accessing this right restrict the full exercise of autonomy. In its more practical dimension, this capacity is linked, for example, to access to clear and timely information for strategic decision-making, to the costs of medicines and services, and to the ability to choose the forms and settings in which procedures are carried out (López & Gaitán, 2021). The collectives and accompaniment groups provided examples of how this has been put into practice in their own experiences:

> "Because it is not the same to make an uninformed decision, even if it seems to me that it is not a free decision, and in reality, if I do not have information, then I am not making a fully informed decision, and without coercion" (Local actor 1 in Cúcuta, personal communication, April 4, 2022)

> "Abortion is performed not only to avoid pregnancy but also to assert one's autonomy over one's own life. So, I can think of tools to reaffirm these places of autonomy, such as mental health spaces or even redirecting people to a site where there are other people's narratives, which would be very helpful." (Local Actor 1 in Bogotá, personal communication, March 30, 2022)

Users associate it with exercising their agency and the possibility of being recognized as people with authority over their own bodies, even when they lack the technical language to explain what is happening to them. They add:

> "With agency, in the sense that I listen to my body, I feel my body, I live my body, and I know when something is normal or not in my body. Because sometimes I even ask myself [...] this [that] is happening to me, is it normal? So, I look for a solution, and if a doctor can tell me that something is normal or not, [then] let him tell me, but after I [have] listened to my body, without ignoring it [...]. Agency is not that [...] the patient should say: "no, no bullshit, I am not undergoing any treatment and let me die." Although this is also agency, it should allow the patient to express what is going on

> and establish the patient's credibility" (Trans man 1 in Bogota, personal communication, March 28, 2022.)

This is consistent with previous sections on the asymmetries of power with medical personnel in contexts of sexual and reproductive health care for young people, and, following what has been stated, proposes horizontalizing the relationship between medical personnel and patients through listening, empathy, respect, and recognition of their decision-making abilities. At the prototype level, this translates into including clear information and the potential redesign of doctor-patient interactions.

Consent

Consent should be understood as a continuous and voluntary negotiation process that can be constantly reaffirmed and in which there are constant opportunities to exercise autonomy (Sadowski & Strengers, 2021). It can be given in various forms, but its binding force is always based on the content's knowledge, intention, competence, voluntariness, reversibility, and acceptability (Walker, 2018). It is a concept shared by both technological designs (concerning the collection of browsing data and privacy conditions) and medicine (associated with a patient's explicit and documented consent to receive medical interventions after considering the potential harms and benefits) (Brach, 2016).

As a principle, it recognizes health service users as autonomous agents who have control over their bodies and can decide what is best for them. It translates into individuals' right and desire to be consulted beforehand on whether they accept the terms under which interventions that directly or indirectly involve them occur.

The health experiences of the people interviewed are full of stories in which their **consent** was not asked or consulted.

The health experiences of the people interviewed are full of testimonies in which their consent was not requested or consulted, thus finding an echo in the premise of the right to decide.:

> "[you] ask, of course! if one decides to accept it, it would be that [...] but then everything often depends on the conditions they give you to guarantee it, so I think one of the most important things is to ask" (Local actor 3 in Popayán, personal communication, March 24, 2022).

> "This discussion essentially becomes the consensus question, "How do you want to be treated?" and treated not only in communication but also in-service during health care. And that you can choose, that you have the autonomy to choose how you want to be treated and the ability to say yes or no." ((Nonbinary person 4 in Soledad, personal communication, April 20, 2022)

According to Planned Parenthood's[16] FRIES model, consenting and asking for consent helps define the scope of interventions and respect the parties' boundaries. For something to be consensual, there must be safe spaces to ask questions again in case of a lack of clarity. Consent, when materialized in digital spaces, implies that it is:

- **Freely given:** Implies the absence of coercion, deception, or manipulation in interface designs and content, allowing people to make decisions consistent with their desires and interests. And, the existence of an interface that will enable people to make decisions consistent with

16. See: (Silvestrini & Naidoo, s.f.)

The information and accompaniment are perceived as fundamental to improve the experiences of people in the context of abortion and facilitating their decisions.

their interests. (The interface should not maliciously mislead people into making decisions they would not normally make.

- **It is reversible:** it gives users the right to limit, pause, and stop interventions or procedures and to delete stored personal data at any time.

- **It is informed:** the prototype should use clear and accessible language to inform about the risks and benefits of using the platform, as well as about data management and storage.

A call to take care and to be taken care of

In practice, abortion self-care extends beyond individual actions for medication self-administration and recognizes the interdependence of these practices with healthcare systems to guarantee the quality and dignity that all people deserve in care. The population views information and accompaniment as critical to improving people's experiences with abortion and facilitating their decisions, particularly in restrictive environments. Focusing attention on care actions (possible even remotely) will be critical to ensure safe, appropriate and accessible reproductive health self-care interventions.

> "Accompanying does not imply giving something and saying goodbye. Accompanying me is not letting go"" (Local actor 3 in Popayán, personal communication, March 24, 2022)

> "I'd like it to be a process, I don't know, like... I am not sure if "informal" is the right word. Perhaps not informal but rather warm, human warmth. Because if it feels like a doctor-patient, it will not be so good. It would be even worse if it felt like customer service for people. I would like it to be more humane, humanized, and focused on the process being experienced. Because you have a lot of emotions and things on your mind at the moment, that is it" (CIS woman 1 in Popayán, personal communication, March 23, 2022)

> "Give them some space because we all know how complicated it is. Although it is an accompaniment, it is only to the extent that the person requests it, because many people prefer to isolate themselves, while others prefer... they do not want to go through it alone and want someone to be there to support them, so it depends a lot on the person." (Local actor 1 in Cúcuta, personal communication, April 4, 2022)

In this sense, the work with the abortion ecosystem in Colombia will be critical in recognizing the care actions that must be integrated into the processes of organizations and service providers to shift from a care model

based on the delivery of medicines to a system that delivers care. According to group and individual testimonies, this appears to be the most urgent and relevant change in the context of abortion self-care needs. According to this vision, the coherence of this call makes sense in the commitment to strengthen people's autonomy, as it provides tools for making informed and safer decisions. An accompanying group explains this reasoning:

> "Yes, we have talked to people about how they feel afterward in a very relaxed way. It is not like a [medical] appointment. It is more like, "how are you?" "how have you been feeling?" "How is your body doing? We still keep in touch by phone once in a while; it's not something so intense either, cause the same thing I told you before, it's not our intention... to make this so complex so no one can do it. It's more like just being aware, and that's it. You assume yourself, and it's like... if later you want to get closer, if you want to get lost, that's fine! [You have to] respect people's decisions; some people abort and don't want to talk about it anymore, well, that's fine. And some people are still there, [saying], "Invite me to more spaces". (Local actor 1 in Bogota, personal communication, March 30, 2022)

9. Recommendations for present and future prototype

In addition to the proposals for meeting the needs mentioned in previous sections, the following is a summary of some of the recommendations that emerged in light of the research findings and that echo the proposals received during the project's socialization with Profamilia teams, as well as the good practices mentioned in interviews by support groups, community-based organizations, and groups advocating for reproductive justice.

1) **There is a need for greater coordination among stakeholders in the abortion ecosystem.** The scalability of the prototype in new territories or with new tools could consider the integration of collaborative and participatory proposals focused on the needs and perspectives of communities, groups, institutions, and abortion service users, which are not based on digital dissemination but on the combined bet of greater dialogue with local decision-makers, the delivery of physical materials for reflection, and other approaches to face-to-face communication that go beyond digital campaigns.

2) **Initially, this bet will exclude those already excluded.** This is an unintended consequence of digital bets, which, despite having a large potential audience eager for health services on these platforms, have significant limitations in reaching a disconnected population with low levels of mobile device ownership and impoverished conditions. Some of the proposals to reach this population that emerged in the framework of interviews with stakeholders included working in a hybrid way with face-to-face and digital media in regions where the digital infrastructure allows it, providing training material so that collectives that do have a presence in disconnected territories can replicate it, and increasing the number of face-to-face and extra-mural activities in prioritized territories.

The **integral perspective** of health as a right, service and set of care in various dimensions, allows us to think systemically about the problems surrounding the access to and provision of these services.

3) **Capitalize on Profamilia's reputation for efficiency and reliability that precedes MIA.** A significant proportion of respondents state that Profamilia's name has a reputation for efficiency - when it effectively connects services - but there are numerous areas for improvement in care, differential focus, timely care, and shifting from a service perspective to an approach focused on care.

   Despite this, it enjoys mainly positive narratives that identify it as a reliable source of sexual and reproductive health information.

4) **Include more holistic perspectives on health looking into the future.** To this extent, including support services focused on mental health care and providing tools to promote well-being after procedures can be a key point.

5) **Develop frameworks for accountability, feedback, and experience evaluation: There is currently no standardized and validated set of abortion quality parameters.** As we do for other basic services like prenatal care and vaccines, creating frameworks for assessing quality may be part of standardizing abortion services within healthcare delivery systems. We lack a common terminology with users to evaluate abortion services. Such metrics would provide evidence of the effectiveness, efficiency, accessibility, equity, and safety of abortion services, ultimately helping to improve care.

10. Conclusions

Advances in telemedicine legislation and the C-055 ruling of 2022 have configured a panorama of unprecedented opportunities for positioning abortion self-care in digital health contexts. These advancements, when combined with a feminist agenda that is slowly but steadily establishing itself at the national level, can foster the advancement of policies, programs, and services that make abortion a more dignified, accessible, and safe practice.

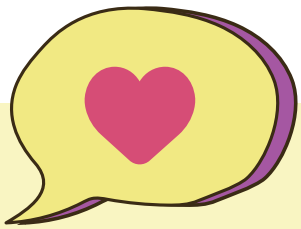
Telemedicine, particularly for young people, provides extremely valuable opportunities to overcome the barriers to sexual and reproductive health education and health care, such as cost, privacy, timely response, and stigma-free care. To leverage these advantages, the design of solutions in this field may allow closing significant inequality gaps that positively impact autonomy and well-being in the long term, but must first overcome barriers related to the inclusion of differential approaches, the possibility of expanding ways of attention and care, ensuring confidentiality and more complex, the challenge of including hybrid bets that allow connecting with people excluded by the digital gap.

In addition to this bet, there is the challenge of identifying and including those who historically have not been comprehensively addressed: racialized population, people living in impoverished and homeless conditions, people who live in rural and peripheral areas, people with dissident identities, people with disabilities, etc. In this sense, abortion would be more than just a women's issue in cities. It is a phenomenon that, as mentioned throughout the document, involves a large ecosystem of stakeholders and users, including men with transgender life experience and non-binary people assigned female at birth. Naming and including them will be critical to protecting their rights and avoiding the invisibility and violence they currently face in the health system.

The comprehensive perspective of health as a right, a service, and a set of care in various dimensions allows us to think systemically about the problems surrounding access to and delivery of these services. Understanding the interconnectedness and simultaneity of the experiences of mental, physical, sexual, and reproductive health concerning abortion experiences is crucial for designing solutions in this field. In this way, it is possible to comprehend the perceived need for a comprehensive understanding of the person and her body during the procedures, to look at how people can ensure their care, and to consider which mechanisms are thought to be effective by both medical professionals and individuals in the context of abortion.

In anticipation, it is important to remember that telemedicine services will inherit many of the problems and stigmas of the face-to-face health-care system and that potential solutions can be found in tools that transfer power and agency to patients during procedures. In this sense, the lessons of care and empathy mentioned by the support groups interviewed can be key to overcoming these obstacles. Believing what the patient says, asking for consent, providing space and opportunities to ask questions, and providing information in simple language are some of the actions that can have a positive impact at a low cost. Simultaneously, there is an opportunity to consider other stakeholders in the abortion ecosystem that are already playing significant roles in the procedures, such as local pharmacies (as suppliers of medicines, either officially or clandestinely), feminist groups and abortion support groups, and networks of family members and friends who are present throughout these experiences. Strategic articulation with prioritized actions, especially in small municipalities, can play a decisive role in transforming abortion practices to make them safer and stigma-free.

The significant information gap on sexual and reproductive health identified in the testimonies, surveys, and literature reviewed could present an opportunity for the digital solution under consideration. The young population, in particular, is eager to find and consult centralized and simple information on these topics, and the digital solution being developed can provide mechanisms for interaction and consultation to connect physical and personal realities with strategic concepts that allow for more informed decision-making. In this same line of thought, it is a priority to develop comprehensive care routes to guide contraceptive use, which is



Telemedicine translated into care and accompaniment will play a central role, not only in ensuring the effectiveness of this approach, but also in the role it would play in contributing to the transformation of the stigma attached to abortion.

also positioned as a potential way to continue exploring services for young people while addressing the underlying issues of economic, cultural, and timely care barriers.

The experiences documented in this research and the expectations of the population surveyed make a strong case for focusing the design of tele-abortion technologies and services on the right to decide. To decide about gestation and sexuality, the type of care they would like to have, how they want to receive information and care, and the actions that can accompany the procedures at home in a dignified manner. Telemedicine, translated into care and accompaniment, will play a central role not only in guaranteeing the efficacy of this approach but also in contributing to the transformation of the stigma associated with abortion, as it will allow for a reinterpretation of the actions and roles of the stakeholders involved and will mobilize new narratives towards horizons of dignity and autonomy.

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Appendixes

Appendix 1. List of regulatory policies and legal framework for abortion service delivery via telemedicine in Profamilia

Legal Instrument	Object
Law 1341 of July 30, 2009	Determines the general framework for formulating public policies that will govern the Information and Communications Technologies sector, including its general regulation, the competition regime, user protection, issues relating to coverage, quality of service, investment promotion in the field, and the development of these technologies.
Law 1419 of December 13, 2010	Its goal is to advance telehealth in Colombia as a complement to the General System of Social Security in Health under the fundamental legal principles of efficiency, universality, solidarity, comprehensiveness, unity, quality, and the basic principles contemplated in current law
Law 1438 of January 19, 2011	Its goal is to strengthen the General Social Security Health System by implementing a public health service delivery model that, within the framework of the Primary Health Care strategy, enables coordinated action by the State, institutions, and society to improve health and create a healthy environment that offers higher quality, inclusive, and equitable services, with the country's citizens as the focus and the goal of all endeavors
Resolution 2003 of 2014	This resolution aims to define the procedures and conditions for registering health care providers and authorizing health services, as well as to adopt the Manual for Registration of Health Care Providers and Authorization of Health Services, which is an integral part of this resolution
Resolution 5857 of 2018	The purpose of this resolution is to update the Health Benefit Plan paid by the UPC as a collective protection mechanism, as well as to establish the coverage of health services and technologies to be guaranteed by the Health Promoting Entities (EPS) or institutions acting in their stead, to the beneficiaries of the General Social Security Health System (SGSSS), on the national territory, under the quality conditions established by the regulations in force
Resolution 2654 of 2019	The goal of this resolution is to establish telehealth provisions and parameters for the practice of telemedicine, its categories, the use of technological means, the quality and security of care, as well as the use of information and data to preserve the quality and safety of care, as determined by laws 527 of 1999, 1266 of 2008, 1581 of 2012, 1712 of 2014, and Decree 1377 of 2013.
Resolution 3100 of 2019	In addition to adopting the Manual for the Registration of Health Service Providers and Authorization of Health Services as a technical annex to this administrative act, the resolution's purpose is to define the requirements and processes for registering health service providers and authorizing health services.
Press Release No. 190, March 29 2020: Institutions should continue with sexual and reproductive health care	It provides indications to prevent the spread of the coronavirus and emphasizes that sexual violence cannot be made invisible. Therefore, health care for victims of sexual violence, including the Voluntary Termination of Pregnancy (VTP), cannot be suspended since it is urgent.

Legal Instrument	Object
Resolution 536 of March 31, 2020, "Action Plan for Health Service Delivery During Containment and Mitigation of the SARSCoV-2 Pandemic" (COVID-19)	Its purpose is to organize the delivery of health services of hospitalization, surgical, outpatient, emergency, specific protection, and early detection, and diagnostic support and therapeutic complementation services, provided in Colombia within the framework of the pandemic and health emergency due to SARSCoV-2 (COVID-19), declared by the Ministry of Health and Social Protection.
Technical guidelines for Addressing the Effects of the pandemic by COVID-19 on fertility as of April 21, 2021	Seeks to strengthen interventions that guarantee sexual and reproductive rights, especially those aimed at the reproductive autonomy of women, girls, and adolescents, a vulnerable population in the health emergency context.
""Provisional guidelines for newborn and breastfeeding health care in the context of the COVID-19 pandemic in Colombia," June 16, 2021	The "general considerations for the health care of pregnant women" are presented, according to which abortion care cannot be interrupted. The EPS and IPS must make the necessary adjustments to their models of care and delivery of this procedure, not only to prevent the spread of COVID-19 but also to ensure this medical service, informing according to the provisions of Ruling C-355 of 2006, without ignoring counseling and delivery of postpartum contraceptives.

Appendix 2. List of nodes and categories used in processing semi-structured interviews

Central node	Sub-nodes										
Telemedicine	Positive telemedicine experiences	Telemedicine Narratives	Negative experiences of telemedicine	Health narratives							
Abortion	MIA abortion experience	Abortion Narratives	Unsafe abortion experience	Negative experience of abortion	Barriers to abortion access	Missing elements in reported abortion experiences	Positive elements in abortion experiences	Decision making process	2022 New Ruling	Ruling 2006	Privacy
Care	Narratives of care	Community care	Absence of care	Holistic care practices (use of alternative medicine and traditional practices-herbs)	Self-care	Abortion accompaniment					
Prototype	Accessibility	Prototype acceptability	Design	Privacy	Personalization and notifications, messages	Barriers to deployment/use of digital solution	Content preferences (information)	Tools	Referenced health apps	Social networks	Information trust
Autonomy and agency	Consent and agency	Gender-based violence	Mobilizers for autonomous decision making	Experience of coercion							
Sexual and reproductive health	Sexual health and reproductive health narratives	Experiences in SRHR services	Where to find SRHR information	Contraception	Migration and SRH	Interculturality and SRH	Violence, armed conflict	Needs of people with trans life experiences			
Profamilia	Positive narratives of profamilia	Negative narratives of profamilia	Strategies to reach disconnected territories								
Municipalities	Popayan - Speech on rights and health SRR	Bogota - Speech on rights and health SRR	Cucuta - Speech on rights and health SRR	Soledad - Speech on rights and health SRR	Mitù - Speech on rights and health SRR						