Bogota, August 2025

Committee on Economic, Social and Cultural Rights Secretariat
Office of the United Nations High Commissioner for Human Rights
Palais Wilson – 52, rue des P Pâquis CH-1201
Geneva-Switzerland

Re: Independent information on Colombia, submitted for consideration by the Committee on Economic, Social and Cultural Rights for the 78th Session

Distinguished Committee Members,

The Causa Justa Movement, the Corporación Colectiva Justicia Mujer, Católicas por el Derecho a Decidir, Women's Link Workdwide and the Red Nacional de Mujeres seek to contribute to the Committee's review of Colombia's implementation of and compliance with the International Covenant on Economic, Social, and Cultural Rights (ICESCR), particularly on the State's obligation to protect, respect, and fulfill women's rights to physical and mental health. We submit this report for the 78th Session of the Committee on Economic, Social and Cultural Rights, at which the 7th Periodic Report of Colombia will be considered.

This document focuses on: (i) *the situation in respect to teenage pregnancy*; (ii) *the situation in respect of maternal mortality*; and (iii) *measures taken to eliminate existing barriers to access to voluntary termination of pregnancy, or any pregnancy prevention and family planning*. These issues seek to address points 29 and 30 of the List of Issues related to the 7th Periodic Report of Colombia.

1. The sexual and reproductive health needs of adolescents

[1]. After the Constitutional Court's decision in C-055 of 2022, liberalizing abortion until the 24th week of pregnancy, the Ministry of Health (MOH) issued Resolution 051 of 2023.[1] Particularly relevant to girls and adolescents, the Resolution reiterates the rights of girls and adolescents to access services related to the voluntary termination of pregnancy (VTP) in a way that respects their right to autonomy and privacy. The Resolution outlines that there is no requirement for parental or third-party authorization if a minor requests a termination of pregnancy.

[2]. The Ministry of Health has also implemented models of care that are friendly to the needs of adolescents and youth.[2] These services provide an emphasis on the sexual and reproductive health of girls and adolescents. The Ministry of Health has also indicated that adolescents are encouraged to participate in the development, implementation and evaluation of public policy related to sexual and reproductive health rights, but details on these mechanisms remain unavailable. The Ministry of Health has also noted an increase in the accessibility and use of long-term contraceptive methods for young people.

[1] Ministry of Health, *Resolution 051 of 2023*, available at: https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No.%20051%20de%202023.pdf
[2] Ministry of Health, *Servicios de salud amigables para adolescentes y jovenes*, available at: https://www.minsalud.gov.co/salud/publica/ssr/Paginas/Servicios-de-salud-amigables-para-adolescentes-y-jovenes-SSAAJ.aspx.

[3]. The Superintendent of National Health also issued Circular 2024150000000009-5,[3] which adopted the Constitutional Court's decision and provided guidance to healthcare providers on how to implement the decision. The circular notes that women and pregnant patients that are underage are capable of receiving and consenting to sexual and reproductive healthcare services without parental or third-party authorization.

[4]. In 2021, there was an increase in the rates of childbirth to mothers between the ages of 10-14, with a subsequent decrease in 2022 and 2023. In Colombia, any pregnancy in girls between the ages of 10 and 14 is considered a crime, based on the presumption that the pregnancy results from sexual violence. This amounts to a violation of their rights to bodily autonomy and a life free from violence.

[5]. Specifically, Profamilia[4] identified that out of the 569,311 births in Colombia in 2022, 4,169 were for girls between the ages of 10 and 14, while 93,096 were for adolescent girls between 15 and 19.[5] This results in 1% of births being from mothers between the ages of 10 and 14, and 16% of births being from mothers between the ages of 15 and 19. Birth rates for mothers between the ages of 15-19 have continued to decline for 2021, 2022, and 2023.

[6]. Despite these advances in protecting and ensuring access to adequate sexual and reproductive health services, barriers and violations to girls' and adolescents' rights persist. For example, the Corporación Colectiva Justicia Mujer[6] noted most of the women seeking abortion services were under the age of 30.[7] This showcases that strategies must be implemented to support the particular needs of young women, including underage girls and teenagers, who may face unique barriers to care. Some of these barriers include perceptions that they are unable to make decisions about their bodies because of their age, or the mistaken idea that they need parental or third-party authorization to obtain an abortion.

[7]. Failure to address the barriers adolescents and minors face in accessing quality sexual and reproductive healthcare services violates their rights to health, dignity, bodily autonomy, and equality under the law, amongst many others.

2. The situation of maternal mortality and maternal health rights in Colombia

[8]. Colombia has made significant advances in protecting maternal health rights. In 2022, Law 2244 was passed, which protects the rights of women during pregnancy, labor and childbirth, and postpartum. The law calls for integral care that is adequate, timely, and effective, and that women do not face administrative barriers when receiving care.

[9]. The Constitutional Court has also issued decisions that expand maternal health rights in the nation. Ruling T-128 of 2022 ordered that traditional midwives, particularly those from Afro-descendant communities, must be integrated into the social security system. Similarly, the Court condensed multiple

[3] Superintendence of Health, *External Circular 2024150000000009-5 of 2024*, available at: https://docs.supersalud.gov.co/PortalWeb/Juridica/CircularesExterna/Circular%20externa%20n%C3%BAmero%2020241500000000009-5%20de%20%202024.pdf

[4] A private nonprofit healthcare organization, promoting sexual and reproductive health rights in Colombia.

[5] Profamilia, *Embarazo en Adolescentes en Colombia* (2023), available at: https://profamilia.org.co/wp-content/uploads/2023/03/NOTA-POLITICA_PROFAMILIA.pdf.

[6] An organization providing accompaniment services to patients seeking abortion care.

[7] Corporación Colectiva Justicia Mujer, *Activismo por Justicia Sexual y Reproductiva para una vida Libre de Violencias* (2024), available at: http://colectivajusticiamujer.org/wp-content/uploads/2025/02/Exp_y_barreras_acceso_a_la_IVE_en_Antioquia_2023-2024.pdf

claims of violations to maternal health rights in the decision SU-048 of 2022, which addressed obstetric violence. One such case (T-576 of 2023) determined that women seeking a voluntary termination of pregnancy must be guaranteed services without any sort of violence, including obstetric violence.

[10]. Certain departments have also taken steps to promote maternal health rights. For example, in Cundinamarca, the Secretary of Health adopted the Departmental Plan to Accelerate the Reduction of Maternal Mortality. This Plan seeks to improve access to maternal health services and promotes strengthening the quality of attention by providing greater training and guidance to healthcare providers.

[11]. These efforts have translated into an improvement in maternal mortality rates. For instance, while maternal deaths increased in 2021, they continued to decrease in 2022, 2023, and 2024. The most common reason for maternal mortality is hemorrhage.[8] While fully disaggregated data was not publicly available, the rates of maternal mortality in Indigenous populations increased between 2023 and 2024. Maternal mortality rates also continue to be higher in rural areas.

[12]. The rates of birth attended by healthcare professionals have also increased since 2021. In 2021, approximately 98% of deliveries were assisted by healthcare professionals. Between 2022 and 2023, 98.6% of births took place in hospitals and 1.2% took place at home.

[13]. Despite these advances, barriers to quality maternal healthcare persist. In May of 2024, the National Movement for Sexual and Reproductive Health published the results of the "First National Survey on Childbirth and Birth in Colombia."[9] This survey examined the experiences of women and pregnant individuals who gave birth between 1970 and 2023 across the five regions in Colombia. The survey showed that almost 40% of births were delivered via cesarean section; a high rate given that the World Health Organization has established that cesarean rates above 10% are not associated with reductions in maternal and neonatal mortality rates. Individuals who underwent cesarean sections also reported restricted movement and lack of informed consent before the procedure. This percentage was higher among adolescents (52.1%), rural women (44.4%), those from the Caribbean region (47.1%), and single women (45.9%).

[14]. This survey also reflected violent practices during vaginal births. 94% of women reported not having the opportunity to choose their birthing position, and 59.8% complained they were administered medication to induce or intensify contractions. This practice was most common among Afro-Colombian women (65%) and rural women.

[15]. These findings suggest there continues to exist a need for policy and legal reforms that guarantee equal and dignified treatment in maternal healthcare settings. Healthcare personnel should also be informed and trained on these developments. Disaggregated data should be available, not only differing between Indigenous and non-Indigenous maternal mortality rates, but recognizing the diverse population of pregnant individuals, including migrant women, Afro-descendant women, and rural women, amongst others.

3. Existing barriers to access voluntary termination of pregnancy, and attempts to remedy said barriers

[8] Instituto Nacional de Salud, *Informe de Evento: Mortalidad Materna* (2024), available at: https://www.ins.gov.co/buscador-eventos/Informesdeevento/MORTALIDAD%20MATERNA%20PE%20VI%202024.pdf
[9] MOVIMIENTOSSR, Encuesta Nacional de Parto y Nacimiento, available at: https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.

i. *Background*

[16]. In February 2022, Colombia's Constitutional Court issued ruling C-055/2022, which liberalized abortion during the first 24 weeks of pregnancy. This means that no person can be criminalized for accessing abortion services during that period, nor can administrative or procedural limitations be imposed. After the 24-week period, abortion is permitted on the limited grounds recognized in the Court's previous ruling, C-355/06, without gestational limits.

[17]. This historic ruling is a step in the right direction of fulfilling the rights recognized under the ICESCR, including the rights to health, autonomy, and bodily autonomy and integrity. A year after the adoption of the Court ruling, there was a significant increase in women accessing abortion through healthcare providers.

ii. *Current regulations and good practices*

[18]. Since the ruling, Colombia has made progress in adopting measures for its effective implementation. In 2023, the Ministry of Health issued Resolution 051, which updated the technical guidelines to guarantee abortion services in the nation. This resolution clarifies the obligations of healthcare providers regarding abortion services, leading to a greater and better implementation of the Constitutional Court's order. The resolution notes that access to abortion care is essential and must be readily available in all regions of the country. It also adopts midwives, community health workers, and traditional healthcare providers as agents capable of orienting and supporting access to abortion care. There should be no delays in providing abortion care, except in exceptional and justified cases, at which point the abortion must occur within 5 days. All abortion services must be free, exempt from copays and quotes. Healthcare providers are required to maintain confidentiality for any services related to abortion, which means there can be no report or complaint against a patient that accesses abortion care. Migrant women and non-citizens also have the right to access these services, and they must be made available free of charge. The resolution outlines steps for healthcare staff to exercise their right to conscientious objection, but indicates it cannot be institutional or collective.

[19]. The Ministry of Health has also engaged in efforts to educate healthcare staff for the years of 2021, 2022, and 2023. There were also two campaigns to share information on the normative changes regarding reproductive healthcare in 2021 and 2023.

[20]. In 2024, the Superintendent of National Health also prepared Circular 2024150000000009-5, which seeks to guarantee access, quality and integrity in the provision of abortion services. This circular reiterates the instructions imposed by the Ministry of Health in Resolution 051 of 2023. Amongst many things, it specifically calls for healthcare providers, institutions, and systems to prevent imposing barriers to abortion services, and to avoid engaging in discriminatory practices or obstetric violence.

[21]. The Attorney General's Office issued Directive 009 in 2023, regarding the investigation and criminalization of the crime of abortion.[10] This directive includes the principals and constitutional considerations that must be considered during the investigation and criminalization of abortion, guidelines for the classification of abortion crimes, instructions for the investigation and prosecution of a crime of

[10] Attorney General's Office, *Directive 009 of 2023*, available at: https://www.fiscalia.gov.co/colombia/wp-content/uploads/2023-DIRECTIVA-0009-INV-Y-JUD-DEL-ABORTO.pdf

abortion, and steps to ensure the confidentiality of information throughout the procedures. The purpose of the directive is to prevent criminalization of abortions that are liberalized through the Constitutional Court's jurisprudence.

[22] In response to the COVID-19 pandemic, Colombia implemented measures to expand sexual and reproductive healthcare services that remain in force. One such measure is Resolution 51 of 2020, which expands access to sexual and reproductive care through telemedicine and other outpatient efforts.

[23] The Constitutional Court has continued to issue decisions that expand access to sexual and reproductive health rights. In T-144 of 2022, the Court recognized that access to *in vitro* fertilization is an essential component of the right to reproductive health. Another decision in 2023 concluded that women and pregnant individuals seeking abortion care services must not be subject to obstetric violence. There were also two recent decisions that reiterated that access to abortion care is a fundamental right in Colombia. In these two decisions, the Fourth Review Chamber of the Constitutional Court had initially ruled that Indigenous authorities and healthcare providers could deny or concede an Indigenous woman's request for an abortion. The Full Chamber of the Court ultimately overruled these two decisions, finding that healthcare providers could not impose additional barriers to abortion care and that access to an abortion was a fundamental right, based on the rights to equality, personal freedom, and freedom of conscience, among others.

[24] Localities, municipalities, and certain departments have also undertaken efforts to ensure compliance with the Constitutional decision and subsequent norms. For instance, the Mayor's Office in Medellín organized a commission tasked with monitoring the implementation of the C-055 decision and Resolution 051. The Ombudsman's Office in Antioquia has been recognized for demanding an institutional response if there are delays or impediments to accessing care. Similarly, departments and municipalities have implemented media campaigns to share information related to reproductive health. For example, the Secretary of Health in Cundinamarca started a campaign to promote sexual and reproductive health rights in 2022, did a vaccination day for HPV and other sexually transmitted infections (STIs), and signed a Pledge for a Chosen, Planned, and Happy Motherhood.

[25]. Additionally, in response to state measures aimed at eliminating barriers to abortion, the most notable are the VTP Technical Roundtables, led by departmental and district health secretariats, in conjunction with the Delegate on Women's Rights and Gender Issues of the Ombudsman's Office, and civil society organizations like La Mesa por la Vida y la Salud de las Mujeres ("La Mesa"). These technical roundtables are instances of inter-institutional collaboration, in which all entities involved in the VTP access route, such as health providers and institutions (hospitals, health centers, clinics, etc.), work together to identify and eliminate barriers to abortion access in their respective territories. Currently, in conjunction with the Roundtable for Women's Life and Health, VTP Technical Roundtables are being led in Cartagena and the departments of Bolívar, Tolima, Putumayo, Guaviare, and Guajira.

[26]. Moreover, thanks to the advocacy efforts of civil society organizations, the Department of Antioquia established the Commission for the Monitoring of Voluntary Termination of Pregnancy (VTP), led by the Medellín District Ombudsman's Office. Its objective is to promote the monitoring and oversight of compliance with Ruling C-055 of 2022, Resolution 051 of 2023 issued by the Ministry of Health, and other regulations concerning the right to VTP by institutional actors in the District of Medellín, through preventive actions, coordination efforts, institutional strengthening, and public policy monitoring, with the

aim of expanding the guarantee of this right for women, trans men, and non-binary individuals in the city. The commission receives technical assistance from the Colectiva Justicia Mujer Corporation.

iii. *Existing barriers*

[27]. Despite a strong legal and policy framework protecting the right to abortion in Colombia, barriers abound. It is difficult to provide a comprehensive view of where these barriers are most present and who is most impacted, as there is currently no source of information and disaggregated data broken down by categories such as ethnic-racial affiliation on the application of the legal and regulatory framework on abortion. This factor prevents the recognition of the barriers faced by women who are subject to different categories of oppression from an intersectional perspective. Nonetheless, civil society organizations and government entities have identified multiple barriers still present in the provision of abortion services.

[28]. The Ombudsman's Office issued a report on Voluntary Termination of Pregnancy and Implementation of Judgment C-055 of 2022, a year after the decision was published. It identified the remaining barriers related to abortion, including sociocultural barriers, stigmatization, and lack of knowledge on sexual and reproductive rights; reproductive violence; discrimination; criminalization; and barriers to access related to the understanding of the legal framework.

[29]. La Mesa has grouped barriers to abortion into multiple categories, including structural barriers, barriers related to the legal framework, barriers to and within the healthcare system, barriers to the self-management of abortion, barriers to information and misinformation, and personal and interpersonal barriers. The Corporacion Colectiva Justicia Mujer, identified that in 74% of their cases from 2023 and 2024, women experienced barriers related to abortion care. These included barriers related to social and cultural stigmatization, lack of adequate and truthful information, availability of quality services in rural areas or marginalized communities, and the inadequate implementation of conscientious objections.

a. Structural Barriers

[30]. Structural barriers are those related to social, cultural, economic, political, race, and gender vulnerabilities. They include limited access due to **unequal distributions of power and systemic inequalities**. For example, migrant women, particularly those from Venezuela, have been found to face increasing difficulties in accessing abortion. Trans men and non-binary people are also often ignored in reproductive healthcare services, including abortion care. These barriers may also impact rural women or specific geographical locations, evidenced by the Corporación Colectiva Justicia Mujer, who identified that of all the cases they handled in Antioquia, most were centralized in Medellín (48%)[11].

[31]. Another structural barrier may be the **opposition of anti-rights organizations** that continue to restrict or challenge people's access to reproductive healthcare. One such example is the introduction of Law 290/2024C, which sought to add requirements for women seeking to terminate their pregnancy. These requirements were invasive and unnecessary, such as requiring an ultrasound. While the law did not pass, it poses a threat to the continuous protection of pregnant people's rights to life, health, dignity, autonomy, and equality. These threats are ever present, evidenced also by the two rulings of the Fourth

[11] Corporación Colectiva Justicia Mujer, *Activismo por Justicia Sexual y Reproductiva para una vida Libre de Violencias* (2024), available at: http://colectivajusticiamujer.org/wp-content/uploads/2025/02/Exp_y_barreras_acceso_a_la_IVE_en_Antioquia_2023-2024.pdf

Review Chamber, which found Indigenous leaders had the power to approve or refuse an Indigenous woman's request for an abortion. The Full Chamber of the Constitutional Court overturned the decision, but it shows how the right to abortion is not yet fully protected in the country.

[32]. Similarly, there are no bills in the Colombian Congress seeking to expand access to abortion or guarantee the enjoyment of sexual and reproductive rights for people with disabilities and diverse abilities. However, there are several initiatives that would create environments of delegitimization and even greater discrimination, such as Bill 200/24, currently in the Senate (or Upper House), which seeks to allow parents to modify school curricula that they disagree with, such as topics on sexuality and inclusion. Also, Senate Bill 039/24, which seeks to establish National Family Day, attempting to reinforce the traditional roles of men and women, especially those in which caregiving and reproductive tasks fall to women. Furthermore, attempts at regression have been observed in certain administrative and political initiatives in some regions, instrumentalizing mental health as a reason to access abortion services.

[33]. Regarding access to sexual and reproductive health services, we note with concern the lack of implementation of Resolution 1904 of 2017 of the Ministry of Health.[12] This resolution guarantees the sexual and reproductive health rights of people with disabilities and rejects the use of stereotypes, taboos, and discriminatory acts against people with diverse capacities or disabilities in the healthcare system or in health science facilities. It also calls for the provision of care in conditions that align with human rights standards, ensuring the dignity of the patient and quality of the services.

[34]. It is important to emphasize that there is a missing intersectional perspective in the legal and normative framework of abortion care in Colombia. The current legal and normative framework fails to address the unique barriers pregnant individuals may face based on race, socioeconomic status, disability, sexual orientation or gender identity, physical location, and other vulnerabilities.

a. Personal and interpersonal barriers

[35]. These relate to the personal and interpersonal circumstances of each person, interconnected with the structural barriers previously identified. They may appear as limited financial resources, lack of emotional support, fear of social ostracization or stigmatization, or other barriers related to their familial or romantic relationships. For example, some women sought assistance from the Corporación Colectiva Justicia Mujer for financial assistance to cover their lodging, meals, and transportation necessary to access abortion care.

[36]. The Ombudsman's Office also noted that cultural and religious beliefs may negatively affect views and perceptions of abortion, leading to blame and judgment of women who wish to exercise their right to abortion. These personal and sociocultural barriers also arise from harmful stereotypes relating to gender and maternity. One study in the region of Pereira focused on Afro-descendant women and the barriers they face in accessing reproductive care. These included a history of forced and violent reproductive treatment, as a consequence of slavery, that led to distrust in the medical field, as well as cultural perceptions of a family model where women have value only as mothers.[13]

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[12] Ministry of Health, *Resolution 1904 of 2017*, available at: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-1904-de-2017.pdf.

[13] Maturana Maturana, Dora Inés, Maturana Córdoba, María Lucelly, Angulo Góngora, Luz Carime, Mena Valderrama, Leidys Emilsen. *Diagnóstico sobre la garantía del acceso a la interrupción voluntaria del embarazo en mujeres afrodescendientes de Pereira* (2023). La Mesa por la Vida y la Salud de las Mujeres. Available at: https://despenalizaciondelaborto.org.co/wpcontent/uploads/2023/05/Diagnostico-garantia-accesos-IVE-Pereira.pdf

b. Barriers related to the legal framework

[37]. A barrier that remains is a **lack of understanding of the legal framework** around abortion. Healthcare providers may not know or understand the jurisprudence, legal policy and normative framework regulating abortion. This can result in delays of care or a lack of availability in services needed to satisfy the legal and normative requirements for abortion. A misunderstanding of the law can also result in criminalization of abortion patients, as healthcare providers may not know that the care undertaken, sought, or received is legally protected as a fundamental right.

[38]. **Criminalization** continues to be an issue in Colombia. Between February 2022 and August 2023, there were 119 complaints of unlawful abortion, as qualified under Article 122 of Colombia's Penal Code.[14] Of these, 81% were against women, and 37 of them (31%) were dismissed or archived as they did not qualify as an unlawful act under the law. Another example was the case of a 19-year-old woman, who sought abortion care from a public healthcare facility. The doctor who provided the abortion care reported her to the authorities, violating professional ethics and the duty of confidentiality, as well as the patient's right to privacy. This shows that liberalizing abortion in the first 24 weeks is not enough to remove all barriers to the right to access abortion care. The only way to provide access to abortion services without any barriers is with the full decriminalization of abortion, in all circumstances and at all times.

[39]. A **restrictive interpretation of the legal framework** may also impede access to healthcare services. This can be presented by imposing additional, and unnecessary requirements, to obtain abortion care. For example, there have been reports of women being coerced into long-term contraceptive care after receiving abortion care because healthcare staff believe it is required under the law. Other times, women have been required to have someone attend the appointment for an abortion, which is not required under the law and violates their right to privacy and dignity. Finally, there may be institutions that attempt to exercise a collective conscientious objection by noting that all their healthcare personnel morally object to abortion, which is in direct contravention of the law.

c. Barriers in the provision of healthcare

[40]. One of the main barriers women and pregnant individuals experience is **failures in the provision of abortion care**. This is reflected as mistakes, problems, or deficiencies present in the healthcare system and professionals at the time of providing an abortion. For instance, some pregnant individuals may be charged for abortion services, with one study reporting up to 56% of abortion patients had to cover abortion care out-of-pocket, and another 10% relied on subsidies to pay for their abortion. Other patients may not be referred to a healthcare provider that can help them, such as being referred to the limited providers that can conduct an induction of fetal asystole. Some patients still experience stigma and discrimination from providers, leading to mistreatment and obstetric violence. Finally, this also is present when healthcare facilities do not have sufficient staff, instruments and medication to provide the necessary abortion care.

[41]. The Ombudsman's Office in Colombia tracked 254 complaints related to abortion care between February of 2022 and August of 2023.[15] The breakdown of these complaints is as follows: 69 of the

[14] Defensoría del Pueblo, Fondo de Población de Naciones Unidas 2024, informe defensorial. *Interrupción Voluntaria del Embarazo e implementación de la sentencia C-055 de 2022*. Pág. 78.

[15] Attorney General's Office and United Nations Population Fund, Ombudsman's Report, *Voluntary Interruption of Pregnancy and Implementation of Sentence C-055 of 2022* (2024), pg. 90, available at: https://repositorio.defensoria.gov.co/server/api/core/bitstreams/548897b2-3221-45fe-a01d-96287e93e8d4/content

complaints related to a delay in scheduling surgical procedures; 24 were regarding the misapplication of standards, guidelines, or care protocols; 21 were delays in the authorization of procedures; 19 were related to a delay in assigning specialized consultation appointments; 16 were on misinformation about their rights, duties, and protocols; 11 were due to a lack of available surgical procedures; 8 were because of a lack of gynecological appointments; 6 related to a delay in referral or counter-referral; and 5 were because of a delay in providing reimbursements.

[42]. Another example is the current shortage of mifepristone and misoprostol, as well as contraceptive medication. This particularly affects the rights of women and girls to sexual and reproductive health, as well as their rights to life, health, dignity, freedom of conscience, and to choose the number and spacing of their children. A failure to provide contraceptive care restricts their ability to make decisions about their bodies, life plans, and to exercise their right to a free and satisfactory sexual life. Similarly, a lack of access to medication abortion is a direct affront against their right to voluntarily terminate a pregnancy, recognized as a fundamental right by the Constitutional Court. Furthermore, the Instituto Nacional de Vigilancia de Medicamentos y Alimentos (National Institute for Food and Drug Surveillance) still requires a prescription for pregnant individuals to access medication abortion.

[43]. Another significant barrier pregnant individuals may face is **delays in service provision**, which often increase the gestational age at the time of abortion. One study concluded that 52% of women serviced by the organization were in their second trimester when they obtained an abortion. This was particularly high because women often accessed the services of this organization *after* facing delays or barriers to abortion care, which align with a delay in service provision and later gestational period for the abortion.

[44]. This is most evident in historically discriminated women, such as indigenous women, who must overcome barriers in their territories, such as the long distances they face to access a medical center and even barriers within their communities that are not overcome by the health system, but rather reinforced. The Constitutional Court addressed this situation in ruling SU-176 of 2025, which asked indigenous structures to refrain from impeding access to IVE and drew attention to the responsibility of the State.

d. Barriers to self-managed abortion

[45]. A **lack of policies and regulations regarding telemedicine** and its applicability to reproductive health also promotes a failure in the provision of abortion care. There are outdated policies, implemented during the COVID-19 pandemic, but they should be updated to always reflect the accessibility of telemedicine for reproductive care. Similarly, the legal framework around **self-managed abortion and medication abortion should be expanded**. Medication abortion has been recognized by the World Health Organization as a safe abortion method within the first 12 weeks of pregnancy. With the liberalization of abortion during the first 24 weeks of pregnancy in Colombia, medication abortion should be an accessible method to expand abortion care to all people. It not only protects their rights to privacy and bodily autonomy, but it assists in overcoming many of the barriers that are present in the country, such as geographical limitations to reproductive healthcare clinics. It is important to note that women and people with the capacity to gestate who are of African descent and indigenous and live in areas without good internet connection or access to cell phones or computers cannot access this possibility in the absence of differential actions by the State. According to the 2019 National Quality of Life Survey (ENCV), while 51.9% of households in Colombia have an Internet connection, access for people living in population centers and scattered rural areas is only 20.7%. According to the National Population and

Housing Census, municipalities with the largest Afro-Colombian populations have, on average, a lower coverage rate for this service and a significant difference of 5.22 points less than the rest of the country's municipalities.

e. Barriers to Information and Misinformation

[46]. This barrier is present when patients seeking abortion care cannot find information about the services available and their rights, or when the information provided is incorrect, incomplete, or biased. It also relates to healthcare professionals' misunderstanding or not knowing the legal framework around abortion care. If healthcare staff are uninformed about the rights of patients to access abortion, they may spread misinformation or deny information on safe abortion practices.

[47]. Similarly, many schools do not yet provide **comprehensive sexual education**, based on human rights, which may lead to further informational barriers to pregnant people's rights to access sexual and reproductive healthcare, including abortion. This is particularly harmful for girls, adolescents, and young women.

[48]. This barrier may also be present when there are attempts to **censure reproductive rights advocates** or when there is a lack of national and regional campaigns to promote reproductive rights. For example, the state of Argelia de María faces structural issues that make access to abortion complicated, including being a rural area, impoverished, with high rates of racial inequality, and a history of violence from the armed conflict. There is one hospital available in the municipality, which has not recorded a single abortion since the Constitutional Court's decision in 2022. An action for constitutional enforcement was presented, after which human rights defenders for reproductive rights were threatened and hostile action taken.

4. *Recommendations*

[49]. We respectfully suggest the Committee make the following recommendations to Colombia:

i. **Regarding the rights of adolescents to sexual and reproductive health**

[50]. Develop effective mechanisms for adolescent participation in the design, implementation, and evaluation of public policies related to their sexual and reproductive health needs. These mechanisms should be readily available and accessible to adolescents, with clarity on how to participate in these opportunities.

[51]. Promote comprehensive sexual education in all schools, ensuring access to clear, precise, and complete information.

ii. **Regarding the situation of maternal health rights in Colombia**

[52]. Provide fully disaggregated data on maternal mortality and morbidity rates, including data on race, ethnicity, sociocultural status, geographical location, and other categories.

[53]. Require training and capacitation of healthcare staff on legal developments related to maternal health rights, including obstetric violence.

[54]. Strengthen participation of midwives, community health workers, and traditional medicine in the healthcare system. Encourage and seek their participation in the design, implementation, and evaluation of public policies.

iii. **Regarding the regulation of abortion**

[55]. Decriminalize abortion in all instances, regardless of gestational limit.

[56]. Require all healthcare actors, including traditional midwives and community health workers, to fully comply with their obligation to provide accurate and timely information on abortion, including the legal framework under Ruling C-055 of 2022 and Resolution 051 of 2023.

[57]. Strengthen personnel capacity and knowledge of abortion care. This includes capacitation of technical skills in providing safe and dignified abortion care, as well as clarity on their legal obligations under the framework of Ruling C-055 of 2022 and Resolution 051 of 2023.

[58]. Ensure access to abortion across all levels of healthcare, with particular emphasis on rural and remote areas. It is also imperative to guarantee access for women subject to intersecting forms of discrimination, such as migrant and Afro-descendant women.

[59]. Adopt an intersectional perspective and ethnic-racial approach when designing and implementing policies related to reproductive health and services, considering the particular needs and barriers of vulnerable and marginalized groups.

[60] Review policies related to telemedicine and clarify the scope of telemedicine in reproductive healthcare services. Expand access to abortion through the implementation of telemedicine practices.

[61]. Develop and continue federal and state monitoring of the implementation of Ruling C-055 of 2022 and Resolution 051 of 2023, as well as the advancement and protection of abortion rights and services.

[62] Develop systems for the monitoring and collection of data. This should include disaggregated data on gestational age, affiliation status, and population groups, including whether they are migrants or belong to an ethnic or racial group.

[63]. Guarantee access to clear, precise and complete information. This requires the development of media and communication campaigns that promote information on how to access abortion services and other reproductive rights, as well as the provision of comprehensive sexual education at all levels. This must be tailored to the needs and possibilities of the territories, as well as the forms of communication of historically discriminated groups.

[64]. Guarantee that insurance and basic healthcare plans include reproductive healthcare services. Ensure no pregnant patient is required to pay out-of-pocket for abortion services. These must be considered urgent and necessary services, and must be provided under human rights standards.

[65]. Assign sufficient resources to defend efforts to limit or restrict reproductive rights, especially in areas that show greater barriers in their healthcare structure and that are generally associated with the concentration of negatively racialized groups

[66]. Promote effective coordination between the Ministry of Health, territorial health entities, governors' offices, and mayors' offices to ensure real and effective access to abortion services, especially in rural and

decentralized areas. This includes strengthening the public network of healthcare providers and mechanisms for inspection, monitoring, and control.

We appreciate the Committee's longstanding commitment to reproductive rights. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Causa Justa Movement

Corporación Colectiva Justicia Mujer

Católicas por el Derecho a Decidir- Colombia

Women's Link Worldwide

Red Nacional de Mujeres