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May 5, 2006

The Committee on the Rights of the Child (CRC)

Re: Supplementary information on Colombia
Scheduled for review by the Committee on the Rights of the Child during its 42nd Session

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by Colombia, which is scheduled to be reviewed by the Committee on the Rights of the Child (the Committee) during its 42nd session. The Center for Reproductive Rights, an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Rights of the Child (Children's Rights Convention). This letter highlights several areas of concern related to the status of the reproductive health and rights of girls and adolescents in Colombia, with a focus on discriminatory or inadequate laws and policies.

Because reproductive rights are fundamental to adolescents' health and equality, states parties' commitment to ensuring them should receive serious attention. Further, adolescent reproductive health and rights receive broad protection under the Children's Rights Convention. Article 24 of the Children's Rights Convention recognizes girls' and adolescents' right "to the enjoyment of the highest standard of health and to facilities for the treatment of illness and rehabilitation of health." It also requires states parties to take appropriate measures "to develop family planning and education services." Yet, despite these protections, the reproductive rights of girls and adolescents in Colombia continue to be neglected and, at times, violated.

We wish to bring to the Committee's attention the following issues of concern, which directly affect the reproductive health and rights of girls and adolescents in Colombia.

I. The Right to Family Planning Services and Information (Article 24 of the Children's Rights Convention)

The Committee has regularly expressed concern in its Concluding Observations where adolescents have limited access to reproductive health services and has asked states parties to increase women's and adolescents' access to such services.[1] It has frequently highlighted the need to address unsafe or illegal abortion[2] and teenagers' lack of access to reproductive health services.[3] In its General Comment on Adolescent Health and Development, the Committee urges governments "to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, [and] adequate and comprehensive obstetric care and counselling."[4] Furthermore, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) has recommended that governments engage in efforts to prevent unwanted pregnancy through family planning and sex education and also to reduce maternal mortality rates through safe motherhood services and prenatal assistance.[5] The

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Committee has even encouraged that legislation criminalizing abortion be amended, such that punitive measures are not imposed on women who undergo abortion.[6] In addition, the Committee has recommended that states parties strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other sexually transmitted infections (STIs).[7]

A. Contraception

It is critical that adolescents have access to contraceptives and dual protection methods for the purpose of preventing unwanted pregnancies and STIs. The Committee has regularly expressed concern in its Concluding Observations regarding limited access to family planning services and low levels of contraceptive use among adolescents, and has recommended that states parties work toward making family planning services more widely available.[8]

Based on statistics, it is evident that there is an unmet need for contraception among the adolescent population in Colombia. First, the fact that the fertility rate among adolescents in urban areas of Colombia has been increasing since 1990 suggests that there is an unmet need for contraception among this population. The fertility rate among adolescents aged 15-19 has increased overall since 1990: the rate was 70 births per thousand in 1990, 89 in 1995, and by 2005, the rate had further increased to 90 births per thousand.[9] This increase has occurred in urban zones (from 71 births per thousand to 79 births per thousand), while in rural zones, fertility rates among adolescents have decreased (from 134 births per thousand to 128 births per thousand).[10] Overall, a great discrepancy in the fertility rate exists between rural and urban areas: the rate is 79 births per thousand in urban zones, and 128 births per thousand in rural areas, suggesting the need for efforts targeted at urban adolescents in particular.[11]

Statistics regarding the number of adolescents who are or have been pregnant, and those who are already mothers, further demonstrates the unmet need for contraception among adolescents. In its most recent 2005 survey, Profamilia[12] discovered that out of 6,902 adolescents who have been pregnant, 20% had already been pregnant, 16% were already mothers, and 4% were awaiting the birth of their first child at the time of the survey.[13] While the proportion of adolescents who were already mothers decreased from the year 2000 in coastal regions, it increased in other regions, particularly in Bogotá and the Oriental region.[14] The greatest increase in the proportion of pregnant adolescents was found in Bogotá and the Santanderes, suggesting the need for targeted efforts aimed at these particular regions.[15]

Significantly, there exists a high correlation between level of education and pregnancy rates among adolescents. That is, the rate of pregnancy among adolescents without any level of education is 52.3%.[16] This rate decreases slightly to 42.3% among adolescents with primary education.[17] However, among those adolescents with a "superior" level of education, the rate of adolescent pregnancy dramatically decreases to 9.0%.[18] These statistics demonstrate the direct link between education and pregnancy rates and the tremendous impact that increasing educational opportunities might have on lowering pregnancy rates among adolescents.

Similarly striking is the relationship between wealth and pregnancy rates among adolescents. Among those adolescents who belong to the lowest strata of economic wealth, the pregnancy rate is 31.5%; the rate decreases to 25.6% among those in the second lowest strata; the rate further decreases to 22.1% among those in the middle range.[19] The rate of adolescent pregnancy among those at a level of "high" economic wealth – 14.4% – is less than half the rate among those at the opposite end of the spectrum.[20] Finally, the rate of adolescent pregnancy among those at the highest level of economic wealth is 10.7%.[21] The steady decrease in adolescent pregnancy rates

in correlation with elevated economic status and the pronounced contrast in pregnancy rates between the lowest and highest levels of economic status is compelling evidence of the impact of economic status on pregnancy rates. These statistics demonstrate how important it is for the government to provide information and services with regard to contraception to all adolescents, and especially to those individuals who are most economically deprived.

It is noteworthy that the lowest rate of contraceptive use among married women was found in those aged 15-19, where the rate of contraceptive use among 934 women was 57.2%.[22] Not only was this the lowest rate, but it was significantly lower (by at least 15 percentage points) than contraceptive use among all other age groups.[23] Among 734 adolescents who were not married or in union and were sexually active, the rate was 79.4%. The rate was lower only among those aged 40-44 and 45-59.[24]

The most obvious evidence that adolescents' contraceptive needs are unmet is that among 934 women aged 15 – 19 in union, 16.2% expressed that their family planning needs, defined as the spacing and limiting of births, were unsatisfied.[25] The rate of unsatisfied demand for family planning was greatest in this age group (compared to the overall rate among all women in union which was only 5.8% out of the 19,762 women surveyed), demonstrating the necessity for both increased and better quality information and services among adolescents.[26]

Thus, it is critical that the government of Colombia place greater emphasis on the provision of accurate information to adolescents regarding contraceptive use in a way that is both comprehensive and accessible to members of this age group. Efforts to disseminate this information must incorporate practical information as to where adolescents can access contraception as well as where they can access affordable medical services in relation to contraception. Finally, it is critical that information and services reach all segments of the adolescent population, including those with no or minimal education and, further, that efforts be made in general so that educational opportunities are more widely accessible. It is also necessary for information and services to reach those belonging to the lowest socio-economic groups.

B. The Right to Safe and Legal Abortion Services (Articles 6 and 24 of the Children's Rights Convention)

Contrary to efforts to liberalize laws criminalizing abortion, Colombian law prohibits abortion under all circumstances including preservation of physical health, preservation of mental health, rape or incest, fetal impairment, for economic or social reasons, and upon request.[27]

Despite the criminalization of abortion, it is estimated that 450,000 abortions occur every year in Colombia[28] and that approximately 24% of all pregnancies are terminated by abortion.[29] Because abortion is illegal, it is common for women to use unsafe procedures to terminate unwanted pregnancies and, as a result, nearly 30% of women who have abortions suffer complications,[30] making unsafe abortion the third leading cause of maternal death.[31] According to UNFPA Colombia's most recent statistics, the maternal mortality rate per 100,000 live births was 130.[32] This Committee has expressed concern about the impact of abortion on maternal mortality rates.[33] Studies indicate that among those who undergo illegal abortions, the proportion of adolescent girls is higher than adult women.[34]

The criminalization of abortion has a discriminatory effect on impoverished women. On the one hand, women who belong to higher socio-economic classes can obtain safe, though illegal, abortions. On the other hand, women who belong to lower socio-economic classes are unable to do so and instead obtain dangerous backroom abortions. As a result, maternal mortality rates in

rural areas are high.[35] Additionally, poorer women are generally more likely to become pregnant as a result of lack of access to both sex education and to contraception.[36]

The criminalization of abortion violates many of the most fundamental rights that are guaranteed by international human rights treaties, namely the right to dignity, reproductive self-determination, equality, freedom from non-discrimination, life, health, integrity, and freedom from inhuman and degrading treatment. This Committee as well as other committees, including the CEDAW Committee and the Human Rights Committee have issued concluding observations to Colombia expressing serious concern about the prohibition of abortion and even recommending the revision of this legislation.

For example, in Concluding Observations issued to Colombia in 1999, the CEDAW Committee stated the following:

> The Committee notes with great concern that abortion, which is the second cause of maternal deaths in Colombia, is punishable as an illegal act. No exceptions are made to that prohibition, including where the mother's life is in danger or to safeguard her physical or mental health or in cases where the mother has been raped. The Committee is also concerned that women who seek treatment for induced abortions, women who seek an illegal abortion and the doctors who perform them are subject to prosecution. The Committee believes that legal provisions on abortion constitute a violation of the rights of women to health and life and of article 12 of the Convention.[37]

The Committee even went on to recommend that the government "consider taking immediate action to provide for derogations from this legislation."[38]

Similarly, this Committee expressed almost identical concerns in its Concluding Observations to Colombia, stating:

> The Committee is also concerned about the high maternal mortality and teenage pregnancy rates, as well as about insufficient access by teenagers to reproductive health education and counselling services. In this connection, concern is expressed that the practice of abortion is considered the leading cause of maternal mortality (see the concern expressed by the Committee on the Elimination of Discrimination against Women (CEDAW): A/54/38, para. 393).[39]

Finally, in 2004, the Human Rights Committee expressed the following concerns:

> The Committee notes with concern that the existence of legislation criminalizing all abortions under the law can lead to situations in which women are obliged to undergo high-risk clandestine abortions. It is especially concerned that women who have been victims of rape or incest or whose lives are in danger as a result of their pregnancy may be prosecuted for resorting to such measures (art. 6).[40]

As a result of this concern, the Human Rights Committee made the following recommendation:

> The State party should ensure that the legislation applicable to abortion is revised so that no criminal offences are involved in the cases described above.[41]

An initial challenge to reform Colombia's abortion law was presented before the Constitutional Court of Colombia on April 14, 2005.[42] A decision was issued on December 7, 2005, when the

Constitutional Court decided not to rule on the challenge.[43] On December 12, 2005, a second suit seeking to decriminalize abortion was filed before the same court.[44]

It is hoped that the Constitutional Court of Colombia will decide to decriminalize abortion. Once it does so, it is expected that the government of Colombia will take immediate steps to ensure that the decision is enforced, for example by issuing guidelines and regulations such that all members of the population – including impoverished women and internally displaced women – will have access to safe abortion services in a manner that is prompt and respectful of women's decisions to undergo abortions.

II. Prevention of HIV/AIDS and STIs

The estimated number of adults (15-49) living with HIV at the end of 2003 was 180,000.[45] Of this total, the number of women (15-49) living with HIV was 62,000.[46] Thus, the percentage of women living with HIV was approximately 34%. The number of children living with HIV was 10,000.[47]

According to the "AIDS epidemic update" of December 2005, increasing numbers of women in Colombia are becoming infected with HIV from men who have unsafe sex with men, while also maintaining sexual relationships with women.[48] This phenomenon is particularly prevalent along the Caribbean coast as well as in the northeast part of the country.[49]

The level of knowledge of HIV/AIDS is lowest in extreme age groups, including among young people, aged 15 to 19 years old. While overall, 98.4% of the 38,355 Profamilia survey participants had heard of HIV/AIDS, among those aged 15-19 years old, only 97.7% of the 6,902 participants had heard of HIV/AIDS.[50] This was the lowest percentage out of all age groups.[51] In addition, among 1,035 adolescents, only 11.9% believed that they faced a risk of contracting AIDS.[52] Again, this was the lowest percentage out of all groups.[53] If adolescents tend to believe that they do not face any risk of contracting AIDS, they are less likely to take necessary precautionary steps to avoid contracting AIDS. Further, among 6,740 adolescents who had heard of AIDS, only 9.5% had been tested for AIDS.[54] Once again, this rate was the lowest among all age groups (for example, the overall rate of testing was 18.4% out of 37,734 women, almost twice the rate for adolescents).[55] If adolescents are not tested for AIDS, they face the danger of living with AIDS without knowing it, and they therefore do not obtain necessary treatment. They also likely do not take the necessary steps to prevent spreading AIDS.

Lack of knowledge about issues related to HIV/AIDS, including where to get tested for HIV is also particularly pronounced among the internally displaced population. Among marginalized women, most (97%) reported knowledge of AIDS.[56] Further, one in every three women felt she could contract HIV.[57] However, half of the women did not know where to get tested for HIV, thus creating a situation in which a woman, while believing that she is in danger of contracting HIV, lacks the knowledge about where to get tested.[58] This lack of knowledge is particularly worrisome because it is likely that forced displacement increases the risk that women face in acquiring HIV.[59] It is evident from these statistics that there exists a crucial need for efforts aimed at disseminating information about HIV/AIDS, particularly among the most vulnerable groups, including adolescents and the internally displaced population.

Currently, there are no specific healthcare guidelines for women living with HIV/AIDS. The Network of Positive Women and the Girasol Project are currently active in this effort. Thus, the

government should create and adopt such healthcare guidelines for women, with input from organization such as these two.[60]

In September 2005, Colombia adopted Law 972, according to which combating HIV/AIDS is set as a national priority.[61] Under the law, health authorities are to provide treatment to those individuals living with HIV and to work towards eliminating the spread of HIV.[62] The law also calls upon the Ministry of Social Protection to disseminate the message of prevention and to encourage HIV testing.[63] However, the full potential of the law is limited by the fact that the costs of treatment are restricted by the amounts approved by the National Council of Social Security and Health (el Consejo Nacional de Seguridad Social en Salud).[64] Further, there is no specific mention of the health needs of adolescents or women in relation to HIV/AIDS. As a result, the law may fail to address the particular ways in which adolescents and women are affected by HIV/AIDS.

Finally, it should be noted that this Committee has issued Concluding Observations to Colombia, encouraging efforts to prevent HIV/AIDS.[65] In its Concluding Observations, this Committee referenced recommendations that it adopted on its Day of General Discussion on "Children living in a world with HIV/AIDS."[66] These recommendations include adopting "a children's rights-centered approach to HIV/AIDS," encouraging more research on mother-to-child transmission, and paying particular attention to the way in which gender-based discrimination places girls at higher risk in relation to HIV/AIDS and, in order to diminish the effects of this discrimination, targeting girls for access to services, information and participation in HIV/AIDS-related programmes.[67]

As is the case with HIV/AIDS, lack of knowledge about STIs is greatest among young women, as well as among the rural population, those living in the Oriental region, and among those without education and those living in poverty.[68] Among the 6,902 adolescent girls aged 15-19 years old who were surveyed in the 2005 Profamilia survey, 21.7% did not know of STIs, with knowledge measured as an understanding of the symptoms associated with STIs.[69] This percentage was significantly higher than the 17.5% out of 38,355 women overall who did not have knowledge about STIs, indicating the critical need for increased educational efforts aimed at adolescents.[70]

Not only is there a serious lack of knowledge about STIs among the adolescent population but, relatedly, the rate of STI infection among this age group is the highest among all ages. While among all age groups, 7.8% of 2,136 surveyed women who are sexually active and have knowledge of STIs are infected with an STI, the rate for those aged 15 – 19 years of age is 11.0% of the 266 women surveyed.[71] An additional source of concern is that a significant proportion of those infected with an STI do not seek medical treatment: of the 266 surveyed adolescent girls, 38.2% (the highest percentage among all age groups) did not seek medical treatment for their STI.[72] The reasons for their not seeking treatment reflect both the prohibitive cost of accessing services as well as lack of knowledge. The reasons given for not seeking treatment are (in descending order): difficulty making an appointment, not being able to afford treatment, thinking that the problem would pass, other, and fearing the opinion of a medical professional.[73] Of the 2,136 women of all age groups with an STI, 21.0% did not seek medical treatment. Among this population, the number one reason for not seeking treatment was not having the financial resources to pay for treatment (28.6%).[74] The fact that 17.4% of adolescent girls and 28.6% of all women with STIs did not seek medical treatment for their STIs because of their inability to afford the cost suggests the critical need for affordable medical treatment, particularly treatment related to sexual and reproductive health, for adolescent girls and women.

III. The Status of Internally Displaced Women and Children

The violence in Colombia has resulted in the internal displacement of three million Colombians since 1985.[75] Among internally displaced persons (IDPs), about 49 to 58 percent of the population consists of women.[76] When children are included in this figure, the percentage rises to 74% and even 80% when the displaced population found in large urban areas is included.[77] Between 49 and 58 percent of internally displaced households are headed by women.[78]

In addition to women being particularly affected by internal displacement because they make up a numerical majority of the internally displaced population, women are also uniquely affected because of the distinct ways in which they are impacted by the violence that results in their internal displacement and the state of their internal displacement itself.

IDPs, like many Colombians, lack access to reproductive health care because of the lack of clarity between national policy at the central level and services to the population at decentralized levels.[79] However, the problem is exacerbated for IDPs. First, the government depends upon Profamilia[80] to provide sexual and reproductive health care to IDPs.[81] However, Profamilia cannot reach all regions or all individuals, nor can it provide services free of charge.[82] IDPs are unable to afford even the small user fees charged by Profamilia, and thus they are oftentimes prevented from accessing services or medicines.[83]

The minimum initial services package (MISP) of reproductive health services that is considered a basic standard of care in emergency situations, has not been implemented in a way that reaches IDPs.[84] Specifically, free services, including emergency contraception, are unavailable, for example to victims of violence; condoms and clean delivery kits that could be used by pregnant internally displaced women for home deliveries in rural areas are likewise not free and widely available to IDPs.[85] As a result both of their lack of medical coverage as well as discrimination, internally displaced women who go to hospitals are turned away, even in emergency obstetric cases, or when they are suffering from pregnancy and delivery complications, thus delaying life-saving care.[86]

In addition, despite the fact that once they are displaced, IDPs are entitled to three months of government emergency assistance through the Sole Registry of the Displaced Population (Registro Unico de Población Desplazada), IDPs often do not receive this assistance.[87] In order to receive this assistance, IDPs must register and be certified by the government.[88] However, women, particularly from the rural sector, are less likely to possess identification than men, and are thus impeded from accessing services.[89] Further, IDPs fear that if they do obtain identification, they will be stigmatized for registering for this assistance.[90] They also fear the implications of giving up their anonymity.[91] In other cases, IDPs are unaware of their right to this assistance.[92] Thus, according to Colombian NGOs, less than 22% of IDPs are registered with the government and receive the assistance to which they are entitled.[93]

A. Gender-based Violence Among Internally Displaced Women and Children

Internally displaced women, girls and adolescents suffer from gender-based violence, including rape, forced contraception and sterilization, forced prostitution, sexual slavery and domestic abuse.[94] Regarding sexual violence, one in every five displaced women reports having been a victim.[95] Twenty-four percent reported having been raped.[96]

In regards to domestic abuse, 52% of displaced women experience domestic abuse, as compared to 20% of non-displaced women.[97] According to estimates from the Inter-American Commission

on Human Rights, less than half of battered women seek help and only 9% present formal complaints in the legal system.[98] This lack of reporting is exacerbated by legislation, as adopted by President Alvaro Uribe, according to which only the victim of abuse can make an official complaint and initiate the legal process against the perpetrator.[99] Thus, the likelihood of legal prosecution is reduced and women are less protected.[100]

Internally displaced women are also subject to reproductive and sexual violence from members of the armed forces. Female combatants are forced to use contraception involuntarily.[101] For example, guerillas have directed nurses to insert intrauterine devices in women and girls.[102] FARC members have mandated abortion when a woman has become pregnant, regardless of the mother's decision as to whether to continue with her pregnancy.[103] This has led to instances of attempted escapes by women who want to continue with their pregnancies, which in turn has led to the deaths of women who have died trying to escape because of the distance between the camps where they were based and the settlements where they would have sought assistance.[104]

B. The Right to Family Planning Services and Information Among Internally Displaced Adolescents

Internally displaced adolescents lack necessary family planning information and services. For example, 30% of internally displaced adolescents are pregnant, as compared to 18% in the general population, thus constituting the group with the highest pregnancy rates in the country.[105] Further, 30% of internally displaced adolescents are already mothers or else pregnant with their first child, and as a result, are in need of family planning services.[106] It is noteworthy that among these pregnant adolescents aged 13 – 19 years of age, over half would have liked to have postponed their pregnancy and 20% did not want to get pregnant, thus indicating a serious gap in access to family planning services and the demonstrating the crucial need for family planning information and services, particularly aimed at adolescent girls.[107]

We hope that the Committee will consider addressing the following questions to the Colombian government:

1. What steps are being taken to ensure that women have access to reproductive health services, including the provision of contraceptive methods and the dissemination of information regarding contraception, particularly among adolescent girls and the internally displaced population, and, further, within these subpopulations, those with minimal levels of education and those who are most economically impoverished?

2. What initiatives are being planned to ensure that, should the Constitutional Court decide to decriminalize abortion, necessary regulations are immediately implemented to ensure that abortion services are made available to all women, including those who are living in conditions of impoverishment as well as those who are internally displaced?

3. What steps are being taken to disseminate information about and provide treatment for HIV/AIDS and STIs to women, particularly to adolescent girls?

4. Are steps being taken to create and implement healthcare guidelines for adolescent girls and women living with HIV/AIDS?

5. What steps are being taken in relation to the prevention and provision of treatment of HIV/AIDS, particularly among adolescent girls and women?

6. What efforts are being made to ensure that Law 972 fulfils its maximum potential in the treatment and elimination of HIV/AIDS, especially among adolescent girls and women?

7. What efforts have been made to reduce rates of violence, including sexual violence, committed against adolescent girls and women, particularly among the internally displaced population?

There remains a significant gap between the provisions of the Children's Rights Convention and the reality of adolescents' reproductive health and lives. We appreciate the active interest that the Committee has taken in the reproductive health and rights of adolescents and the strong concluding observations and recommendations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Colombian government's compliance with the provisions of the Children's Rights Convention. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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Legal Adviser for Latin America and the Caribbean
Center for Reproductive Rights

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[1] *See, e.g.*, *Concluding Observations of the Committee on the Rights of the Child: Central African Republic,* U.N. Committee on the Rights of the Child (CRC), 25th Sess., 669th mtg., paras. 60–61, U.N. Doc. CRC/C/15/Add.138 (2000); *Concluding Observations of the Committee on the Rights of the Child: Benin,* CRC, 21st Sess., 557th mtg., para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); *Concluding Observations of the Committee on the Rights of the Child: Cambodia,* CRC, 24th Sess., 641st mtg., para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations of the Committee on the Rights of the Child: Mexico,* CRC, 22nd Sess., 586th mtg., para. 27, U.N. Doc. CRC/C/15/Add.112 (1999); *Concluding Observations of the Committee on the Rights of the Child: Kyrgyzstan,* CRC, 24th Sess., 641st mtg., paras. 45–46, U.N. Doc. CRC/C/15/Add.127 (2000); *Concluding Observations of the Committee on the Rights of the Child: Lithuania,* CRC, 26th Sess., 697th mtg., para. 40, U.N. Doc. CRC/C/15/Add.146 (2001); *Concluding Observations of the Committee on the Rights of the Child: Spain,* CRC, 30th Sess., 798–799th mtgs., para. 39, U.N. Doc. CRC/C/15/Add.185 (2002).

[2] *See, e.g., Concluding Observations of the Committee on the Rights of the Child: Chad,* CRC, 21st Sess., 557th mtg., para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Concluding Observations of the Committee on the Rights of the Child*: *Colombia,* CRC, 25th Sess., 669th mtg., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Concluding Observations of the Committee on the Rights of the Child: Guatemala*, CRC, 27th Sess., 721st mtg., para. 40, U.N. Doc. CRC/C/15/Add.154 (2001).

[3] *See, e.g., Concluding Observations of the Committee on the Rights of the Child: Cambodia,* CRC, 24th Sess., 641st mtg., para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, CRC, 26th Sess., 697th mtg., para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Concluding Observations of the Committee on the Rights of the Child: Guinea*, CRC, 20th Sess., 531st mtg., para. 27, U.N. Doc. CRC/C/15/Add.100 (1999).

[4] Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, 33rd Sess., para. 31, U.N. Doc. CRC/GC/2003/4 (2003).
[5] Committee on the Elimination of Discrimination against Women (CEDAW), *General Recommendation No. 24: Women and Health,* 20th Sess., para. 31(c), U.N. Doc. A/54/38 (1999).
[6] *Id.*
[7] *See Concluding Observations of the Committee on the Rights of the Child: Argentina*, CRC, 8th Sess., para. 19, U.N. Doc. CRC/C/15/Add.35 (1995); *Concluding Observations of the Committee on the Rights of the Child: Egypt*, CRC, 26th Sess., para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Concluding Observations of the Committee on the Rights of the Child: Georgia*, CRC, 24th Sess., para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Concluding Observations of the Committee on the Rights of the Child: Latvia*, CRC, 26th Sess., paras. 39-40, UN. Doc. CRC/C/15/Add.142 (2001); *Concluding Observations of the Committee on the Rights of the Child: Russian Federation*, CRC, 22nd Sess., para. 48, U.N. Doc. CRC/C/15/Add 110 (1999).
[8] *See Concluding Observations of the Committee on the Rights of the Child: Central African Republic,* CRC, 25th Sess., 669th mtg., paras. 60–61, U.N. Doc. CRC/C/15/Add.138 (2000); *Concluding Observations of the Committee on the Rights of the Child: Cambodia,* CRC, 24th Sess., 641st mtg., para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations of the Committee on the Rights of the Child: Kyrgyzstan,* CRC, 24th Sess., 641st mtg., paras. 45–46, U.N. Doc. CRC/C/15/Add.127 (2000); *Concluding Observations of the Committee on the Rights of the Child: Lithuania,* CRC, 26th Sess., 697th mtg., para. 40, U.N. Doc. CRC/C/15/Add.146 (2001); *Concluding Observations of the Committee on the Rights of the Child: Spain,* CRC, 30th Sess., 798–799th mtgs., para. 39, U.N. Doc. CRC/C/15/Add.185 (2002).
[9] PROFAMILIA, SALUD SEXUAL Y REPRODUCTIVA EN COLOMBIA ENCUESTA NACIONAL DE DEMOGRAFÍA Y SALUD [SEXUAL AND REPRODUCTIVE HEALTH IN COLOMBIA DEMOGRAPHIC AND HEALTH SURVEY] 109 (2005), *available at* http://www.profamilia.org.co/encuestas/01encuestas/2005resultados_generales.htm [hereinafter PROFAMILIA]. (All demographic and health surveys that Profamilia has conducted since 1990 can be found at the following web link: http://www.profamilia.org.co/encuestas/index.htm.)
[10] *Id.* at 97.
[11] *Id.*
[12] Since 1990, Profamilia, a private non-governmental institution that works to improve the sexual and reproductive health of adults and adolescents throughout Colombia and that also works to develop social programs for those segments of the population that are the most poor, the most vulnerable and the most marginalized, has conducted a comprehensive survey of women's health every five years.
[13] PROFAMILIA, supra note 9, at 108.
[14] *Id.* at 109.
[15] *Id.*
[16] *Id.* at 108.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.* at 116.
[23] *Id.*
[24] *Id.*
[25] *Id.* at 166.
[26] *Id.*
[27] Although the abortion law does not expressly allow abortions to be performed to save the life of the woman, general principles of criminal legislation allow abortions to be performed for this reason when necessary. UNITED NATIONS POPULATION DIVISION DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, ABORTION POLICIES, A GLOBAL REVIEW, *available at* www.un.org/esa/population/publications/abortion/profiles.htm.
[28] News Release, Human Rights Watch, Colombia: Women Face Prison for Abortion (June 27, 2005), *available at* http://hrw.org/english/docs/2005/06/22/colomb11202.htm [hereinafter Human Rights Watch].

[29] News Release, Women's Link Worldwide, Abortion Reform Advocate Files Second Suit Before Colombia's Highest Court (Dec.12, 2005), *available at* http://www.womenslinkworldwide.org/pdf/proj_news_121205release.pdf [hereinafter Women's Link Worldwide].
[30] *Id.*
[31] *Id.*
[32] UNFPA WORLDWIDE: POPULATION, HEALTH AND SOCIO-ECONOMIC INDICATORS/POLICY DEVELOPMENTS, *available at* http://www.unfpa.org/profile/colombia.cfm; UNAIDS, PAN AMERICAN HEALTH ORGANIZATION, UNICEF, WHO, EPIDEMIOLOGICAL FACT SHEETS ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS 3 (2004) [hereinafter EPIDEMIOLOGICAL FACT SHEETS].
[33] *Concluding Observations of the Committee on the Rights of the Child: Colombia,* CRC, 25th Sess., 669th mtg., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000). The Committee is also concerned about the high maternal mortality and teenage pregnancy rates, as well as about insufficient access by teenagers to reproductive health education and counselling services. In this connection, concern is expressed that the practice of abortion is considered the leading cause of maternal mortality (see the concern expressed by the CEDAW Committee: U.N. Doc. A/54/38, para. 393). The increasing rates of substance abuse and of HIV/AIDS among children and adolescents and the constant discrimination they are exposed to are also matters of concern.
[34] Human Rights Watch, *supra* note 28.
[35] INTERNATIONAL WOMEN'S RIGHTS ACTION WATCH, COUNTRY REPORT FOURTH PERIODIC REPORT (1997), *available at* http://iwraw.igc.org/publications/countries/colombia.htm.
[36] *Id.*
[37] *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Colombia,* CEDAW, 20th Sess., para. 393, U.N. Doc. A/54/38 (1999).
[38] *Id.* at 394.
[39] *Concluding Observations of the Committee on the Rights of the Child: Colombia,* CRC, 25th Sess., 669th mtg., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000).
[40] *Concluding Observations of the Human Rights Committee: Colombia,* HRC, 80th Sess., para. 13, U.N. Doc. CCPR/CO/80/COL. (2004).
[41] *Id.*
[42] Women's Link Worldwide, *supra* note 29. The case was brought by Mónica Roa, the director of Latin American programs at Women's Link Worldwide, an international non-governmental organization working to advance women's rights through the implementation of international human rights law and the use of international tribunals and strategic litigation.
[43] *Id.*
[44] *Id.*
[45] UNAIDS, UNITING THE WORLD AGAINST AIDS COLOMBIA (2003), *available at* http://www.unaids.org/en/Regions_Countries/Countries/colombia.asp [hereinafter UNITING THE WORLD AGAINST AIDS]; EPIDEMIOLOGICAL FACT SHEETS, *supra* note 32, at 2.
[46] UNITING THE WORLD AGAINST AIDS, *supra* note 45; EPIDEMIOLOGICAL FACT SHEETS, *supra* note 32, at 2.
[47] UNITING THE WORLD AGAINST AIDS, *supra* note 45; EPIDEMIOLOGICAL FACT SHEETS, *supra* note 32, at 2.
[48] UNAIDS/WHO, AIDS EPIDEMIC UPDATE LATIN AMERICA 61 (December 2005), *available at* http://www.unaids.org/epi/2005/doc/EPIupdate2005_html_en/epi05_09_en.htm [hereinafter AIDS EPIDEMIC UPDATE].
[49] *Id.*
[50] PROFAMILIA, *supra* note 9, at 290.
[51] *Id.*
[52] *Id.* at 293.
[53] *Id.*
[54] *Id.* at 294.
[55] *Id.*
[56] MARIE STOPES INTERNATIONAL WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN, DISPLACED AND DESPERATE: ASSESSMENT OF REPRODUCTIVE HEALTH FOR COLOMBIA'S INTERNALLY DISPLACED PERSONS 19 (February 2003), *available at* http://www.womenscommission.org/pdf/co_rh.pdf [hereinafter DISPLACED AND DESPERATE].

[57] *Id.*
[58] *Id.*
[59] AIDS EPIDEMIC UPDATE, *supra* note 48, at 61.
[60] María Isabel García, *Health-Colombia: 'Positive' Women Buoyed by HIV/AIDS Network,* INTER PRESS SERVICE NEWS AGENCY, April 11, 2002, at 3, *available at* http://ipsnews.net/print.asp?idnews=13360.
[61] Ley Número 972 de 2005 [Law Number 972 of 2005], Diario Oficial 45.970 de Julio de 2005 [Official Daily 45.970 of July of 2005], *available at* http://www.minproteccionsocial.gov.co/MseContent/images/news/DocNewsNo610002.pdf.
[62] *Id.*
[63] *Id.*
[64] Red de Educación Popular Entre Mujeres de América Latina y el Caribe [Network of Popular Education Among Women from Latin America and the Caribbean], La Red Va, http://www.repem.org.uy/laredva378.htm.
[65] *Concluding Observations of the Committee on the Rights of the Child: Colombia,* CRC, 25th Sess., 669th mtg., para. 48 and 49, U.N. Doc. CRC/C/15/Add.137 (2000).
[66] *Id.*
[67] *Committee on the Rights of the Child: Report on the nineteenth session,* CRC, para. 243, U.N. Doc. CRC/C/80 (1998).
[68] PROFAMILIA, *supra* note 9, at 301.
[69] *Id.* at 302.
[70] *Id.*
[71] *Id.* at 306.
[72] *Id.* at 309.
[73] *Id.*
[74] *Id.*
[75] Neil Jeffery, *The Impact of War on Women: Current Realities, Government Responses and Recommendations for the Future,* February 2004, at 1, *available at* http://www.peacewomen.org/resources/Colombia/USOfficeColRealities.html.
[76] Commission on Human Rights, *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 2001/49 Addendum Mission to Colombia,* para. 68, U.N. Doc. E/CN.4/2002/83/Add.3 (2002) [hereinafter *Violence Against Women: Colombia*].
[77] *Id.*
[78] DISPLACED AND DESPERATE, *supra* note 56, at 7.
[79] *Id.* at 1.
[80] Profamilia is a private non-governmental institution that works to improve the sexual and reproductive health of adults and adolescents throughout Colombia and that also works to develop social programs for those segments of the population that are the most poor, the most vulnerable and the most marginalized.
[81] Jeffery, *supra* note 75, at 3.
[82] *Id.*
[83] DISPLACED AND DESPERATE, *supra* note 56, at 2.
[84] *Id.*
[85] *Id.*
[86] *Id.* at 2 and 19.
[87] Jeffery, *supra* note 75, at 2.
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] DISPLACED AND DESPERATE, *supra* note 56, at 9.
[93] *Id.*
[94] Jeffery, *supra* note 75, at 1.
[95] DISPLACED AND DESPERATE, *supra* note 56, at 20.
[96] *Id.*
[97] Jeffery, *supra* note 75, at 2.

[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] DISPLACED AND DESPERATE, *supra* note 56, at 19; *Violence Against Women: Colombia, supra* note 76*,* para. 56.
[102] Jeffery, *supra* note 75, at 2.
[103] *Violence Against Women: Colombia,* supra note 76, para. 56.
[104] *Id.*
[105] Jeffery, *supra* note 75, at 3; DISPLACED AND DESPERATE, *supra* note 56, at 21.
[106] DISPLACED AND DESPERATE, *supra* note 56, at 21.
[107] *Id.*