

MAKING RIGHTS A REALITY: ACCESS TO HEALTH CARE FOR AFRO-COLOMBIAN SURVIVORS OF CONFLICT-RELATED SEXUAL VIOLENCE

Deborah Zalesne*

ABSTRACT

In 2008, Colombia enacted Law 1257, which states that “women’s rights are human rights,” and that women’s rights include “the right to a dignified life,” including the right to “physical health” and “sexual and reproductive health.” In 2016, the Colombian government signed a peace accord with the Revolutionary Armed Forces of Colombia (“FARC”), which included groundbreaking racial and gender justice provisions. In the years since, the government has

* Professor of Law, City University of New York School of Law. B.A., Williams College; J.D., University of Denver College of Law; LL.M., Temple University School of Law. The author was a member of a delegation of faculty from the Human Rights and Gender Justice (HRGJ) Clinic at CUNY Law School that met with Afro-Colombian women activists from Proceso de Comunidades Negras (PCN) in Cali, Colombia to discuss issues concerning gender-based human rights violations committed against Afro-Colombian women since the Colombian Peace Accords. I would like to extend my gratitude to the PCN participants in this meeting for their candid and detailed recounting of personal stories of issues faced by members of their communities who have been victims of violence and for their thoughtful ideas and suggestions. I would like to thank Professor Lisa Davis, director of the HRGJ clinic, for inviting me to be a part of the delegation, and Professors Rebecca Bratspies, Babe Howell, and Julie Goldscheid, the other members of the CUNY Law delegation, for their participation in these important conversations with PCN members and for their helpful remarks about issues presented in this paper. I would also like to thank CUNY Law student Maricelly Malave for leading a human rights fact-finding delegation to territories of the Middle Pacific and Chocó regions of Colombia and conducting in-depth interviews with Afro-Colombian, Indigenous, and campesino communities for this Article. In addition, I thank my fabulous research assistants Genevieve Marcy, Stephanie DeMartini, Vladimir Martinez, and Cristina Carvajal for their invaluable research assistance. Finally, I would like to acknowledge the generous support of the University of Los Andes Law School in Bogota, Colombia, where I currently have the honor of working as a Visiting Professor.

failed to fully implement the accord's protections against gender violence and has failed to rectify disparities in the availability, accessibility, and quality of women's health services throughout Colombia. Indigenous and Afro-Colombian women in rural and remote areas have felt these failures more than anyone else. The intersection of race, class, and gender creates unique issues for Afro-Colombian victims of sexual violence, which can result in a complete lack of health care options. This Article spotlights the many structural barriers that Afro-Colombian women face in realizing their right to health and health care in Colombia. The Article draws heavily from conversations and interviews with Afro-descendant Colombian members of *Proceso de Comunidades Negras* ("PCN") and community leaders and activists from the rural Pacific Afro-Colombian river communities of San Juan and Naya River. Part I of this Article gives a brief overview of the history of race discrimination and violence against women in Colombia and of the specific situation of Afro-Colombian women. Part II then gives an overview of the health care system in Colombia and the national health law, which guarantees health care as a right to all citizens, including free and compulsory basic health services. Part III details the many obstacles that cut off populations of Afro-Colombians from access to appropriate medical care altogether, despite the national guarantee of the right to health care. Finally, in the Conclusion, the Article proposes some basic responses to the deficits highlighted in Part III. To bring the provision of health services in line with the law's mandate, policy makers must consider how the intersection of race, class, and gender uniquely affects Afro-Colombian victims of sexual violence. To obtain health equity, policy makers must address structural and institutional issues that cause the disparities.

TABLE OF CONTENTS

Introduction	671
I. Roots and Reality of Violence Against Afro-Colombian Women ...	676
II. Limits to Colombia's Progressive Health Care Law.....	684
A. Separate but (Un)Equal: Racialized and Class-Based Health Gaps Between the Public Subsidized Plan and the Private Contributory Plan	686
B. Limitations of Colombia's Rape Law.....	689
III. Lack of Access for Afro-Colombian Communities to Health Care Clinics and to Sufficient Post-Rape Health Care Services: Through the Eyes of Victims	693
A. Inaccessible Clinics.....	693
B. Post-Rape Medical Care: Deficits in Services Provided	703
C. Inadequate Abortion Services.....	710
1. Legal and Administrative Barriers to Abortion.....	712
2. Cultural Obstacles to Abortion	716
3. Financial Barriers to Abortion.....	717
Conclusion.....	719

INTRODUCTION

The right to health is a fundamental human right.¹ In 2008, Colombia enacted Law 1257, which states that “women’s rights are human rights,” and that women’s rights include “the right to a dignified life,” including the right to “physical health” and “sexual and reproductive health.”² Victims of sexual violence are specifically granted “the right to receive comprehensive, sufficient, accessible, and quality care” as well as “the right to receive clear, complete, true, and timely information regarding sexual and reproductive health.”³ In interviews and in-depth conversations with community leaders and activists in rural Pacific Afro-Colombian communities,⁴ no one believed that women in these communities were receiving health care nearly up to these standards.

This Article spotlights the many structural barriers that Afro-Colombian women face in realizing their right to health and health care in Colombia. The Article draws heavily from conversations and interviews with Afro-descendant Colombian members of Proceso de Comunidades Negras (“PCN”)⁵ and community leaders and activists from the rural Pacific Afro-Colombian river communities of San Juan and Naya River. The contributions of the PCN members were solicited at a meeting with the CUNY School of Law Human Rights and Gender Justice Clinic (“HRGJC”)⁶ and representatives from

1. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 49 (Constitute, Constitute through 2005 amendments), https://www.constituteproject.org/constitution/Colombia_2005.pdf [<https://perma.cc/34LW-RHA4>]; *Human Rights and Health*, WORLD HEALTH ORG. (Dec. 29, 2017), <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> [<https://perma.cc/5YB4-CRZK>].

2. L. 1257, arts. 6, 7, diciembre 4, 2008, DIARIO OFICIAL [D.O.] (Colom.) (“Los derechos de las mujeres son Derechos Humanos”; “[L]as mujeres tienen derecho . . . a la integridad física, . . . a la salud, a la salud sexual y reproductiva . . .”).

3. L. 1257, art. 8, diciembre 4, 2008, D.O. (“Toda víctima de alguna de las formas de violencia previstas en la presente ley . . . tiene derecho a . . . [r]ecibir atención integral a través de servicios con cobertura suficiente, accesible y de la calidad; . . . [r]ecibir información clara, completa, veraz y oportuna en relación con la salud sexual y reproductiva . . .”).

4. See *infra* notes 5, 6 & 8 and accompanying text.

5. PCN is an Afro-descendant collective of more than 100 grassroots organizations, Community Councils, and individuals formed in Colombia in 1993. *Quienes Somos*, PROCESO DE COMUNIDADES NEGRAS, <https://renacientes.net/quienes-somos/> [<https://perma.cc/5Y4G-563V>].

6. The HRGJ Clinic began working with PCN in 2017 in their struggle to implement Colombia’s Peace Accords from an ethnic, racial, and gender perspective.

MADRE,⁷ held between February 23rd and 25th, 2019 (“PCN Meetings”), and contributions of the leaders and activists of the river communities were gathered at a meeting with the Witness for Peace Delegation in August 2019 (“Witness for Peace Interviews”).⁸

While Colombia has made significant legal progress in the recognition and protection of the right to health, there are still substantial disparities in the availability, accessibility, quality, and affordability of health care services throughout Colombia, particularly affecting women living in rural and remote areas, Indigenous and Afro-Colombian women, and women who have been victims of conflict-related violence, and especially at the intersection of all these groups.⁹ These disparities typically result from continued

7. MADRE is an international women’s human rights organization that works in partnership with community-based women’s organizations worldwide to address issues of health and reproductive rights, economic development, education, and other human rights issues. See MADRE: FIGHTING FOR FEMINIST FUTURES, <https://www.madre.org/> [<https://perma.cc/58XC-67F4>].

8. Meeting of Witness for Peace Delegates with Afro-Colombian and Indigenous Communities of the Conpaz Network—Communities Building Peace in the Territories, in Buenaventura (Department of Valle del Cauca), López de Micay (Cauca), Litoral de San Juan (southern Chocó), and territories of the Middle Pacific and Chocó region (August 2–13, 2019) (hereinafter Witness for Peace Interviews) (on file with the *Columbia Human Rights Law Review*). The Witness for Peace delegation of citizens of the United States, led by CUNY law student Maricelly Malave, visited two of the sixteen prioritized regions to help implement the Final Agreement of the Peace Accords for the termination of the conflict and the construction of a stable and lasting peace in Colombia. The main purpose of the delegation was to gather testimonies of community leaders of the Conpaz Network about the human rights situation in the community since the signing of the Peace Accords.

9. In addition to facing disproportionately severe barriers to health care, Afro-Colombian and Indigenous women have also been disproportionately subject to displacement and struggle over land rights, violence (including sexual violence), human rights violations, and overall have generally had the least access to justice, among other things. See generally Rebecca Bratspies, *‘Territory is Everything’: Afro-Colombian Communities, Human Rights and Illegal Land Grabs*, 4 HRLR ONLINE (forthcoming Spring 2020) (on file with the *Columbia Human Rights Law Review*) (arguing that in compliance with domestic and international law, more must be done to protect land-grabbing disproportionately affecting Afro-Caribbean and Indigenous women); Julie Goldscheid, *Gender Violence and Afro-Colombian Women: Making the Promise of International Human Rights Law Real*, 4 HRLR ONLINE (forthcoming Spring 2020) (on file with the *Columbia Human Rights Law Review*) (finding that Afro-Colombian and Indigenous women are the most vulnerable groups as it relates to violence, including sexual violence and HR violations); Babe Howell & Naree Sinthusek, *In the Crosshairs: Centering Local Responses to SGBV in Afro-Colombian Communities*, 4 HRLR ONLINE (forthcoming Spring 2020) (on file with the *Columbia Human Rights Law Review*)

gendered violence in in the regions along the Pacific Coast inhabited by Afro-Colombians,¹⁰ the low social status of Afro-descendant and Indigenous Colombians,¹¹ and persistent cultural attitudes and practices surrounding sexual violence, abortion, and women's reproductive health in general.¹² The intersection of race, class, and gender creates unique issues for Afro-Colombian victims of sexual violence, which can result in a complete lack of health care options. And, since sexual violence is not considered to be a medical emergency by authorities, medical needs of victims are not prioritized.

In 2016, the Colombian government signed a peace accord with the Revolutionary Armed Forces of Colombia ("FARC"),¹³ which included groundbreaking racial and gender justice provisions.¹⁴ Since that time there has been significant disarmament of the FARC.¹⁵ However, by all accounts, the government has failed to fully implement the accord,¹⁶ and the sections focused on gender have been the least implemented¹⁷—armed actors continue to commit violence

(explaining the unique struggles faced by Afro-Colombian and Indigenous women regarding access to justice in relation to sexual and gender-based violence).

10. See *infra* notes 40–41, 67–69, 127 and accompanying text.

11. See *infra* notes 36–39 and accompanying text.

12. ABCOLOMBIA, COLOMBIA: WOMEN, CONFLICT RELATED SEXUAL VIOLENCE AND THE PEACE PROCESS 1 (2013), https://reliefweb.int/sites/reliefweb.int/files/resources/ABColumbia_Conflict_related_sexual_violence_report.pdf [<https://perma.cc/6ZZW-9SRC>].

13. Final Agreement to End the Armed Conflict and Build a Stable and Lasting Peace, Colom.-FARC, Nov. 24, 2016, <http://especiales.presidencia.gov.co/Documents/20170620-dejacion-armas/acuerdos/acuerdo-final-ingles.pdf> [<https://perma.cc/S2F6-VU5G>] [hereinafter FARC Final Agreement].

14. See *id.*, Provisions 1.3, 1.3.2, 1.3.2.2, 1.3.4, 2.2.1, 2.2.3, 2.2.4, 2.3.1-2.3.8, 3.4.4, 4.1.2, 4.2.1.4, 5.1.1.2, 5.1.2, 5.1.3.4, 5.1.3.5, 5.1.4, 5.2.

15. Nicholas Casey & Joe Parkin Daniels, 'Goodbye, Weapons!' FARC Disarmament in Colombia Signals New Era, N.Y. TIMES (June 27, 2017), <https://www.nytimes.com/2017/06/27/world/americas/colombia-farc-rebels-disarmament.html> (on file with the *Columbia Human Rights Law Review*).

16. PROCESO DE COMUNIDADES NEGRAS ET AL., VIOLATIONS OF AFRO-COLOMBIANS' GENDER-BASED HUMAN RIGHTS: A REPORT FOR THE UNITED NATIONS COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN 1 (Feb.–Mar. 2019), <https://www.madre.org/sites/default/files/PDFs/CERD%20LOT%20FinalEnglish9.6.19.pdf> [<https://perma.cc/772D-WY6V>].

17. Kimberley Brown, *For Many Women in Colombia, Peace Never Arrived*, AL JAZEERA (May 9, 2019), <https://www.aljazeera.com/indepth/features/women-colombia-peace-arrived-190509194227891.html> [<https://perma.cc/A39N-HWP3>]. See also Goldscheid, *supra* note 9, at 2 (noting that "[t]he Peace Accord included 100 provisions on gender equality and women's human rights, several of which

against women with impunity. Afro-Colombian and Indigenous women and girls in particular are doubly vulnerable, and they “continue to live disproportionately in conflict-ridden areas and to be at high risk for displacement and other violence, including sexual and gender-based violence.”¹⁸

Despite Colombia’s fairly progressive health laws,¹⁹ health care is nearly impossible to access for many victims of sexual violence. The lack of data disaggregated by race or ethnicity makes it difficult to determine precisely the impact of gender-based violence on Afro-descendant communities. However, it seems clear from the interviews and discussions conducted for this Article that the combined forces of poverty, discrimination against Afro-Colombian people, and dismissive cultural attitudes toward violence against women effectively prevent Afro-Colombian victims of gender-based violence from accessing adequate health care. This is not a surprise, considering the legacy of slavery and discrimination against Afro-descendant and indigenous people, as well as gender discrimination and cultural stigma surrounding sexual violence. Of those that do seek help, many victims are unable to get the medical attention they need, either because there are no accessible health care clinics, or because any available clinic lacks the necessary supplies or resources to handle medical issues associated with sexual violence.²⁰

Part I of this Article gives a brief overview of the history of race discrimination and violence against women in Colombia and of the specific situation of Afro-Colombian women. This Part describes the hyper-sexualization of Afro-Colombian women and how stereotypes surrounding their sexuality contribute to violence against them.

Part II then gives an overview of the health care system in Colombia and the national health law, which guarantees health care

address conflict-related sexual violence, but research indicates that only four percent of those provisions had been implemented by mid-2018”).

18. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 1; *see also* Goldscheid, *supra* note 9, at 1 (noting that “gender violence in Colombia continues with devastating effect, and with a particularly harmful impact on Afro-descendant and Indigenous women and their communities”).

19. *See infra* notes 80, 83–88 and accompanying text; *see generally* FED. RESEARCH DIV., LIBRARY OF CONGRESS, COLOMBIA: A COUNTRY STUDY 112–15 (Rex. A Hudson, ed., 5th ed. 2010), <https://cdn.loc.gov/master/frd/frdcstdy/co/colombiacountrys00huds/colombiacountrys00huds.pdf> [https://perma.cc/XQL4-FB8E] (providing an overview of health in Colombia).

20. *See infra* Sections III.A and III.B.

as a right to all citizens, including free and compulsory basic health services.²¹ This Part examines the ways in which the health care system operates to the detriment of low-income people, specifically because of inequalities between the private contributory plan and the public subsidized plan.

Part III details the many obstacles that cut off populations of Afro-Colombians from access to appropriate medical care altogether, despite the national guarantee of the right to health care. Based in part on conversations and interviews with Afro-descendant Colombian members at the PCN Meetings and at the Witness for Peace Interviews, Section III.A studies the on-the-ground reality, demonstrating that in rural areas, where most communities are majority Afro-Colombian,²² clinics have been shut down at alarming rates²³ or have such infrequent hours of operation as to make them virtually useless to some women.²⁴ Indeed, Indigenous and Afro-

21. See *infra* note 83 and accompanying text.

22. DEPARTAMENTO ADMINISTRATIVO NACIONAL DE ESTADÍSTICA (DANE) [NATIONAL ADMINISTRATIVE DEPARTMENT OF STATISTICS], LA VISIBILIZACIÓN ESTADÍSTICA DE LOS GRUPOS ÉTNICOS COLOMBIANOS 24 (2005), https://www.dane.gov.co/files/censo2005/etnia/sys/visibilidad_estadistica_etnicos.pdf [<https://perma.cc/T4KU-7Z5C>] (explaining that Afro-Colombians are the majority in Buenaventura, the rural area discussed in Part III.A).

23. “Many clinics have closed. Con-famar, Pro-Familia, and other health clinics have all closed because there is no infrastructural support.” Interview by Witness for Peace Delegates with Nora Isabel Castro Panameno (“Chava”), Leader, Humanitarian Space, in Puente Nayro (Aug. 2–13, 2019) (on file with the *Columbia Human Rights Law Review*). Chava explains further:

When Pro-Familia’s clinic (a public clinic) closed it was devastating for women in the area because that was the only clinic that helped women get birth control and have operations for not having more children. Now since it has been closed it blocks women’s ability to do any family planning. Now all women have to go to Cali for reproductive services. It’s devastating. Women have had to go to private doctors here. So now poor women literally have no access for reproductive health services.

Id.

24. See, e.g., Florence Panoussian, *Hospital Ship Plies Turbulent Waters of Colombia’s Pacific Coast*, MEDICAL XPRESS (May 10, 2019), <https://medicalxpress.com/news/2019-05-hospital-ship-plies-turbulent-colombia.html> [<https://perma.cc/4M6V-ZJQR>] (noting that “for hundreds of miles along Colombia’s Pacific coast . . . there are no hospitals, and medics and medicine are rare”); *Venezuelans in Colombia Struggle to Find Health Care: “This Is a Crisis,”* DOCTORS WITHOUT BORDERS (Jul. 16, 2019), <https://www.doctorswithoutborders.org/what-we-do/news-stories/story/venezuelans-colombia-struggle-find-health-care-crisis> [<https://perma.cc/7MY7-LWFN>] (explaining that access to clinics in rural areas

Colombian people in rural areas are often forced to choose between remaining in their ancestral land and moving to the urban centers where full-service clinics are easier to access.²⁵ Section III.B examines deficits in health services available for victims of sexual violence, even where women are able to access a clinic. Appropriate facilities, trained providers, and necessary supplies such as rape kits are often unavailable in existing rural clinics, and psychosocial services are effectively non-existent.²⁶ Section III.C specifically addresses the many barriers to abortion for survivors of sexual violence.

Finally, in the Conclusion, the Article proposes some basic responses to the deficits highlighted in Part III. To bring the provision of health services in line with the law's mandate, policy makers must consider how the intersection of race, class, and gender uniquely affects Afro-Colombian victims of sexual violence. To obtain health equity, policy makers must address structural and institutional issues that cause the disparities. Specifically, law, policies, and systems must be leveraged to address social determinants of health for those marginalized by virtue of race, gender, poverty, or any combination of these characteristics. This Article seeks to highlight and examine the issues related to access to health care for Afro-Colombian survivors of sexual violence and to start a conversation that will hopefully lead to viable solutions to improve the reality on the ground for these survivors.

I. ROOTS AND REALITY OF VIOLENCE AGAINST AFRO-COLOMBIAN WOMEN

Sexual violence against Afro-Colombian women stems from historical antecedents of race- and gender-based discrimination as well as stereotypes that are still to-date engrained in the sociocultural fabric of the country. While discrimination is one part of the problem, growing conflict and violence in regions with high concentrations of Afro-Colombian populations, as well as barriers to reporting sexual violence and accessing medical help, further

has simply been nonexistent for a long time, and/or services have been overwhelmed by displaced individuals); *see infra* notes 136, 138, 146–149 and accompanying text (interviews describing how the difficulty in accessing modern health care has forced many women to rely on “traditional doctors” or brave dangerous journeys through paramilitary-controlled areas).

25. *See generally infra* Section III.A (describing the poor quality of health care in rural areas of the Naya River Basin).

26. ABCOLOMBIA, *supra* note 12, at 19.

exacerbate the risk of and the consequences of sexual violence for Afro-Colombian women.

The history of Black/African slavery in Colombia, not surprisingly, continues to have reverberations on race politics in Colombia today.²⁷ Although much positive change has occurred since total emancipation in 1852, the foundational belief of Colombian identity that Colombia is a “post-racial” society fuels the denial of racial discrimination and reproduces, on a daily basis, the invisibility and marginalization of Afro-Colombians.²⁸ In reality, however, there is little political will to address racial discrimination, and the Colombian government has typically only acted when pressured to do so by civil society and international human rights bodies.²⁹ Interviews with Afro-Colombian women in rural river communities reveal that race-based discrimination is pervasive and part of everyday life:

People see my black skin and assume I am not an important person and am not educated. That I have no intellectual capacity. When people actually see me talk about my experience you can see their shock. The government treats Afro-Colombian communities badly. They discriminate us and keep us in misery. They want to be above us. When Afro-Colombian community members try to demand their rights with the government accuses us of lying or just making trouble.³⁰

Sociocultural status is a prominent measure of place in Colombian society. Colombia is considered one of the most ethnically diverse countries in the Western Hemisphere with eighty-five ethnic

27. Third Report on the Human Rights Situation in Colombia, Inter-Am. Comm'n H.R., OEA/Ser.L/V/II.102, doc. 9 rev.1, 155–60 (1999).

28. CÉSAR RODRÍGUEZ GARAVITO ET AL., RACE AND HUMAN RIGHTS IN COLOMBIA: REPORT ON RACIAL DISCRIMINATION AND RIGHTS OF AFRO-COLOMBIANS 8 (Fatimah Williams Castro trans., 2009), <https://www.dejusticia.org/en/publication/race-and-human-rights-in-colombia-report-on-racial-discrimination-and-rights-of-the-afro-colombians/> [https://perma.cc/QS3R-D385].

29. *Id.* at 13–14.

30. Interview with Nora Isabel Castro Panameno, *supra* note 23; Bratspies, *supra* note 9, at 6 (noting that negative stereotypes of Afro-Colombians are common in television news, print media, and advertisements, and that according to the Inter-American Commission on Human Rights, there is a continuing “pattern of racial discrimination and systematic historical exclusion” of Afro-Colombians) (citing Inter-Am. Comm'n H.R. [IACHR], *The Situation of People of African Descent in the Americas*, at 34, OEA/Ser.L/V/II. Doc. 62 (Dec. 5, 2011), <https://www.refworld.org/docid/51ff743e4.html> [https://perma.cc/B828-FBZL]).

groups represented in the population.³¹ There are three officially recognized ethnic minority groups—Afro-Colombian, Indigenous, and Romani.³² Whites and Mestizos make up 86% of the population,³³ and 10.5% of the population is Afro-Colombian.³⁴ According to an in-depth study of the Afro-Colombian labor situation in four major Colombian cities by the National Union School, some 65% of Afro-Colombians in the informal sector and 29% in the formal sector make less than the minimum wage.³⁵

Afro-Colombian and Indigenous people are “much more likely to be poor or extremely poor” than white or Mestizo people.³⁶ According to the 2005 census, in Chocó, the department (a geographical division equivalent to a U.S. state) with the highest percentage of Afro-Colombian residents, 70.5% of residents live below the poverty line, with 41% of residents living in extreme poverty.³⁷ Chocó has the “lowest per capita level of social investment and ranked last in terms of infrastructure, education, and health.”³⁸ It also continues to be the venue of some of the country’s worst political violence, as paramilitaries and guerrillas “struggle for control of the department’s drug- and weapons-smuggling corridors.”³⁹ Continued violence in Afro-Colombian territories like Chocó has triggered increased forced displacement, which has contributed to a greater risk of sexual violence.⁴⁰

Gender discrimination persists, and rape and sexual violence continue to be everyday occurrences in geographic regions of conflict.⁴¹ There continues to be much stigma surrounding sexual

31. FED. RESEARCH DIV., *supra* note 19, at 86.

32. *Id.*

33. *Id.* at 86–87.

34. *Id.* at 86.

35. Tula Connell, *Afro-Colombians Fighting Against Discrimination at Work*, SOLIDARITY CENTER (AFL-CIO) (March 12, 2013), <https://www.solidaritycenter.org/afro-colombians-fighting-against-discrimination-at-work/> [https://perma.cc/RGF9-UV5F].

36. Bratspies, *supra* note 9, at 7.

37. U.S. DEP’T OF STATE, BUREAU OF DEMOCRACY, HUMAN RIGHTS AND LABOR, COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 2011: COLOMBIA 24 (2012).

38. *Id.*

39. *Id.*

40. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 12–13 (noting that “human rights advocates have reported increases in incidences of sexual violence where armed groups are operating in Afro-Colombian and Indigenous territories”).

41. See *infra* notes 67–75, 127 and accompanying text.

violence—victims are often afraid to report rape, authorities fail to take reports seriously, and perpetrators go unpunished.⁴² In 1982, the Colombian government ratified the Convention on the Elimination of All Forms of Discrimination Against Women (“CEDAW”),⁴³ and in July 2019, Colombia introduced a landmark law that recognizes that sexual violence can constitute a crime against humanity and provides for reparations, psychosocial support, and free medical care for survivors of sexual violence.⁴⁴ However, despite the laws in place, many women are not informed about their options for placing a formal complaint and the vast majority of physically abused women never even visit a health center, usually out of fear of reprisals.⁴⁵ Although Law 1236 of the Colombian Penal Code, passed in 2008, states that the punishment for “violent physical access” is twelve to twenty years in prison,⁴⁶ rapists very rarely go to jail,⁴⁷ so it is hardly surprising that women do not want to talk.

Colombian society, like many societies on the planet and especially in Latin America with its complicated and violent colonial past, is plagued with a unique combination of racism and sexism that functions to create a hypersexualization of Black women. This hypersexualization can contribute to and even be used to justify violence against Black women.⁴⁸ According to a study of sexual violence against women in the context of armed conflict from 2010 to 2015, “Afro-descendent women from the ages of 15–24 residing in housing classified as the lowest income bracket are more exposed to being victims of sexual violence than women from other ethnic origins, age ranges and housing brackets.”⁴⁹

42. See *infra* notes 121–126 and accompanying text.

43. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW].

44. L. 1719, arts. 15, 23–25, junio 18, 2014, DIARIO OFICIAL [D.O.] (Colom.).

45. See *infra* notes 129–130 and accompanying text.

46. L. 1236, julio 23, 2008, DIARIO OFICIAL [D.O.] (Colom.).

47. See Brown, *supra* note 17.

48. NAT’L ORG. FOR WOMEN, BLACK WOMEN AND SEXUAL VIOLENCE 1 (2018), <https://now.org/wp-content/uploads/2018/02/Black-Women-and-Sexual-Violence-6.pdf> [<https://perma.cc/574A-5VHY>]; Goldscheid, *supra* note 9, at 8 (noting that “factors such as ethnicity/race, indigenous or minority status, colour, socioeconomic status and/or caste, language, religion or belief, political opinion, national origin, marital and/or maternal status, age, urban/rural location, health status, disability, property ownership, being lesbian, bisexual, transgender or intersex, are ‘inextricably’ linked to women’s experience of violence”).

49. DIEGO CANCINO, EXECUTIVE SUMMARY: SURVEY ON THE PREVALENCE OF SEXUAL VIOLENCE AGAINST WOMEN IN THE CONTEXT OF THE COLOMBIAN

The National Organization for Women (“NOW”) issued a report that details the history of sexualization of black women: “The myth that Black women were vessels for sexual desire was used to justify enslavement, rape, forced reproduction, and other forms of sexual coercion in the early onset of Western colonization.”⁵⁰ Black women are often stereotyped as “‘naturally’ voracious” and more likely to have consented to sex than white women.⁵¹ Black rape victims are also more likely to be seen as having suffered little harm from a sexual assault because of their perceived sexual experience.⁵² According to the Afro-Colombian participants in the February 2019 PCN Meetings, Afro-Colombian women are often thought to have “big breasts” and “big butts,” to dress provocatively, and to be “more sexual” than non-Black women.⁵³ Such myths contribute to their sexualization and exacerbate the sexual violence against them.⁵⁴ Because of their perceived hyper-sexuality, they are often blamed for sexual violence against them. One health provider told researchers just last year that women who experience sexual violence may be at fault because of the way they dress:

It depends on how the woman is dressed. So if the woman is dressed in a certain way, then they start yelling things at her or abusing them, because she was dressed that way and she was teasing men to do it.⁵⁵

During the Witness for Peace Interviews, community members discussed having experienced that blame firsthand:

Reporting [r]ape is often a problem because the government[] staff that takes the testimony of the abused women will ask why they didn’t fight the person off and [government staff] will blame them.

ARMED CONFLICT (2010–2015), at 7 (2017), https://www.oxfamamerica.org/static/media/files/COLOMBIA_SURVEY_SEXUAL_VIOLENCE_EXEC_SUM.pdf [<https://perma.cc/47SW-5UPJ>].

50. NAT’L ORG. FOR WOMEN, *supra* note 48, at 1.

51. Stacey P. Dougan, *With Justice for Whom? The Presumption of Moral Innocence in Rape Trials*, 71 IND. L.J. 419, 437 (1996).

52. Kim Taylor-Thompson, *Empty Votes in Jury Deliberations*, 113 HARV. L. REV 1261, 1294 (2000).

53. Interview with Proceso de Comunidades Negras (Feb. 23–25, 2019) (on file with the author); *see also supra* notes 5 & 6 (providing the context for the PCN interviews) [hereinafter Interview with PCN].

54. *See* Interview with PCN, *supra* note 53.

55. MADRE & PROCESO DE COMUNIDADES NEGRAS, AFRO-COLOMBIANS HUMAN RIGHTS: A CALL FOR RACIAL AND GENDER JUSTICE IN PEACEBUILDING 25 (2018).

This is because Afro-Colombian women are always questioned. They are supposedly the ones who seduce people, and the ones to blame.⁵⁶

In addition to being a factor in the violence against Afro-Colombian women, cultural attitudes about Indigenous and Afro-Colombian women and their proper role in society also subject women to discrimination in the medical care they receive after incidents of sexual violence.⁵⁷ One interviewee recounted:

Once when I went to a medical clinic in Cali, Colombia and I noticed they took only the white people, many who arrived after me. When I asked about when we were going to be seen he told me that I had to wait in the line for black people. This happened about 2 years ago.⁵⁸

Reportedly, health center personnel do not treat Afro-Colombian women with the same level of care and attention:

[B]ecause we do not speak fluent Spanish, because we do not understand Western medical diagnosis, because we do not take drugs, because we cannot read, because we do not allow our bodies to be touched when we are being medically examined, because indigenous women do not arrive perfumed and well dressed.⁵⁹

Discrimination also occurs when harmful customary practices such as genital mutilation or “la pelona”⁶⁰ are not properly treated or prevented because what would be deemed abuse for the general population is excused as a customary practice of the Indigenous community.⁶¹

Further, female victims, and especially Afro-Colombian victims, are discouraged from complaining or seeking help for their own issues, encouraged instead by society to “ignore their own

56. Interview with Nora Isabel Castro Panameno, *supra* note 23.

57. ORGANIZACIÓN NACIONAL INDÍGENA DE COLOMBIA ET AL., A LOOK AT THE HUMAN RIGHTS OF INDIGENOUS WOMEN IN COLOMBIA 6, 13, 18–19 (2013), <https://www.forestpeoples.org/sites/fpp/files/news/2013/10/REPORT%20CEDAW%20INDIGENOUS%20WOMEN%20IN%20COLOMBIA.pdf> [<https://perma.cc/8K87-LN98>].

58. Interview with Nora Isabel Castro Panameno, *supra* note 23.

59. ORGANIZACIÓN NACIONAL INDÍGENA DE COLOMBIA ET AL., *supra* note 57, at 19.

60. *Id.* at 15 (describing the customary practice of pulling out the pubic hair when a young woman reaches puberty).

61. *Id.*

affectations in order to care for others.”⁶² Victims of violence are often pressured to reconcile with their abusers,⁶³ which is inconsistent with reporting the abuse. Women from this population who report rape are often thought to have imagined the attacks or just misinterpreted what transpired.⁶⁴ Such treatment itself can lead to “sickness, permanent stress, depression, suicide, poverty, and hopelessness,” on top of the physical harm already suffered from the actual violence.⁶⁵

The recent surge in criminal activity in formerly FARC-controlled territories, which have high populations of Afro-Colombians, means increased sexual violence against women and girls.⁶⁶ The violence is often “vicious and terroristic, reflecting the conflict’s violent strategies,”⁶⁷ including rape, physical assaults, severe bodily injury, assassinations, and dismemberments. The violence is so normalized that “women are often unaware that the abuse they suffer is not the accepted social or legal norm.”⁶⁸ Imprisoning women is commonplace in certain regions, and women often hold the beliefs that they deserve the physical abuse because they “provoked him” and that “if he hits me, he loves me.”⁶⁹

The excessive violence against and treatment of Afro-Colombian women also results from the outsized and highly visible role they continue to play in combating the normalization of gender-

62. Brown, *supra* note 17.

63. INTERNATIONAL HUMAN RIGHTS CLINIC AT LOYOLA LAW SCHOOL, CORPORACION CASA DE LA MUJER & TALLER ABIERTO, NGO PARALLEL REPORT ON COLOMBIA’S NINTH REPORT ON THE IMPLEMENTATION OF THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN 7 (2018).

64. *Id.* at 6.

65. Brown, *supra* note 17 (quoting RUTA PACÍFICA DE LAS MUJERES, COLOMBIAN WOMEN’S TRUTH AND MEMORY COMMISSION: EXECUTIVE SUMMARY 3, <http://www.rutapacifica.org.co/descargas/comisionverdad/TruthandMemoryCommission.pdf> [<https://perma.cc/TSY9-BU3R>]) (internal quotation marks omitted)).

66. See U.S. DEP’T OF STATE, *supra* note 38, at 47–48, and accompanying text (discussing violence and poverty in Chocó and Narino, both of which have high Afro-Colombian populations); PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 9–10, and accompanying text (noting that “human rights advocates have reported increased incidences of sexual violence where armed groups are operating in Afro-Colombian and Indigenous territories”).

67. THE ADVOCATES FOR HUMAN RIGHTS & THE HUMPHREY SCHOOL OF PUB. AFFAIRS, SUBMISSION TO THE COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN: RELATING TO ACCESS TO JUSTICE, DISCRIMINATORY GENDER STEREOTYPES AND VIOLENCE AGAINST WOMEN 3 (Jan. 28, 2019) [hereinafter 2019 CEDAW SUBMISSION].

68. *Id.* at 6 (internal quotation marks omitted).

69. *Id.* (internal quotation marks omitted).

based violence.⁷⁰ More than 340 Colombian human rights defenders were killed between early 2016 and August 2018, “mostly by paramilitaries trying to squash community activism.”⁷¹ An April 2019 alert email written by the Washington Office on Latin America (“WOLA”), a human rights think tank, has called this violence against and intimidation of social leaders and human rights defenders “assassinations of Colombia’s indigenous people” and an attempt at “the extinction of a social movement” by targeting “visible leaders” in order to “suppress their activism.”⁷² The alert warned that “female social leaders have a 66% higher risk of being sexually assaulted or tortured than their male counterparts” and that “51 percent of murdered female social leaders are ethnic minorities or from rural communities.”⁷³ Sexual violence perpetuated against Afro-Colombian women is used to “‘dehumanize’ women and spread terror among the community, as a way to control the local population with Afro-Colombian and women being particularly vulnerable.”⁷⁴ The

70. Gerry Emmett, *Afro-Colombian Women: Defeating Invisibility*, NEWS & LETTERS COMMITTEES, <https://newsandletters.org/afro-colombian-women-defeating-invisibility/> [<https://perma.cc/4DTF-TDMZ>]. According to Chava:

The *machismo* culture is stereotypically against women being part of the activist movement and being part of the spaces where change is demanded and created. I have been a human rights leader for about 5 years now against paramilitary violence and corruption. I’ve had times that I go to governmental institutional offices to advocate for my community and the men in charge tell me that they won’t speak to me and will only speak with a man. I tell them “not today.” I told them I also have a voice and deserve a role in the process. It has been hard to break the norm but I do it.

Interview with Nora Isabel Castro Panameno, *supra* note 23.

71. Brown, *supra* note 17.

72. E-mail from Maricelly Malave to author (Apr. 2, 2019) (on file with the *Columbia Human Rights Law Review*) (including posting by Gimena Sanchez, Director for the Andes, WOLA). This alert email was written in response to indigenous protests known as the MINGA taking place throughout Colombia to pressure the Duque administration to fulfill its commitments to indigenous communities.

73. *Id.* (citing *Las violencias contra las lideresas son más crueles que contra los líderes: Codhes*), ESPECTADOR (Colom.) (Mar. 27, 2019), <https://www.elespectador.com/colombia2020/pais/las-violencias-contra-las-lideresas-son-mas-cruelles-que-contra-los-lideres-codhes-articulo-857808> [<https://perma.cc/5LDF-6RS8>].

74. Brown, *supra* note 17 (citing Inter-American Comm’n on Human Rights [IACHR], *Violence and Discrimination Against Women in the Armed Conflict in Colombia*, OEA/Ser.L/V/II. Doc. 67. (Oct. 18, 2006), <https://www.cidh.oas.org/>

dangerous cycle of activism and victimization is a death sentence for so many in this population.

Because of historical discrimination against the Afro-Colombian people, and Afro-Colombian women in particular, and because of the enduring poverty plaguing these communities, race- and gender-based sexual violence is most prevalent in predominantly Afro-Colombian FARC-controlled regions. The consequences of the violence are only exacerbated by the lack of accessible health care in those same regions.

II. LIMITS TO COLOMBIA'S PROGRESSIVE HEALTH CARE LAW

Colombia's health care law seems expansive and progressive on paper, but it fails to protect all Colombians' right to health equally. In particular, the law fails to guarantee effective legal protections for survivors of rape and sexual violence. In 1993, Colombia undertook a massive overhaul of its health care system when it enacted Law 100.⁷⁵ Colombia's health care reform was motivated by inefficiency in government-sponsored entities tasked with providing health care services, a mounting budget deficit, and sparse coverage—only 21% of the population had health care prior to the enactment of Law 100.⁷⁶ The overhaul was intended to change the structure of the entire health care system.⁷⁷ The reform of the Colombian health care system had three main goals: (1) the achievement of an antitrust policy, to avoid the state health monopoly; (2) the incorporation of private health providers into the health care market; and (3) the creation of a subsidized health care sector covering the poorest of the population.⁷⁸

While the reforms succeeded in increasing insurance coverage, they failed to guarantee the same services to individuals on the private contributory and public subsidized regimes, and decentralization and lack of effective government regulation led to unexpected inefficiencies in the provision of services and collection of

countryrep/ColombiaMujeres06eng/Informe%20Colombia%20Mujeres%20Ing.pdf [https://perma.cc/F97R-92PH]).

75. Rod Mangrum, *Ley 100 (Law 100) in Colombia*, INT'L SECTION NEWS, October 1999, at 9, <https://www.soa.org/globalassets/assets/library/newsletters/international-section-news/1999/october/isn-1999-iss20-mangrum.pdf> [https://perma.cc/3F22-FXS3].

76. *Id.*

77. *Id.*

78. *See id.*

payments from members.⁷⁹ At the same time, the 1991 Constitution both guaranteed the right to health and opened judicial avenues to vindicate these rights, effectively encouraging individuals to challenge inequalities in the system via *tutela* (a writ for satisfaction of constitutional rights).⁸⁰ Therefore, by 2008, the Constitutional Court's precedent established health care as a basic right, with attendant duties that the government was failing to fulfill.⁸¹

In 2008, in the wake of thousands of individual rulings on the right to health, Colombia's Constitutional Court issued a structural decision, *T-760*, ordering government entities to identify flaws that made the country's health system outdated and inequitable and to take correctional measures.⁸² The mandate that the Constitutional Court set forth in its decision—that health care is a right—led the Colombian state to provide all citizens free and compulsory basic health services.⁸³ The mandate that the Constitutional Court set out requires the Social Security System to “coordinate, provide, and control an effective, universal, and collective public health service.”⁸⁴ Under the mandate, health services management and delivery were decentralized to strengthen the role of departments and municipalities, and the private sector was incorporated within the insurance and health services delivery functions.⁸⁵

After this decision, “Congress and the executive branch have increasingly included a rights-oriented perspective in public policies,” and health is now seen as a fundamental and justiciable right.⁸⁶ As a result of the Constitutional Court's many rulings, there is now a

79. See Rodríguez-Monguió Rosa & Infante Campos Alberto, *Universal Health Care for Colombians 10 Years After Law 100: Challenges and Opportunities*, 68 HEALTH POL'Y 129, 138–39 (2004) (describing suggested improvements to the Colombian healthcare regime).

80. See Everaldo Iamprea & Johnattan García, *Closing the Gap Between Formal and Material Health Care Coverage in Colombia*, 18 HEALTH HUM. RTS. 49, 50 (2016) (describing recommendations to improve the Colombian Universal Health Care system using a policy-based approach).

81. *Id.* at 56.

82. Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08, <https://www.corteconstitucional.gov.co/relatoria/2008/t-760-08.htm> [<https://perma.cc/7TLA-MWLR>].

83. Rosa & Alberto, *supra* note 79, at 129.

84. *Id.*

85. Alejandro Gaviria et al., *Assessing Health Reform in Colombia: From Theory to Practice*, 7 ECONOMÍA 29, 32–34 (2006).

86. Aquiles Ignacio Arrieta-Gómez, *Realizing the Fundamental Right to Health Through Litigation: The Colombian Case*, 20 HEALTH & HUM. RTS. J. 133, 133 (2018).

public, subsidized health plan, under which health care is guaranteed to those who could not otherwise afford it.⁸⁷ The World Health Organization lists Colombia's health care law and structure as the twenty-second best of 191 countries surveyed.⁸⁸ However, the progressive health care law does not benefit all Colombians equally. This Part analyzes the inadequacies of the health care system and laws in Colombia. Section II.A discusses the unequal access to health care services as well as treatment experienced by individuals subscribing to the public plan, who are low-income individuals and usually ethnic minorities like the Afro-Colombian populations. Section II.B then highlights the inadequacies of the country's rape laws, which, when combined with the race- and class-based treatment of Afro-Colombian populations in the public plan, further exacerbate the health care disparities of survivors of sexual violence in this population.

A. Separate but (Un)Equal: Racialized and Class-Based Health Gaps Between the Public Subsidized Plan and the Private Contributory Plan

As a part of the overhaul of the health care system in 1993, Law 100 created two parallel health care systems: the private contributory system and the public subsidized plan.⁸⁹ The contributory plan is available only to workers and families making above minimum wage, and is financed using a mandatory payroll tax—formal employment is required for coverage through the contributory plan.⁹⁰ On the other hand, the subsidized plan is available only to those who submit to means testing by local government.⁹¹ Colombians covered by the subsidized plan have been entitled to the same health services as those covered by the contributory plan only since 2012, when the Colombian Regulatory Body in Health unified the benefits of each plan.⁹²

87. *Id.* at 138–39.

88. Ajay Tandon et al., *Measuring Overall Health System Performance For 191 Countries* 18 (World Health Org. GPE Discussion Paper Series No. 30, 2018), <https://www.who.int/healthinfo/paper30.pdf> [<https://perma.cc/9248-A5EN>].

89. Rosa & Alberto, *supra* note 79, at 131.

90. Ursula Giedion & Manuela Villar Uribe, *Colombia's Universal Health Insurance System*, 28 HEALTH AFF. 853, 853 (2009), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.28.3.853> [<https://perma.cc/3BEF-XY6A>].

90. *Id.*

91. *Id.*

92. Arrieta-Gómez, *supra* note 86, at 141.

However, although Colombia recognizes the right to health as a justiciable right, and Colombian people have the legal right to free health care under the public health plan, there are stark class-based health disparities between the individuals subscribed to the public subsidized plan legally available to all, and those with the private contributory plan, which is strongly tied to participation in the formal economy.

First, while the subsidized plan guarantees access to health care, many of the poorest Colombians, who are often indigenous people living in rural departments, do not have any insurance.⁹³ A 2011 study of the uninsured in La Guajira, a rural department, attempted to collect information about the benefits desired and barriers to care faced by these residents.⁹⁴ Nearly half of those surveyed were indigenous, whose communities tended to be isolated, as are many in rural departments.⁹⁵ Uninsured respondents overwhelmingly (88%) reported that a lack of assistance in applying for insurance was their primary reason for being uninsured, with premiums and co-payments being another concern.⁹⁶ Notably, despite the remote nature of the department, few individuals surveyed cited travel time as a barrier to care.⁹⁷ While those surveyed generally saw obtaining subsidized care as a better option than being uninsured, a majority still felt that subsidized coverage required longer wait times, and half of female respondents felt it provided lower choices in providers than remaining uninsured.⁹⁸ Female respondents in particular expressed a desire for better family care and more doctor choice for patients, and they were attuned to the absence of specialized care under the subsidized plan.⁹⁹

Even in rural departments that have equal or higher levels of insurance coverage compared with other localities, there is a significant difference in the availability of treatment and patients' health outcomes with the subsidized plan, as compared to the

93. Participants need to apply for the subsidized plan's insurance in order to be able to utilize the services. *See, e.g.,* Iamprea & García, *supra* note 80, at 59.

94. Christine Buttorff et al., *Low Rural Health Insurance Take-up in a Universal Coverage System: Perceptions of Health Insurance Among the Uninsured in La Guajira, Colombia*, 30 INT'L J. HEALTH PLAN. & MGMT. 98, 99 (2013).

95. *Id.*; DEPARTAMENTO ADMINISTRATIVO NACIONAL DE ESTADÍSTICA (DANE), *supra* note 22, at 30–33.

96. Buttorff et al., *supra* note 94, at 105.

97. *Id.* at 108 tbl.3.

98. *Id.* at 106 tbl.2.

99. *Id.* at 106 tbl.2, 108 tbl.3.

contributory plan.¹⁰⁰ In rural departments of Colombia, many residents with subsidized coverage face excessive wait times, a lack of facilities and providers, and higher mortality rates.¹⁰¹ These rural regions tend to have large populations of indigenous residents, and include Chocó, the only department with an Afro-Colombian majority.¹⁰²

This is true even though many poorer, rural departments tend to make tutela claims at around the same rate as richer, urban departments.¹⁰³ First, the fact that poorer departments have roughly the same level of tutela claims indicates that the lack of services is not due to the population's lack of knowledge or misunderstanding of their rights. Second, it indicates that there seems to be little correlation between tutela claims and availability of treatment, as residents of poorer regions have sought a vindication of their right to health care (and therefore an increase in availability of treatment) with limited measurable success.¹⁰⁴ Even in large urban centers, Colombians on the subsidized plan encounter lower survival rates and longer time-to-treatment from diagnosis than those on the contributory plan.¹⁰⁵ In a study of women receiving surgery for breast cancer at Las Américas Oncology Institute in Medellín, for example, 23% of those with subsidized coverage died during the course of the study, compared to 10.3% of those with contributory coverage.¹⁰⁶ The City of Manizales maintains a cancer registry that shows a significant difference in survival between patients with subsidized coverage and patients with contributory coverage.¹⁰⁷ According to the registry, those with subsidized coverage are less likely to survive breast, lung, prostate, and stomach cancer than those with

100. Iamprea & García, *supra* note 80, at 60–62.

101. *Id.*

102. DEPARTAMENTO ADMINISTRATIVO NACIONAL DE ESTADÍSTICA (DANE), *supra* note 22, at 30.

103. Iamprea & García, *supra* note 80, at 62.

104. *Id.*

105. Jorge Armando Egurrola-Pedraza et al., *Diferencias en supervivencia debidas al aseguramiento en salud en pacientes con cáncer de mama atendidas en un centro oncológico de referencia en Medellín, Colombia* [Survival Differences Due to Health Insurance in Breast Cancer Patients Treated at a Specialized Cancer Center in Medellín, Colombia], 34 CADERNOS SAÚDE PÚBLICA, no. 12, 2018, at 1, 7.

106. *Id.* at 4.

107. Nelson Enrique Arias-Ortiz & Esther de Vries, *Health Inequities and Cancer Survival in Manizales, Colombia: A Population-Based Study*, COLOM. MÉDICA, Jan–Mar. 2018, at 63, 65, 68.

contributory coverage.¹⁰⁸ Women with subsidized coverage also waited over twice as long as those with contributory coverage to start treatment.¹⁰⁹ Therefore, those on the subsidized plan, who are usually people of low-income, living in rural areas, and ethnic minorities, are at a greater risk of worse treatment in the health system as well as worse health outcomes overall.

B. Limitations of Colombia's Rape Law

While the structure of the health care system in Colombia is one factor that contributes to poor treatment and access to health care for Afro-Colombians, the existing rape laws in the country further worsen the outcomes for survivors of sexual violence. In 2012, the health minister created a protocol, binding on health care providers, that sought to guarantee that health care providers offer victims of sexual violence appropriate post-rape care.¹¹⁰ Through fifteen steps, this law gave health sector personnel the necessary guidelines to follow in order to maintain the minimum conditions necessary to provide comprehensive care.¹¹¹ Further, the law provides procedures for voluntary interruption of pregnancy and guarantees access to specialized health care services, including mental health services.¹¹²

In the years following the 2012 protocol, implementation of basic reproductive and maternal health care services provided to victims was spotty. So, in 2014, the Colombian Congress passed Law 1719, intending to improve implementation of the 2012 protocol and further protect victims of sexual violence.¹¹³ Law 1719 recognizes that “sexual violence can constitute a crime against humanity and enhances the status of sexual violence survivors so that they can receive reparations, psychosocial support, and free medical care.”¹¹⁴

108. *Id.* at 64.

109. Egurrola-Pedraza et al., *supra* note 105, at 7.

110. Ministerio de Salud y Protección Social [Ministry of Health and Social Protection], R. 459 de 2012, marzo 6, 2012, at 2, <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/Resolucion-0459-de-2012.PDF> [<https://perma.cc/7JMQ-3RH5>] (Colom.).

111. *Id.* at 14.

112. *Id.* at 30, 34.

113. L. 1719 de 2014, junio 18, 2014, DIARIO OFICIAL [D.O.] (Colom.).

114. Lisa Macarani, *Peace in Colombia Relies on Tackling Systemic Violence Against Women*, GUARDIAN (May 25, 2015), <https://www.theguardian.com/global-development/2015/may/25/peace-in-colombia-tackling-systemic-violence-against-women> [<https://perma.cc/E5C2-LUTT>].

The law made important progress on many fronts, including guaranteeing a victim's privacy and confidentiality, and recognizing that sexual violence can, under certain conditions, be considered a crime against humanity.¹¹⁵ However, there are two significant perceived obstacles to the full and effective implementation of the law: it is widely perceived that implementation of the law is optional for health providers, and it is perceived that victims are required to report abuse to authorities before they can gain access to necessary health care.¹¹⁶

First, despite the intention of the law to provide post-rape care to all victims of sexual violence, Law 1719 signaled that it was optional for health providers to complete the protocol for post-rape care created by the Ministry of Health. The law stated that health care entities had the "facultad" (roughly, power/ability or faculty) to complete the protocol, which was interpreted as giving health providers an ability but not an obligation to provide this care. This indication prompted women's organizations to file a case in the Constitutional Court.¹¹⁷ The Constitutional Court found the "optional" interpretation inconsistent with the constitutional right to health and gender equality, and replaced the word "facultad" with "obligación."¹¹⁸ Despite the Constitutional Court ruling that Law 1719 requires health professionals to provide comprehensive medical and psychosocial care with dignity to victims of sexual violence,¹¹⁹ completing the protocol is still treated as optional in many parts,¹²⁰ probably due to the lack of ramifications for those who violate it.

115. Amanda Klasing, *Dispatches: Broken Promise to Colombia's Women*, HUM. RTS. WATCH (July 6, 2015), <https://www.hrw.org/news/2015/07/06/dispatches-broken-promise-colombias-women> [<https://perma.cc/LN8N-TMSU>].

116. MADRE & PROCESO DE COMUNIDADES NEGRAS, *supra* note 55, at 24–25; see Klasing, *supra* note 115.

117. Klasing, *supra* note 115.

118. *Id.*

119. Corte Constitucional [C.C.] [Constitutional Court], diciembre 10, 2015, Sentencia C-754/15, <http://www.corteconstitucional.gov.co/relatoria/2015/C-754-15.htm> [<https://perma.cc/LR7S-V7GJ>].

120. Summary of Stakeholders' submissions on Colombia, Rep. of the Off. of the U.N. High Comm'r for Hum. Rts. of Its Thirtieth Session, ¶ 82, U.N. Doc. A/HRC/WG.6/30/COL/3 (Mar. 12, 2018) (Amnesty International pointing to a lack of institutional cultural change leading to a failure to implement protocols); Sophie M. Morse & Michele R. Decker, *Response to Sexual Assault in Bogotá, Colombia: A Qualitative Evaluation of Health Providers' Readiness and Role in Policy Implementation*, 40 HEALTH CARE FOR WOMEN INTERNATIONAL 1249 (2019) (indicating that providers' failure to implement the protocols was primarily due to a lack of training).

The second pronounced barrier to medical treatment is the false belief that victims of sexual violence are required to file a police report in order to receive post-rape medical care.¹²¹ The reality is that reporting abuse to authorities or seeking medical support carries risks. A 2009 report by Doctors Without Borders highlights the obstacles to filing a report due to possible retribution.¹²² Many women fear their aggressors will threaten them or their families:¹²³

It is well known that there are criminal actors involved with the police and penal system who communicate with paramilitaries anytime witnesses come forward about a rape or murder they were involved in. We have seen that if someone denounces the rape or murder the police still release the suspected person then the witness is usually killed shortly afterward.¹²⁴

Further, women are often judged for being raped and are often re-victimized by degrading comments, denial of humane services (such as in cases where young women getting abortions are denied anesthesia) or denial of services outright.¹²⁵ Although the Colombian government has an obligation to enforce penalties for perpetrators of sexual violence, women often feel shame or are afraid

121. MADRE & PROCESO DE COMUNIDADES NEGRAS, *supra* note 55, at 25 (explaining that, despite “clear legal protocols that victims are not required to have a police report” before receiving post-rape health care, medical facilities will often deny access to victims who haven’t filed a report nonetheless).

122. MÉDECINS SANS FRONTIÈRES [DOCTORS WITHOUT BORDERS], SHATTERED LIVES: INTERMEDIATE MEDICAL CARE VITAL FOR SEXUAL VIOLENCE VICTIMS 1, 25 (2009), https://www.msf.org.uk/sites/uk/files/Shattered_lives_2nd_Ed_June_2009_200907153112.pdf [<https://perma.cc/8R9U-7GUF>].

123. *Id.* (statement of Doctors Without Borders psychologist Magaly Manco). One woman spoke about the fear and helplessness widely felt after a rape:

When girls tell the paramilitaries no or reject them they will threaten to kill them or their families so girls are always forced by fear. There have been many cases of sexual violence right here on this street of Puerto Nayero. For example, several years ago three young girls were raped here by paramilitaries. Two of the girls got pregnant from the rapes. No one was punished for the rapes because the girls were threatened by the paramilitaries not to talk to police but the girls talked to us and told us what was happening. This was one of the catalysts for our movement to make our neighborhood a humanitarian space and kick out the paramilitaries as a community.

Interview with Nora Isabel Castro Panameno, *supra* note 23.

124. Interview with Nora Isabel Castro Panameno, *supra* note 23.

125. *Id.*

of stigma and retaliation and choose not to report the crime. There is also a strong cultural belief in family cohesion over individual rights or safety that further impedes women from reporting sexual violence.¹²⁶

In addition, violence has become so normalized in indigenous regions of Colombia that it is rarely punished: “At least three cases of sexual abuse occur every hour.”¹²⁷ Only 5% of reported cases of sexual violence in 2017 led to a criminal conviction,¹²⁸ so victims recognize the low probability of winning their case in court. And women are implicitly and explicitly discouraged from seeking help and justice. Indeed, according to one study, “between 2010 and 2015, in a time of armed conflict in Colombia, only 20 percent of the approximately 875,400 women who suffered from sexual assault reported it to the police,”¹²⁹ and according to the 2015 Demographic Health Survey, “only 21 percent of physically abused women reported visiting a doctor or health centre for treatment.”¹³⁰ Normalization of violence in the country and sociocultural obstacles, such as stigma, fear of retaliation, and ideas about family cohesion, alongside the perceived optional nature of Law 1719 and the belief that reporting is necessary to receive post-rape medical care, in effect, cause the law to have no teeth, and the mandate to be in name only. Even if the mandate were

126. OLIVIA JACKSON, OPEN DOORS INT’L, COLOMBIA: COMPOUND STRUCTURAL VULNERABILITIES FACING CHRISTIAN WOMEN UNDER PRESSURE FOR THEIR FAITH 1, 34 (2018), <https://www.worldwatchmonitor.org/wp-content/uploads/2018/11/COLOMBIA-Compound-structural-vulnerabilities-facing-Christian-women-2018-FINAL-WITH-PREFACE.pdf> [https://perma.cc/6Q6C-L5BF] (explaining that the problems are manifold: female victims may not report violence because it is seen as normal or, in the case of domestic violence, a private matter; due to shame and fear of stigmatization; because they fear retaliation; from a belief in family cohesion over individual rights or safety; because they do not trust authorities and fear mistreatment or not being taken seriously; because they do not know how to complain; they lack financial resources; they rely upon their abuser for money, food or shelter; or because they may never see justice even if they do report crime).

127. María Antonia García De La Torre, *The Silence of Abused Women in Colombia*, N.Y. TIMES (Mar. 1, 2018), <https://www.nytimes.com/2018/03/01/opinion/abuse-women-colombia-silence.html> (on file with the *Columbia Human Rights Law Review*).

128. Brown, *supra* note 17.

129. García De La Torre, *supra* note 127 (citing CANCINO, *supra* note 49, at 3, 13).

130. Sara Lisa Ørstavik & Andrés Lizcano R., *Colombia’s Gender Problem*, WORLD POL’Y (Nov. 25, 2013), <https://worldpolicy.org/2013/11/25/colombias-gender-problem/> [https://perma.cc/QL3N-SQKL] (citing the 2015 Demographic Health Survey).

effective, discrimination of Afro-Colombian women based on their race, gender, and class creates additional barriers to accessing health care. All of this results in Afro-Colombian rape and sexual violence survivors not receiving the health care that they need and are constitutionally guaranteed.

III. LACK OF ACCESS FOR AFRO-COLOMBIAN COMMUNITIES TO HEALTH CARE CLINICS AND TO SUFFICIENT POST-RAPE HEALTH CARE SERVICES: THROUGH THE EYES OF VICTIMS

Aside from limits to the enforcement of the law, Afro-Colombian communities face particular concrete obstacles to accessing health clinics. The Afro-Colombian population is “highly concentrated and geographically segregated.”¹³¹ About 50% of the Afro-Colombian population is found in the departments of Valle del Cauca (of which the Naya River forms the southern boundary), Antioquia, and Bolivar.¹³² Indeed, “parts of the Pacific coast have Afro-Colombian populations as high as 90%.”¹³³ Hospitals and medical clinics and access to any medicine in the Pacific and river regions are extremely limited. Women often walk for days to reach the nearest center, dubbing this journey “The Path of Death.”¹³⁴ And even if they get to a clinic, most rural clinics do not have the capacity to treat victims of sexual violence. This Part examines the specific obstacles encountered by Afro-Colombian survivors of sexual violence in fulfilling their right to health care in the form of inaccessibility of clinics and inadequacy of post-rape medical care and abortion services.

A. Inaccessible Clinics

A right to health and health care services is meaningless if members of the public who need the services are unable to access them, as is the case for most occupants of the Naya River Basin. The

131. Bratspies, *supra* note 9, at 5.

132. Gloria Amparo Rodríguez, *Continúa la exclusión y la marginación de las comunidades negras colombianas*, 29 DIÁLOGOS DE SABERES 215, 220 (2008) (Colom.). Traditionally the majority of Afro-Colombians lived on the Pacific coast, but due to internal displacement, there are now also concentrations of Afro-Colombians in city municipalities. AMNESTY INT’L, COLOMBIA 2017/2018, <https://www.amnesty.org/en/countries/americas/colombia/report-colombia/> [<https://perma.cc/78NE-VSSL>].

133. Bratspies, *supra* note 9, at 5.

134. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 16.

Naya River Basin is located in the Municipality of Buenaventura south of the Pacific Ocean and is made up of sixty-four communities, with more than 20,000 people. Of those sixty-four communities there is one small indigenous community called Juaquincito—the rest are Afro-Colombian.

In this region, there is only one Class 1 hospital, which is a hospital with resources for basic check-ups and wellness, located in Puerto Merizalde, an Afro-Colombian community located in the low zone.¹³⁵ This so-called “hospital” has no electricity or potable water, is reluctant to prescribe medication due to scarce supplies, and is rarely staffed.¹³⁶ At the same time, there are no pharmacies or any places to get modern medicines of any kind.¹³⁷ The doctors practicing at this clinic are interning in rural medicine and are not usually knowledgeable about the unique diseases endemic to such a rural territory.¹³⁸ The cases that are seen in Merizalde usually involve pregnant women and people wounded from daily tasks in the river community, such as mining, cutting wood, and other labor.¹³⁹ Naya is also a malaria endemic zone and in general mosquito bites cause many different diseases in the community.¹⁴⁰ Occasionally, people from this region with cases like these die due to the lack of doctors and adequate hospitals.¹⁴¹

Nora Isabel Castro Panameno (“Chava”), a leader of the Humanitarian Space in Payita Buenaventura, reports the following about the conditions at Merizalde:

The Puerto Merizalde hospital (PM Hospital) for many years was criticized for being so bad. A few years ago they got more funding for electricity and improved slightly to be able to provide basic services, but it is still not an adequate hospital to service the entire population of the Naya River. The basic services are just 1 level and don't provide much

135. Carolina Bohórquez, *Los ruegos en Buenaventura por un mejor hospital*, TIEMPO (Mar. 17, 2016), <https://www.eltiempo.com/archivo/documento/CMS-16540012> [<https://perma.cc/J8CE-X2YG>].

136. Interview with Nidiria Ruiz Medina, Gen. Coordinator, AINI Women's Ass'n of the Naya River and Representative of Colombia's Nation-Wide Compaz Network (Mar. 29, 2019) [hereinafter Medina Interview] (on file with the *Columbia Human Rights Law Review*).

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

assistance. . . . Women cannot count on PM for any high-risk child birth. No one with bullet or knife wounds is able to be helped there either. If people come to the PM hospital with injuries like that they are sent to Buenaventura and the hospital doesn't assist with transport. They do have a boat for emergencies but we have never seen them use it. They don't prioritize people.

In general people in Naya kn[ow] that there [a]re so many difficulties regarding the ability of the PM hospital to give services and long waiting time that people in general just ma[k]e the longer trip to Buenaventura because they know PM hospital [i]s not reliable. The doctors do not have the capacity to see so many people and were over saturated and on top of that they were not experienced.

People mostly do not rely on the PM hospital because of the types of cases that they will help with are so restricted. Also the PM hospital only prescribe basic medicines, medicine that is so basic that it doesn't make sense for the complicated diseases that people in Naya have.¹⁴²

Because of the remoteness of the communities, physical access is very limited and travel throughout these zones is very difficult—it is accordingly incredibly difficult for Naya inhabitants to reach the only medical clinic in Merizalde.¹⁴³

Outside of Merizalde, options are even more limited. Although the government is required under the Peace Accords to “undertake” plans to provide better health care to rural areas,¹⁴⁴ the government clearly has not been complying. For example, the government established the Cabeceras Health Clinic when the Cabeceras community signed with the government as a returning internally

142. Interview with Nora Isabel Castro Panameno, *supra* note 23 (statement of Nora Isabel Castro Panameno “Chava,” who helped lead a community expulsion of paramilitaries from their neighborhood after they tortured and killed many people publicly); *see also supra* note 8 and accompanying text (providing the context for the Witness for Peace interviews).

143. Medina Interview, *supra* note 136.

144. PRESIDENCIA DE LA REPÚBLICA, SUMMARY OF COLOMBIA'S AGREEMENT TO END CONFLICT AND BUILD PEACE 8 (2016), <http://www.altocomisionado.paralapaz.gov.co/herramientas/Documents/summary-of-colombias-peace-agreement.pdf> [<https://perma.cc/53SP-8WPC>].

displaced community in March 2018.¹⁴⁵ But, this is a clinic in name only:

There is a health clinic here but anyone can see it is just a shell and is totally abandoned. There is a staff assigned to the clinic who is a health promoter and she does what she can, but she has to buy supplies and medicine for the clinic herself and there is never enough. There is no electricity there. Also it is almost always closed. I don't know when she has hours. The last time I saw it open was last week but the clinic is mostly just closed. The health promoter lives in the town and if you want an Advil you need to go to her house and knock to see if she is home. Even though she lives in town, people almost always have to go to Buenaventura (about 3 hours away) and it is very expensive to pay for the boat, minimum 1,000,000 Colombian Pesos [about USD \$230] for one-way journey to Buenaventura. On top of transport, they will have to also pay for anything the hospital would need for their testing or medicines.¹⁴⁶



145. Nicolás Sánchez, *El desencanto de las comunidades del río San Juan tras su retorno*, ESPECTADOR (Sept. 8, 2018), <https://www.elspectador.com/colombia2020/territorio/el-desencanto-de-las-comunidades-del-rio-san-juan-tras-su-retorno-articulo-857152> [<https://perma.cc/XGW6-FY3L>].

146. Interview by Witness for Peace Delegates with Angie Michelle Retan Mosquera, Member of the Consejo Comunitario for Cabeceras in Baja San Juan River (Aug. 2–13, 2019) (on file with the *Columbia Human Rights Law Review*).



Therefore, not only are the clinics inaccessible but also, in most clinics in indigenous communities, “there is no staff, medicines or instruments; and infrastructure is inadequate to address situations of medium and high severity.”¹⁴⁷ Significantly, “transportation does not exist to ensure that patients can be moved to

147. MADRE & PROCESO DE COMUNIDADES NEGRAS, *supra* note 55, at 18.

centres offering higher level health care.”¹⁴⁸ Marua Francisco Angulo Moreno is a government health clinic worker at Concepcion Puesto de Salud, a health clinic in Concepcion, Naya River. She explains the reality of the lack of government support:

There is a health brigade that comes sometimes and they leave the leftover supplies here with us at this clinic. The difficult thing is that when that medicine runs out and it is up to me to go to Buenaventura or Puerto Merizalde. I need to get gloves and gaussees [gauzes]. I have to pay my own transport which is 100,000 Colombian Pesos. There are times that we are out of supplies and I simply cannot afford to get more so we go without.¹⁴⁹



The nearest full hospital is in Buenaventura Center, the urban capital with about 400,000 people, and is a full day’s travel away by motorboat out of the Naya River and through the Pacific Ocean.¹⁵⁰ Buenaventura has the only public hospital for the entire population (Luis Ablanque de la Plata). Because of this, it is near

148. *Id.*

149. Interview by Witness for Peace Delegates with Marua Francisco Angulo Moreno, Government Health Clinic Worker at Concepcion Puesto de Salud (Aug. 2–13, 2019) (on file with the *Columbia Human Rights Law Review*).

150. See Medina Interview, *supra* note 136.

impossible to be seen by a doctor there, and the majority of the very sick patients referred to this city clinic die.¹⁵¹

Chava recounts her experiences with the Buenaventura Hospital:

It is total chaos there. Literally, it takes about 8 days to contact them on the phone because they never answer. The only way to have a chance is to go in person. To get an appointment in person you have to go the night before to make sure you get to speak to someone. You need to go around 12am and stay the whole night in line and hope you get in. I did it once and slept on the ground there hoping to be seen when the window opened at 8am. They told me that they were only seeing 20 or 30 people that day and that I had to go back again another day and try to make it earlier. It is a miserable situation. They simply turn people away and you have to go all the way back home. It is so dangerous to stay there sleeping all night . . . It's almost impossible to be seen there.¹⁵²

Even if a patient can manage to get in to see a doctor, the hospital often is not equipped to handle the case:

Once was the case of my sister, who was bitten by a snake when she was two months old. We had to take her to Buenaventura. From Buenaventura she was taken to Cali (another 3 hours away) because the Buenaventura hospital did not have what she needed. She was in Cali hospital for 6 months.

Another case from my family is the case of my brother who I have had to get out of the river during an emergency. [He] has Peritonitis, so he has a lot of problems and needs to go to the hospital and I am the one that needs to take him. We have been to the Buenaventura hospital several times and many of the times that we have gone all the way to Buenaventura

151. *Id.* Marua Francisco Angulo Morena explains what happens when people have to go to Buenaventura for an appointment:

At the hospital people always have to wait for an appointment for a minimum of 15 days, one or two months. You have to go in person and ask for an appointment at the public hospital (in Buenaventura). Once you go ask for an appointment, the hospital can make you wait a month or two. If it is a serious case people simply die waiting.

Interview with Marua Francisco Angulo Moreno, *supra* note 149.

152. Interview with Nora Isabel Castro Panameno, *supra* note 23.

and they tell us that the machines needed for his treatment are broken and they tell us to come back many weeks or months later. There is always some kind of problem. Basically in the city people have to rely on private clinics but they are very expensive.¹⁵³

The reality for most inhabitants of this region is that if they need health care, they will have to figure out how to make what is typically a day-long journey to find a functioning hospital:

When people get sick in the river. First people could try to get from their town to Puerto Merizalde and see if Hospital San Augustin hospital can help them. From this area to PM it can take about 4-5 hours. The service there in Puerto Merizalde is a little better but still very limited. It is a little better in PM because they have medicines in PM that other river clinics cannot because we don't have any access to refrigerators because there is not power here. In PM there is a generator so they keep vaccines and anything that needs to be refrigerated there. But still many people end up needing to go all the way to Buenaventura.¹⁵⁴

Another major problem in the Naya River Basin is internal displacement of river communities living on the frontline with paramilitary violence.¹⁵⁵ According to reports, Afro-Colombian and Indigenous people make up a majority of displaced people,¹⁵⁶ and the main victims of forced displacement are children and women, widows, and female heads of household.¹⁵⁷ Once Nayero community people are displaced, the closest shelter to the river opening is Puente Nayero, a Humanitarian Space in Buenaventura where many internally displaced people temporarily settle. The conditions in Puerto Nayero, however, are very basic and, as in much of the rest of Buenaventura, there are insufficient sanitation services, water supplies, electricity, and few passable roads.¹⁵⁸ Although the government established this shelter to protect internally displaced people and to provide a safe humanitarian space for victims of the armed conflict under the

153. Interview with Angie Michelle Retan Mosquera, *supra* note 146.

154. Interview with Marua Francisco Angulo Moreno, *supra* note 149.

155. AMNESTY INT'L, *supra* note 132 (describing the presence of paramilitaries in the basin and the increased risk of violence against indigenous communities).

156. Goldscheid, *supra* note 9, at 4; Bratspies, *supra* note 9, at 4.

157. ORGANIZACIÓN NACIONAL INDÍGENA DE COLOMBIA ET AL., *supra* note 57, at 7.

158. Medina Interview, *supra* note 136.

heightened protections of Law 1448,¹⁵⁹ in reality, the conditions are some of the worst in the country and continue to deteriorate. For example, because of an abandoned construction operation in Puente Nayero, there are various uncovered holes three meters deep that fill up with filth, excrement, and disease, creating a health crisis above and beyond the crises already faced by this displaced community.



159. AMNISTÍA INTERNACIONAL [AMNESTY INT'L], COLOMBIA: LA LEY DE VÍCTIMAS Y DE RESTITUCIÓN DE TIERRAS (2012).



Similar conditions exist in most other displaced river communities in Buenaventura.¹⁶⁰ For example, when the Cabeceras

160. Georgia Orenstein, *Top 10 Facts About Living Conditions in Colombia*, BORDEN PROJECT (Oct. 31, 2018), <https://bordenproject.org/top-10-facts-about->

community was displaced, the government placed them in an outdoor sporting arena, where many people got sick and a good number died because of the horrendous conditions:

My grandmother died in the displacement site (like a refugee camp). We were internally displaced from our town due to paramilitary violence against our town and the town next to ours. There was a massacre in the town next to ours where 5 people were slaughtered. Paramilitaries threatened to do the same to our town so we left. The government put us in a coliseum in Buenaventura where we were staying for about a year. She got thrombosis and went into a coma for several days and then she died. So many people got sick while we were in that displacement camp. So many women got urinary tract infections. People would have horrible outbreaks on their skin. It was miserable.¹⁶¹

Because of inadequate infrastructure, governmental assistance services entitled to survivors are often late to arrive or never arrive, and families who remain in the area waiting for assistance run the risk of continuous threat from the same armed actors that displaced the community on the river. Furthermore, since there is no electricity service to the area and no potable water, the sanitation problems in the territory are exacerbated and certain medical resources become impossible to provide.¹⁶² As a result, because hospitals are inaccessible and, in the instance that survivors can endure the journey to these hospitals, hospital resources are generally inadequate, Afro-Colombian survivors of sexual violence—including internally displaced populations due to escalating conflict in the region—rarely if ever receive adequate care.

B. Post-Rape Medical Care: Deficits in Services Provided

Even where access to health clinics is technically possible, the types of services available at most clinics serving predominantly Afro-Colombian communities are inadequate. In particular, most clinics serving these communities do not provide sufficient care for survivors

living-conditions-in-colombia/ [https://perma.cc/ULB2-ZJRA] (describing the “weak community infrastructure” outside the cities affecting “individuals residing in rural areas” and “displaced people and ethnic minorities” the most).

161. Interview with Angie Michelle Retan Mosquera, *supra* note 146; *see also supra* note 8 (providing the context for the Witness for Peace interviews).

162. Medina Interview, *supra* note 136.

of sexual violence, such as psychosocial services or abortion procedures.

Health care and services provided in the clinics in the poorest departments are generally of lower quality than elsewhere, and facilities are often not properly equipped and are generally inferior.¹⁶³ Rural residents have fewer medical appointments and fewer procedures than urban residents, and the care that is available is of lower quality.¹⁶⁴ For example, none of Colombia's poorest departments (Chocó, La Guajira, Amazonas, Vichada, Vaupes, and Guainia) have chemotherapy chairs available, and only one has a pediatric ICU.¹⁶⁵ This may contribute to the elevated maternal and infant mortality rates in poor, rural regions: children under five are 2.3 times more likely, on average, to die in poor departments than children in rich departments, and women are considerably more likely to die due to pregnancy-related causes in poor, rural departments.¹⁶⁶ Decentralization has meant that health care responsibilities that were previously the exclusive domain of the government are now being shared with private entities.¹⁶⁷ This has allowed national entities to avoid responsibility for these deficiencies by shifting blame to other actors.

Such deficiencies are even more pronounced when it comes to health care for victims of sexual violence. Through the Ministry of Health's resolution 459, which does not specifically address the needs of victims of conflict-related violence, and Law 1719, which focuses on the needs of that population, victims of sexual violence are supposed to receive comprehensive health care from Colombian providers.¹⁶⁸ Comprehensive care should include appropriate care for physical injuries, which might involve "injuries to their breasts, or rectal injuries, burns, gunshot wounds, or lacerations," or other scarring or injuries that can result from female genital cutting or strangulation.¹⁶⁹ Appropriate care should also include pregnancy testing, STI testing and treatment, counseling and social support

163. *Id.*

164. *Id.*

165. Iamprea & García, *supra* note 80, at 60.

166. *Id.* at 59.

167. *See id.* at 50.

168. ABCOLOMBIA, *supra* note 12, at 19; Viviana Waisman, *An Important Step Forward for Victims of Sexual Violence in Colombia*, OXFORD HUM. RTS. HUB (March 7, 2016), <http://ohrh.law.ox.ac.uk/an-important-step-forward-for-victims-of-sexual-violence-in-colombia/> [<https://perma.cc/4WZM-YBUZ>].

169. Goldscheid, *supra* note 9, at 7.

services, and a series of at least two to three follow-up consultations for the monitoring of physical injury, further pregnancy testing, abortion procedures, and STI testing and treatment, as well as mental health evaluations and services.¹⁷⁰ For populations with low levels of literacy, secure facilities that allow for privacy and an assurance of confidentiality are essential for providing STI testing and mental health services.¹⁷¹

However, like many of the protocols adopted by the Ministry of Health, the services are mostly in name only,¹⁷² and deficiencies in care for survivors of sexual violence in rural areas are the most pronounced. Afro-Colombian and Indigenous women face many obstacles in getting services due to this population's location in conflict-ridden rural areas.¹⁷³ Appropriate facilities, trained providers, and necessary supplies are almost always unavailable in rural areas, which is especially critical when timely treatment is required, and, for the most part, the type of comprehensive care necessary and mandated by law to treat rape victims is near impossible to obtain for rural survivors of sexual violence.¹⁷⁴ In addition, though the law permits abortion under certain circumstances, it is unavailable in most cases, especially for the poorest segments of society.¹⁷⁵ Overall, access to health care for rape survivors in majority Afro-Colombian regions is scarce.¹⁷⁶

Perhaps the biggest deficiency in post-rape medical care is in mental health services. Sexual violence can be especially devastating to survivors when emotional or social support is non-existent or when they do not receive appropriate care to recover from mental damage.¹⁷⁷ Apart from the immediate physical and mental stress, women are at increased risk of developing long-term health problems such as "chronic pain, physical disability, misuse of drugs and alcohol

170. WORLD HEALTH ORG., GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 63–74 (2004), <https://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf> [<https://perma.cc/6W4Y-PCXA>].

171. *Id.* at 21, 96 (emphasizing the importance of security, privacy, and confidentiality in providing care for victims of sexual violence).

172. *See* ABCOLOMBIA, *supra* note 12, at 19.

173. *Id.* at 7–8.

174. WORLD HEALTH ORG., *supra* note 170, 63–74.

175. *See infra* Section III.C.

176. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 21.

177. AMNESTY INT'L, COLOMBIA: "SCARRED BODIES, HIDDEN CRIMES"—SEXUAL VIOLENCE AGAINST WOMEN IN THE ARMED CONFLICT (2004), <https://reliefweb.int/report/colombia/colombia-scarred-bodies-hidden-crimes-sexual-violence-against-women-armed-conflict> [<https://perma.cc/DC3J-EETY>].

and depression.”¹⁷⁸ Rape can also cause other health or psychosocial issues such as infertility or miscarriages, and it can result in unsafe self-induced abortions. Many survivors experience “depression, loneliness, and self-hatred.”¹⁷⁹ In terms of reproductive health, sexually abused women are more likely to have unwanted pregnancies, gynecological problems, and unhealthy sex lives.¹⁸⁰

Rape can also cause spiritual suffering of the family and the community. In one account, for example, a survivor described the effect of her rape on her family: “an armed group . . . entered shooting. They tied up my children, my husband, and me. In front of my family I was raped and because of this, my husband left me.”¹⁸¹ All of these consequences greatly exacerbate the devastating effects of sexual violence on daily and long-term existence, which makes psychological and psychiatric care even more essential.¹⁸²

Despite the legal mandate of CEDAW Article 14 requiring states to provide adequate mental health counseling and treatment,¹⁸³ and even since 2015 when the Constitutional Court declared that victims of sexual violence must be provided with

178. *Id.*

179. ABCOLOMBIA, *supra* note 12, at 19.

180. *Id.* at 9, 19.

181. *Id.* at 19.

182. *Id.* The need for psychological support goes well beyond anything imaginable:

Psycho-Social support is needed very badly here in Puente Nayero because we suffered the history of the “Casa de Pique” which was a house at the end of this street where the paramilitary groups used to chop up people publicly to terrorize the community. This impacted our community profoundly. Hearing the screams and seeing the violence impacted the children. As mothers and Afro-Colombian women, we suffered a lot because we knew our children were witnessing something so horrible that we couldn’t protect them from. Our children saw how people were killed, chopped up into pieces, and how they screamed as they were dying. The children started to imitate the “Casa de Pique” by killing the stray kittens and chopping the kittens up like the paramilitaries were chopping people up. As mothers, we saw that it was a symptom of a chain of violence started by the paramilitaries. This was what made us start our community programs against violence to break the cycle of violence with our children.

Interview with Nora Isabel Castro Panameno, *supra* note 23; *see also supra* note 8 and accompanying text (providing the context for the Witness for Peace interviews).

183. CEDAW, *supra* note 43, art. 14.

psychosocial care, there is little evidence to prove that sufficient measures are in place to provide mental health resources to victims.¹⁸⁴ Psychosocial care for victims of sexual violence is available only to the extent that such care is already available to anyone under the universal health care system, “unless a specific municipality has created and funded its own program.”¹⁸⁵ Even when such services are technically available, appointments usually take months to secure and require significant travel. For example:

In Puente Nayero it is very difficult to get access to a psychologist. The only access is that here sometimes Doctors Without Borders comes here to help people set up appointments. That process is also strange because then you have to have a phone interview with someone you cannot see and who you don't know.¹⁸⁶

But in most cases in rural Colombia, there may be no access at all to psychological support for survivors of sexual violence.¹⁸⁷

In addition to the lack of psychosocial services, PCN activists also highlighted the lack of availability of plastic surgery to reconstruct burns, lacerations, genital mutilation, and other aesthetic scarring that frequently results from acid attacks, a common form of violence against women in Colombia.¹⁸⁸ Estimates from 2016 indicate that at least 100 women were victims of acid attacks in the preceding year¹⁸⁹—most of the victims were intimately involved with the perpetrators and as a result, this crime is considered one of domestic violence.¹⁹⁰ Prior to 2016, acid attacks were dealt with as causing a personal injury and perpetrators very rarely received criminal penalties. However, in 2016, legislation created a new sentencing

184. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 16.

185. 2019 CEDAW Submission, *supra* note 67, at 13.

186. Interview with Nora Isabel Castro Panameno, *supra* note 23.

187. *See id.*

188. *See* Interview with PCN, *supra* note 53; *see also supra* notes 5 & 6 (providing the context for the PCN interviews).

189. Simeon Tegel, *Colombia Finally Cracks Down on a Horrific Wave of Acid Attacks Against Women*, PUB. RADIO INT'L (Jan. 21, 2016), <https://www.pri.org/stories/2016-01-21/colombia-finally-cracks-down-horrific-wave-acid-attacks-against-women> [<https://perma.cc/9SQN-6FL2>].

190. Evelyn Nieves, *Lens: Capturing the Strength of Women Who Survived Acid Attacks in Colombia*, N.Y. TIMES (May 24, 2018), <https://www.nytimes.com/2018/05/24/lens/capturing-the-strength-of-women-who-survived-acid-attacks-in-colombia.html> (on file with the *Columbia Human Rights Law Review*).

scheme for acid attacks, ranging from twelve to fifty years behind bars, depending on the severity of the victim's injury.¹⁹¹

Decree 1033 of 2014 guarantees that "victims have the right to receive, free of charge and at the expense of the State, the services, medical and psychological treatments, procedures and interventions necessary to restore the physiognomy and functionality of the affected areas."¹⁹² However, reconstructive services are not offered at most clinics, and advocates for victims say that more must be done to ensure women can access the services that are actually available.¹⁹³ Gina Potes, one of the nation's first acid attack victims, stresses that many women cannot afford to get to the locations where services are offered.¹⁹⁴ As a result, women who are located in more rural areas are effectively shut out from the help that the government guarantees them.

Besides calling for the government to improve and supplement existing care and facilities, indigenous residents have also called for the integration of both indigenous knowledge and indigenous communities into the medical system.¹⁹⁵ For starters,

[c]are in hospitals and medical centres does not include culturally appropriate care protocols: there is no translation into indigenous languages, there are no conditions for indigenous patients to be accompanied by family members, there are no indigenous-friendly information systems that contribute to our understanding of the medical procedures we may face.¹⁹⁶

Government clinics have not recognized "the vital and effective role that coordination between traditional health networks and the formal health system could play."¹⁹⁷ Additionally, community members spoke in depth about the importance of traditional medicine to the Afro-Colombian people.

191. Tegel, *supra* note 189.

192. *Frequently Asked Questions*, FUNDACIÓN NATALIA PONCE DE LEÓN, <https://fundacionnataliaponcedeleon.org/preguntas-frecuentes/?lang=en> [<https://perma.cc/URD4-V3ER>] (last visited Jan. 12, 2020).

193. Tegel, *supra* note 189.

194. *Id.*

195. See Interview with PCN, *supra* note 53; see also *supra* notes 5 & 6 and accompanying text (providing the context for the PCN interviews).

196. ORGANIZACIÓN NACIONAL INDÍGENA DE COLOMBIA ET AL., *supra* note 57, at 18–19.

197. *Id.* at 18.

The issue of traditional medicine and midwives in Buenaventura is actively being promoted by activists in the area. In the rural communities of Valle del Cauca, traditional medicine and medicine made locally in the communities has a strong presence. Unfortunately, traditional medicine is not recognized in the medical centers or contemporary hospitals.¹⁹⁸

For the Afro-Colombian population, ancestral, plant-based medicine is culturally important to natural healing processes,¹⁹⁹ but homeopathic traditional medicine is not covered under state health plans and generally not practiced by health care providers, who overwhelmingly are not Afro-descendant.²⁰⁰

To help lessen the impact of diseases and because of the lack of access to health clinics, Afro-Colombian people rely heavily on ancestral practices and traditional medicine. People turn to “comadronas” and “yerbateros,” as the traditional doctors are called, who make all their remedies using ancestral teachings. This is how the majority of all diseases are treated in the area. Traditional medicine specialists handle everything from childbirth to simple headaches, as well as treatment for people with fever or exhaustion. Such traditional medicine is entirely lacking at state hospitals and clinics for survivors’ emotional and physical healing.

In addition to the particular services that are lacking, Afro-Colombian advocates for survivors of gender-based sexual violence criticized the lack of confidentiality a woman has when she reports an incident to the authorities, which contributes to the very low reporting statistics.²⁰¹ When Afro-Colombian women do choose to report a crime it is likely that their names and other personal information will be exposed to the public.²⁰² Doctors Without Borders has reported that:

[P]olice and prosecutors have initiated investigations without redacting names or other personal information from claims, revealing claimants’ identities to the general public. Those who report human rights violations, including sexual violence, to

198. Interview by Witness for Peace Delegates with Maria Eugenia Mosquera, Member of the Consejo Comunitario for Cabeceras in Baja San Juan River (Oct. 3, 2019) (on file with the *Columbia Human Rights Law Review*).

199. *Id.*

200. *Id.*

201. PROCESO DE COMUNIDADES NEGRAS ET AL., *supra* note 16, at 12.

202. *Id.*

police or military are at high risk of retaliation from armed groups, and brutal practices that stem from the armed conflict, including mutilation of women, continue to haunt survivors and their advocates. Afro-descendant women also face severe stigmatization when reporting sexual and gender-based crimes and risk isolation, loss of income, or further threats and violence from the community for speaking out.²⁰³

Speaking out in areas where armed groups are still active is particularly dangerous, so absent confidentiality and privacy, some of the worst violence continues to go unreported, which often means that it also goes untreated.²⁰⁴ The lack of stringent confidentiality protections along with the lack of adequate mental health services, access to plastic surgery, and integration of traditional medicine were voiced as main concerns about the often-inaccessible post-rape medical care currently experienced by Afro-Colombian survivors.

C. Inadequate Abortion Services

In addition to deficient post-rape health care services, survivors of sexual violence who get pregnant also generally lack access to abortion, as well as counseling regarding possible alternative courses of action. In 2006, the Constitutional Court overturned Colombia's total ban on abortions,²⁰⁵ and abortion is now legal in cases where: (1) a pregnancy threatens a woman's life or physical/mental health; (2) a fetus has a life-threatening abnormality; or (3) a woman is a victim of rape or incest.²⁰⁶ The Court's decision was framed in terms of women's constitutional rights to health and life.²⁰⁷ However, even with the ban lifted, few health care facilities offer abortion services, and the vast majority of health care facilities that do offer abortion services are private. It is possible to access abortion services at public hospitals, but some women who have done

203. *Id.* at 12–13.

204. CENTRO NACIONAL DE MEMORIA HISTORICA, LA GUERRA INSCRITA EN EL CUERPO [THE WAR INSCRIBED IN THE BODY] 389–390 (2017).

205. Eduardo Diaz Amado et al., *Obstacles and Challenges Following the Partial Decriminalisation of Abortion in Colombia*, 18 REPROD. HEALTH MATTERS, 118, 118 (2010).

206. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, GUTTMACHER INST. (Oct. 2013), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-and-induced-abortion-colombia> [<https://perma.cc/4PRE-NPH6>].

207. Amado et al., *supra* note 205, at 119.

so have stated that they received poor care at those facilities.²⁰⁸ Even when poor women in rural areas are able to access abortion, they are less likely to be aware of the safest options, more likely to face complications, and less likely to have access to appropriate post-abortion care.²⁰⁹ Therefore, while access to post-abortion care has improved for other populations of Colombian women, it has not for poor, rural Colombian women.²¹⁰

In conjunction with the Constitutional Court's decree, Agreement 350/2006 states that abortion services should be a part of public health care plans available to Colombians,²¹¹ and that people insured by the public health care system can receive abortions free of charge.²¹² However, major barriers remain for some women seeking abortions. These barriers are much the same as the barriers to receiving post-rape care, seen in the form of legal provisions and administrative roadblocks exercised by medical professionals, patients' lack of knowledge concerning the law, cultural stigma,²¹³ and patients' lack of financial resources.²¹⁴ Afro-Colombian women, Indigenous women, and women from low-educated and low-income sectors of the population, as well as women in situations of forced displacement, are affected the most by such barriers, and are more exposed to illegal and unsafe abortions because of difficulties in accessing reproductive health services.²¹⁵

208. Teresa DePiñeres et al., *"I Felt the World Crash Down on Me": Women's Experiences Being Denied Legal Abortion in Colombia*, 14 REPROD. HEALTH 1, 1 (2017).

209. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, *supra* note 206.

210. Elena Prada et al., *Health Consequences of Unsafe Abortion in Colombia, 198–2008*, 118 INT'L J. GYNECOLOGY & OBSTETRICS S92, S93 (2012).

211. Amado et al., *supra* note 205, at 124.

212. DePiñeres et al., *supra* note 208, at 2.

213. MONICA MONTAÑEZ MARTÍNEZ, STRATEGIES TO ELIMINATE THE BARRIERS TO ACCESS SAFE AND LEGAL ABORTION SERVICES IN COLOMBIA 3, <https://www.engender.org.uk/files/strategies-to-eliminate-the-barriers-to-access-safe-and-legal-abortion-services-in-colombia.pdf> [<https://perma.cc/Z9GA-NJAU>] ("Women who decide to interrupt their pregnancy in State hospitals are exposed to cruel and inhumane treatments by medical personnel who judge them, do not provide the necessary medication to manage pain, and must share rooms with women in labor.").

214. *Id.* at 2.

215. *Id.* at 3.

1. Legal and Administrative Barriers to Abortion

Colombia's high court ruled in decision C-355 that all health service providers must provide safe abortions to women.²¹⁶ However, Colombia's legislature does not actively monitor the Ministry of Health to ensure that specific guidelines for safely terminating pregnancy are followed across the country.²¹⁷

While there is no practical government oversight of abortion methods, organizations that specialize in women's health and reproductive services are providing extensive information regarding the costs and benefits of varied methods, including post-abortion care, to women via their websites.²¹⁸ Profamilia and Oriéntame cite manual vacuum aspiration—as does the World Health Organization²¹⁹—or the use of medication as the safest ways to terminate pregnancy.²²⁰ Of the abortions performed at these clinics, 62% are done by aspiration and 36% are done using medicine such as misoprostol and mifepristone.²²¹ Half of all abortions in Colombia are done via misoprostol, although not without risks.²²² Women face the possibility of heavy bleeding and/or incomplete abortions if they do not use the medicine under the advice of a medical professional.²²³

The decentralized nature of the health care system in the country makes gathering formal statistics regarding abortion procedures difficult.²²⁴ However, many respondents interviewed for an article in the *International Journal of Obstetrics and Gynecology* were concerned that service providers are still using dilation and sharp curettage as opposed to aspiration or medicinal methods.²²⁵ While only 3% of abortions are done in the public sector, of those 3%

216. Bianca M. Stifani et al., *Abortion as a Human Right: The Struggle to Implement Abortion Law in Colombia*, 143 INT'L J. GYNECOLOGY & OBSTETRICS (SPECIAL ISSUE) 12, 13 (Supp. 2018).

217. *See id.* at 15.

218. *Métodos para abortar*, ORIÉNTAME, <https://www.orientame.org.co/embarazo-no-deseado/metodos-para-abortar/> [https://perma.cc/UR3Y-GKMK] (Colom.); *Aborto seguro, la decisión es tuya*, PROFAMILIA, <https://profamilia.org.co/servicios/aborto-seguro/> [https://perma.cc/WE2Q-Z74S].

219. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, *supra* note 206.

220. Stifani et al., *supra* note 216, at 15.

221. *Id.*

222. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, *supra* note 206.

223. *Id.*

224. Stifani et al., *supra* note 216, at 16.

225. *Id.*

58% were done using sharp curettage, which does not meet the standard of care.²²⁶ Further, there are pharmacists who provide high doses of oral contraceptives, nurses who employ oxytocin injections and/or insertion of catheters, and traditional midwives who insert sharp instruments into women or provide herbal combinations—all of which help facilitate abortions.²²⁷

A woman's geographic location and level of wealth often dictate the type of abortion she will receive.²²⁸ The most common method of abortion for urban women is through misoprostol.²²⁹ Conversely, only half of poor women in rural areas have access to this type of abortion.²³⁰ Abortion administered by a midwife or through self-induction is most common for this demographic.²³¹

Post-abortion care is offered disproportionately around the nation but is lacking overall.²³² It is estimated that in 2013, 20% of women who had abortion-related complications did not get the services they needed;²³³ 33% of all women who had clandestine abortions needed medical care but of that number, 53% of poor, rural women suffered from complications that warranted medical attention.²³⁴ The highest rate of complications was found in the Pacifica region while the lowest rate was found in Bogotá.²³⁵ These numbers illustrate an inverse relationship between levels of wealth and rates of complication.

If a woman is unaware of her legal rights, an advocate is crucial to her navigation of the complex system. Legal support and counseling are needed sometimes just to determine whether a woman's situation falls within the three legal indications, and psychological evaluation is required if a woman is seeking abortion based on her psychological health. But often, women in rural areas have less access to information about their rights and also find it hard to locate advocates who can help them.²³⁶

226. *Id.*

227. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, *supra* note 206.

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. *Id.*

236. Amado et al., *supra* note 205, at 124.

Of all the legal barriers to abortion faced by women, the most prohibitive for poorer women appears to be the gestational age limit. According to Colombian law, a woman who is eligible for an abortion may receive one at any time during her pregnancy, provided she can find a facility and pay for the procedure.²³⁷ However, primary health²³⁸ facilities only provide abortions for women who are fewer than fifteen weeks pregnant.²³⁹ Oftentimes, however, women seek abortions after fifteen weeks of pregnancy because they do not realize they are pregnant until it is too late,²⁴⁰ they do not realize abortion is now legal in certain circumstances,²⁴¹ they face logistical barriers, or

237. See Arjun Harindranath, *Colombia's Constitutional Court Rejects Time Limits on Abortion*, BOGOTA POST (Oct. 18, 2018), <https://thebogotapost.com/colombias-constitutional-court-rejects-time-limits-on-abortion/32837/> [https://perma.cc/K3D7-TV8B].

238. In Colombia, there are three different levels of care offered: primary, outpatient secondary, and emergency care. “Care is organized by levels of complexity, with primary care as the entry point and care coordinator for the patient and the secondary level in a supporting role. In the private healthcare subsystem, outpatient secondary care services can be accessed directly (via a private health plan or out-of-pocket payment).” Irene Garcia-Subirats et al., *Inequities in Access to Health Care in Different Health Systems: A Study in Municipalities of Central Colombia and North-eastern Brazil*, 13 INT’L J. EQUITY HEALTH, Jan. 31, 2014, at 1, 2.

239. Abortion services are available to women who are more than fifteen weeks pregnant but those services are only through the secondary providers. *Fact Sheet: Unintended Pregnancy and Induced Abortion in Colombia*, *supra* note 206. These providers usually take only private or privately subsidized insurance. See Garcia-Subirats et al., *supra* note 238, at 2.

240. See, e.g., DePiñeres et al., *supra* note 208, at 4 (For example, one woman explained, “I haven’t had my period for about 5 months. I thought the injections I was using for contraception had made my menstruation irregular. That made me think everything was normal.” Another, who sought abortion at 16 weeks, said: “My period came normally, but I realized that I was pregnant when I started to see I was looking fat and that my belly was hard. I took a pregnancy test but it was negative . . . later I did a blood test and it was positive.”).

241. See, e.g., DePiñeres et al., *supra* note 208, at 3 (quoting one woman who thought abortion “was illegal, that it was denying life to a human being and no one could do it legally”). None of the women interviewed knew there was a health exception, and certainly did not know that the health exception included mental health. See *id.* at 4 (quoting one woman who explained “I hadn’t even thought of the possibility that if you were in a bad emotional state, like I was, you could find legal support for the procedure. I didn’t know that. . . . They don’t provide information about it, because of the Church and people’s ideas, so many taboos.”).

they simply need more time to decide how to proceed with the pregnancy.²⁴²

Another legal roadblock to abortion for women who have been raped involves reporting. As often perceived with respect to receiving post-rape medical treatment, but true as it pertains to receiving an abortion, when a pregnancy results from an incident of rape or incest abortion is only available after the incident has been duly reported to the authorities.²⁴³ However, as discussed above, a majority of victims either wait to report sexual violence or do not report it at all.²⁴⁴ A study published in *Reproductive Health* highlighted that on average, women waited seventy-two days to report a rape.²⁴⁵ Given that the average number of days between a woman reporting a rape and receiving an abortion is seventy-nine, the average woman who delays reporting her rape would be twenty-one weeks pregnant by the time she could receive an abortion, which is not enough time to obtain an abortion at a primary care facility given the fifteen week time limit.²⁴⁶ For many women, these delays eliminate altogether the option of terminating the pregnancy.

Even if a victim herself does not delay in reporting, administrative roadblocks can have the effect of causing delays that render abortion effectively unavailable. Women sometimes face delays because clinic personnel erroneously tell them they must obtain judicial authorization in the form of signatures or stamps for an abortion to be completed,²⁴⁷ even though the only authorization the law actually requires is a doctor's certification that continuing a pregnancy would harm a woman's physical or mental health or that the fetus is not viable.²⁴⁸ In the case of rape or incest, the facility is not permitted to ask the woman about the validity of her

242. DePiñeres et al., *supra* note 208, at 3–6. For example, *Reuters* describes a case where a woman was turned down for an abortion after waiting eighty-four days for her doctor to make a decision. After this denial, she had to continue the pregnancy and eventually gave birth to a baby with severe disabilities. Anastasia Moloney, *In Colombia, Abortion is Legal, But Denied to Many Women, Advocates Say*, *REUTERS* (May 25, 2016), <https://www.reuters.com/article/us-abortion-colombia-law/in-colombia-abortion-is-legal-but-denied-to-many-women-advocates-say-idUSKCN0YG1GX> [<https://perma.cc/SMD9-53Q6>].

243. Rebecca J. Cook, *Excerpts of the Constitutional Court's Ruling that Liberalized Abortion in Colombia*, *REPROD. HEALTH MATTERS*, May 2007, at 160.

244. *See supra* notes 45, 128–129, and accompanying text.

245. Amado et al., *supra* note 205, at 120.

246. *Id.* at 121.

247. *Id.* at 120.

248. Stifani et al., *supra* note 216, at 13.

claim²⁴⁹—the only requirement is that a woman reports allegations to authorities.²⁵⁰ But insisting on these so-called requirements can delay the procedure and contribute to women coming up against the gestational age limit.²⁵¹ Therefore, structural barriers in the form of legal and administrative hurdles are sometimes so insurmountable for women, especially Afro-Colombian women, that they render the right to abortion meaningless.

2. Cultural Obstacles to Abortion

Afro-Colombian and Indigenous women typically face obstacles in obtaining abortions before the gestational limit at a higher rate than other women.²⁵² Specifically, cultural obstacles play an important role in creating these disparities. Accessing abortions before the gestational limit is harder for Indigenous women who do not speak Spanish and may not have access to a translator.²⁵³ Further, many Afro-Colombian women feel that being the victim of a forced sexual interaction is taboo—Afro-Colombian and Indigenous women often fear being blamed by members of the public sector who are supposed to help them.²⁵⁴ Often this stems from a lack of connection with the state after almost five decades of living in areas ruled by guerilla or paramilitary groups.²⁵⁵ All of these factors make it harder for women to report the crimes, which is a requirement for abortion access.²⁵⁶

Even where abortion services are offered, and where victims can get past administrative hurdles, many “women who dare to demand the termination of pregnancy usually face resistance and are offered psychological or psychiatric services to talk them out of their decision.”²⁵⁷ The Colombian government allows doctors to deny abortion services even to women who meet the criteria set out by the

249. Cook, *supra* note 243, at 116; Amado et al., *supra* note 205, at 122 (“However, the Court ruled that in cases of rape and incest it is necessary to consider the good faith and responsibility of the pregnant woman.”).

250. Cook, *supra* note 243, at 116.

251. Amado et al., *supra* note 205, at 120.

252. See JACKSON, *supra* note 126, at 29–34.

253. *Id.* at 34.

254. *Id.*

255. *Id.* at 29–30, 34.

256. *Id.* at 34.

257. MARTÍNEZ, *supra* note 213, at 3.

Constitutional Court in 2006, based on “conscientious objection.”²⁵⁸ A doctor who is otherwise qualified to perform the service can object to doing so based on moral or religious grounds.²⁵⁹ If this occurs, a woman is forced to find another provider, which can be difficult for people who live in rural areas where there is a deficit of providers.²⁶⁰ For example, one fourteen-year-old victim of sexual assault could not locate a provider where she lived in the Amazon, and was forced to travel to Bogotá for care.²⁶¹ This type of refusal is “widespread” throughout the country.²⁶²

Finally, on the chance that a woman is aware of her rights, is within the gestational limit, and can access a clinic that provides abortion services, women who terminate a pregnancy in state hospitals can be exposed to “cruel and inhumane treatments.”²⁶³ Often medical personnel judge Afro-Colombian and Indigenous women, due to cultural stereotypes about their sexual behavior.²⁶⁴ Inhumane treatment can come in the form of refusing to provide the necessary medication to manage pain or forcing women who are terminating a pregnancy to share rooms with women in labor.²⁶⁵

3. Financial Barriers to Abortion

Finally, the cost of abortion drugs and lack of funding for private organizations make abortion services inaccessible for many poor women. The majority of abortions in Colombia are performed by private non-profit organizations.²⁶⁶ However, if these sites do not have enough funding, they cannot provide free or low-cost services. On the other hand, wealthier women in Colombia have options. They can choose to terminate their pregnancies in their own homes with

258. Liza Kane-Hartnett, *Colombia's Constitutional Court Defends Abortion Rights*, INTERNATIONAL WOMEN'S HEALTH COALITION (Oct. 22, 2018), <https://iwhc.org/2018/10/colombias-constitutional-court-defends-abortion-rights/> [<https://perma.cc/7W58-6P95>].

259. *Id.*

260. Amado et al., *supra* note 205, at 122.

261. Moloney, *supra* note 242, at 3.

262. Courtenay Strickland, *What Colombia Can Teach the US About Abortion*, HUFFINGTON POST (July 24, 2013), https://www.huffpost.com/entry/what-colombia-can-teach-t_b_3634922 [<https://perma.cc/US59-P6BZ>].

263. MARTÍNEZ, *supra* note 213.

264. JACKSON, *supra* note 126, at 34.

265. MARTÍNEZ, *supra* note 213, at 3.

266. DePiñeres et al., *supra* note 208, at 2.

the purchase of certain drugs or they can go to a non-profit facility for the procedure and pay for the services.²⁶⁷

When abortion became legal in Colombia, not-for-profit clinics were able to offer abortions to clients on a sliding scale based on a patient's ability to pay.²⁶⁸ As a result, clinics made more money when they treated wealthier women.²⁶⁹ Throughout the 2000s, clinics, such as Oriéntame (Colombia's version of Planned Parenthood), were financially stable because they treated women of all classes in Colombia.²⁷⁰ However, women who were able to pay stopped seeking services at these clinics due to the increased availability of pregnancy-ending self-administered drugs such as misoprostol, and eventually the clientele was derived only from Colombia's poorer classes.²⁷¹ Misoprostol is very difficult for poorer women to obtain, which furthers the gap in accessing abortions for low-income women:²⁷²

Along the sidewalks outside of Oriéntame, Villarreal [director of the organization] points to corner stores where women can buy the compound for about \$50, a sum beyond the reach of many Colombian women. Ordering the drug over the phone or online requires an international cell-phone plan, an internet connection, or, at the very least, an address where it can be shipped. Wealthy families have always had access to abortions, whether through a flight to another country or by paying a private obstetrician for a covert procedure. Misoprostol could become just another option for well-connected, well-off women.²⁷³

267. Joshua Lang, *The Clinicians*, CAL. SUNDAY MAG. (Dec. 7, 2014), <https://story.californiasunday.com/villarreal-latin-american-abortion-clinics> [<https://perma.cc/X5MU-HDGL>].

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

272. *Id.*

273. *Quienes Somos, Donaciones*, ORIENTAME, <https://www.orientame.org.co/quienes-somos/> [<https://perma.cc/N86E-S6VU>]. Today, Oriéntame appears to be functioning well due to private donations, but it appears that low cost or free services are the reason why women go to this organization. If donations were to cease, the problems described above would likely resurface to the same extent. See *Aborto en Colombia, Una Opcion Para Mujeres de Cualquier Pais*, ORIENTAME BLOG. (Apr. 27, 2018), <https://www.orientame.org.co/aborto-en-colombia-una-opcion-para-mujeres-de-cualquier-pais/> [<https://perma.cc/R9R2-AKW6>].

Today, Oriéntame appears to be functioning well due to private donations, but it appears that low cost is the reason why women go to this organization. If

In the end, the combinations of legal, administrative, cultural, and financial obstacles prevent many women from accessing their legal right to abortion after being raped.

CONCLUSION

There is a health crisis in Colombia, but this crisis primarily affects the poor. The disparities have the greatest effect on women living in rural and remote areas, Indigenous and Afro-Colombian women, and women who have been victims of conflict-related violence. Under the government's subsidized health insurance scheme, technically no one gets turned away, but the quality of public health care is radically inferior to the private facilities. For people living in rural areas, there are very few health care options. For survivors of sexual violence in rural river communities, there is basically no post-rape care. For a certain segment of the population, violence is rampant, and health care is near non-existent.



donations were to cease, the problems described above would likely resurface to the same extent.



Laws protecting victims of violence and guaranteeing minimal health care are in place in Colombia and have been clarified and confirmed by the Constitutional Court. At this point, it is clear that the social determinants of health, such as poverty, infrastructure, race, and stigma, are the real obstacles in the path of Afro-Colombian victims in need of health care. Poor or nonexistent implementation of treatment protocols prevents victims of sexual violence from receiving the health care rights promised to them by law. In order to guarantee that even the poorest and most vulnerable segments of society have access to adequate health care, policy makers must address the structural and institutional issues surrounding race, gender, and poverty that are at the root of the problem.

Furthermore, comprehensive care for a victim of sexual violence must include not just appropriate care for physical injuries, but also pregnancy testing, STI testing and treatment, counseling and social support services, and secure facilities that allow for privacy and an assurance of confidentiality. In addition, traditional medicine should be incorporated into emotional and physical healing, and victims must have access to abortion, as well as the availability of and counseling regarding other alternative courses of action. Finally, full treatment also requires the availability of aesthetic reconstruction for burns, lacerations, genital mutilation, and other scarring that frequently results from sexual violence.

Because many of the principal stipulations of the 2016 peace deal with FARC²⁷⁴ have not materialized in any definitive way, there has been little progress in shifting social attitudes around the normalization of sexual violence. Thus, the culture of sexual violence that existed during those most intense moments of armed conflict largely remain to this day.²⁷⁵ Much of this violence, sexual and otherwise, is suffered disproportionately by Afro-Colombian women.²⁷⁶ Overall, these problems are difficult to address in a male-dominated political system and society.²⁷⁷

Since 2008 there has been wholesale legal transformation, but it could take generations for accompanying social transformation. The law cannot be relied upon as the sole method of altering behavior. If a law is regularly not enforced, the prohibited conduct is legitimized. Without the cultural influence, the immoral and illegal behavior will not be controlled. Even the best-intentioned law will not have the anticipated effect on the lives of real people if those called upon to evaluate the underlying incidents are laden with biases about the crime and its victims. The law must be viewed as having external legitimacy—it must be seen as reflecting a majority cultural perspective. The ultimate success and utility of the law will therefore depend on the erosion of deep-rooted gender inequality and racism in the legal system, as well as in the broader society.

Health equity issues implicate not only public health laws, but also civil rights, human rights, and poverty. In Colombian tradition and culture, racism and violence against women are endemic. Sexual abuse is so common that it is discussed in a casual

274. FARC Final Agreement, *supra* note 13, at 300–23 (providing the right to peace; comprehensiveness and precedence of the Agreement’s amnesties, pardons, and criminal treatments; amnesty for political crimes; differentiated special criminal treatment for state agents; duty to investigate, establish the truth, prosecute, and sanction; due process; legal certainty; and contribution to the realization of victims’ rights).

275. *Colombia*, UNITED NATIONS: OFF. OF THE SPECIAL REPRESENTATIVE OF THE SECRETARY GENERAL ON SEXUAL VIOLENCE IN CONFLICT, <https://www.un.org/sexualviolenceinconflict/countries/colombia/> [<https://perma.cc/68QM-Q59Z>].

276. JACKSON, *supra* note 126, at 34.

277. Reports indicate that Colombia is lagging behind its neighbors in terms of female representation in political positions of power. With only 12% of seats in national parliament held by women, Colombia ranks 106th out of 187 countries, according to the Inter-Parliamentary Union. Ørstavik & Lizcano R., *supra* note 130.

way, and many adolescents see it as an expression of love.²⁷⁸ Violence against women is “learned and reproduced in the house, starting from childhood.”²⁷⁹ As Martha Minow has said, “Redefining as unacceptable that which previously has been acceptable will remain difficult unless society can acquire a different language, a language that reflects the experiences of those abused”²⁸⁰ Until the cycle of discrimination and violence changes, laws meant to protect Afro-Colombian victims in Colombia will continue to have only minimal effect.

278. *Young People in Latin America Still Think Violence Against Women Is “Normal”*: Oxfam, OXFAM INT’L (July 25, 2018), <https://www.oxfam.org/en/pressroom/pressreleases/2018-07-25/young-people-latin-america-still-think-violence-against-women> [https://perma.cc/7HMA-VU7K].

279. Brown, *supra* note 17.

280. Martha Minow, *Words and the Door to the Land of Change: Law, Language, and Family Violence*, 43 VAND. L. REV. 1665, 1672 (1990).