BAD IF THEY DO,
BAD IF THEY DON'T

VIOLENCE THAT PUNISHES WOMEN'S OBSTETRIC, REPRODUCTIVE, AND SEXUAL DECISIONS IN SANTANDER AND NORTE DE SANTANDER

Calle 21 # 26-21
Bucaramanga, Santander
PBX: (57-7) 6341589
www.mujeryfuturo.org

Author:
Judith Vanessa Gómez Higuera

Strategic Line Advisor:
María Claudia Caballero Badillo

Editor:
Christiane Lelievre

Institutional Coordinators:
Lizeth Mayerly Carreño Núñez
Tatiana Mayerly Cordero González
Edda Nayibe Fuentes González

Design and Layout:
Dorely Sarabia Velásquez

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"Gender Data" is an institutional information and communication strategy for advocacy, focused on knowledge management from a human rights, gender, intersectionality, and migration perspective. It is developed from the perspective and experiences of women, with the aim of strengthening the production, systematization, and dissemination of information that is useful for political and social action.

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WHAT THIS REPORT REVEALS:
A SYSTEM THAT PUNISHES WOMEN

This brief analyzes the ways in which obstetric, reproductive, and sexual violence manifest against women and people with the capacity to gestate in the departments of Santander and Norte de Santander, based on testimonies and cases documented by the Fundación Mujer y Futuro (FMF). Although this analysis focuses primarily on obstetric violence in the context of Voluntary Termination of Pregnancy (VTP), it recognizes that such violence does not occur in isolation, but rather is intertwined with other expressions of violence against women—such as reproductive or sexual violence—often normalized and rendered invisible, and even more so in contexts shaped by armed conflict.

The report seeks to make visible how stigma, moral judgment, and misinformation translate into systematic forms of mistreatment and dehumanization by health personnel before, during, and after sexual and reproductive health procedures. It takes obstetric violence— a form of gender-based violence exercised by those responsible for health care against women during pregnancy, childbirth, and the postpartum period— as the axis from which other forms of violence are interwoven. In this context, reproductive violence, defined following the proposal of the Center for Reproductive Rights as ***"practices that directly or indirectly compromise and violate reproductive autonomy, understood as the capacity of individuals to decide whether or not to have children and when, as well as to access information and sexual and reproductive health services such as contraception, safe abortion, or gynecological and obstetric health services,"*** [1] finds in medical care a space for systematic reproduction. Although cases of reproductive violence tend to be less identified than those that also constitute obstetric violence, this phenomenon responds to the difficulties in recognizing it or to fear of reporting it, especially in areas affected by armed conflict, where even the circulation of information about sexual and reproductive rights is restricted.

Likewise, sexual violence—expressed in actions that ***"force a person to engage in sexualized contact, physical or verbal, or to participate in other sexual interactions through the use of force, intimidation, coercion, blackmail, bribery, manipulation, threats, or any other mechanism that nullifies or limits personal will"***[2] forms part of the web of violence surrounding health care. It is further aggravated when, after surviving assaults, women are revictimized by the system through the denial of care, the requirement to file prior complaints, or the ineffectiveness of care pathways[3]. In some documented cases, not only are protocols breached, but stereotypes that blame victims are reproduced.

One of the most serious findings of the brief is that the exercise of bodily autonomy continues to be sanctioned: women are judged for becoming mothers or for deciding not to do so, for seeking care or for remaining silent, for reporting or for feeling afraid to report. This constant blaming reveals a structural pattern of violence, in which the right to decide over one's body and life is conditioned, stigmatized, or directly violated.

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1 *Center For Reproductive Rights. (2020, julio) Pág. 13.*
2 *Law 1257 of 2008 (Ley 1257 de 2008) "By which provisions are established for awareness-raising, prevention and sanction of forms of violence and discrimination against women, amendments are introduced to the Criminal Code, the Code of Criminal Procedure, Law 294 of 1996, and other provisions are enacted."*
3 *Resolution 459 of 2012 of the Ministry of Health and Social Protection (March 6, 2012) contains the Protocol and Comprehensive Health Care Model for Victims of Sexual Violence.*

This brief does not merely document facts; it denounces a structural reality in which women's bodies remain contested. Obstetric violence is the visible center of a system that also reproduces sexual and reproductive violence, particularly in territories marked by fear, conflict, and silence.

Finally, the report calls for a comprehensive transformation of the health system that integrates education, oversight, accountability, and institutional and cultural awareness-raising. Women's voices are at the core of this proposal: testimonies that denounce, resist, and demand the full exercise of their rights.

1 WHEN JUDGMENT WEIGHS MORE THAN HEALTH: AN APPROACH TO THE DEFINITION OF OBSTETRIC VIOLENCE AND ITS NORMATIVE FRAMEWORK

> **Women have the right to live a life free from obstetric violence, and States are under the obligation to prevent it, punish it, and refrain from engaging in it, as well as to ensure that their agents act accordingly.**
>
> *Brítez Arce et al. v. Argentina.*[4]

For centuries, gender roles imposed on women have fostered the exercise of various forms of violence, manifested across multiple spheres of their lives. One such expression is obstetric violence, one of the most normalized forms of violence against women.

In general terms, obstetric violence is defined as a form of gender-based violence prohibited by regional human rights treaties,[5] exercised against women and other persons with the capacity to gestate[6] by officials of health institutions when health services are required during pregnancy, childbirth, and the postpartum period.[7]

By 2024, the **National Childbirth and Birth Survey in Colombia**, reported that the largest proportion of responses described negative experiences during pregnancy, childbirth, and the postpartum period. The terms most frequently used to refer to those experiences were: ***"stereotypes, inhumane, traumatic fear, aggressive, uncomfortable, tension, mockery, pain, humiliation, violent procedure, insult, unjust, inhumane, lack of information, without consent, obstetric violence, disrespectful"*** (National Movement for Sexual and Reproductive Health in Colombia & Universidad Icesi & Universidad Antonio Nariño & Profamilia, 2024).

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4 *Judgment issued by the Inter-American Court of Human Rights in which obstetric violence is recognized for the first time as a form of gender-based violence that violates human rights treaties and the Belém do Pará Convention. See Inter-American Court of Human Rights. Case of Brítez Arce et al. v. Argentina. Merits, Reparations and Costs. Judgment of November 16, 2022. Series C No. 474.*

5 *Colombia has ratified various regional instruments for the protection of women's human rights, including the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Belém do Pará Convention").*

6 *Other persons with the capacity to gestate are those who, regardless of their gender identity, possess the biological conditions necessary to carry a pregnancy. This term seeks to recognize that not only cisgender women have the capacity to gestate, but also transgender men and non-binary persons who retain reproductive organs such as the uterus.*

7 *This concept of obstetric violence has been developed by Fundación Mujer y Futuro, based on existing legal frameworks and lived experiences.*

Moreover, the same national survey revealed, among many other figures on obstetric violence, that:

- **Women and other persons with the capacity to gestate face personnel** who ignore, omit, or neglect them (42.4%); criticize and repress expressions of pain and emotions of pregnant persons (35.7%); threaten or intimidate them with phrases such as, "if you keep screaming like that, we won't give you anesthesia" (27.1%); engage in disrespectful treatment for being "too tight" (7.9%), for being a single mother (4.6%), or for being older (3.4%); breach confidentiality (14.8%); and fail to provide information about their health status (12.3%).

- **In procedures, non-recommended practices prevail,such as** (...) the Kristeller[8] maneuver (33.1%) (...) [or] episiotomy[9] without prior authorization (37.7%).

Obstetric violence affects the right to health in all its dimensions (physical, mental, and social), as well as sexual and reproductive rights, normalizing a medical model in which the bodies, life cycles, and processes of women and other persons with the capacity to gestate are reduced to their reproductive potential. Consequently, the capacity to procreate ends up defining their lives.

Within that model, the rule **"procreate and do it well"** harms both women who wish to exercise their motherhood and those who seek to exercise their right to Voluntary Termination of Pregnancy (VTP), who are also at a stage of their reproductive process and may become victims of this type of violence.

For women and other persons with the capacity to gestate who decide to exercise their fundamental right to VTP, obstetric violence may intensify and manifest in differentiated ways. The imposition of motherhood on women and their bodies directly affects the quality of sexual and reproductive health service provision, and the social penalization expressed may be much greater.

Although access to VTP is supported by constitutional rulings—among which Decisions C-355 of 2006[10] and C-055 of 2022[11] stand out—as well as by resolutions of the Ministry of Health and Social Protection of Colombia (051 of 2023) and directives of the Office of the Attorney General (009 of 2023), it is evident that there remains ***"the presence of a stigma toward abortion that goes beyond the laws governing it"***(Profamilia, 2020).

Marta's[12] testimony illustrates the above:

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8 *It is a technique consisting of applying pressure to the abdomen of the pregnant person, at the level of the uterus, during childbirth. This practice has been questioned, as it may cause harm to the woman's health. The World Health Organization (WHO) discourages its routine use due to the risks involved.*
9 *A surgical incision made in the perineum during vaginal childbirth to enlarge the opening of the birth canal. In many cases, this practice is performed without medical justification, and its use is currently recommended to be limited, as it may cause complications and recovery difficulties.*
10 *Judgment of the Colombian Constitutional Court that decriminalizes the crime of abortion under specific circumstances applicable at any gestational age: when continuation of the pregnancy endangers the life or health of the woman or other person with the capacity to gestate; when the fetus presents malformations incompatible with life outside the womb; and when the pregnancy results from sexual violence, incest, non-consensual artificial insemination, or non-consensual transfer of a fertilized ovum.*
11 *Judgment of the Constitutional Court that decriminalizes abortion up to 24.6 weeks of gestation, without the need to fall within any of the grounds established in Judgment C-355 of 2006.*
12 *The accounts presented in this document are testimonies of women assisted by Fundación Mujer y Futuro in Bucaramanga, its metropolitan area, and Ocaña. All names have been changed to ensure their protection.*

> **I had a history of severe preeclampsia[13] in all my pregnancies to the point that I had a loss and a threat of permanent kidney damage, which is why I had a Pomeroy procedure (a permanent contraceptive method). Three years later, I realized I was 13.5 weeks pregnant (...) I did not want to continue the pregnancy for obvious reasons (...) I was examined by five professionals. The gynecologist was a conscientious objector; he refused to provide me with information or care and wrote in the medical record: Patient expresses desire for VTP due to high obstetric risk and complications; however, considering gestational age over 12 weeks and being a conscientious objector, I consider the pregnancy viable and not for VTP; there is no 24/7 gyneco-obstetric availability, therefore discharge is granted.**

The account reveals that the influence of beliefs, stereotypes, and the restrictive interpretation or non-compliance with regulations surrounding conscientious objection affect the guarantee of a right, which in this case materializes through the availability, acceptability, quality, and accessibility of the VTP procedure. Despite the risk to her health and life, Marta was only able to receive specialized care later, after initiating legal action and reiterating that conscientious objection—although a fundamental right—has limits, and that objecting medical personnel must guarantee information and make an immediate referral, in accordance with the institutional obligation to ensure the availability of non-objecting medical personnel in such cases, given that VTP is an essential and urgent procedure, as established in Article 9 of Resolution 051 of 2023 of the Ministry of Health, which adopts the unified regulation for comprehensive health care in cases of Voluntary Termination of Pregnancy (VTP) and amends section 4.2 of the Technical and Operational Guideline of the Comprehensive Maternal and Perinatal Health Care Pathway adopted through Resolution 3280 of 2018 by the same entity.

The Constitutional Court of Colombia[14] has established a "Typology of practices constituting obstetric violence":

1. **Abuses:** forced surgery, non-consented medical procedures, rape, physical restraint, and other types of abuse (mockery, humiliating comments, hostile treatment, and similar acts).
2. **Coercion:** through judicial intervention, intervention by authorities of the Colombian Family Welfare Institute, denial of treatment, manipulation of information, or emotional pressure.
3. **Disrespect:** Medical personnel accuse women of being overly sensitive to pain and incapable of handling pain without medication; they shout at them for feeling fear or vocalizing loudly during contractions, or tell them that their performance during childbirth reflects the poor performance they will have as mothers. Women are also ignored when they ask questions about treatment or are made to feel guilty for their decisions when complications arise.

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13 *A severe pregnancy complication that can affect vital organs such as the kidneys, liver, and brain, and may be fatal.*
14 *Judgment SU-048 of 2022. Reporting Justice: Cristina Pardo Schlesinger.*

This typology of practices is insufficient in light of the diversity and deepening of violence in Voluntary Termination of Pregnancy procedures, considering that it was only with Decision T-576 of 2023[15], that the Court recognized that protecting women from obstetric violence in the VTP procedure is a way of guaranteeing the rights to live free from violence, to health, and to reproductive self-determination.

2 THE IMPACT OF STIGMA IN THE STRUGGLE FOR THE RIGHT TO DECIDE

"Good morning, I would like information about Voluntary Termination of Pregnancy (VTP),[16] is one of the most frequent messages on our organization's social media. This request represents only the tip of the iceberg of a reality faced by many women in Santander and Norte de Santander when attempting to exercise their fundamental right to VTP. Behind these words lie stories marked by obstacles, stigma, and, in many cases, experiences of obstetric violence.

Uttering or writing those words is not easy. Although significant progress has been made in recognizing women's reproductive autonomy, stereotypes that deny their sexuality and pleasure and confine them exclusively to reproduction and motherhood continue to carry different weights in each experience. Conversations with the women we support in the region have allowed us to identify the ways in which obstetric violence operates within Voluntary Termination of Pregnancy procedures. Many of these cases are not described within the existing typology and yet occur constantly.

En el diagnóstico "Nuestro cuerpo, nuestro territorio: situación del acceso a la IVE en el área metropolitana de Bucaramanga" la Fundación Mujer y Futuro reveló que existen barreras sociales, institucionales y fallas en la prestación del servicio que terminan imposibilitando el acceso al derecho a la IVE y, facilitando las violencias obstétricas.

Through interviews and case documentation, the report recorded that:

"Violence begins from the moment the woman learns she is pregnant, because in some cases the professional team congratulates her without consulting her about her desire to become a mother, and they set aside their duty to inform her of the possible options in accordance with the maternal and perinatal care pathway. Violence is also identified when medical personnel inform women of the number of weeks of gestation without asking whether they wish to know that information. (...) In health institutions, there have also been acts of violence such as showing the expelled fetus to the woman without her consent, even when she had clearly expressed from the outset her desire not to see it."
(Fundación Mujer y Futuro, 2022).

15 *Fundación Mujer y Futuro submitted a citizen intervention in the aforementioned judgment. In it, obstetric violence was presented as an expression of violence against women within the framework of voluntary termination of pregnancy procedures.*
16 *Information obtained from the records of the health strategy hotline of the Mobile Medical Unit.*

Women and other persons with the capacity to gestate, within the framework of VTP procedures, are exposed to obstetric violence throughout the entire process:

a. **From the moment the need for information about VTP is verbalized:** Andrea, whom we accompanied in filing a call to action for the non-repetition of obstetric violence in a hospital in the metropolitan area of Bucaramanga, stated: ***"During the consultation I mentioned that I was not ready to be a mother and asked about options (...) the doctor almost silenced me; he told me to be careful about what I was saying, that it was prohibited."***

Camila, a woman we supported after she was a victim of obstetric violence, told us: ***"At 10 p.m. they gave me four pills; since they did not inform me of anything, I searched online. It said I needed to prepare items such as sanitary pads and supplies. I had nothing; everything I knew about my VTP I read on the internet."***

b.Extending through the expulsion process and the handling of biological material: María told us that during her expulsion process she felt alone and received no support from health personnel: ***"It all started around 9:00 a.m. in the emergency bathroom; I called, but no one came. Seeing me in such bad condition, another patient looked for staff. A nurse came; I asked for something for the pain, but she never returned (...) 40 minutes passed; they helped me call a nurse again, who looked at me and left (...) this happened four times. In the end, after spending a long time in the bathroom with blood and the fetus, a nurse arrived with a red bag; I saw everything (...) I left the bathroom at 2:30 p.m.; it was five hours of suffering."***

c.Even during post-procedure recovery and follow-up appointments: Ana shared what happened during her follow-up visit: ***"When I entered the office, the doctor who had told me I was pregnant was there; they greeted me as 'mommy.' When he began the examination, he realized there was nothing; he asked me, 'the baby?' I told him (...) he responded with, 'ok, a voluntary one.' Everyone's attitude changed immediately; they mistreated me, and I felt very judged."***

Across these experiences, violence and mistreatment by health personnel are another frequent occurrence. These practices ***"seek to make women change their decision and/or feel guilt or regret for their decision"*** (La Mesa por la Vida y la Salud de las Mujeres, 2017)

The following testimonies make these situations visible:

Carolina: ***"The gynecologist was rough while performing the procedures; she provided care angrily, said many things, and questioned me."***

Sandra: ***"The psychologist told me to think about it, to keep it, that I was close to finishing the process and that if I had not even realized I was pregnant, it was because it had not been so terrible."***

In this context, collecting women's voices serves a dual purpose. On the one hand, they reflect an alarming reality: obstetric violence within Voluntary Termination of Pregnancy procedures is not an isolated event; it is a systematic practice that perpetuates stigma, judgment, and dehumanization. On the other hand, in the face of the normalization of this violence, women's voices are an indispensable tool for advancing processes of characterization, in order to propose and demand institutional and State measures for its eradication.

In our region, women's stories have allowed us to identify other typologies of practices that constitute obstetric violence, not specified by the Constitutional Court and occurring especially in VTP procedures:

1.Delays in access to the VTP procedure.

2.Violations of, or threats to, the principle of confidentiality.

3.Acts of revictimization and blaming for the decision to undergo VTP.

4.Lack of support and lack of understanding of pain during expulsion processes.

5.Dehumanizing and inadequate practices according to gestational age.

6.Use of obsolete or prohibited practices such as curettage.

7.Inadequate and/or revictimizing handling of the final disposition of biological material resulting from VTP.

8.Threats of criminalization.

To a large extent, the persistence of obstetric violence within VTP procedures is closely linked to prejudice and social barriers.

The narrative report of the abortion ecosystem assessment in Santander conducted by Profamilia notes that the greatest weaknesses are found precisely there—in discrimination and stigma—and that the legal decriminalization of abortion was not accompanied by social decriminalization (Profamilia, 2024). Accordingly, the Office of the Attorney General reported that, in the department of Santander, between February 12, 2022, and August 31, 2023, there were still eight cases registered for the offense of consensual abortion[17] (Defensoría del Pueblo & United Nations Population Fund & La Mesa por la Vida y la Salud de las Mujeres, 2024).

3 WOMEN'S AUTONOMY AS ANOTHER BATTLEFIELD

In the region, war has left marks on the histories and bodies of women. One of the women supported by FMF recounted: ***"Some armed men arrived and forced us out of the house (...) they separated us, they groped me and forced my partner to kneel, and several of them shot him."*** This testimony not only reveals the physical and emotional brutality of war, but also represents how armed conflict exacerbates the hypersexualization of women, stigma, and stereotypes, enabling violence in areas such as obstetric, reproductive, and sexual health to occur invisibly and with impunity due to fear of reporting. Additionally, these forms of violence occur with greater cruelty and normalization, as women's bodies and reproductive capacities become commodities, instruments of control, territories of symbolic dispute, or even spoils of war.

17 *Although the crime of abortion is established in Article 122 of the Colombian Criminal Code, it must be interpreted in light of Judgments C-355 of 2006 and C-055 of 2022 issued by the Constitutional Court, which decriminalize the conduct through a system of grounds applicable at any gestational age and up to 24.6 weeks of gestation without the need to invoke specific grounds.*

It is important to emphasize that reproductive and sexual violence in general, but especially in the context of armed conflict, cannot be understood in isolation from other forms of gender-based violence. However, distinguishing them is essential, given their different physical and mental impacts on women. As noted by the Center for Reproductive Rights (2020), ***"historically there has been an almost exclusive emphasis on rape and its use as a weapon of war. As a result, modalities of reproductive violence — that is, those that undermine reproductive autonomy — have been subsumed under a broad concept of sexual violence, which has led to less identification and reparation of these harms."*** Recognizing this, in the report **"My Body Is the Truth. Experiences of Women and LGBTIQ+ People in the Armed Conflict,"** the Truth Commission provides a clear conceptualization of reproductive violence as follows:

"Reproductive violence refers to any action or omission aimed at affecting, on the one hand, women's right to make decisions about their reproductive lives and, on the other, their health in relation to their reproductive capacity or the integrity of their reproductive organs. These forms of violence are often ignored and subsumed under the category of sexual rights."[18]

Although the report acknowledges that reproductive violence is subsumed under sexual violence in some sections, it highlights the urgent need to separate the concepts. It notes that both forms of violence ***"were used by legal and illegal armed actors as strategies of subjugation and terror,"*** constituting serious human rights violations, war crimes, and crimes against humanity.

Similarly, the Truth Commission identifies manifestations of sexual violence as including ***"rape, threat of rape, sexual harassment, trafficking for purposes of sexual exploitation, sexual slavery, forced witnessing, performing or allowing sexual acts, forced nudity, and mutilation of sexual organs."*** It identifies reproductive violence modalities as ***"forced contraception and sterilization, forced pregnancy and forced abortion, torture during pregnancy, as well as forced motherhood or forced child-rearing."***

These manifestations of reproductive and sexual violence respond to structural gender patterns intensified by war, though exacerbated by the armed conflict context. This perpetuates the consequences of such violence amid institutional precarity, fear, and lack of protection. In this regard, the health system becomes, in many territories, another space of risk and control, characterized by scarce resources and high levels of stigmatization. An example is access to voluntary termination of pregnancy (VTP), which ceases to be a viable option not only due to inaccessibility or lack of information, but also because of fear generated by armed actors who have prohibited the procedure or access to information on sexual and reproductive rights.

One of our professionals recalls the story of a woman who was a victim of sexual violence and was approached by two individuals identified as members of an illegal armed group. **After being denied health services, she recounted:** ***"They approached me on an empty street (...) they intimidated me (...) one grabbed my breasts (...) the other penetrated me."*** The consequences of such acts do not end when the violence stops; they continue to manifest in the ways these women are treated — or neglected — within health services. This can result in severe revictimization by a system that should protect them and ensure their rights (health, autonomy, a life free from violence, among others).

18 *Truth Commission of Colombia. (2022). Footnote 173, p. 67.*

Fieldwork by Fundación Mujer y Futuro has also documented cases of **denial of examinations related to sexually transmitted infections.** In some cases, despite being victims of sexual violence in the context of armed conflict, women are required to file a formal complaint to access health services — including examinations and post-exposure treatments that form part of the care pathway for sexual violence cases. This pathway prioritizes immediate health care due to urgency, followed by referral to protective entities for comprehensive support. Therefore, requiring a complaint as a prerequisite constitutes an additional access barrier.

Likewise, the following cases of reproductive violence have been documented:

- **Forced or non-consensual sterilization or contraception.** Karina stated: ***"The nurse was there (...) she grabbed me and said: come here, I have one left over, I'll put it in; I told her NO, but she didn't listen, she didn't even assess me, even though I told her I have hypothyroidism (...) she inserted it without authorization and without consent."*** This constitutes a practice in which health personnel impose limits on reproductive autonomy based on authority, disregarding the decision and physical, social, or mental needs of patients.

- **Denial of removal of contraceptive methods.** Claudia, a migrant woman and victim of armed conflict, reported: ***"They told me they couldn't help me because I don't have health insurance (...) I want to remove the implant and no one has helped me."*** In this case, health authorities imposed administrative barriers to avoid removing implants. Often, these limitations are based on stereotypes or discriminatory criteria that disproportionately affect migrant women.

In this scenario, reproductive and sexual justice in these territories must be addressed as part of peacebuilding processes, alongside real guarantees of non-repetition. Silence and normalization of such violence cannot be an option; we must advocate for its recognition, reparation, and transformation.

CONCLUSION

The multiple forms of obstetric violence documented in Santander and Norte de Santander, particularly in VTP procedures, demonstrate that social judgment and stigma persist as structural barriers that seriously affect the fundamental rights of women and people with the capacity to gestate. These dehumanizing practices, contrary to human rights standards and progressive legal frameworks, reflect a critical gap between law and implementation. Nevertheless, this document provides a starting point, reflecting an ecosystem oriented toward guaranteeing rights. It is therefore urgent that health institutions, alongside political and social actors, implement concrete measures to remove barriers to the effective exercise of rights and recognize the voices of those who have experienced such violence, advancing reproductive justice.

In this context, it is essential to recognize that women's sexual and reproductive autonomy has also been a battlefield within the armed conflict. Testimonies collected by Fundación Mujer y Futuro show how reproductive and sexual violence have been used as strategies of control, punishment, and domination by

legal and illegal armed actors, and simultaneously reflect a system that continues to violate women's most fundamental rights, particularly those from populations affected by armed conflict or by compounded impacts of forced migration.

These often invisible forms of violence must be urgently addressed through a gender-based approach, as their reparation and non-repetition are also conditions for real and feminist peace.

RECOMMENDATIONS

To close the gap between recognized rights and their effective exercise, Fundación Mujer y Futuro proposes the following recommendations, differentiated by key stakeholders:

Health Service Providers (Public and Private)

- Strengthen training of health personnel in sexual and reproductive rights, with emphasis on current legal frameworks on VTP, elimination of stigma, humanized care, and gender-sensitive protocols centered on the well-being of women and people with the capacity to gestate.
- Implement effective monitoring, oversight, and sanctioning mechanisms against obstetric violence practices, ensuring safe and confidential reporting channels without fear of retaliation.
- Prioritize comprehensive and humanized support in VTP procedures, recognizing users' voices and experiences as a basis for improving service quality and preventing revictimization.
- Create and update VTP protocols centered on needs and well-being, with a gender perspective.
- Guarantee immediate and comprehensive care in cases of sexual violence without requiring prior complaint, in accordance with current regulations.
- Eradicate practices that prioritize statistics over women's autonomy, eliminating forced contraception or sterilization and ensuring full information in procedures.
- Guarantee service availability without any form of discrimination.

Departmental and Municipal Health Secretariats

- Reinforce dissemination of key regulations, such as Circular 013 of February 14, 2023, among health personnel and institutions, ensuring effective knowledge and implementation.
- Strengthen identification and sanctioning of obstetric violence cases, promoting safe spaces for reporting without fear of retaliation.
- Promote community education campaigns on obstetric violence and VTP, including how to respond to denial of access.
- Establish safe reporting channels for women who have experienced violence in institutional health settings.
- Ensure effective implementation of health care pathways for sexual and reproductive violence cases, including rural and hard-to-reach areas.

National Government and Judicial Authorities

- Strengthen and institutionalize the Intersectoral Technical Roundtable on VTP at national and territorial levels, creating a concrete agenda and defined meeting schedule.
- Promote interinstitutional coordination among health, justice, and education sectors to ensure real implementation of laws and rulings protecting sexual and reproductive rights.
- Formally recognize reproductive violence as a differentiated form of violence and develop comprehensive policies to address it.

- Strengthen funding and coverage of sexual and reproductive health services in conflict-affected regions and areas with high migrant populations.
- Support national awareness and training campaigns on reproductive autonomy and invisible forms of violence in wartime contexts.

Civil Society and Human Rights Organizations

- Design and implement education and cultural transformation campaigns aimed at the social decriminalization of VTP, highlighting its status as a fundamental and public health right.
- Accompany and amplify testimonies of women who have experienced obstetric, reproductive, and sexual violence as tools for political advocacy and institutional transformation.
- Recognize reproductive violence as an autonomous form of gender-based violence.

Parallel to these measures, interinstitutional coordination among health, justice, and civil society sectors is required to ensure effective implementation of existing laws and policies.

It is essential to prioritize comprehensive and humanized support for women exercising their right to VTP, recognizing their voices as drivers of change and as key tools for advancing toward a more equitable society, free from violence and respectful of human rights.

REGULATORY GLOSSARY

Judgment on the Merits, Reparations, and Costs in the Case of Brítez Arce et al. v. Argentina (Inter-American Court of Human Rights): Case decided by the Inter-American Court of Human Rights on November 16, 2022. It concerns the death of a woman who was nine months pregnant and died after receiving deficient medical care at a public hospital in Buenos Aires. The Court determined that the Argentine State violated the victim's rights to life, personal integrity, and health. In this judgment, the Court referred for the first time to acts constituting obstetric violence and set a precedent for reproductive justice in such cases. Additionally, it must be noted that Inter-American jurisprudence is applicable in Colombia through the constitutional bloc doctrine (bloque de constitucionalidad).

Judgment C-355 of 2006 (Colombian Constitutional Court): Although this ruling does not explicitly mention obstetric violence, it represents a milestone in the protection of women's sexual and reproductive rights in Colombia. The decision addresses institutional practices that may be considered as such, particularly in contexts where access to voluntary termination of pregnancy (VTP) is denied or hindered. The case examined the constitutionality of the crime of abortion in Colombia and ultimately decriminalized it under three specific circumstances:
i) when continuation of the pregnancy poses a risk to the life or health of the woman;
ii) when there is severe fetal malformation making life unviable; and
iii) when the pregnancy results from conduct constituting rape or non-consensual sexual acts, non-consensual artificial insemination, or non-consensual transfer of a fertilized ovum.

Judgment C-055 of 2022 (Colombian Constitutional Court): Through this ruling, abortion was decriminalized up to the 24th week of gestation. The Court expressly recognized the need to guarantee VTP services free from obstetric violence. The decision establishes that criminalization of abortion perpetuates structural barriers that disproportionately affect women and aims to reduce those barriers and promote effective and dignified access to sexual and reproductive health services.

Judgment SU-048/22 (Colombian Constitutional Court): In this ruling, obstetric violence is condemned as a violation of women's human rights during pregnancy, childbirth, and the postpartum period. The Court reaffirmed that women's right to dignified and respectful treatment in reproductive health care is constitutionally protected. Accordingly, health institutions must guarantee respectful care, reproductive autonomy, and women's informed participation in decisions related to their health. The judgment further emphasizes that obstetric violence includes actions or omissions by health professionals that cause physical or psychological harm during obstetric care and calls upon authorities to implement appropriate public policies.

Judgment T-576 of 2023 (Colombian Constitutional Court): This ruling represents a jurisprudential milestone by addressing obstetric violence for the first time in the context of voluntary termination of pregnancy (VTP). The case involved a woman who, upon requesting the procedure, faced multiple institutional barriers, including unjustified delays, violations of her rights to confidentiality and privacy, and exposure to cruel and poor-quality treatment. The Court concluded that these acts constituted obstetric violence and ordered the clinic and the health insurance entity (EPS) to conduct internal investigations and apply corresponding sanctions. It also urged compliance with established guidelines for providing adequate and quality health services, including staff training and strict respect for patient confidentiality.

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