CENTER FOR REPRODUCTIVE RIGHTS

September 12, 2001

The Committee on Economic, Social, and Cultural Rights

Re: Supplementary information on Colombia
Scheduled for review by the U.N. Committee on Economic, Social, and Cultural Rights during its August 2001 session

Dear Committee Members:

The purpose of this letter is to provide some independent information regarding Colombia, which is scheduled to be reviewed by the Committee on Economic, Social, and Cultural Rights during its November session. Non-governmental organizations, such as the Center for Reproductive Law and Policy (CRLP) can play a central role in providing the committee with information that is reliable, accurate and independent concerning the rights covered by the International Covenant on Economic, Social, and Cultural Rights (Economic Rights Covenant). This letter will highlight several particular areas of concern related to the status of women's reproductive rights in Colombia.

Reproductive rights are fundamental to women's health and equality and we believe that states parties' commitment to ensuring said rights should receive serious attention. Further, women's reproductive health and rights are a part of the Committee's mandate under the Covenant on Economic, Social, and Cultural Rights.

CRLP has identified for the Committee the following issues of concern, which directly affect the reproductive health and lives of women in Colombia:

A. The Right to Reproductive Health and Family Planning (Articles 12, 10, and 15(1)(B) of the ICESCR)

Article 12 protects the right of all persons to enjoy the highest attainable standard of physical and mental health. This article is complemented by Article 15(1)(b), which grants all persons the right to benefit from the advances of scientific research and its applications. Under this provision, women are entitled to enjoy advances in research in the reproductive health field. Article 10 grants special protection to pregnant women before and after delivery as well as to adolescents and children.

These provisions require governments to make reproductive health, family planning, and safe motherhood services and information accessible to women. Without

these services, women and adolescents may have undesired pregnancies, potentially resulting in death or illness because of a lack of adequate maternal health care. The Committee on Economic, Social, and Cultural Rights has expressed its concern over the inequitable distribution of health services among urban and rural regions.[1] The Committee has noted that a lack of integration of family planning centers into primary health care hinders women's ability to access affordable contraception. It has also advised states parties to guarantee adequate assistance to persons afflicted with HIV/AIDS, without discrimination as to race, origin, nationality, or gender.[2]

1. Family Planning

Family planning services are a component of the primary health care program,[3] and every health center and hospital must provide family planning services to low-income individuals.[4] However, resources continue to be concentrated in certain areas of the country, which means that a significant portion of the low-income population lacks access to these services.[5]

According to government information sources, the state has supported family planning services and incorporated them in population policy for many years.[6] In 1993, nevertheless, the state system coverage is limited, only 20% of contraceptive methods countrywide.[7] Although awareness of various family planning methods is high, women do not have accurate information on the methods, how to use them and their side effects.[8]

2. Abortion

Abortion in Colombia is a public health problem of unknown magnitude, principally due to its illegality, which in turn contributes to substantial under-reporting. According to 1993 data, approximately 450,000 abortions occur in Colombia every year.[9] A 1996 study of maternal mortality in Colombia[10] estimated that in 1994, abortion was the second-leading cause of maternal mortality, which correlates with the high rate of unsatisfied demand for contraceptive methods. The same study shows that the 20-29 age group reported the highest incidence of abortion-related deaths.[11] According to the President's Council on Women, approximately 20% of Colombian women of child-bearing age (about 1.5 million) had at least one abortion in 1993. This number included women of all ages and social classes, although young women aged 16-27 had the highest incidence of abortion. Women under age 15 also have abortions, and abortion is the fourth leading cause of hospitalization for this group.[12]

In 1995, approximately 80% of abortions were due to the absence of contraceptive methods; the remaining 20% occurred due to failures in contraceptive methods.[13] Both the choice of method and its consequences are directly related to the type of practitioner and the social class of the pregnant woman. Poor women from both rural and urban areas suffer the most complications (50-60%) from either self-induced abortions or those performed by others.[14]

3. Maternal Mortality

While Colombia's maternal mortality rate is declining (1986: 119.8 deaths per 100,000 live births; 1994: 98.2), it remains a serious health issue, as do problems of under-reported data.[15] Poor women and those living in rural areas have higher rates of morbidity and mortality.[16] For example, the Pacific Coast's maternal mortality rates are three times higher than the national average and nine times higher than the rate in the Medellín metropolitan area.[17] For females aged 10-14 and 15-19, the leading cause of hospitalization is to give birth.[18]

4. HIV/AIDS and Sexually Transmissible Infections (STIs)

The number of people living with HIV and AIDS in Colombia has risen since the first AIDS cases were reported in 1983. Through 1994, Colombia reported 85 cases of HIV/AIDS per one million inhabitants.[19] Data from 1992 showed 2,855 cases of AIDS in men and 212 in women.[20] In 1993, there were 2,855 cases of HIV and 3,304 of AIDS.[21]

Discrimination in health services exists against people, whether male or female, suffering from HIV/AIDS or STIs. This discrimination denotes prejudice and a lack of open discussion about sexual differences generally. No data exist to determine either the number of discrimination cases or of official responses to sanction abuses and discriminatory practices.

In order to receive medical attention for AIDS within the social security system, people must pay into the system for one hundred weeks (two years). This requirement means that as result, many people end up not being covered.[22] It is furthermore believed, given under-reporting and the fact that the social security system does not include everyone, that rates of people living with HIV and AIDS are much higher than those officially reported.

5. Adolescent Reproductive Health

Although some private health care organizations such as PROFAMILIA offer reproductive health services on a sliding fee scale to adolescents, in practice, male and female adolescents lacking economic resources do not have adequate access either to reproductive health care or to contraceptive methods because the government does not cover such services.

Pregnancy at a young age is part of the cultural heritage in some regions. In most cases, however, these pregnancies are unwanted and involve single mothers who have usually been abandoned by their partners.[23] Furthermore, many of these pregnancies end in costly clandestine abortions performed under inadequate conditions.[24] Of every 100 women who become pregnant before age 19, 45 have

an abortion. According to hospital records, abortion is the third leading cause of maternal mortality among adolescents.[25]

B. Violence Against Women (Articles 12 and 10(3) of the ICESCR)

Article 10(3) requires states parties to take all appropriate steps to protect children and adolescents. This article, combined with Article 12, protects children and adolescents against all forms of physical abuse and violence. In the same way, Articles 10 and 12 encompass protections for women prohibiting all forms of sexual and/or physical violence. Thus, when women, whether they are minors or of majority age, are victims of sexual abuse, domestic violence, or female circumcision/female genital mutilation (FC/FGM), their rights under these provisions are violated.

The Committee on Economic, Social, and Cultural Rights has expressed its concern over the problem of violence against women. It has noted that violence against women, both within and outside the family has serious effects on a woman's physical and mental health.[26] It strongly advises states parties to adopt effective measures to combat violence against women.

1. Sexual Violence

While recent changes have increased penalties for sexual crimes, serious difficulties remain in the ways such crimes are investigated. Specific problem areas include procedural issues, evidentiary issues, and lack of respect for victims' rights.[27] In addition, authorities lack the technical and economic resources needed to conduct investigations, and the existing institutional infrastructure is not adequate for proper investigations.

Some judges' approach to sentencing sexual aggressors perpetuates prejudices such as the belief that women cause sexual violence by acting provocatively.[28] Furthermore, other stereotypes continue to prevent equal justice for women in the judicial system. Specifically, protection is limited according to subjective arguments of the woman's "honesty" or "good name," as well as the belief that women are not credible witnesses, particularly when the aggressor is a family member or otherwise unknown to her.

2. Domestic Violence

Despite government efforts to address domestic violence, such efforts fail to address the issue in an integrated and systematic way. Efforts are particularly insufficient in two respects: compensating victims and humanizing their treatment within the criminal justice system.

In 1997, 145 homicides resulted from domestic violence.[29] Of these homicides, 57% of the victims were women.[30] According to 1995 statistics, women living with a partner suffered abuse as follows: 33% suffered verbal abuse from their partner or spouse; 19% suffered physical abuse[31]; and 6% suffered sexual abuse.[32]

In 1995, the Institute of Legal Medicine recorded 42, 963 cases involving injury due to domestic violence.[33]

The available data concerning domestic violence represent only a small part of the problem's true magnitude. No definitive estimates about under-reported data exist. Nevertheless, some data do indicate that although women know the institutions where they can file domestic violence complaints against their husbands, only 27% of victims have done so.[34] Thus, a more accurate estimate of the problem's extent would mean multiplying existing data by four.

The law provides that as a temporary measure, judges can order housing for victims of domestic violence in half-way houses or shelters. Such orders, however, rarely occur because few shelters exist and most of these cater principally to minors. The shelters are usually administered by NGO's without government aid.

C. The Right to Equitable and Favorable Working Conditions (Articles 6, 7, and 10 of the ICESCR)

Article 6 guarantees the right of every person to freely work and to freely choose or accept employment, and Article 7 establishes the minimum conditions in which this work should be carried out. Article 10 protects the rights of working women before and after pregnancy.

Consequently, these provisions guarantee women access to employment without discrimination and to protection during pregnancy. The Committee on Economic, Social, and Cultural Rights has strongly advised states parties to the International Covenant to adopt all the necessary measures to guarantee women equality of treatment in employment.[35] The committee has expressed its concern regarding countries which lack a law concerning sexual harassment, the victims of which are women.[36]

Pregnant women and women of child-bearing age continue to be discriminated against in the labor market. For example, companies prefer to hire men because if a female employee becomes pregnant, she is more expensive than a male employee.[37] Generally women do not file complaints with the Ministry of Labor because they do not realize that they have suffered actionable discrimination, and because they fear losing their jobs. In the latter case, they prefer to keep silent and avoid calling attention to the treatment they have suffered.[38]

The labor rights of both pregnant women and women of child-bearing age are often violated. Legal mechanisms for addressing such violations, however, are ineffective. On occasion, women have found some success – though not consistently – through *tutela* claims.[39]

D. The Right to Education (Articles 13, 14, 15, and 12 of the ICESCR)

Articles 13 and 14 protect children's rights to compulsory primary education, free of charge for everyone. Article 15 recognizes the importance of access to information and materials from diverse sources. Article 12, when read together with these articles, establishes the link between education, the right not to be subject to discriminatory treatment based on gender, and the right to health education.

The Committee on Children's Rights has noted that girls represent two-thirds of the 100 million children worldwide who have not had a basic education, and that the literacy rate of female adolescents is much lower than that of male adolescents.[40] The Committee on Economic, Social, and Cultural Rights has recognized children's right to education and training that permits integration into the socio-economic mainstream. It has also called upon governments to take all the necessary steps to guarantee girls' access to education.[41]

The illiteracy rate among women has decreased from 29% in 1964 to 11.6% in 1993.[42] At almost every educational level, enrollment is equally distributed by sex. In fact, the percentage of female students enrolled in higher education has climbed to 51.7%,[43] much higher than the 1960 level of 18.4%.[44] However, rural women continue to have less access to education than urban women.[45]

The Committee should also consider addressing the following questions to the Colombian government:

1. What steps are being taken to address the high level of maternal mortality in Colombia, particularly among rural women? What is being done to address the barriers that women face in accessing full and affordable reproductive health and family planning services?

2. What measures are being taken to address the issue of unsafe and illegal abortion, one of the primary causes of maternal mortality? What governmental efforts exist to ensure post-abortion care for complications as well as for reproductive health counseling?

3. What governmental efforts have been made to ensure that all persons living with HIV/AIDS have access to comprehensive medical services? What measures have been taken to combat discrimination and prejudiced practices against persons living with HIV/AIDS?

4. What governmental programs have been established to ensure that adolescents of all social classes have access to reproductive health services, and what efforts have been made to ensure that adolescents' rights to privacy and confidentiality are respected when seeking such services? Have any initiatives been taken to ensure that health care providers are sensitized to the specific reproductive health needs of adolescents? What measures have been taken to institutionalize sexual education programs?

5. What governmental efforts have been made to counter the increase in sexual and domestic violence? Are there any public campaigns to raise awareness about violence against women? Are there plans to increase the number of shelters for women faced with violence within the family? What efforts are being made to create adequate institutional infrastructures that conduct proper investigations for sexual crimes?

Finally, we have included the following supporting documentation for the Committee's reference:

- The Colombia Chapter of *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Latin America and the Caribbean*, by CRLP and DEMUS, Estudio para la Defensa de los Derechos de la Mujer.

- *Women's Reproductive Rights in Colombia: A Shadow Report*, by CRLP and Corporación Casa de la Mujer.

There remains a significant gap between the provisions contained in the International Covenant on Economic, Social, and Cultural Rights and the reality of women's reproductive health and lives. We appreciate the active interest that the Committee has taken in the reproductive health and rights of women in the past, stressing the need for governments 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 to the provisions contained within the International Covenant on Economic, Social, and Cultural Rights. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

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[1] Julie Stanchieri, Isfahan Merali, and Rebecca J. Cook, The Application of Human Rights to Reproductive and Sexual Health: a Compilation of the Work of UN Treaty Bodies, June 1999 (unpublished, on file with

CRLP), *citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: Paraguay, 05/28/96, E/C.12/1/Add.1.

[2] *Id., citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: for example, Germany, 04/12/98, E/C.12/1/Add.29; Russian Federation. 05/20/97.E/C.12/Add.13.

[3] UNITED NATIONS POPULATION FUND, PROGRAM REVIEW AND STRATEGY DEVELOPMENT REPORT-COLOMBIA (1993) at 23.

[4] *Id.*

[5] Presentación conjunto de los informes periódicos segundo y tercero, revisados, de los Estados-partes, Colombia [Combined presentation of the revised versions of the second and third periodoc reports of States Parties, Colombia], U.N. Doc. CEDAW/C/COL/2-3/Rev.1, at 48-49.

[6] UNITED NATIONS POPULATION FUND, *supra* note 3, at 23.

[7] *Id.*

[8] In rural areas, 58% of the women who use the pill do so with mistakes, and 75% obtain it directly from pharmacies, which may result in improper use. ALAN GUTTMACHER INSTITUTE, *Aborto clandestino: Una realidad latinoamericana* [*Clandestine Abortion: A Latin American Reality*], New York and Washington, 1994.

[9] PRESIDENTIAL COUNCIL FOR WOMEN, CHILDREN AND FAMILY. Second and Third Periodic Reports presented before the Committee for the Elimination of All Forms of Discrimination against Women (CEDAW). Bogotá, January 1994.

[10] PRESIDENT OF THE REPUBLIC OF COLOMBIA, WORLD HEALTH ORGANIZATION, ET AL. 1996: MORTALIDAD MATERNA EN COLOMBIA [1996: MATERNAL MORTALITY IN COLOMBIA].

[11] *Id.,* at 13.

[12] *Id.,* at 39.

[13] PROFAMILIA, ENCUESTA NACIONAL DE DEMOGRAFIA Y SALUD [NATIONAL DEMOGRAPHIC AND HEALTH SURVEY], at 101 (1995).

[14] *Latinoamérica aborta por montones* [*Latin America aborting in masses*] in EL TIEMPO, Bogotá, April 28, 1994.

[15] *Dialoguemos. . . sobre Salud Sexual y Reproductiva* [*Let's Talk about Sexual and Reproductive Health*], Bulletin No. 1, February 1998, at 2.

[16] NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings from the Workshop LA SALUD DE LAS MUJERES EN EL MARCO DE LA LEY 100/93 [WOMEN'S HEALTH WITHIN THE FRAME OF LAW 100 OF 1993], May 1997, at 13.

[17] *Dialoguemos. . . sobre Salud Sexual y Reproductiva* [*Let's Talk about Sexual and Reproductive Health*], *supra* note 17, at 2.

[18] NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings, *supra* note 18.

[19] MINISTRY OF HEALTH, PROGRAMA NACIONAL DE PREVENCION Y CONTROL DE LAS ETS-VIH/SIDA [NATIONAL PROGRAM TO PREVENT STIS AND HIV/AIDS], at 25 (1995).

[20] United Nations, Combined Presentation of the Revised Versions of the Second and Third Periodic Reports of States Parties – Colombia, at 47.

[21] *Id*.

[22] Victor de Currea Lugo, *Derechos Humanos y Salud: La Letra Munuda de la Ley 100* [*Human Rights and Health: The Fine Print of Law 100*] in Revista Nova & Vetera, at 67.

[23] NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 15, at 39.

[24] *Id*.

[25] MUÑOZ, MONTSERRAT. INFORME NACIONAL A LA REUNION REGIONAL DE AMERICA LATINA SOBRE SALUD SEXUAL Y REPRODUCTIVA DE LOS ADOLESCENTES COLOMBIANOS [NATIONAL REPORT TO THE REGIONAL MEETING ON THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS] at 13 (1997).

[26] Stanchieri et al., *supra* note 1, *citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: for example, El Salvador, 05/28/96, E/C.12/Add.4; Dominican Republic, 12/12/97, E/C.12/Add.16; Israel, 04/12/98, E/C.12/1/Add.35.

[27] COMITE INTERINSTITUCIONAL PARA LA REVISION DE LOS PROCEDIMIENTOS DE ATENCION A LAS MUJERES VICTIMAS DE VIOLENCIA SEXUAL [INTER-INSTITUTIONAL COMMITTEE FOR THE REVISION OF LEGAL PROCEDURES IN ATTENDING FEMALE VICTIMS OF SEXUAL VIOLENCE]. DERECHO, ORDENAMIENTO LEGAL Y PROCESO JUDICIAL, [LAW AND THE JUDICIAL PROCESS] with regard to sexual crimes against minors between 14 and 18 years of age and minors under 14 years of age.

[28] *See* Supreme Court Decision, Court of Appeals, May 22, 1992. (Presiding judge: Gustavo Rendón Gaviria.)

[29] These represent 2% of homicides.

[30] National Reference Center on Violence, National Institute of Legal Medicine and Forensic Sciences. CRNV Bulletin Vol. 3, No. 5, May 1998, at 6.

[31] NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 15, at 157.

[32] *Id*., at XXXI.

[33] NATIONAL COUNCIL ON EQUALITY FOR WOMEN, LOS DERECHOS DE LA MUJER EN COLOMBIA [THE RIGHTS OF WOMEN IN COLOMBIA] 47 (Mar. 1997).

[34] NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 15, at XXXI. *See also* at 157. This number is higher than that recorded in 1990. In that year, only 11% of abused women filed complaints.

[35] Stanchieri et al., *supra* note 1, *citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: for example, Israel, 12/04/98.E/C.12/1/Add.27; Nigeria, 5/13/98, E/C.12/Add.23.

[36] *Id*., *citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: for example, Poland, 06/16/98. E/C.12/1/Add.26; Nigeria, 5/13/98, E/C.12/Add.23.

[37] OFFICE OF THE OMBUDSMAN, FOURTH ANNUAL OMBUDSMAN'S REPORT BEFORE THE COLOMBIAN CONGRESS, at 457.

[38] *Id.*

[39] CIJUS, Center of Social and Legal Investigations. OBSERVATORIO DE LA MUJER. Santafé de Bogotá, 42 (Universidad de los Andes, September 3, 1998).

[40] UNICEF, IMPLEMENTATION HANDBOOK FOR THE CONVENTION ON THE RIGHTS OF THE CHILD 611, et seq. (1998) [hereinafter IMPLEMENTATION HANDBOOK].

[41] Stanchieri et al., *supra* note 1, *citing* Concluding Observations of the Committee on Social, Economic, and Cultural Rights: for example, Algeria, 12/28/95, E/C.12/1995; Dominican Republic, 12/12/97, E/C.12/1/Add.16.1; Libyan Arab Jamahiriya, 05/16/97, E/C.12/1/Add.15.

[42] PRESIDENCY OF THE REPUBLIC OF COLOMBIA, COLOMBIA PAGA SU DEUDA A LAS MUJERES. INFORME NACIONAL DEL GOBIERNO DE COLOMBIA. CUARTA CONFERENCIA MUNDIAL SOBRE LA MUJER [NATIONAL REPORT FROM COLOMBIA. NATIONAL REPORT OF THE COLOMBIAN GOVERNMENT. FOURTH INTERNATIONAL CONFERENCE ON WOMEN], at 21 (1995).

[43] United Nations, *supra* note 22, at 26.

[44] *Id.*

[45] United Nations, *supra* note 22, at 61. In 1990, the female population in rural areas had an average of 3.2 years of education, compared to 5.8 years for women in urban zones. Among rural women, 13.9% have no education at all, while the number in urban zones is 6.3%. As to primary education (the first six years of school), 40.2% of rural women have had primary education, while 60% of urban women have done so. As to secondary education, 12.9% of rural women have completed at least one year, while 35% of urban women have done so. Finally, as to higher education, 0.5% of rural women have completed higher studies, compared to 7.5% of urban women.