

Abortion as a human right: The struggle to implement the abortion law in Colombia

Bianca M. Stifani^{1,*} | Laura Gil Urbano² | Ana Cristina Gonzalez Velez^{3,4,5} |
Cristina Villarreal Velásquez⁶

¹Department of Obstetrics, Gynecology and Women's Health, Albert Einstein College of Medicine/Montefiore Medical Center, New York, NY, USA

²Fundación ESAR, Bogotá, Colombia

³Grupo Médico por el Derecho a Decidir en Colombia, Bogotá, Colombia

⁴La Mesa por la Vida y la Salud de las Mujeres, Bogotá, Colombia

⁵Global Doctors for Choice, New York, NY, USA

⁶Fundación Oriéntame, Bogotá, Colombia

*Correspondence

Bianca M. Stifani, Albert Einstein College of Medicine/Montefiore Medical Center, New York, NY, USA.

Email: bstifani@montefiore.org

Funding Information

UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

Abstract

In 2006, a Colombian Constitutional Court decision legalized abortion in cases of risk to a woman's physical or mental health, fetal malformation incompatible with life, or rape or incest. This decision resulted from legal action brought by feminist groups, and frames abortion as a human right. Advocates played a key role in implementing the new law by educating providers and the public about its broad interpretations. Healthcare providers and facilities did not have an organized response to the new law. Nonprofit organizations filled this gap, and provide a majority of legal abortions throughout the country. Civil society facilitated implementation of the new law by providing legal accompaniment to women facing barriers to accessing abortions. Despite these efforts, few legal abortions are performed each year, and clandestine, often unsafe abortions continue to prevail. Lack of information about the new law, stigma, and fluctuating political will remain key barriers.

KEYWORDS

Advocacy; Colombia; Human rights; Implementation; Legalization; Public health; Safe abortion

METHODOLOGY FOR ALL CASE STUDIES

This case study is one of six comprising a comparative examination of varied countries' approaches to the implementation of national abortion service programs, following changes in laws or policy guidelines that established or expanded access to services. In addition to Colombia, case studies were conducted in Ghana, Ethiopia, Portugal, South Africa, and Uruguay, as they had all either implemented new abortion laws or policies, or changed interpretations of existing laws or policies, within the past 15 years. Each study used the Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to organize the analyses. i-PARIHS posits successful implementation to be a function of the *innovation* to be implemented and its intended *recipients* in their specific context, with

facilitation as the "active ingredient" aligning innovation and recipients.¹ For each country case, two types of data sources were used: an in-depth desk review and 8–13 semistructured, in-depth interviews with key stakeholders and experts in each country, selected in collaboration with in-country partners. Respondents provided written informed consent and were guaranteed confidentiality. Several respondents from each country served as in-country coauthors, in doing so giving up their anonymity as participants of the study, although no quotations provided as respondents are directly attributed to them. Respondents included healthcare providers, public health and government officials who had been involved in establishing or expanding the service, academics, and members of nongovernmental organizations (NGOs) and legal and feminist advocacy groups; in some countries interviewees came from the full range listed, in others, from a subset

This is an open access article under the terms of the Creative Commons Attribution IGO License which permits unrestricted use, distribution and reproduction in any medium, provided that the original work is properly cited. In any reproduction of this article there should not be any suggestion that WHO or the article endorse any specific organization or products. The use of the WHO logo is not permitted. This notice should be preserved along with the article's URL.

© 2018 World Health Organization; licensed by John Wiley & Sons Ltd on behalf of International Federation of Gynecology and Obstetrics.

(Table 1). Interviews were conducted by a Spanish speaking physician member of the team. Quotes presented are from interviews without attribution as we promised confidentiality. Data analysis comprised a multistep iterative thematic analysis, with coding structured to follow the i-PARIHS framework. The WHO's Research Ethics Review Committee approved this study (protocol ID A65920). A full discussion of background and methodology can be found in Chavkin et al.²

1 | CONTEXT

Prior to 2006, abortion was illegal in Colombia under all circumstances. Unsafe abortions were common and were the second leading cause of maternal mortality in the mid-1990s.³ A new Constitution in 1991 emphasized the fundamental rights of the individual and established the "tutela," a mechanism enabling citizens to demand that every law or decision be in accordance with the protection of these rights.⁴ In 2006, the Colombian Constitutional Court issued a landmark decision (C-355) liberalizing the country's abortion law; the decision came in response to a constitutional challenge filed as part of a concerted strategic litigation effort led by Women's Link Worldwide in alliance with other women's and legal advocacy groups.^{5,6} After 2006, advocacy efforts continued and were key in ensuring implementation of the law. For example, La Mesa por la Vida y la Salud de las Mujeres (henceforth, LaMesa), a group of non-profit organizations and individuals, provided advice and support to women who had been denied or had difficulty obtaining legal abortions, and documented these experiences.⁷ Such advocacy efforts led the Court to issue at least 15 other decisions to protect Colombian women's access to abortion.

Particular features of the Colombian healthcare system are key to understanding successes and barriers in the implementation of the new abortion law. In 1993, a national health system was established that aimed to provide universal access to health care, now considered a right of all Colombians. This is a public-private system financed primarily through contributions from employers and workers and includes a subsidized regime for the poor and unemployed who receive services for small or no fees. All citizens are entitled to receive the same basic package of healthcare services. An element of an earlier health system reform was to decentralize the provision of health services, which are now provided at the

TABLE 1 Professional domains of interviewees in Colombia.

Professional domain	Number of interviewees
Medical professional	2
NGO	5
Government	5
Other ^a	1

Abbreviation: NGO, nongovernmental organization.

^a"Other" comprises academics, or individuals from feminist or legal advocacy groups, or UN agencies.

local level.⁸ The health management information system was also decentralized.³ The reform has resulted in remarkable increases in healthcare coverage (from 23% of the population in 1990 to 97% in 2015), decreases in out-of-pocket spending, improvement in overall health status, and reductions in maternal and infant mortality rates.⁸ Despite these successes, inequities persist: rural and poor urban people have much lower coverage rates, and quality of care can vary dramatically.⁹ The high number of people displaced due to long-standing internal conflict (one of the world's highest at 6.4 million) came mostly from rural areas, which further aggravated geographical health inequities.⁸

2 | INNOVATION

The Colombian abortion law was groundbreaking in that it was one of the first judicial decisions to uphold abortion rights on the grounds of equality and human rights.⁵ This decision came in response to a constitutionality challenge that was based on the premise that a total prohibition of abortion was against women's fundamental rights, including the right to life, health, and physical integrity; the right to equality and nondiscrimination; and the right to dignity, reproductive autonomy, and development of personality.¹⁰ As a result of decision C-355, abortion is not a crime under three conditions: if a woman's life or health (understood as a complete state of physical and mental well-being) is at risk, which must be certified by a physician or psychologist; when there are fetal malformations incompatible with life, which must be certified by a physician (not necessarily a specialist); and when pregnancy is a result of criminal acts that have been officially reported (which includes rape, incest, or if the pregnancy is a result of unwanted artificial insemination or implantation of a fertilized ovum). Importantly, there are no gestational age limits for abortions provided within these guidelines.¹⁰ This topic became a subject of debate among implementers after the law was passed. As one interviewee explained:

[...] just thinking of the technical roundtable, [...] we had a very important discussion around whether the Ministry should have a limit on gestational age, given that the court had not established limits. At the time, the Ministry had said that they were receiving a lot of external pressure, especially from gynecologists, that there should be a limit for gestational age [...] obviously, we [advocates] were of the belief that there should be no gestational age limit. [...] The take away at the end of that meeting was that the Ministry didn't have the authority to limit the gestational age.

The Court also set forth that all health service providers, public and private, are obliged to offer safe abortions. The law also established standards for conscientious objection, including that it can only be exercised by individuals, not by institutions; that objectors must provide unbiased information and refer to other providers; and that conscientious objection does not apply when there is an immediate

risk to life and no other providers are available.¹⁰ Ministry of Health regulations stipulate that medical and surgical abortion are included in the mandatory health plan and therefore must be covered without cost to women. Finally, there must be no more than 5 days between the woman's request and the abortion.¹¹

Several other Latin American countries also authorize abortion in similar circumstances as exceptions to the criminal code but have not done so in human rights terms. Also, these other countries have narrowly interpreted and infrequently utilized these exceptions, with limited efforts to implement abortion services.^{12,13} In Colombia, feminist groups and legal advocates quickly recognized that focusing on the interpretation of the law would be essential and would lead to radically different results in terms of implementation. They organized media campaigns and trained healthcare providers to ensure understanding of the law. They used the WHO's comprehensive definition of health to include mental health and the social dimension, and explained that the concept of risk to health comprises future risks that could arise from motherhood for an otherwise healthy woman.^{12,14} They also educated providers about the sexual violence statute, and emphasized, for example, that it did not require a formal conviction.¹⁵ Informational campaigns were also used to empower women to demand the services. As one interviewee explained:

It was more about getting people to understand what the meaning of the law was [...] people have difficulty understanding that the health statute is for overall health of the mother: people [...] didn't accept that a woman can choose to terminate a pregnancy because her health and mental well-being will be affected.

Another added as an example of the complex interpretation of the law:

Because a malformation affects the mother's well-being, the termination can be done because of the woman's health and not necessarily solely due to the malformation [...] it's been a process, years in the making, to get clarity [...] if you look closely at the health judgment, that means that abortions are totally legalized, in their entirety, here in Colombia. Given the complexity, the fact that there is no defined gestational age, it basically means that it's the only one in its comparable peer [country] group that has this.

While there are limited national data regarding abortion, data from private organizations and from the health department of Bogotá suggest that most legal abortions are now being performed under the health exception (up to 99%¹⁶).

3 | RECIPIENTS

The main recipients of the new law are Colombian women, whose rights are protected by the Constitutional Court. Colombia is a large

country with a heterogeneous population, high levels of socioeconomic inequality, a wide variety of geographical environments, and high numbers of individuals displaced by conflict—all of which have made it difficult to disseminate information about the new law to potential users. Civil society organizations planned campaigns to inform the public, and the Ministry of Health has started to release videos and informational materials in the last few years. Public opinion about abortion is becoming more favorable; 65% of households surveyed by an advocacy group in 2017 support abortion in the three circumstances allowed by law.^{17,18} However, Colombian women as a whole remain relatively uninformed about the specifics of the 2006 law. According to the 2015 Demographic and Health Survey, more than 50% of women knew that abortion was permitted in some circumstances, but only about 40% knew that one of these was a risk to a woman's mental health. Poorer women and rural women were much less likely than others to be informed about the law.¹⁹ Some interviewees believe that women face many barriers to seeking abortions—some, for example, did not realize that services are supposed to be free or covered by insurance, and thus paid for services at private clinics or had unsafe abortions thinking they could not afford a legal abortion. Other women know that the costs of services are covered, but fear judgment, mistreatment, lack of confidentiality, and long waiting periods.

Recipients of the new law also include the healthcare personnel who provide abortion services. In Colombia, general practitioners may provide abortion services. Interviewees explained that some providers are misinformed and think that only gynecologists can provide lawful abortions. However, the majority of procedures are actually provided by general practitioners who are trained by the leading NGO abortion provider (Orientame).

In the early years after the ruling, some physician advocates worked closely with the Ministry of Health to draft clinical guidelines and protocols and educate other healthcare providers on the details of the law. Some physicians in public healthcare facilities also played a key role by starting to provide services despite administrative barriers and stigma. However, many physicians, particularly gynecologists, were resistant to providing services. Some respondents explained that healthcare providers as a whole initially did not have a strong unified position on the new law and did not play an active role in implementation. Other interviewees explained that the Colombian Federation of Obstetrics and Gynecology (FECOLSOG) has taken an increasingly active role over time and has now clearly expressed its support for making safe abortion accessible, even though many of its members remain resistant to providing services. A recent survey conducted within the Federation found that 47% of obstetricians/gynecologists provide legal abortions when requested, 32% never provide abortions, and 21% do so in certain cases.²⁰ Despite increasing professional involvement in improving access to abortion, there has not been a systematic effort to integrate abortion into medical education. As a result, many physicians continue to be inadequately informed about the law and do not understand the circumstances under which they can provide legal abortions.²¹

Responses to the new law were varied at the level of the health facility, and at the level of the health insurance companies, which must arrange for their beneficiaries to obtain covered services. Despite the Constitutional Court's decision that abortions should be provided at all health facilities and paid for by insurances, initially, the majority of health-care providers did not deliver services. As one respondent explained:

Health institutions were foreign to the movement [to decriminalize abortion], and at the beginning their approach was to try and ignore the judgment, to do what they could, so they wouldn't have anything to do with it. At first, women were rarely requesting the service, which was perfect because they didn't have to do anything. Once women started to request it, the position of the health providers, as well as the insurers, was to put up as many barriers to access as possible.

Although the central regulatory agency for healthcare (Superintendencia de Salud) issued guidelines for all healthcare facilities to provide services, many facilities (public and private) were initially able to avoid establishing services owing to insufficient oversight from the agency. Insurance companies also did little to ensure that women could find service providers, or to establish referral networks in response to lack of availability of services at the local level. One interviewee explained:

[the availability of abortion] doesn't really depend on whether it's private or public, it comes down to the willingness of [hospital administrators]. In the first few years, there was very little oversight to make sure that the services were being offered, unless there was some sort of complaint due to someone being denied the service. As additional judgments were handed down by the court, in which they clarified the need to offer services and fines were levied, there was more oversight in terms of services being offered.

Healthcare providers and insurers have now become more open to providing and paying for services in order to comply with the law, but organized efforts to provide access to abortion at the hospital or clinic level and established referral networks remain rare.

4 | FACILITATION

Soon after the Constitutional Court's ruling, it became clear that it would not easily translate into the establishment of abortion services. The same civil society organizations that had lobbied for legal change played a key role facilitating access to abortion during this period. First, advocacy organizations pushed the Ministry of Health to issue regulations and technical guidelines so that the law could be implemented. LaMesa played a key role in this phase as it included health-care personnel who provided technical assistance to the Ministry of Health to develop the clinical protocols necessary for the implementation of services. As one interviewee explained:

When the law came out, and even before that, we were already working with the Minister of Health [...] since he didn't have a team of people within the Ministry, we offered technical assistance. We mounted a technical roundtable within the Ministry, where we attended a meeting once a month, to discuss issues. Which is what we did for about a year. At that technical roundtable, we had very difficult and challenging conversations.

Throughout this process, abortion advocates sought allies within the Ministry of Health and acted as catalysts to transform political will into action.

Advocacy groups also played a key role by continuing their efforts with strategic litigation, focusing on women who had been denied access to legal abortions. LaMesa positioned itself as a legal expert able to develop an interpretation of the law.⁷ Cases brought by LaMesa on behalf of women have led the Constitutional Court to clarify certain aspects of the law, including when and how conscientious objection can be invoked; that healthcare providers are not allowed to make additional demands on women seeking legal abortions; that the woman's emotional status should always be assessed when she requests an abortion; that the woman alone can decide whether to have an abortion; and that judges who fail to protect a woman's right to abortion may be investigated.⁴

The other important way in which civil society organizations facilitated implementation of the law was by quickly starting to provide services. Two large, well-established nonprofit women's health clinics, Oriéntame and Profamilia, took the lead in establishing clinical abortion services in several cities. These groups already had experience providing postabortion and contraceptive care, and were well positioned to expand their services to include legal abortion. To this day, a majority of legal abortions performed in Colombia are performed in their clinics. According to statistics by the Health Department of Bogotá, 97% of abortions in Colombia are provided by these two clinics (62% by manual vacuum aspiration and 36% with medication).¹⁶ These organizations were also essential in registering misoprostol for use in medical abortion, and in introducing mifepristone in the country. As one interviewee summarized:

[Almost] all of the countries in Latin America, have statutes [for legal abortion] on paper, but nobody uses them [...] I believe that a big take away is that you can't wait for the state to do things, you have to push the state from civil society. This topic is too challenging, too stigmatized for the state to be able to accomplish things on its own. The things we've accomplished in Colombia, we've accomplished because we've pushed.

5 | REMAINING CONCERNS

The most important concern about the implementation of abortion services in Colombia is that few legal abortions are being performed,

and that illegal ones still prevail.²² Importantly, it is difficult to quantify the number of legal procedures because there are no accurate records of services demanded or provided. The decentralized nature of the health information system further complicates obtaining accurate, national-level data. As one respondent who had been involved in the initial Ministry of Health discussions explained:

The registry [of abortions] is not very good [...] it was really difficult to be able to keep count of abortions because there were no codes for legal abortions. Even after the codes were created, to avoid issues of stigma, institutions continued using the codes for incomplete abortions. So, it was always a problem, we were making the argument that services were probably being provided, but we had no figures to prove that [...] there was never an effort [on our part] to make a monitoring plan, to obtain figures that would be tracked [because] that was just too far removed from our universe.

The estimates for abortions performed nationally are limited and not up to date.²³ However, they suggest that there is a large gap between the total numbers of abortions performed and the numbers of abortions legally reported. For example, for the region of Bogotá, the latest estimates are that 117 000 legal and illegal abortions were performed in 2008,²³ whereas only about 10 000 legal ones were reported in 2014 and 2015.¹⁶

The main barriers to accessing legal abortion are lack of knowledge of the law, narrow interpretations of the law, and lack of service provision at the health sector level.²¹ Lack of information is central to the problem as it affects women who are not aware of their rights, and providers who do not have comprehensive knowledge of the law and remained confused that abortion is a right under certain indications but remains a crime otherwise.

Fluctuating political will has also been a key barrier to establishing abortion services in Colombia. Respondents cited several examples of specific health sector initiatives that were established to increase access to abortion, but which were later dismantled owing to changes in political leadership. One such case involved a public hospital in Bogotá in which women's health services including abortions had been established, but these were closed with the arrival of a new mayor who did not prioritize the implementation of abortion services. Interviewees explained that support for the new law changed based on leadership within the Ministry of Health, and that without strong central support, abortion opponents blocked many initiatives to establish services. As one respondent explained:

It's very important to have a seed, whether it's in the public or private [sector], as well as having support within the Ministry of Health, to have the backing of the Ministry of Health. Having that support will allow institutions, say a public hospital, to provide an abortion and not have the fear of the police showing up and saying they're performing something that's illegal. They will be able to say, this is

not illegal, the Ministry of Health has asked us to perform these procedures. It's clearly laid out in the protocol, and they have the backing from the Ministry of Health. So, not only having a group of people that are willing to provide the service but having people from the oversight institutions that will provide them with their backing.

Another remaining concern is provider resistance to providing abortion services due to conscientious objection. While conscientious objection is well defined in Colombian law, and abortion advocates have made efforts to educate providers and the public, the constraints on it are not enforced.²⁴ Interview respondents cited many instances when individuals, departments, or institutions illegally claimed conscientious objection. For example, whole departments claimed conscientious objection whereas the law only permits individuals to object. Furthermore, while a recent survey of obstetricians/gynecologists conducted by Global Doctors for Choice Colombia found that only 8% declared explicit conscientious objection, many more providers cite conscientious objection as a cover for other reasons for not providing abortions. These reasons may include fear of being stigmatized or of facing discrimination in the workplace, or disagreement with particular patient decisions or disagreement with the lack of gestational age limits. Some clinicians who might have willingly provided abortions did not do so when faced with pressure and intimidation from local political leaders. Finally, objectors are required to refer patients to willing providers, but referral networks are not well defined, and patients face geographical and bureaucratic barriers to obtaining services as a result.

The complex nature of the Colombian healthcare system has also affected the implementation of the new law. It is a public-private system with limited continuity of care, as users can seek healthcare services from a number of different providers and facilities that are paid by their insurer. In the case of abortion, some obstetric care providers claim they do not provide the service, forcing insurers to look for other willing service providers. The lack of referral systems in response to patchy service provision has led to a wide variety of access to services across geographical regions and socioeconomic status. Another concern is the application of updated clinical protocols. While protocols were written in accordance with existing WHO guidelines and some efforts were made to train healthcare providers, there have been no centralized concerted efforts to ensure that the guidelines are followed across the national territory. Formal statistics regarding the types of procedures performed are lacking, but respondents expressed concern that many service providers are still performing abortion by dilation and sharp curettage rather than by manual or electric vacuum aspiration or medical abortion. According to statistics by the Health Department of Bogotá,¹⁶ of the 3% of abortions performed in the public sector, 58% were by sharp curettage, which imposes risk and has not been the recommended standard of care for several years.²⁵ According to one interviewee, one barrier to using manual vacuum aspiration is that the equipment itself is stigmatized as something only used for induced abortion. In addition, physicians do not receive training in manual vacuum aspiration during their undergraduate or graduate medical education.

Training in dilation and evacuation (D&E) for second trimester abortions is also scarce. Second trimester terminations are performed by induction of labor, except at Oriéntame where providers were trained abroad to perform D&E.

6 | LESSONS LEARNED

The Colombian law is exemplary in its focus on human rights, its provisions on conscientious objection, and its lack of gestational age limits. In Colombia, civil society played a catalytic role in obtaining legal change and implementing the new law. Feminist groups used legal advocacy to obtain legal access to abortion on specified grounds and promoted implementation by strategically educating providers and the public about the Constitutional Court's broad interpretation of the law, and particularly of the health exception. They also provided ongoing legal support to women who were being denied abortions, thus identifying barriers to obtaining abortions and leading to further legal protections for Colombian women seeking abortions.

However, implementation of the law has been limited by a complex public-private healthcare system with inadequate government oversight. Despite being mandated by law, many hospitals and clinics have failed to establish abortion services. Civil society groups, including some physician advocates, have stepped up and played a leadership role, as nonprofit organizations were quick to launch services and now provide a majority of abortions throughout the country.

Despite these efforts, the 2006 Colombian abortion law has not led to equitable access to safe abortions. There is no accurate registration of abortions in Colombia, since a centralized monitoring system was not included in the initial planning strategies. Further efforts are needed to ensure that these data are available while maintaining patient confidentiality. However, it is known that the number of legal abortions being performed remains relatively small, and that clandestine, often unsafe abortions are common. Lack of information about the law and lack of political commitment to ensure that it is implemented remain important barriers to accessing abortion services.

AUTHOR CONTRIBUTIONS

BMS: Contributed to the initial proposal, interview instrument, conducted Colombia interviews, wrote the first draft of the paper, and collated edits and reviews. LGU: Advised on interview instrument, interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points. ACGV: Interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points. CVV: Interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points.

ACKNOWLEDGMENTS

This work was funded by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored programme executed by the World Health Organization (WHO).

CONFLICTS OF INTEREST

Laura Gil Urbano, Ana Cristina González Vélez, and Cristina Villarreal Velásquez functioned as key informants, were interviewed, and served as coauthors of this case study. The authors have no conflicts of interest to declare.

REFERENCES

1. Harvey G, Kitson A. PARIHS revisited: From heuristic to integrated framework for the successful implementation of knowledge into practice. *Implement Sci.* 2016;11:33.
2. Chavkin W, Stifani BM, Bridgman-Packer D, Greenberg JMS, Favier M. Implementing and expanding safe abortion care: An international comparative case study of six countries. *Int J Gynecol Obstet.* 2018;143(Suppl.4):3-11.
3. Prada E, Singh S, Villarreal C. Health consequences of unsafe abortion in Colombia, 1989-2008. *Int J Gynecol Obstet.* 2012;118 (Suppl.2):S92-S98.
4. Amado ED, Calderón García MC, Cristancho KR, Salas EP, Hauzeur EB. Obstacles and challenges following the partial decriminalisation of abortion in Colombia. *Reprod Health Matters.* 2010;18:118-126.
5. Ruibal A. Movement and counter-movement: A history of abortion law reform and the backlash in Colombia 2006-2014. *Reprod Health Matters.* 2014;22:42-51.
6. Jaramillo Sierra IC, Alfonso Sierra T. *Mujeres, Cortes y Medios: La Reforma Judicial del Aborto.* Bogotá: Universidad de los Andes; 2008.
7. Vélez ACG, Jaramillo IC. Legal knowledge as a tool for social change: La mesa por la vida y la salud de las mujeres as an expert on Colombian abortion law. *Health Hum Rights.* 2017;19:109-118.
8. OECD. *OECD Reviews of Health Systems: Colombia 2016.* Paris: OECD Publishing; 2015. https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-colombia-2015_9789264248908-en#page1. Accessed June 20, 2018.
9. Webster PC. Health in Colombia: A system in crisis. *CMAJ.* 2012;184:E289-E290.
10. Corte Constitucional de la República de Colombia. Sentencia C-355 de 2006. <http://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm>. Accessed June 20, 2018.
11. Superintendencia Nacional de Salud. Circular Externa 3 de 2013 (Abril 26). https://docs.supersalud.gov.co/PortalWeb/Juridica/OtraNormativa/C_SNS_0003_2013.pdf. Accessed June 20, 2018.
12. González Vélez AC, Bohórquez Monsalve V, Castro González L, Bareiro L, Ruiz-Navarro C. *Las Causales de la Ley y la Causa de las Mujeres. La implementación del aborto legal en Colombia: diez años profundizando la democracia.* Bogotá: 2016. <http://www.despenalizaciondelaborto.org.co/wp-content/uploads/2016/11/Las-causas-de-la-ley-y-la-causa-de-las-mujeres-Es-un-hecho-abortar-es-un-derecho.pdf>. Accessed June 20, 2018.
13. FLASOG, Mesa por la Vida y la Salud de las Mujeres, ANDAR. Causal salud. Interrupción legal del embarazo, ética y derechos humanos. <http://www.despenalizacion.org.ar/pdf/publicaciones/causal-salud.pdf>. Accessed June 20, 2018.
14. González Vélez AC. "The health exception": A means of expanding access to legal abortion. *Reprod Health Matters.* 2012;20:22-29.

15. Bergallo P, Gonzalez Velez AC. Interrupción legal del embarazo por la causal violación: enfoques de salud y jurídico. Bogotá: 2012. http://www.safeabortionwomensright.org/wp-content/uploads/2016/04/Causal-Violacion_salud_juridico.pdf. Accessed June 20, 2018.
16. Secretaría de Salud de Bogotá. Cifras SDS Bogotá 2014-2016. Report provided to LaMesa in February 2018.
17. Rubiano MP. El 65% del país le dice sí al aborto legal. *El Espectador* 2017. <https://www.elespectador.com/noticias/salud/el-65-del-pais-le-dice-si-al-aborto-legal-articulo-715353>. Accessed June 20, 2018.
18. La Mesa. Encuesta de percepción sobre interrupción del embarazo. 2017. <http://www.despenalizaciondelaborto.org.co/2017/09/28/encuesta-de-percepcion-sobre-interrupcion-del-embarazo/>. Accessed June 20, 2018.
19. Encuesta Nacional de Demografía y Salud: Componente de Salud Sexual y Salud Reproductiva. Bogotá: 2015. <http://www.profamilia.org.co/docs/TOMO%20II.pdf>. Accessed June 20, 2018.
20. González Vélez AC. Que es la objeción de conciencia?: Reflexiones desde la bioética y los derechos humanos. Paper presented at: Congreso Nacional de Ginecología y Obstetricia. Cali, Colombia: May 25–28, 2016.
21. Gonzalez Vélez AC, Castro L. Barreras de acceso a la Interrupción Voluntaria del Embarazo de las mujeres en Colombia. Bogotá: La Mesa por la Vida y la Salud de las Mujeres, 2017. http://www.despenalizaciondelaborto.org.co/wp-content/uploads/2017/05/Barreras_IVE_vf_WEB.pdf. Accessed June 20, 2018.
22. Maloney A. Unsafe abortions common in Colombia despite law change. *Lancet*. 2009;373:534.
23. Prada E, Biddlecom A, Singh S. Induced abortion in Colombia: New estimates and change between 1989 and 2008. *Int Perspect Sex Reprod Health*. 2011;37:114–124.
24. Harris LF, Awoonor-Williams JK, Gerds C, et al. Development of a conceptual model and survey instrument to measure conscientious objection to abortion provision. *PLoS ONE*. 2016;11:e0164368.
25. World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd edition. Geneva: WHO; 2012.