PARTICIPATORY DIAGNOSIS:

Critical Barriers to Sexual and Reproductive Rights

TERRITORIES OF NORTE DE SANTANDER, COLOMBIA, 2025

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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 perspectives and experiences of women, with the aim of strengthening the production, systematization, and dissemination of information useful for political and social action.

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Introduction

Norte de Santander constitutes a priority territory for the exercise of Sexual and Reproductive Rights (SRR) due to the convergence of three structural factors: its condition as a border department with high mixed migratory flows, the influence of the armed conflict generating divided territorial power between state and non-state actors, and institutional gaps in guaranteeing access to sexual and reproductive health services.

Within this context, women — particularly migrants, victims of armed conflict, and those living in rural areas — face multiple barriers in accessing family planning and Voluntary Termination of Pregnancy (VTP). These restrictions configure a system of control over women's sexual and reproductive autonomy, limiting their ability to decide over their bodies and life projects.

This diagnosis pursues a threefold objective:

(i) To document violations of SRR in Cúcuta and Ocaña through triangulated evidence from women service users, community leaders, and public officials.

(ii) To identify structural patterns that hinder the effective exercise of SRR in the territories studied.

(iii) To provide technical inputs enabling competent authorities to design urgent interventions and differentiated public policies to guarantee SRR under sustained conditions of inequality and institutional neglect.

Methodology

A qualitative design with an intersectional approach was implemented, prioritizing women's voices as the primary source of evidence. During August 2025, 21 semi-structured interviews were conducted, strategically distributed in the municipalities of Cúcuta and Ocaña, selected due to their territorial relevance regarding the enjoyment and full guarantee of SRR.

Participant profile:

- **6 community leaders in Cúcuta:** providing monthly support to approximately 627 women in highly vulnerable territories[1], with between 5 and 11 years of experience.
- **10 women service users of Fundación Mujer y Futuro in Ocaña:** 70% in situations of human mobility from Venezuela; 60% victims of armed conflict; 70% residing in urban areas and 30% in rural zones; aged between 25 and 48.
- **5 public officials with competence in SRR:** 3 at the departmental level and 2 in Ocaña, with professional experience ranging from 4 to 27 years.

Triangulation and cross-validation across these three perspectives allowed identification of patterns of SRR violations in Cúcuta and Ocaña. Methodological rigor was ensured by acknowledging that, although the study is not statistically representative of the entire population, it documents consistent findings: when independent sources report the same issues, their systematic nature is confirmed.

All interviewees provided informed consent, and testimonies were anonymized to protect identities, following the principle of "do no harm," particularly relevant in contexts of armed conflict and territorial control.

Each interview was analyzed through an intersectional lens, highlighting how migration status, rurality, armed conflict, and other identity markers produce multiple forms of discrimination that condition access to rights depending on the specific territories where women live.

Main Findings: Five Patterns of Structural Violation

Triangulation confirms that the documented violations are not accidental failures but institutionalized mechanisms of subordination operating as an unwritten policy. Five critical patterns were identified:

1. **Structural deficit in access to information:** Absence or ineffectiveness of state-led SRR education enabling widespread misinformation as a mechanism of reproductive control.
2. **Systematic discrimination:** Denial of services based on nationality, irregular migratory status, and lack of health insurance affiliation (EPS[2]), constituting an institutional structure of exclusion.
3. **Barriers to contraception and VTP access and commodification of rights:** Institutional denial, improper invocation of conscientious objection, non-enabled administrative systems, delays resulting in forced motherhood, and unlawful fees that transform constitutional rights into economic privileges.
4. **Sexual and reproductive violence:** Partner control over reproductive decisions, sexual division of contraceptive labor, medical paternalism, mistreatment during VTP requests, obstetric violence, forced pregnancies, and extreme violence in contexts of armed conflict and sexual exploitation.
5. **Territorial fragmentation of sovereignty:** Non-state actors determining real access to SRR in areas under their control, without institutional response.

These patterns configure what we denominate **territories of exception in sexual and reproductive health**: spaces where the exercise of fundamental rights is conditioned by dynamics of armed conflict, territorial control, and illegal economies, evidencing state relinquishment to the detriment of women's sexual and reproductive decision-making.

[1] Women community leaders with experience in highly socially vulnerable communities characterized by migration, informality, and limited access to services, located in urban border zones, informal settlements, and peripheral neighborhoods of Cúcuta.

[2] EPS (Entidad Promotora de Salud) refers to the public or private health insurance entities within Colombia's General System of Social Security in Health. These entities are responsible for affiliating users, managing contributions, and guaranteeing access to health services under the national health system.

Evidence demonstrates state responsibility by action (discrimination, denial of lawful VTP, unlawful fees, administrative barriers), by omission (lack of oversight, insufficient training, absence of protocols), and by institutional tolerance (known male control, tolerated obstetric violence, commodification of services, territorial cession to armed actors). Although some state officials acknowledge these violations, the responses implemented remain insufficient.

Structure of the Document

The document first presents the **analytical framework** explaining why we refer to a "systemic crisis in territories of sexual and reproductive exception," characterized by permanent failures within public institutions that normalize rights violations.

The second section documents the **findings by territory**, presented in two differentiated subsections:

- **Cúcuta:** demonstrates the five critical patterns through reports from community leaders who provide monthly accompaniment to hundreds of women in vulnerable contexts.
- **Ocaña:** validates these patterns through the direct experiences of women service users and reveals unique dynamics of intersectionality among migration, armed conflict, and rurality.

The third section presents the **institutional perspective**, which triangulates the previous findings: state officials acknowledge awareness of the documented violations, thereby configuring responsibility by action, omission, and institutional tolerance.

The **conclusions** articulate the findings into convergent patterns and establish implications for public policy at multiple levels: from immediate interventions (official investigations into reproductive and obstetric violence, mandatory external oversight, and protection measures for women human rights defenders) to long-term structural transformations (comprehensive sexuality education, effective state presence in territorially controlled areas, and health system reform).

A Gender Data Production

This bulletin forms part of the **Gender Data** strategy, through which Fundación Mujer y Futuro manages information using a gender-based, intersectional, and territorial approach to support multi-level and multi-actor feminist policy advocacy.

Gender Data transforms women's experiences into critical knowledge aimed at making structural inequalities visible, supporting claims before competent authorities, and providing rigorous inputs for the design of differentiated public policies. The information presented adopts a clear political stance: it exposes systematic violations of fundamental rights through the voices of those who confront them daily.

This diagnosis generates specific evidence to challenge the identified violations and to demand effective guarantees. The data serve to position Sexual and Reproductive Rights where they belong: at the center of state responsibility — not as institutional favors, but as constitutional guarantees that the authorities of Norte de Santander are obligated to fulfill immediately.

Analytical Framework: Systemic Crisis in Territories of Sexual and Reproductive Exception

Systemic Crisis

Our findings reveal a systemic crisis characterized by persistent structural failures in public institutions, not a temporary emergency. Violations form part of the ordinary service model, replicate across territories, and involve state participation.

This type of crisis transcends general weaknesses identified by the Economic Commission for Latin America and the Caribbean (ECLAC) and the Pan American Health Organization (PAHO) in Latin American health systems (underfunding, fragmentation, segmentation by ability to pay)[3]. When human rights violations are structural, it is necessary to transform the conditions perpetuating discrimination rather than merely compensating individual harm. In *Brítez Arce v. Argentina* (2022), the Inter-American Court of Human Rights established state responsibility when systematic institutional barriers in reproductive health services are tolerated.

Reparations for structural violations must include: mandatory training of health personnel with certified evaluation of results; adoption of binding protocols with disciplinary sanctions for non-compliance; monitoring and oversight systems ensuring effective enforcement; legislative and administrative reforms eliminating unlawful requirements; massive rights dissemination campaigns, particularly targeting vulnerable populations[4].

Territories of Exception in Sexual and Reproductive Health

The systemic crisis manifests as "territories of exception in sexual and reproductive health"[5], characterized by subordination of SRR to armed conflict dynamics, territorial control, and illegal economies. Although rights formally remain constitutionally valid, they are practically suspended in specific zones of Norte de Santander. Constitutional guarantees exist on paper but not in reality, creating spaces where the State displaces its reproductive sovereignty toward non-state actors.

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[3] Economic Commission for Latin America and the Caribbean and Pan American Health Organization. (2024). *The urgency of investing in health systems in Latin America and the Caribbean to reduce inequality and achieve the Sustainable Development Goals.*

[4] Inter-American Court of Human Rights. (2022). *Case of Brítez Arce et al. v. Argentina. Judgment of November 16, 2022.*

[5] Concept adapted from Agamben (2004), who defines the "state of exception" as a situation in which the State suspends the normal legal order — ostensibly on a temporary basis — yet such suspension becomes a permanent mode of governance. In these contexts, the law is applied at the same time that it is annulled, creating zones in which legal guarantees formally exist but do not operate in practice.
Agamben, G. (2004). *Estado de excepción. Homo sacer II*, *1* (A. Gimeno Cuspinera, Trad.). Pre-Textos.

Feminist anthropologist Rita Laura Segato argues that in contexts of armed conflict and territorial dispute, women's bodies become territory itself: aggression against the body — sexual, physical, reproductive — expresses domination and sovereignty over a body-territory[6,7].

In Norte de Santander, this manifests specifically: "chulos"[8] exert sexual and reproductive control over women in sexual exploitation to demarcate territorial dominance; moreover, armed groups determine who may cross informal border paths ("trochas"), exercising sovereignty over bodies and mobility, thereby delimiting access to SRH services.

This territorial logic also operates in "private" and "institutional" spaces: partners subordinate reproductive decisions through violence; public hospital personnel improperly invoke conscientious objection, transforming state institutions into spaces of moral authority over women's bodies. In each case, sexual and reproductive control communicates and materializes domination over women's bodies and the territories they inhabit.

Identified Characteristics

Fragmentation of sovereignty: the State transfers control to non-state actors (armed groups, "chulos," and health personnel who engage in discriminatory practices). The public health system does not assume authority to determine who accesses Voluntary Termination of Pregnancy (VTP) or family planning services; instead, these agents make such determinations in specific sectors. This fragmentation reveals a territorial cession of reproductive sovereignty grounded in the domination exercised by various actors over women's bodies and decision-making.

Territorialization of control: Sexual and Reproductive Rights (SRR) vary according to location, creating differentiated geographies. In Cúcuta, differentiated control is exercised over informal border crossings ("trochas") — La Platanera, Las Pampas, El Centeno, Los Mangos — where armed groups determine who may cross to receive services, as well as in urban territories where different groups regulate zones of sexual exploitation. In Ocaña, restrictions linked to armed conflict in rural areas impede mobility toward health centers, alongside systematic institutional discrimination based on Venezuelan nationality and irregular migratory status. This demonstrates that the exercise of rights depends not on the constitutional framework, but on the distribution of power.

Normalization of rights violations: sexual and reproductive exception operates as an unofficial territorial norm. Rights violations are not perceived as systemic failures, but as part of ordinary functioning. Women develop survival strategies premised on the suspension of their rights: coordinating VTP procedures with menstrual cycles to conceal them from controlling partners, altering their appearance to cross informal border paths without being recognized by armed groups, paying unlawful fees assumed to be inevitable. These survival mechanisms reveal agency in contexts of total control, yet simultaneously normalize sexual and reproductive exception as a permanent condition.

Differentiated access through intersecting factors: specific intersections determine which rights are exercisable depending on territory and profile. The combination of migration, armed conflict, and rurality produces triple territorial exclusion (geographical, politico-legal, and security-based). The intersection of sexual exploitation, armed control, and impoverishment generates specific forms of reproductive subordination. The convergence of Venezuelan nationality, irregular migratory status, and age constitutes compounded discrimination that excludes women from the public system. Armed conflict acts as a multiplier of violations by restricting mobility, generating self-censorship among SRR defenders through threats, and fragmenting access to rights. Forced migration aggravates these violations: public-network health providers (IPS) deny services to migrant women or impose additional requirements due to their irregular migratory status[9].

These four characteristics document how the practical suspension of SRR operates in the municipalities of Cúcuta and Ocaña. The detailed findings presented in the following sections evidence the concrete manifestations of each characteristic through testimonies from community leaders, service users, and public officials.

Public Policy Implications

The combination of a systemic crisis in territories of sexual and reproductive exception requires recognizing that the problem does not lie in the limited implementation of existing policies; rather, it demands confronting the practical suspension of the constitutional order with respect to SRR. This entails:

1. **Profound structural reforms, not administrative adjustments.** It is necessary to transform the ordinary functioning of institutions that systematically violate rights, not merely to provide temporary humanitarian assistance or staff training without consequences for non-compliance.
2. **Design of territorially differentiated policies according to specific power dynamics.** Strategies must be developed acknowledging the domination exercised by multiple actors (state and non-state) over women's bodies and reproductive decisions. The real geographies of power (controlled informal crossings, zones of sexual exploitation, and rural areas with armed presence) determine territory- and population-specific interventions, rather than generic reforms that assume homogeneity.
3. **Confronting territorial control dynamics as a precondition for guaranteeing rights.** As long as armed groups determine access to services, as long as "chulos" decide on contraceptive methods for women in sexual exploitation, and as long as intimate partners exercise reproductive violence without consequences, health system reforms will be insufficient. Effective state presence, comprehensive protection for SRR defenders, and the design and dissemination of safe pathways to access rights are indispensable.
4. **Explicit recognition and operationalization of state responsibility.** The State is not a passive victim of conflict, but an agent that discriminates, omits its obligations, and tolerates violations. State officials acknowledge these violations yet systematically implement deficient responses, thereby configuring responsibility by action, omission, and tolerance — which requires effective sanctioning mechanisms and accountability frameworks.

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[6] Segato, R. L. (2014). Las nuevas formas de la guerra y el cuerpo de las mujeres. *Sociedade e Estado*, 29(*2*), 341-371.

[7] Segato, R. L. (2016). *La guerra contra las mujeres*. Traficantes de Sueños.

[8] "Chulos": local term used to refer to men who exercise total control over women in situations of sexual exploitation, including decisions concerning their sexual and reproductive health.

[9] La Mesa por la Vida y la Salud de las Mujeres (2019). *Migrantes venezolanas en Colombia: barreras de acceso a la Interrupción Voluntaria del Embarazo.*

1. CÚCUTA: Systemic Crisis Documented Through Community Leaders

1.1. Information Access Deficit as a Policy of Control

"There is a lot of lack of knowledge about sexual and reproductive rights, like about 60% of women." "I have to explain rights from scratch, especially when they are migrant women. They think that because they are migrants [in an irregular situation], they are not taken into account."

"Women are surprised about deciding not to have intimacy. They answer me: 'Oh, but if I don't want to and my partner does want to, I have to do it by force.'"

The above testimonies indicate the generalized lack of knowledge among women regarding SRHR and the specific lack of knowledge about sexual autonomy, which is not accidental but rather the result of the absence of state education on SRHR, affecting migrant women in a differentiated manner. They face additional exclusion due to their lack of knowledge of Colombia's specific legal frameworks and institutional discrimination that generates fear of accessing their rights.

Restrictions on access to information maintain subordination because they preserve the lack of knowledge about rights, facilitate violations by limiting the ability to claim them, and transform constitutional rights into institutional "favors."

Additionally, the women leaders indicated that there is an educational deficit in:

- Sexual autonomy: the right to decide when and how to have sexual relations without pressure.
- Voluntary termination of pregnancy (VTP): up to week 24 without the need for justification and applicability of the grounds after week 24.
- Free access: contraceptive methods at no cost.
- Reproductive autonomy: deciding how many children to have and when to have them.
- Non-discriminatory services: regardless of nationality or migration status.

1.2. Institutional Discrimination

"In health institutions, if migrant women do not bring identification documents or do not have EPS coverage, they are not even given guidance."

"Venezuelan women are told to go back to their country, that here in Colombia they have nothing to do. They feel discriminated against; that is why they do not access the health system. Besides being subjected to violence, getting a medical appointment is a terrible process."

Bureaucratic obstacles and discriminatory treatment marginalize women in situations of human mobility even from access to basic information about SRHR. In many cases, institutions condition guidance — a service that does not involve a medical procedure nor generate costs — on the presentation of identity documents or affiliation with an EPS. These practices also affect women with regular migration status, demonstrating that xenophobia constitutes a structural barrier within the sexual and reproductive health system.

Institutional xenophobic mistreatment goes beyond the specific denial of services and generates preventive self-exclusion. When health personnel explicitly tell migrant women *"to go back to their country,"* they not only deny a specific service: they communicate that their very presence is illegitimate within the Colombian health system. Women internalize this message and stop seeking care, anticipating rejection.

This forced renunciation constitutes one of the most invisibilized effects of institutional discrimination; rights violations do not appear in statistics because women do not even attempt to access services. Thus, the system succeeds in leaving them on the margins without formally rejecting each individual request, normalizing the absence of migrant women in sexual and reproductive health services.

The articulation of administrative barriers, verbal violence, and institutional xenophobia consolidates a structural exclusion that restricts effective access to free family planning, legal VTP, and comprehensive reproductive care. As a result, many women in situations of human mobility are exposed to the informal market without medical guidance, resort to risky or ineffective methods, face the commodification of their rights, and suffer serious health consequences or unwanted pregnancies without institutional alternatives for protection.

1.3. Access to VTP: Misinformation and Institutional Denial

Mass lack of knowledge of VTP[10] and the 2022 legal framework[11]

Desconocimiento masivo de la IVE[12] y el marco legal de 2022[13]

"About 80% or 90% have no knowledge of VTP."

"They do not know the legal framework. They arrive asking: 'I am four months pregnant, and I do not want my family to find out. I need a place to have an abortion.'"

"Girls and women are convinced that VTP is a crime."

"They thought that if they had a VTP they would go to prison."

Despite three years having passed since Judgment C-055 of 2022, which fully decriminalized VTP up to week 24, there remains a profound lack of knowledge about this right. Women continue to be unable to identify available care pathways or the institutions responsible for guaranteeing the

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[10] Colombian Constitutional Court. (2006). Judgment C-355 of 2006. *Partial decriminalization of abortion in Colombia.* Reporting Justices: Jaime Araújo Rentería and Clara Inés Vargas Hernández.

[11] Colombian Constitutional Court. (2022). Judgment C-055 of 2022. *Full decriminalization of voluntary termination of pregnancy up to 24 weeks of gestation*. Reporting Justices: Antonio José Lizarazo Ocampo and Alberto Rojas Ríos.

[12] Corte Constitucional de Colombia. (2006). Sentencia C-355 de 2006. *Despenalización parcial del aborto en Colombia*. M.P. Jaime Araújo Rentería y Clara Inés Vargas Hernández.

[13] Corte Constitucional de Colombia. (2022). Sentencia C-055 de 22. *Despenalización total de la interrupción voluntaria del embarazo hasta la semana 24 de gestación.* M.P. Antonio José Lizarazo Ocampo y Alberto Rojas Ríos.

procedure, and they maintain unfounded fear of criminal sanctions. The lack of accessible information in the territories consolidates a scenario of structural misinformation that inhibits the exercise of their rights.

Systematic institutional denial

"In the Nueva EPS entity, women have been told that VTP cannot be performed, that they must pay, and they do not have money."

"IMSALUD officials question the moral and mental capacity of the patient requesting VTP."

"Health personnel tell women about VTP: 'My God, that is homicide,' 'That is a living being,' 'Didn't you know you could go to jail?'"

The testimonies reveal a systematic practice of institutional denial of the right to VTP, which directly contradicts the current legal framework. Health entities resort to stigmatization, false legal threats, and moral or religious misinformation to discourage requests for the procedure. Additionally, the imposition of improper charges excludes those facing economic vulnerability, transforming a fundamental right into a privilege conditioned on ability to pay or institutional arbitrariness.

To this scenario are added structural barriers related to irregular migration status, lack of affiliation with the health system, improper use of conscientious objection, and unjustified delays in care, all of which have direct effects on women's reproductive autonomy and life projects:

"Not having Temporary Protection Permit nor EPS is the strongest barrier for migrant women."

"There are institutions and personnel who are conscientious objectors, and they say: How are you going to do that? How can you even think of it if it is a sin?"

"One woman was passed from doctor to doctor, until at eight months she went into labor. There are survivors of sexual violence who were forced by the health system to have the baby. Other women had to use traditional methods for VTP with risks to their health."

These accounts reveal a chain of barriers that restrict access to VTP, structured in two main filters. The first filter, based on massive misinformation about legality and care pathways, inhibits women from the outset. The second filter, grounded in institutional violence, is expressed through improper conscientious objection, delay, intimidation, false legal threats, and improper charges. Together, these mechanisms generate physical, emotional, and social harm, violate the State's duty to guarantee timely, safe, and free access to VTP, and reproduce inequalities of gender, class, and migration status.

1.4. Access to Contraceptive Methods: Misinformation, Shortages, and Commodification

Misinformation about constitutional free access

"Many women do not know about family planning methods nor that they can access them free of charge; that information does not reach them."

The lack of knowledge about the right to free contraception reflects an institutional information gap that enables its commodification. Without clear guidance to demand the free provision of contraceptive methods, women are forced to assume illegal charges that distort their nature as a fundamental right, subordinating it to ability to pay.

Shortages: limited supply as institutional control

"When health brigades are carried out, women are frequently told that there are no contraceptive pills available and that they only bring subdermal implants."

The shortage does not constitute an isolated technical failure but rather a form of institutional regulation of contraceptive supply. Institutions selectively offer long-acting implants while reporting scarcity of short-acting methods, such as contraceptive pills. This restriction of supply limits women's reproductive autonomy by reducing their options to a single method, regardless of their preferences, health conditions, or life contexts.

Documentary barriers to implant removal

"To remove the implant, even if it is expired, they ask for the card stating when and by whom it was inserted; most migrant women cannot keep those documents."

Arbitrary administrative requirements to remove contraceptive implants constitute barriers that restrict reproductive autonomy, when the woman's express will is sufficient without the need for justification or additional procedures. Requiring documentation regarding the prior insertion of the method turns a reversible procedure into a bureaucratic obstacle that disproportionately affects women in situations of human mobility who face precarious living conditions in which preserving documents is impossible.

Commodification of implant removal: autonomy conditioned on ability to pay

“In a large part of the organizations, they do not remove implants when the woman wishes; going elsewhere is not free. In Nueva EPS/Coosalud, to remove the subdermal device, they charge 180,000 pesos. In Profamilia, implant removal costs women 120,000 pesos.”

Charges for the removal of contraceptive implants transform reproductive autonomy into an economic privilege: women with resources can exercise their decision freely, while those who lack the ability to pay are forced to maintain the method against their will.

The convergence between institutional refusal and commodification of the service creates a structural trap: the public system refuses to perform removals and the private sector charges prohibitive amounts, leaving women without accessible alternatives to exercise effective control over their bodies.

The documented amounts constitute insurmountable economic barriers for women in vulnerable situations, forcing them to maintain contraceptive methods they wish to remove due to side effects, changes in their reproductive plans, or any other reason.

Triple systematic exclusion

The combination of misinformation (lack of knowledge about free access), shortages (supply limited to a single method), and commodification (charges for implant removal) sustains an institutional system of control over contraceptive autonomy that operates through multiple exclusions:

- Informational exclusion: without knowledge about free access, they cannot claim the right.
- Exclusion of choice: without a variety of methods, they cannot choose according to their needs.
- Economic exclusion: without ability to pay, they cannot remove unwanted methods.

This institutional framework deepens the subordination of reproductive decisions to administrative and economic logics, demonstrating that institutional violence also manifests in the management of contraception.

1.5. Male Sexual and Reproductive Control

Partner control

“They ask their partner about everything. They have to ask for authorization to get an implant inserted, to take contraceptive pills.”

“Seventy percent of the girls cannot give any opinion about the contraceptive method; it is their partners who decide.”

“For VTP they say: ‘Let me ask my husband if he wants to, if he gives me permission,’ out of fear of losing food, shelter, or what they are obtaining from their partner.”

Violence due to autonomy

“Partners want them to get the arm implant; if women do not agree, they are physically abused.”

“They are physically and psychologically abused for using family planning; they are told they are worthless, that without them they are nothing.”

Specific methods controlled

“Partners tell them to take pills, that the implant makes them ugly and that they do not like condoms.”

“They pressure them to use the Rhythm Method; they want to use pills, but their partner says no.”

Concealment of VTP

“She was seeking VTP because she already had five children and her partner would not allow her to be sterilized. She told me: ‘I am coming to have it done, but I have very little time before my husband finds out.’ She wanted it to coincide with her menstruation, because as soon as it stopped she had to have sexual relations with him.”

Between 50% and 70% of women cannot make autonomous sexual and reproductive decisions, according to consistent estimates from multiple women leaders. Male control includes which contraceptive method to use, when to have sexual relations, and the possibility of terminating pregnancies. Women develop extreme strategies (coordinating procedures with menstruation) to act on their own without being detected.

Control manifests through:

- Economic subordination instrumentalized through threats of loss of housing or food in response to attempts at sexual and reproductive autonomy.
- Physical violence as punishment for independent decisions.
- Specific methods controlled: pressure to use certain contraceptive methods versus rejection of others such as condoms.

1.6. Obstetric violence

Mistreatment as institutional policy

Verbatim statements by health personnel at Hospital Erasmo Meoz reported by women leaders:

- *“If they’re going to have a baby: ‘if you were tough enough to make it, be tough enough to give birth.’”*
- *“You weren’t screaming when you were making it.”*
- *“Who told you to spread your legs.”*

Violence against adolescents: “Oh, but she was so horny that she didn’t even wait until she turned 18. She has all that dirty, all that ugly, all that rotten.” – Medical personnel referring to a 15-year-old minor with HIV, according to the testimony of a woman leader.

The public Hospital Erasmo Meoz is identified by multiple women leaders as a center with systematic discriminatory practices, demonstrating that the violence is not individual but an institutional policy. Personnel use medical care to morally punish women for their sexual activity and reproductive

decisions. Adolescents and women with HIV receive the most violent treatment. One of the women leaders identified nursing staff as primarily responsible for perpetrating verbal violence.

1.7. Cession of Sexual and Reproductive Sovereignty to Armed Actors

Survival in fragmented territories

"If they want to access VTP, they have to risk crossing through the trocha. With the fear of not getting out of there."

"Several women I accompany are from municipalities affected by armed conflict; they are afraid to expose themselves in the street, there is a lot of femicide and they are in danger if they come to Cúcuta. I get them the pills and injections for family planning."

A territorial cession is evident, given that the State has delegated control over access to sexual and reproductive health services to armed groups and territorial actors.

1.8. Sexual Exploitation: Laboratory of Sexual and Reproductive Control

Sexual exploitation is any actual abuse or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes, including the economic, social, or political benefit derived from the sexual exploitation of another person[14]. In Colombia, national legislation defines sexual exploitation as any activity involving the exploitation of another person for sexual-erotic and commercial purposes, abusing their situation of vulnerability or through the use of force, threats, or any other coercive means[15].

In Norte de Santander, sexual exploitation operates as a laboratory with mechanisms of sexual and reproductive control that are later normalized in other contexts of women's subordination. Different patterns are revealed:

Pattern 1. Comprehensive control over sexual and reproductive decisions

"Some girls are with the so-called 'chulos,' who are those men who 'protect' them; they are the ones who decide on the contraceptive method they must use both in their relationship and with other men. This is constant pressure and full of violence."

Control is not limited to the relationship between the "chulo" and the woman but extends to all sexual encounters. The "chulos" determine not only which method to use but how it must be used in each sexual context, revealing total control over the woman's body and decisions.

Pattern 2. Violence as a system of sexual and reproductive subordination

"The 'chulos' maintain constant pressure full of violence that induces women into drug sales as a form of pressure."

The violence is framed within a system where sexual and reproductive control is articulated with economic control (drug sales), creating multiple dependencies that make autonomy impossible. Women become trapped in a network that punishes any attempt to resist sexual and reproductive control through violence that pushes them toward illegal economic activities, deepening their subordination.

Pattern 3. Sexual violence as mass disciplining

"There is a case of a girl who was with a man, and when the condom broke, the man cut open her belly with a knife."

Sexual and reproductive violence reaches severe levels to instill fear and discipline women in the territory. This case is not individual violence but a mechanism of social control: extreme brutality against one woman sends a message of terror to all others about the consequences of any "failure" in the sexual or reproductive sphere.

Pattern 4. The State as legitimizer of violence

"At the police station, at the CAI[16], they made fun of the women and told them that this was their job and that they had to do it. Many of them did not file complaints out of shame that they would be offended at the CAIs or wherever the authority was; they were being subjected to many institutional barriers."

The State acts by legitimizing rights violations, denying protection, and normalizing sexual exploitation as "work" that justifies sexual and reproductive violence.

Pattern 5. Survival versus rights

"How am I supposed to work those 15 days? If I undergo VTP, how do I survive during that rest period?" – Testimony regarding the impossibility of post-VTP rest for a client, as reported by a woman leader.

A structural trap is configured that turns the right to VTP into an inaccessible privilege, since its exercise requires rest that entails the loss of immediate means of subsistence. It is the most refined expression of rights denial: valid in law, but nullified by material conditions.

Pattern 6. Territorialization of sexual and reproductive control

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[14] United Nations. (2003). Secretary-General's Bulletin: Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13).

[15] Congress of the Republic of Colombia. Law 1336 of 2009. By which Law 679 of 2001 is supplemented and strengthened to combat exploitation, pornography, and sex tourism involving children and adolescents.

[16] CAI (Centro de Atención Inmediata) refers to small neighborhood police stations in Colombia designed to provide immediate response and basic public security services within specific local areas.

"There are different armed groups here and each one fights for its zone. For example, on 13th Street where the bars Bogotá, Cíndere are located, a group led by Carolito controls it; in Parque Mercedes there are three groups."

Specific territories of sexual exploitation identified:

- 13th Street: control by the "Carolito" group in the bars Bogotá and Cíndere.
- Parque Mercedes: division among three groups by blocks.
- Parque Antonio Santos, Parque Internacional: areas of women in situations of sexual exploitation.

In Cúcuta, different armed groups have established specific rules regarding access to sexual and reproductive health services according to the zone they control. This territorial division generates a fragmented landscape in which decisions about women's reproduction and sexuality vary according to geographic area. Each armed group imposes its own criteria and restrictions regarding the services women may receive in its territory, configuring a system where reproductive rights depend more on non-state local authority than on the national legal framework.

Pattern 7. Migration, exploitation, and armed control

Differentiated control through recognition

"It happens that if one of the guerrilla members there recognizes one of the girls from the bars, brothels, or those engaged in prostitution, that girl stays there. That day they try to pass wearing sweaters, without makeup, without visible tattoos in order to get through."

Specific trochas identified: "La Platanera, Las Pampas, El Centeno, and Los Mangos."

Armed groups have knowledge of women in situations of sexual exploitation and apply differentiated control, configuring a system in which sexual exploitation determines both territorial access and access to sexual and reproductive health services, including VTP and family planning.

Pattern 8. Strategies of resistance and survival

Women in situations of sexual exploitation develop mechanisms to attempt to exercise their SRHR, for example:

- Modification of appearance: avoiding makeup and hiding tattoos in order not to be recognized by armed groups when crossing trochas toward health services.
- Support networks: resorting to the intermediation of community women leaders, who facilitate access to contraceptive methods and VTP services.

These practices demonstrate women's agency and capacity for adaptation in the face of control regimes that severely restrict their autonomy. At the same time, they show the transfer of State responsibilities onto the women themselves, who are forced to assume risks and deploy individual or collective strategies to assert rights that should be institutionally safeguarded.

Public policy must document and understand these practices, not to normalize them, but in order to identify the structural violations that originate them and design effective protection mechanisms.

1.9. Threats against SRHR Defenders: Violence as a Silencing Mechanism

Systematic threats

"We cannot ignore that since last year leaders have received threats... I was threatened with having my house, which is made of 'tabla,' set on fire because of a case of a girl I reported and who was removed from her family nucleus because she was being abused."

Impact on defenders' work

"We have families and if something happens to us, they are the ones who suffer. Even so, I keep a low profile and not as openly as before."

Documented self-censorship

"We avoid those things because we also have families."

The threats constitute a mechanism of silencing that reduces the capacity to accompany sexual and reproductive rights cases, especially in cases of sexual violence against minors. The threats are effective: the women leaders limit their activism to protect their own families**.**

2. OCAÑA: Structural Patterns Revealed by Women Service Users and Triangulation

2.1. Institutionalized Misinformation: The First Filter of Control

The testimonies reveal systematic disinformation as an institutionalized practice. One hundred percent of the women users interviewed were unaware of legal frameworks and basic rights, confirming the estimates of the women leaders.

"I don't know how to tell you what they are, but I suppose the right to decide whether I want to have children."

"I didn't know that we have sexual rights and those reproductive rights in Colombia."

"I don't know any" [regarding SRHR].

Disinformation functions as a mechanism of control that keeps women in subordination: without knowledge of their rights, they cannot exercise autonomy over their sexual and reproductive decisions. This deficit is not accidental, but systematically produced through:

1. Absence of preventive education: none of the women received systematic comprehensive sexuality education.
2. Fragmented access during crises: they receive guidance only during medical emergencies or pregnancies.

3. Informal sources as the only alternative: most depend on rumors, the internet, or friends, without any state guarantee of complete and reliable technical information.
4. Geographic barriers in rural areas: distance and transportation costs to health centers limit participation in educational sessions and counseling consultations[17].

2.2. Institutional discrimination

Systematic confirmation of discrimination

"Because you are Venezuelan, sometimes people look at you badly, and when you go to a service at the hospital they immediately tell you no to everything."

"Here we don't have any rights, that's a lie."

The testimonies reveal the existence of a differentiated system of access to rights based on:

1. Status markers: nationality, documentation, and affiliation to the health system.
2. Anticipatory discrimination: women internalize denial as "normal."
3. Defensive self-exclusion: they avoid seeking services due to prior discriminatory experiences.

In Ocaña, discrimination manifests with less explicit verbal violence than in Cúcuta, but with more systematic bureaucratic barriers.

2.1.2. TVP: confirmation of the double mechanism of denial

Extreme disinformation confirmed:

- **100% of the women lack knowledge** of the 2022 legal framework (abortion legal up to week 24).
- **Genuine reaction of shock:** *"I didn't even know what that was."*

The testimonies confirm the operation of two consecutive filters documented by the women leaders:

First filter – Massive disinformation:

"I had no knowledge, I hadn't heard that it was allowed."

"I didn't know it was a right. I thought it was illegal or dangerous."

Second filter – Institutional barriers:

Although users do not report direct experiences of conscientious objection (due to prior lack of knowledge), they do document expectations of institutional denial based on previous discriminatory experiences in other services.

2.3. Intersectionality: migration, conflict, and rurality as triple territorial exclusion

The testimonies demonstrate a specific territorial intersectionality not documented in Cúcuta:

One of the interviewed users (rural woman, irregular migrant, and conflict victim) indicated the following regarding access to contraceptive methods:

- Transportation: COP 80,000 solely for family planning.
- Total time: 10 hours to access services.
- Risk due to armed conflict along rural routes.

Rurality is not only a geographic barrier but a multiplier of vulnerabilities characterized by:

1. Distance as an economic filter: prohibitive costs functioning as a class barrier.
2. Time as opportunity cost: a full day of informal work lost.
3. Security risk: presence of armed actors along transit routes.

2.4. Commodification aggravated by vulnerability

Documented costs

"I have always paid for the methods I use. For me, the greatest difficulty is the economic part and the treatment I receive for being Venezuelan, since they look at us and treat us with contempt."

Contraceptive method: COP 375,000 total (procedure COP 270,000 + consultation COP 60,000 + tests COP 15,000 + transportation COP 30,000).

These are private costs for a service that should be free in the public system. The user, a Venezuelan migrant with regular status, was excluded from the free public system and had to pay in the private sector to access the contraceptive method. This documents the commodification of family planning, where women are forced into the private sector due to discriminatory barriers.

Another user recounts recurrent economic exclusion: *"There was one time when I didn't have money to buy the injection,"* evidencing forced interruptions in contraception due to lack of economic resources. With monthly costs of COP 111,000 (COP 100,000 transportation + COP 11,000 supply), the contraceptive injection represents an unsustainable financial burden that generates cycles of reproductive unprotection. These financial interruptions significantly increase the risk of unplanned pregnancies.

[17] An interviewed rural woman stated that she needs 45 minutes just to reach the nearest health post, which turns mobility into a structural barrier to accessing timely and reliable information about her sexual and reproductive health and rights.

2.5. Violation of informed consent

"They didn't want to remove the implant because they said the side effects would pass with time."

"They didn't explain the side effects of the contraceptive well before I used it."

These testimonies evidence systematic violations of the right to informed consent through reproductive medical paternalism operating through three mechanisms:

Denial of autonomy: medical personnel make decisions about women's bodies without consulting them, substituting the user's will with professional criteria that prioritize continuity of the method over reported well-being.

Withholding of information: side effects of contraceptives are not explained, violating the right to make informed decisions about one's own body. Women discover the consequences after use has begun.

Coercive retention: refusal to remove contraceptive methods when the woman requests it, arguing that "the effects will pass" or that "she must wait longer," turning a reversible procedure into a prolonged imposition.

This dynamic constitutes a form of institutional control over women's bodies, where health personnel exercise authority over decisions that legally belong to the users.

2.6. Economic reproductive control

"The husband I had before wanted to get me pregnant again. I had no working conditions, and he threatened to leave me."

A specific form of control is exposed that exploits migratory vulnerability to exercise reproductive violence:

1. Threat of abandonment: especially devastating for migrant women without support networks.
2. Economic control: *"No working conditions"* as pressure to accept pregnancies.
3. Isolation: exploitation of migratory status to socially isolate.

While in Cúcuta control was documented through direct physical violence, in Ocaña economic-emotional control predominates, taking advantage of the structural vulnerability of migration.

2.7. Sexual violence and coercion in intimate partner contexts

"My partner used to assault me and forced me to be with him."

"At one point I had an aggressive partner who wanted to force me to do sexual things I did not want."

The testimonies refer to the naturalization of sexual and reproductive violence within intimate relationships:

Normalized sexual violence: the obligation to *"be with him"* assumed as part of the relationship.

Resistance as process: *"Before… now not anymore"* indicates the construction of agency over time.

2.7. Resistances and agency

Informational agency: autonomous pursuit of knowledge

"I have learned here in Colombia that as women we have rights."

"I know it and I enforce it because since I was very young I have not allowed anyone to use me."

Women develop self-education strategies that include:

1. Comparative learning: contrast between countries of origin and destination.
2. Construction of boundaries: progressive establishment of bodily autonomy.
3. Informal networks: exchange of knowledge among women outside institutional health and education channels.

Economic resistance

"When there is no family planning method available, you have to buy it at the pharmacy across the street."

Women develop economic survival strategies that, paradoxically, legitimize commodification while guaranteeing access: although they function as individual resistance to institutional barriers, they simultaneously validate the system that generates exclusion:

1. Payment as autonomy: avoiding dependence on discriminatory systems.
2. Parallel market: use of pharmacies to bypass institutional barriers.
3. Cost-benefit calculation: preferring payment over exposure to discrimination.

The State, by failing to uphold constitutional gratuity, pushes women to commodify their own rights in order to exercise them.

2.8. Emerging finding: Sexual division of reproductive labor

The reproductive burden falls disproportionately on women, who must assume the risks, costs, and side effects of contraception such as: *"A lot of dizziness, headaches, and I gained too much weight."* Men maintain minimal participation limited to occasional condom use *"when it does not bother them,"* and show explicit resistance to permanent methods: *"he refuses to have a vasectomy."* This dynamic perpetuates a cycle in which women must repeatedly undergo procedures, hormones, or devices to prevent pregnancies that biologically require the participation of both.

3. Institutional Perspective: Confirmation of Patterns and State Responsibility

3.1. Structural deficit in access to information

3.1.1. Institutional confirmation of the problem

"Promotional and dissemination actions have been carried out with high effectiveness, in coordination with women's social organizations."

"Direct information is provided through outpatient consultations, emergency room consultations, and health brigades, with broad coverage of the population and high effectiveness."

This statement evidences the gap between institutional discourse and the reality documented in the territory. While a health sector official reports *"high effectiveness"* in the dissemination of SRHR, triangulation with users and women leaders shows the opposite: 100% of the women interviewed were unaware of basic legal frameworks — including the decriminalization of abortion up to week 24 — and women leaders estimated that between 60% and 90% of the women they accompany are unaware of fundamental SRHR.

The institutional framework measures results based on activities carried out, not on knowledge acquired. This approach prevents recognition that informational actions are not reaching or being understood by women, especially those in situations of greater vulnerability — migrants, rural women, or those in contexts of sexual exploitation — thereby reproducing structural inequalities in access to information.

Another institutional testimony admits this ineffectiveness: *"The effectiveness of information on SRHR is very low, because full guarantees do not exist."* The coexistence of success narratives and admissions of failure within the system itself reflects a partial acknowledgment of State responsibility. Institutions comply with information protocols but fail to verify their impact, allowing disinformation to persist as a sustained mechanism of reproductive control.

3.2. Systematic discrimination

3.2.1. Explicit recognition of discrimination against migrant women

"Users report barriers related to nationality, since this area is highly frequented by Venezuelan women who do not have health affiliation and, in many cases, are not even regularized."

"In this institution, services are not provided to women who do not have EPS."

"Institutional measures are scarce, since health institutions are not providing services to migrant women."

These statements demonstrate that institutional personnel assume exclusion based on nationality and migratory status as part of the functioning of the health system. The denial of services to women without EPS affiliation is described as a regular practice, without questioning or intention of correction.

At the same time, it is acknowledged that institutional measures to address this situation are scarce, reflecting awareness of the systematic exclusion of migrant women, but also structural tolerance of its persistence. In this context, discrimination ceases to be perceived as a rights violation, confirming its normalization within the State apparatus.

3.2.2. Xenophobia as an institutional barrier

In relation to SRHR violations, explicit discrimination was documented through xenophobic expressions made by institutional personnel:

"Some officials still tend to say things like: 'Well, you should demand that here in this country,' 'You Venezuelans don't know,' 'You Venezuelans want everything for free.'"

Xenophobia operates as an institutional barrier that not only restricts access to services, but also humiliates and deters women in situations of human mobility from exercising their rights, constituting a form of institutional violence based on nationality and origin.

3.2.3. Absence of differentiated protocols

One official confirmed the lack of institutional mechanisms to guarantee non-discriminatory care: *"For migrant women, there are no differentiated care protocols; moreover, they do not have access to services because they do not have EPS."*

This statement reveals that exclusion does not result from implementation failures, but from a structural absence of institutional design: the system has not created specific pathways to guarantee the SRHR of women in situations of human mobility, thereby condemning them to systematic exclusion from access.

The findings described regarding institutional discrimination demonstrate that State responsibility operates at multiple levels:

1. Through direct action by institutional personnel who discriminate and engage in xenophobia.
2. Through omission, by failing to create differentiated protocols that guarantee access without discrimination.

3. Through institutional tolerance that recognizes insufficient measures for the exercise of SRHR but does not implement effective structural corrections.

The triangulation demonstrates that discrimination against women in situations of human mobility is not an isolated perception of users or community leaders, but a reality acknowledged by State officials themselves. It therefore constitutes an institutional structure of exclusion that systematically and deliberately reproduces violations of fundamental rights.

3.3. Barriers to Access to Contraception and Abortion, and the Commodification of Rights

3.3.1. Barriers to Access to Voluntary Termination of Pregnancy

3.1.1.1. Misinformation Regarding the Legal Framework

"Women arrive with incorrect information, believing they need special permits or that they can only access services in certain places."

Officials acknowledge that women arrive with misinformation about non-existent administrative requirements and false geographic restrictions on the service. This observation aligns with findings from community leaders, who report that most of the women they accompany are unaware of the 2022 legal framework that decriminalized abortion up to week 24 of pregnancy. Users in Ocaña confirmed the widespread nature of this misinformation and expressed genuine surprise, ranging from not knowing what VTP was to believing it was illegal.

Triangulation demonstrates that this misinformation forms part of an institutional pattern restricting access to sexual and reproductive rights: the belief in *"special permits"* discourages women from seeking care from the outset, while the notion that *"only certain places"* provide VTP conceals the legal obligation of all health institutions (IPS) to guarantee the service. Institutional acknowledgment of this lack of knowledge constitutes state responsibility by omission, as authorities allow the circulation of inaccurate information without implementing effective counter-strategies.

3.1.1.2. Administrative Barriers

"In some cases, women must present multiple documents and go through several processes before accessing services such as VTP, which delays or prevents access."

Institutional testimony reveals the imposition of administrative requirements that contradict national standards for sexual and reproductive health care, which guarantee immediate access without documentation beyond the user's expressed will. Triangulation shows that these barriers constitute persistent institutional practices known to health authorities. The expression *"delays or prevents access"* implicitly recognizes that such barriers result in denial of the constitutional right to VTP.

3.1.1.3. Technical Barriers as Institutional Exclusion

"Another significant barrier to VTP is administrative: the service is not enabled, and doctors cannot provide it because they must wait to be assigned a code in the system. Even if the doctor has no conscientious objection, they encounter this problem and tell the woman: 'Go buy this at the pharmacy.'"

"In institutions in Norte de Santander, it is common for the VTP service not to be created or enabled in internal administrative systems. This forces additional activation processes and procedures that delay care and, in some cases, lead users to abandon the request, disregarding that this is a health emergency."

A critical technical-administrative barrier emerges: several institutional systems do not have VTP enabled, preventing provision even when medical personnel do not object. This failure produces two consequences: first, delays caused by activation procedures that may render the procedure unviable; second, referrals to the private sector through instructions such as *"go buy this at the pharmacy,"* thereby commodifying a right that must be free within the public health system.

Community leaders and users confirm this forced commodification, reporting that women face denial in public hospitals and must turn to pharmacies or private clinics, where costs constitute exclusionary economic barriers. The combination of delays, administrative requirements, and financial costs leads to abandonment of the procedure or recourse to unsafe alternatives, exposing women to serious health risks. Forced pregnancies resulting from these structural failures are then falsely framed as individual *"decisions."*

Triangulation reveals direct state responsibility: maintaining systems without enabling VTP services years after Constitutional Court Ruling C-055 of 2022 constitutes not a technical omission but institutional denial through administrative obstacles.

3.1.1.4. Restricted Geographic Availability

"In the municipality of Pamplona, which hosts a significant student population, VTP services are not offered. Users must be redirected to cities such as Cúcuta or Bucaramanga. This represents a significant barrier and a violation of the full exercise of sexual and reproductive rights."

Institutional recognition that entire municipalities lack VTP services confirms systematic territorial exclusion. The obligation to *"redirect to Cúcuta or Bucaramanga"* constitutes a considerable barrier, particularly for rural women, economically constrained students, and women in vulnerable situations, transferring to them the costs and consequences of institutional non-compliance.

3.1.1.5. Institutional Delay

"In some cases, institutions have refused to handle cases, generating delays in guaranteeing VTP. The lack of personnel willing or enabled to corroborate clinical diagnoses—especially in cases involving risk to the woman's life or health—forces second evaluations to continue the process. On one occasion, three doctors refused to perform the procedure, generating delay and affecting timely access."

Institutional testimony documents explicit denial *("have refused")* and delay through unnecessary second evaluations. Community leaders report the extreme outcome of such delay: women subjected to multiple evaluations *"from doctor to doctor until, at eight months, labor pains began,"* demonstrating that delay is not administrative inefficiency but effective denial resulting in forced pregnancies.

The specific case of *"three doctors refusing"* within the same institution confirms what leaders describe as institutional objection: when multiple professionals in a single establishment simultaneously deny the service, the objection ceases to be individual and becomes an unwritten institutional policy.

The reference to *"lack of personnel willing or enabled"* reveals two structural issues: first, insufficient trained personnel—an issue that should have been resolved since 2006 (Ruling C-355) and even more urgently since 2022 (Ruling C-055); second, the absence of institutional guarantees allowing personnel to provide services without administrative barriers or pressure from objecting colleagues.

3.1.1.6. Institutional Denial of VTP and Conscientious Objection as Primary Barriers

Institutional Denial of the Right to VTP

"Some low-complexity health institutions refuse to provide pharmacological VTP after week 12."
"I know that health insurance entities (EPS) and health providers generally refuse to perform VTP."

Officials document that institutions—not only individual professionals—deny VTP services. Statements such as *"IPS refuse"* and *"EPS refuse"* demonstrate institutional rejection of a constitutional right that cannot be legally justified, as institutions are obligated to guarantee the service regardless of individual objections.

Community leaders confirm this institutional denial, reporting that entire public hospitals systematically reject VTP requests. Arbitrary gestational limits do not correspond to clinical criteria but operate as administrative exclusion barriers.

Conscientious Objection

"The main barrier to VTP is conscientious objection."

"They faced difficulties with the E.S.E. Hospital Universitario Erasmo Meoz regarding conscientious objection by medical staff."

Officials identify conscientious objection as *"the main barrier"* to accessing VTP in Norte de Santander, including in public reference hospitals. Leaders confirm that medical personnel invoke conscientious objection while simultaneously subjecting women to verbal mistreatment, questioning their *"moral and mental capacity,"* and threatening them with false legal consequences.

Although conscientious objection is constitutionally protected for health professionals, in practice it is exercised without the safeguards established by jurisprudence: it must be individual (not institutional), declared in advance (not at the time of request), and institutions must ensure immediate access through alternative personnel. Instead, objection is used to deny service across entire facilities, transforming an individual right into a mechanism of institutional exclusion.

Combination of Institutional Denial and Conscientious Objection

Triangulation confirms that the combination of institutional denial and conscientious objection produces significant delays and forces women to seek other providers without guarantee of access. Leaders document the consequences: women pushed toward private alternatives bearing prohibitive costs, others compelled to resort to unsafe methods, and extreme cases of delay until childbirth, resulting in forced pregnancies. Effective access to VTP thus depends on women's economic capacity or exposes them to life-threatening risks.

Institutional acknowledgment of these barriers without effective corrective mechanisms constitutes state tolerance of systematic violation of the right to VTP. Authorities are aware that entire institutions deny services and that conscientious objection operates as the primary barrier, yet this denial persists years after Ruling C-055 (2022), evidencing normalization of practices that disregard legal and clinical standards.

Critical Convergence: Known and Tolerated Systematic Denial

Triangulation confirms that denial of VTP operates as an institutional obstruction mechanism through:

1. **Widespread misinformation** deterring requests (confirmed by all three sources).
2. **Administrative barriers** delaying or preventing access (confirmed by officials and leaders).
3. **Non-enabled systems** preventing service provision even without objection (confirmed by officials).
4. **Geographic exclusion** of entire municipalities (confirmed by officials and users).
5. Delays through multiple evaluations resulting in forced pregnancies (confirmed by officials and leaders).
6. **Institutionalized conscientious objection** as the primary barrier (confirmed by all three sources).
7. **Forced commodification** through referrals to the private sector (confirmed by officials and leaders).

3.3.2. Access Barriers to Family Planning

Institutional confirmation of multiple barriers

"In hospitals, women face various barriers to accessing family planning, ranging from socioeconomic and geographic factors to cultural and personal barriers, including lack of information and stigma for being migrant women."

"Distance to health centers and lack of public transportation hinder access to family planning, especially for women in rural areas."

"Other barriers to family planning include social stigma associated with contraception, lack of knowledge about available methods, and misconceptions about them."

3.3.2.1. Misinformation about contraception

From the institutional perspective, *"lack of knowledge about available methods"* is identified as a significant barrier. Cases of serious misinformation are even documented, exposing women to unintended pregnancies: *"While conducting workshops, we noticed that in some cases participants mentioned that acetaminophen worked as the morning-after pill."*

These findings fully coincide with reports from community leaders, who state that many of the women they accompany lack basic information about contraceptive methods and their gratuity within the public health system. Users interviewed in Ocaña confirm the magnitude of this problem: most were unaware of their sexual and reproductive rights when arriving at FMF services.

Triangulation shows that lack of knowledge regarding contraception constitutes a structural barrier associated with the absence of effective sexual education policies and the lack of clear information from health institutions. Thus, state omission in disseminating accurate information operates as a form of silent exclusion that restricts the autonomous exercise of reproductive rights.

3.3.2.2. Geographic and economic barriers for rural women

Institutions acknowledge that *"distance to health centers and lack of public transportation hinder access, especially for women in rural areas."* A rural user in Ocaña quantified this barrier precisely: she reported transportation costs of COP 80,000 merely to access family planning services on one occasion, with a total of 10 hours invested. Recurring monthly costs generate forced interruptions in contraception due to economic constraints.

The convergence between the institutional observation and users' lived experiences confirms that geographic barriers constitute structural economic exclusion that penalizes rurality in access to contraception.

3.3.2.3. Discrimination against migrant women

Officials identify *"stigma for being migrant women"* as an access barrier. Community leaders confirm this discrimination, reporting that health institutions deny even basic guidance to women without documentation or affiliation with a health insurance entity (EPS). Users in situations of human mobility validate this discrimination through direct experience, reporting systematic denial of services and explicit mistreatment based on nationality, forcing them to pay in the private sector for services that constitutionally must be free.

All three sources agree that nationality and irregular migratory status function as exclusionary barriers within the public contraception system.

3.3.2.4. Commodification: convergence across the three sources with a specific case documented

Officials generically mention *"socioeconomic factors"* without specifying illegal charges. However, in another institutional testimony, the problem is explicitly acknowledged. One official reported the case of a woman who stated: *"Look, I need to have my implant removed, but they told me I had to pay because I am not affiliated with the health system."* The testimony specified that international cooperation programs had inserted contraceptive implants for numerous migrant women, but many were left without affiliation to the health system and later faced charges for removal.

This institutional acknowledgment coincides with documentation from community leaders, who report specific charges ranging between COP 120,000 and COP 180,000 for removal of contraceptive implants in Nueva EPS/Coosalud and Profamilia. Users confirm systematic commodification: they report costs exceeding COP 300,000 for family planning procedures that constitutionally must be free within the public system.

Triangulation confirms a critical pattern: women—especially those in situations of human mobility—receive contraceptive implants as part of cooperation programs, but are later charged for removal when they seek to exercise their right to method reversibility. This practice transforms initial *"free"* contraception into an economic trap that subordinates reproductive autonomy to ability to pay, disproportionately affecting migrant women without health system affiliation.

Institutional acknowledgment of this specific case validates what leaders and users document as a systematic practice: ability to pay determines effective access not only to initial contraception but also to the exercise of the right to remove unwanted methods.

3.3.2.5. Strategic stock shortages: pattern not institutionally recognized

Officials do not mention stock shortages as an access barrier. However, community leaders systematically report limited supply during health brigades, where women are told that *"there are no contraceptive pills"* and only subdermal implants are offered. This restriction of options limits women's autonomy by reducing available contraception to a single long-acting method.

The absence of this issue in institutional testimony, despite consistent documentation by leaders, suggests that officials recognize only certain barriers while rendering invisible those that imply direct responsibility for inventory management and service provision.

3.3.2.6. Administrative and documentary barriers: gap between sources

Officials do not mention specific documentary requirements as a barrier. Community leaders, however, document that institutions require *"the card stating when and who inserted"* the contraceptive implant as a prerequisite for removal, turning a reversible procedure into a bureaucratic obstacle that disproportionately affects women in situations of human mobility.

This divergence indicates that officials may not be identifying all administrative barriers operating in institutional practice.

3.4. Sexual and Reproductive Violence

3.4.1. Partner control over sexual and reproductive decisions

"Sometimes, when accessing sexual and reproductive health services, women are told they are referred to a nearby municipality, but they cannot go or must do so secretly because their partner interferes."

"Many women cannot use family planning because their partners do not allow them."

"One obstacle to contraception is partner opposition."

Institutional testimonies reveal partner control as a persistent form of violence that reaffirms male dominance over women's bodies, sexuality, and reproductive decisions, preventing them from fully exercising their sexual and reproductive rights.

Community leaders confirm this pattern and describe multiple forms of male coercion: requiring permission to use contraception, imposing specific contraceptive methods, and prohibiting access to VTP. This control operates through physical violence when women attempt to exercise autonomy, psychological violence that erodes self-esteem, and economic threats such as loss of housing or food.

Faced with the inability to decide autonomously about family planning or VTP, some women are forced to conceal procedures out of fear of retaliation. One case documented by a community leader describes a woman with five children whose partner had forbidden her from accessing a permanent contraceptive method; she had to coordinate the VTP to coincide with her menstruation to avoid being discovered.

Users report partner control exercised through economic and sexual violence, including threats of abandonment or withdrawal of financial support to force pregnancies, as well as sexual coercion within intimate relationships. In this way, male reproductive control becomes consolidated as a structural mechanism of subordination.

Triangulation allows identification of partner control not merely as an *"access barrier,"* but as a systematic form of sexual and reproductive violence combining physical, economic, psychological, and sexual coercion. This pattern requires institutional responses that strengthen detection, care, and protection mechanisms within sexual and reproductive health services to ensure effective reproductive autonomy.

3.4.2. Sexual division of reproductive labor as a form of control

The institutional perspective explicitly acknowledges gender inequality in contraception and its articulation with male reproductive control:

"Our contraceptives are hormonal; there are women whose bodies do not respond well to hormonal methods. Their bodies do not tolerate them, but they use them because their partner believes condoms reduce sensation, may break, or are too tight."

"Several migrant women cannot use family planning because their partners do not allow them; these men do not want to use condoms."

"In workshops, various myths were identified regarding condom use and the wrongly assigned responsibility placed on women for family planning."

Users and community leaders validate this disproportionate reproductive burden: women are pressured to use contraceptive methods that cause adverse side effects or prevented from accessing any method, while their partners refuse condom use and reject vasectomy, deciding which methods women must use and privileging those that do not affect male sexual experience.

Triangulation confirms that contraception operates as an exclusively female responsibility imposed through male control, with women assuming all physical risks, economic costs, and side effects, while men retain decision-making power without reproductive consequences.

This asymmetry not only reflects patriarchal practices in intimate relationships but is institutionally consolidated: the health system naturalizes reproductive responsibility by centering its supply on female-directed methods and failing to promote male co-responsibility. Public policies thus reproduce gender inequality in contraception, reinforcing a model of reproductive control grounded in women's bodies.

3.4.3. Reproductive medical paternalism

Community leaders and service users report that medical personnel refuse to remove contraceptive implants upon request, sometimes arguing that side effects will disappear or that women must wait longer. Users also state they do not receive sufficient information about side effects. One official confirmed this practice:

"With removal of subdermal implants, we must thoroughly inquire why the user wants it removed; often it is due to spotting. They had not understood that this was a side effect. Ideally, it should not be removed, but rather treatment should be provided to determine whether removal is truly justified."

This institutional testimony highlights medical paternalism as a form of institutional control: health personnel condition removal of the implant on professional evaluation, nullifying women's decision-making capacity and disregarding that contraceptive methods are reversible upon user request, without additional justifications or requirements. Imposing medical criteria over women's reproductive will constitutes a violation of informed consent and reproduces unequal power relations in healthcare.

3.4.4. Institutional violence during VTP requests: violence not recognized

Officials acknowledge denial of access to VTP and conscientious objection as primary barriers, mentioning specific cases in which *"three doctors refused to perform the procedure"* and stating that *"IPS refuse to provide the service."* However, institutional testimonies do not mention the verbal mistreatment, moral judgment, or false legal threats that systematically accompany these denials.

Community leaders reveal that health personnel exercise active forms of institutional violence during VTP requests: telling women they are committing homicide, threatening them with non-existent criminal consequences, and publicly questioning their moral and mental capacity. This verbal abuse is repeated in public institutions and operates as a deterrent mechanism, leading to abandonment of requests due to humiliation and fear.

The gap between institutional acknowledgment of service denial and the absence of reference to accompanying mistreatment demonstrates that officials perceive conscientious objection as an administrative procedure, without recognizing the psychological violence inflicted during the process. This omission reflects state tolerance of institutional abuse, constituting a direct form of reproductive violence.

3.4.5. Obstetric violence: pattern not institutionally recognized

Officials make no reference to obstetric violence in their testimonies on sexual and reproductive health services. This omission contrasts with reports from community leaders, who describe repeated verbal mistreatment during childbirth care at the Hospital Erasmo Meoz, the main public institution in the department.

Leaders recount statements by medical personnel during labor associating pain with punishment for sexuality, blaming women for becoming pregnant, and using language that dehumanizes the reproductive process. They also document specific obstetric violence against adolescents, including the case of a 15-year-old girl living with HIV who was publicly humiliated by medical staff regarding her sexuality and health status, with degrading references to her body.

The complete absence of recognition of these practices by officials, despite repeated documentation by leaders, reveals a critical gap. Institutional actors fail to identify as violence behaviors that constitute professional mistreatment in reproductive contexts, demonstrating normalization of obstetric violence within health services. This invisibilization prevents detection, sanction, and prevention, perpetuating a model of care that violates women's dignity and reproductive rights.

3.4.6. Forced pregnancies as a result of institutional violence

Officials acknowledge delays in guaranteeing the right to VTP, citing cases where several doctors refused to perform the procedure and admitting that these barriers *"delay or prevent access."* However, they omit the extreme outcome of such delays: forced pregnancies resulting from continued denial of services.

Community leaders document situations in which women are repeatedly referred among professionals or subjected to unnecessary evaluations until gestation advances to the point where termination becomes impossible, transforming administrative delay into imposed motherhood. They report cases of survivors of sexual violence forced to continue pregnancies due to repeated refusal by the health system to guarantee VTP. They also document that some women, unable to access services, resort to unsafe and traditional methods, risking their health and lives.

Triangulation shows that what officials describe as *"delays"* or *"access barriers"* translates, in its gravest expression, into forced pregnancies and childbirth. Institutional conscientious objection, multiple evaluations, and total absence of service provision in entire municipalities are not mere administrative failures, but forms of reproductive violence that compel women to carry pregnancies against their will or push them toward unsafe practices.

Partial acknowledgment of barriers without naming their culmination in forced pregnancies invisibilizes one of the most severe expressions of reproductive violence: the obligation to gestate and give birth imposed through systematic denial of legal services, constituting direct state responsibility for failure to uphold constitutional guarantees.

3.4.7. Violence in contexts of armed conflict and sexual exploitation: partial recognition with critical omissions

"Women may be subjected to threats, sexual violence, and forced displacement, leading to unwanted pregnancies, unsafe abortions, and health complications."

"We have known cases in which recruited women were forced to use contraceptive methods or access voluntary termination of pregnancy (VTP), violating their autonomy and decision-making."

Officials explicitly acknowledge sexual and reproductive violence in contexts of armed conflict: threats, sexual violence, and forced displacement exposing women to unwanted pregnancies and unsafe abortions, as well as cases of recruited women forced to use contraception or undergo forced VTP. This institutional admission represents a significant step in recognizing reproductive violence in conflict settings.

However, institutional characterization is limited to enumerating these forms of violence without analyzing specific mechanisms of reproductive control exercised by armed actors or examining the extreme abuses documented by community leaders.

Community leaders report total control over contraceptive decisions exercised by figures known as *"chulos"* in contexts of sexual exploitation, through constant pressure and physical violence to impose which methods women must use, both in intimate relationships and situations of forced prostitution. They also document extreme sexual violence, including the case of a woman whose abdomen was cut with a knife when a condom broke during a sexual encounter.

Partial convergence between officials and leaders confirms recognition of sexual violence, forced pregnancies, and coerced abortions in armed conflict contexts. However, a critical divergence exists regarding state responsibility: while officials describe these abuses as perpetrated by illegal armed groups,

leaders document that some state agents, including members of the police, legitimized violence in contexts of sexual exploitation by telling women *"that was their job"* and trivializing complaints. This response not only omits protection but actively validates sexual violence as normalized exploitation.

Triangulation demonstrates that although institutions acknowledge severe sexual and reproductive violence in conflict contexts, public recognition remains limited to describing the problem without referencing care pathways, differentiated protection measures, or strategies to guarantee sexual and reproductive rights in territories under armed control.

This omission shows that acknowledgment of the problem coexists with absence of effective state response: officials know that women are threatened, sexually assaulted, forcibly displaced, and compelled to use contraception or undergo abortion by armed groups, yet this information does not translate into concrete institutional action or protective protocols. As a result, women in the most vulnerable situations in Norte de Santander remain unprotected.

3.5. Territorial Fragmentation of Sovereignty

3.5.1. Territorial Control over Information and Mobility

"In territories such as Catatumbo, where illegal armed groups are present, there are serious difficulties in speaking openly about sexual and reproductive rights."

"The presence of armed actors and antipersonnel mines generates fear and hinders women's movement to health centers, preventing their access to services, especially in rural areas."

The institutional perspective refers to the cession of sovereignty in territories with the presence of illegal armed groups that regulate what information circulates and which rights can be exercised. The recognized impossibility of *"speaking openly"* about SRHR in Catatumbo reveals a direct restriction of freedoms outside the institutional framework. Antipersonnel mines turn movement toward sexual and reproductive health services into a life-threatening risk for the civilian population.

Community leaders expand this characterization by noting that armed groups prevent community dialogue about SRHR and carry out systematic intimidation, forcing them to reduce their participation or abandon their accompaniment work. Additionally, they warn that many women cannot travel to Cúcuta or circulate through certain areas to access sexual and reproductive health services due to threats and risk of femicide. In response to these obstacles, community leaders facilitate information and contraceptive methods (pills and injections) for women who cannot move without exposing themselves to violence.

Triangulation shows that territorial fragmentation operates through armed control that simultaneously restricts mobility, circulation of information, and the exercise of rights: women lack real possibilities to access services or receive guidance about their rights within their own communities.

3.5.2. Territorial control in contexts of sexual exploitation

Public officials do not refer to territorial fragmentation in urban spaces nor to control over SRHR in areas of sexual exploitation. This omission contrasts with the accounts provided by women leaders, who describe forms of local domination linked to sexual exploitation.

The women leaders indicated that figures known as "chulos" exercise power over entire neighborhoods in Cúcuta, conditioning the reproductive decisions of women in situations of sexual exploitation. These actors determine which contraceptive methods women must use through coercion and the use of physical violence. Such territorial control develops in urban areas where the State has formal presence but does not exercise effective authority to protect women's rights.

Additionally, the women leaders reported that some state agents, such as members of the police, legitimized these forms of violence and minimized complaints. This response not only omits protection but also strengthens the control of the "chulos" over women's bodies and reproductive decisions.

The discrepancy between institutional silence regarding urban territorial fragmentation and the consistent testimonies of the women leaders indicates that public officials recognize the cession of sovereignty only in rural contexts, ignoring its presence in urban environments of sexual exploitation. This omission reflects state abandonment of women subjected to non-armed, yet equally coercive, forms of control that maintain dominance over their reproduction without state intervention or protection.

3.5.3. Systematic territorial discrimination and absence of alternative guarantees

"The most vulnerable territories are remote rural areas due to the lack of infrastructure, transportation, and health personnel, combined with the presence of armed actors."

Institutions acknowledge that the most vulnerable territories combine the absence of state infrastructure with the presence of armed actors. Women leaders explain that this combination generates structural territorial discrimination: women in areas under control face multiple denials of rights based on their place of residence.

While in Cúcuta women confront administrative barriers and institutional discrimination, in Catatumbo or in urban zones of sexual exploitation they additionally endure direct control over their bodies and reproductive decisions, facing the risk of extreme violence or femicide if they attempt to exercise their rights.

Triangulation confirms that institutional recognition of this fragmentation does not translate into effective state strategies. Public officials acknowledge that women cannot speak openly about SRHR, cannot travel to services, and live under armed control, yet they do not specify differentiated pathways, state-protected health brigades, nor mechanisms to guarantee access to contraception and abortion services without requiring dangerous displacement.

In the absence of such measures, women leaders assume risks vis-à-vis armed actors so that women may access contraceptive methods, thereby substituting state functions intended to guarantee SRHR. This convergence evidences abandonment of constitutional responsibilities, as the State recognizes its inability to operate in certain territories but fails to implement alternatives, delegating service provision to community organizations.

The recognition of fragmentation without implementing corrective measures constitutes institutional tolerance of the cession of sovereignty in matters of SRHR. Women in Catatumbo, as well as those living in urban zones of sexual exploitation or in areas affected by antipersonnel mines, remain subjected to the control of non-state actors. This demonstrates that in certain territories constitutional rights are not fully applied and that the reproductive autonomy of specific groups is subordinated to illegal powers without state protection.

Documented State Responsibility

By action:

- Discrimination: open denial of services based on nationality, irregular migration status, and lack of health insurance (EPS).
- Institutionalized xenophobia: discriminatory expressions by staff against Venezuelan women.
- Tolerated institutional objection: allowing public hospitals to deny abortion services.
- Administrative barriers: systems not enabled years after Constitutional Judgment C-055/2022.
- Commodification: illegal charges for services that are constitutionally free and referral to the private sector.
- Medical paternalism: denial of removal of contraceptive implants disregarding women's will.
- Institutionalized delay: multiple assessments for abortion services resulting in forced pregnancies.

By omission:

- Lack of oversight: failure to monitor compliance with constitutional gratuity or sanction denial of services.
- Lack of training: staff without education in SRHR and current legal frameworks.
- Absence of protocols: failure to create effective protection mechanisms for women without health insurance, survivors of intimate partner violence, or women in conflict zones.
- Tolerated misinformation: allowing circulation of inaccurate information without corrective strategies.
- Absence of alternative guarantees: recognizing territorial fragmentation without implementing protected brigades or differentiated alternatives.

By institutional tolerance:

- Known male control: acknowledging that women need partner authorization to access SRHR without deploying effective protection.
- Permitted institutional violence: tolerating verbal abuse during abortion requests and obstetric violence in public hospitals.
- Accepted territorial fragmentation: failing to guarantee reproductive sovereignty in areas under armed control or in contexts of sexual exploitation.
- Invisibilized forced pregnancies: characterizing delay as "procedural setbacks" without acknowledging that they result in forced pregnancies.
- Normalization of violence: failing to recognize medical paternalism, obstetric violence, and mistreatment during abortion services as forms of reproductive violence.

Conclusions: In Norte de Santander, territories of sexual and reproductive exception are configured

The five identified patterns operate jointly as an architecture of reproductive control: massive misinformation prevents women from knowing their SRHR, which the health system subsequently denies through administrative barriers and discrimination, while normalized violence punishes attempts to exercise autonomy, all within territories where fragmentation of sovereignty ensures that these violations operate without consequences. This convergence reveals that violations of SRHR in Norte de Santander are not implementation failures but rather an institutional design marked by deliberate tolerance.

Triangulation confirms a critical finding: the State is aware of every documented barrier. Public officials can precisely enumerate massive misinformation, discrimination based on nationality, institutional denial of abortion services, illegal charges for free services, partner control impeding autonomy, medical paternalism denying method reversibility, delays resulting in forced pregnancies, and the cession of sovereignty in conflict territories.

However, this institutional recognition does not translate into effective oversight, sanctions, differentiated protocols, alternative guarantees, or corrective measures. When the State knows exactly how exclusion operates but allows it to persist years after constitutional rulings that decriminalized abortion and guaranteed reproductive rights, omission becomes action through inaction. This deliberate tolerance maintains reproductive subordination as a tacit policy.

The findings reveal hierarchies of reproductive citizenship in which constitutional rights operate selectively: Venezuelan women without health insurance, rural women without economic access to transportation, women under control of violent partners who demand authorization for contraception, women in armed conflict zones where non-state actors control information and mobility, and women in sexual exploitation under the dominance of "chulos" remain systematically outside the reach of fundamental guarantees.

This differentiated exclusion reveals that, for the Colombian State in the department of Norte de Santander, there exist disposable populations whose reproductive autonomy may be subordinated to non-state actors, economic capacity, male authorization, and armed control without constituting an institutional emergency requiring response. The result is the configuration of territories of exception in sexual and reproductive health: spaces where the exercise of fundamental rights is conditioned by conflict dynamics, territorial control, and illegal economies, evidencing state cession to the detriment of women in the most vulnerable situations.

Such a structure of exclusion contradicts the constitutional obligations of the Colombian State to guarantee real and effective equality and violates international human rights commitments regarding women's rights.

The recognition of a critical situation in SRHR responds to the existence of systematic, known, and tolerated violations that configure direct state responsibility by action, omission, and institutional tolerance. Norte de Santander functions as a laboratory of reproductive impunity in which the institutional dismantling of fundamental rights is precisely documented without consequences, establishing a dangerous precedent: formal recognition of rights may coexist indefinitely with their material denial, and certain populations may remain constitutionally excluded from the exercise of reproductive autonomy without the State considering intervention necessary.

Public Policy Implications

The findings justify recognizing a critical situation in SRHR in Norte de Santander, which requires immediate interventions, structural reforms, and long-term transformations to restore constitutional guarantees.

Immediate Interventions:

- Institutional investigation at Hospital Erasmo Meoz regarding systematic obstetric violence and improper use of conscientious objection in abortion services.
- Mandatory external oversight of compliance with constitutional gratuity through random audits and sanctions for illegal charges.
- Activation of abortion services in the administrative systems of all health service providers (IPS), with guaranteed immediate referral to the appropriate level of complexity when the institution cannot directly provide the service.
- Specific protection measures for SRHR defenders who have received threats and who are substituting state functions, especially in armed conflict zones.
- Differentiated strategies to guarantee SRHR in territories under armed control along identified informal border crossings (trochas), urban zones of sexual exploitation, and Catatumbo.
- Reporting hotline with prioritization of urgent cases and follow-up mechanisms for denial of services, illegal charges, and institutional violence.

Structural Reforms:

- Mandatory training for healthcare personnel on SRHR, the current legal framework, informed consent, and reproductive violence.
- Binding protocols with accountability for violations that guarantee care for women without health insurance (EPS), reversibility of contraceptive methods without medical justification, and abortion services as an emergency.
- Independent citizen monitoring system separate from the State, with participation of women's organizations.
- Mandatory differentiated protocols for women in human mobility, rural women, women in situations of sexual exploitation, and women in territories under armed control.
- Elimination of medical paternalism through removal of contraceptive methods upon the user's request, without additional requirements.
- Specific territorial strategies for informal crossings (trochas) and armed control zones, including protected brigades and direct provision of contraceptive methods.
- Measurement based on verifiable outcomes through population surveys assessing acquired knowledge and effective access, not merely activities carried out.

Long-term Transformations:

- Mandatory comprehensive sexuality education at all educational levels, including information on abortion decriminalization, gratuity of services, and reproductive autonomy.
- Effective state presence in territories controlled by armed actors, guaranteeing reproductive sovereignty.
- Comprehensive protection policy for women in situations of sexual exploitation that acknowledges urban territorial control and police legitimation of violence.
- Guarantees of access to sexual and reproductive health services without discrimination based on nationality, migration status, or lack of health insurance (EPS).
- Visibility and eradication of institutionally normalized violence: verbal abuse during abortion requests, obstetric violence, and forced pregnancies recognized as forms of reproductive violence.
- Detection and protection mechanisms addressing gender-based violence perpetrated by intimate partners to ensure the full enjoyment of SRHR.

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