Displaced and Desperate:
Assessment of Reproductive Health for Colombia's Internally Displaced Persons

Marie Stopes International
Women's Commission for Refugee Women and Children

On behalf of the
Reproductive Health for Refugees Consortium

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The goal of the Reproductive Health for Refugees Consortium (RHRC) is to increase access to a range of quality, voluntary reproductive health services for refugees and displaced persons around the world. The RHRC focuses on four essential and complementary technical areas of reproductive health. These are:

- **safe motherhood, including emergency obstetrics**
- **family planning**
- **sexually transmitted infections, including HIV/AIDS**
- **gender-based violence**

* **Adolescents are a population of special concern**

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Contents

Acronyms i

Map of Colombia ii

Executive Summary 1

1. Methodology 4

2. Background 4

- a. Geography 4
- b. Demographics 5
- c. Recent Political History 5
- d. Economic Context 6
- e. Internally Displaced Population 6
- f. The Colombian Government's Response to Internal Displacement 8

3. Reproductive Health Context 12

- a. National Reproductive Health Situation 12
- b. IDP Reproductive Health 17

4. IDP Findings by City 21

- a. Barranquilla, Atlanticó 22
- b. Cartagena, Magdalena 23
- c. Bogotá, Cundinamarca 26
- d. Quibdó, Choco 32
- e. Puerto Asis, Putumayo 35

5. Conclusions 37

6. Recommendations 39

Appendices 41

- a. Assessment Team Contact Information 41
- b. Colombia Contact list 41
- c. Project Document List 44
- d. Focus Group Summaries 45

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANMUCIC	National Association of Rural and Indigenous Women of Colombia
CEPAL	Latin America and Caribbean Economic Commission
DANE	Colombian National Planning Department
FARC	Revolutionary Armed Forces of Colombia
FAO	Food and Agriculture Organization of the United Nations
FP	Family Planning
GDP	Gross Domestic Product
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
ICBF	Colombian Institute of Family Welfare
IEC	Information, Education, Communication
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
KAP	Knowledge, Attitudes, Practice
MISP	Minimum Initial Services Package
MOH	Ministry of Health
MSF	Médecins Sans Frontières (Doctors Without Borders)
MTCT	Mother-to-child transmission
NGO	Nongovernmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PLWA	People Living With AIDS
RH	Reproductive Health
RHR	Reproductive Health for Refugees
RHRC	Reproductive Health for Refugees Consortium
RSS	Social Solidarity Network (*Red de Solidaridad Social)*
SM	Safe Motherhood
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TGID	Thematic Group on Internal Displacement
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNS	United Nations System
USAID	United States Agency for International Development

VCT Voluntary HIV Counseling and Testing

Map of Colombia

Executive Summary

The Women's Commission for Refugee Women and Children (Women's Commission), in collaboration with Marie Stopes International (MSI), Profamilia and Columbia University's Heilbrunn Center for Population and Family Health at the Mailman School of Public Health (Columbia University), conducted an assessment of reproductive health among internally displaced persons (IDPs) in Colombia from November 11–18, 2001.

Colombia was selected as a site to conduct a reproductive health needs assessment based on the Reproductive Health for Refugees (RHR) Consortium's[1] criteria for assessment missions. The criteria include identifying sites where there is a significant number of refugees or IDPs and where RHR Consortium members do not have a significant presence. Colombia was also selected for a reproductive health needs assessment since it could be integrated with a Women's Commission assessment delegation to Colombia. The purpose of the Women's Commission's delegation was to follow up on findings from a 1998 delegation to assess the conditions facing women, children and adolescents uprooted by war and violence. Findings from the 1998 and 2001 delegations are documented in the reports, *A Charade of Concern: The Abandonment of Colombia's Forcibly Displaced* (1999) and *Unseen Millions: The Catastrophe of Internal Displacement in Colombia* (2000), available on the Women's Commission website at www.womenscommission.org.

Two million Colombians have fled armed conflict and persecution, many of them have been uprooted and displaced repeatedly over the past 15 years. As the war continues to escalate, some people are displaced en masse, but the majority flee as individuals and families and do not want to acknowledge their displaced status for fear of retribution. Many of the displaced are indigenous groups uprooted from rural to urban areas and forced to flee again from one urban *barrio* to another in search of security and survival needs.

The assessment team found that IDPs suffer a critical lack of access to reproductive health care owing to a number of factors. Colombians' access to health care overall is faltering between national policy at the central level and services to the population at decentralized levels, leaving many Colombians, particularly IDPs, to fall through the cracks without health care. While the main role of United Nations (UN) agencies is to support local and national capacity to respond to the humanitarian crisis, the Colombian government has abdicated its responsibility to provide reproductive health services and the result is a tragic dearth of services for IDPs.

Those who are displaced in large groups, who represent less than half of all IDPs, are most likely to receive the extremely limited emergency assistance provided. This assistance, however, does not include reproductive health care. The local Planned Parenthood affiliate, Profamilia (*Asociación Pro-Bienestar*

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[1] The Reproductive Health for Refugees Consortium comprises seven organizations: American Refugee Committee, CARE International, Columbia University, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children. The Consortium works to increase refugee and internally displaced persons' access to good quality, comprehensive reproductive health care.

de la Familia Colombiana), provides most of the reproductive health services in Colombia and is just beginning to significantly increase its outreach to IDPs. However, Profamilia charges a small user fee for services, limiting IDPs' access to medicines and care. Few international organizations are supporting direct services to IDPs, despite the scale of this humanitarian emergency. Finally, lack of funds for services, medicines and transport, as well as discrimination by service providers, also prevents IDPs' access to reproductive health care.

The minimum initial services package (MISP) of reproductive health services, now considered a basic standard of care in emergency situations, is not available to IDPs in Colombia. Free services, including emergency contraception, are not available to manage and support survivors of violence. Condoms and clean delivery kits are not free and widely available to IDPs. IDP women suffering from complications of pregnancy and delivery are turned away from hospitals and life-saving emergency obstetric care.

The team learned that IDPs, particularly women, girls and adolescents, experience horrendous reproductive health problems in Colombia. Gender-based violence (GBV), including rape followed by murder, sexual servitude, forced contraception and abortions, is perpetrated by armed actors, is extensive and is largely unaddressed. In addition to GBV inflicted by armed actors, the situation is desperate for some families; the team heard of some instances of girls and boys being sexually exploited by their parents or turning to prostitution for family survival needs. The assessment team learned from IDP women that domestic violence is a major problem, exacerbated by the difficult living situation for IDPs.

The prevalence of sexually transmitted infections (STIs) among IDPs is unknown but anecdotal reports from government and UNFPA representatives suggest that it is very high. In some indigenous communities, health providers, unable to reach men for adequate treatment, have admitted pregnant women to the hospital to prevent them from becoming re-infected and to prevent mother-to-child transmission. This mobile population living among armed actors and on the whole without access to medical care is in danger of an explosion of STIs, including HIV.

The circumstances for adolescent IDPs is dire, and very little is being done to recognize their specific needs and capacities. Unable to cope with their circumstances or enticed by drug traffickers infiltrating urban barrios, many young boys turn to drugs, alcohol and stealing. Some adolescent girls seek solace and comfort from motherhood, while others would prefer to avoid or delay pregnancy, suggesting a need, currently unmet, for family planning. A recent study by Profamilia indicated that 30 percent of adolescent IDPs were already mothers or pregnant with their first child, a percentage nearly twice that of adolescents in Colombia's general population in 2000. [2]

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[2] Profamilia, *Salud Sexual y Reproductive en Zonas Marginadas - Situación de las Mujeres Desplazadas* (Sexual and Reproductive Health in Marginal Areas - The state of Displaced Women), Profamilia Survey, Colombia, 2001.

Chief Recommendations

The chief recommendations of the assessment team are as follows:

- The Colombian government should provide significantly more financial and technical support for health care, including reproductive health care, to IDPs, particularly at the local level and at referral hospitals for IDP women suffering from obstetric emergencies.

- The Ministry of Health (MOH) should collect and disseminate comprehensive information on who is doing what and where for IDPs and convene representatives of key organizations to improve the coordination of services.

- The MOH and humanitarian assistance providers should improve funding and institute data collection and monitoring mechanisms of IDP health services at major health centers and hospitals.

- The UN should scale up its efforts to promote human rights awareness and knowledge and demand for services among the IDP population.

- The UNFPA should address the MISP in Colombia by providing hospitals and health centers with the MISP kits, including safe delivery supplies, emergency contraception, condoms and essential medicines. UNFPA could also provide MISP kits to Profamilia to facilitate the MISP activities in their community outreach to IDPs.

- The MOH and humanitarian assistance actors should raise awareness about GBV, including sexual violence, by promoting community information and education about GBV and ensuring documentation and verification of incidents to identify and address these widespread human rights violations.

- The government, UN agencies and NGOs should seek to ensure that medical, legal and social services are available for IDP survivors of GBV.

- The government, UN agencies and NGOs should initiate multisectoral efforts to mobilize and support IDP adolescents and their parents. Programs should be implemented to provide health care, including reproductive health services, educational opportunities, recreational activities, income generation projects and family support groups to address household stress and domestic violence.

- Greater efforts must be made by the government, UN agencies and NGOs to conduct community outreach to educate IDPs, especially adolescents, about family planning and emergency contraception.

1. Methodology

The reproductive health assessment team was divided into three groups. While some members of the team visited the capital, Bogotá, and surrounding areas, another team conducted a reproductive health assessment in Cartagena and Barranquilla in northern Colombia. Team members also traveled to Quibdó, Chocó, one of the poorest areas of the country, located in the jungle on the western border and Puerto Asis, Putumayo, in southern Colombia.

The reproductive health assessment team conducted interviews and participated in meetings with a number of representatives in Bogotá working with the Ministries of Health and Education, other governmental organizations addressing the needs of IDPs, United Nations agencies, international NGOs, including the working group on armed conflict and women, the Colombian Institute of Family Welfare, women's rights activists addressing women in armed conflict and IDPs. The team visited villages, IDP camps and other communities and conducted meetings and focus group sessions in assessment sites with men, women and adolescents.

2. Background

a. Geography

Colombia lies between Central America and South America. Colombia is bordered by Panama in the northwest, Venezuela in the northeast, Brazil in the southeast, Peru in the south and Ecuador in the southwest. It is the only country in South America with access to both the Caribbean Sea and the Pacific Ocean.

Colombia's territory is one of the most diverse on earth in terms of flora and fauna, climate and population. It has three Andean mountain ranges or *cordilleras*; a large savanna territory (*Llanos*); part of the Amazonian rainforest; a desert (*Guajira*); and several other micro-regions with their own climates and conditions that have shaped Colombians' lifestyle and history in distinct ways.

Ciudad de la Paz was established in December of 2000 and houses 167 permanent and additional temporary families. The structures are temporary and most are roofed by plastic, utterly inadequate in the heavy rains.

b. Demographics

Before the Spanish conquest, various indigenous communities lived in different parts of the country. Today, the majority of Colombians are *mestizos* (of mixed indigenous and European descent), 20–25 percent are Afro-Colombian and *mulatto*, descendants of former African slaves, and approximately 20 percent are direct descendants of the Spanish. Indigenous tribes today constitute only one percent of the population.

Spanish is Colombia's official language. Since the arrival of the Spaniards, Roman Catholicism had been the principal religion. The 1991 constitution finally eliminated the concept of a Catholic nation. Although today 10 percent of the Colombian population are members of Christian protestant groups, Catholicism still dominates.

In 2001, the Colombian population reached 43 million, with a growth rate of 1.8 percent.[3,4] Population density within Colombia has changed dramatically due to significant migration between rural and urban areas. The intensification of the conflict has forced a considerable proportion of the rural population to leave their land and migrate to towns and cities. Forced displacement has contributed to the urbanization of Colombia, with 74 percent of the country's population now living in cities.[5] In addition, the demand for land by cultivators of illegal crops has pushed some peasants (*campesinos*) to forestry or wildlife reserves.

Another factor affecting Colombia's population is the reduction in infant mortality, spurring an improvement in life expectancy since the 1950s. The Colombian National Planning Department (DANE) estimates life expectancy currently to be 67.25 years for men and 74.25 years for women.[6]

Men are the primary targets of homicides, massacres and selective assassinations, while women tend to suffer from displacement, emotional trauma and a sharp decrease in quality of life and health.

c. Recent Political History

Colombia, heralded as the oldest democracy in Latin America, has experienced internal strife for the past 50 years. The war in Colombia represents the American continent's longest running internal conflict. The parties involved in this conflict are right-wing paramilitary groups, left-wing insurgent groups (guerrillas) and the Colombian armed forces. Contrary to humanitarian law, all parties make use of "dirty war" strategies, namely the targeting of civilians, of which internal displacement is a direct and intended result. Forced displacement figures have increased dramatically in the 1990s, from 600,000 IDPs in 1995 to 1.5 million in 1999, to more than 300,000 newly displaced annually.[7], [8]

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[3] PAHO/WHO, op. cit.

[4] Profamilia, *Salud Sexual y Reproductiva en Colombia* (Sexual and Reproductive Health in Colombia), National Demographic Health Survey, Colombia, 2000.

[5] Ibid.

[6] DANE (Colombian National Planning Dept.) 1998, in: PNUD/UNDP, 'Informe de Desarrollo Humano para Colombia 1998, Departamento Nacional de Planeación, Misión Social,' http://www.pnud.org.co/textos/salu.html, December 2001.

[7] CODHES Informa, Desplazados: Rostros Anonimos de la Guerra Resumen Ejecutivo - 2001, June 21, 2001.

The structural causes of the Colombian conflict are an intermixing of historical legacies, such as social and economic inequality in access to resources and to the political arena. Increasingly it has been transformed into a struggle for the control of territorial and economic resources (further pushed by international interests for exploitation) and was fuelled by the rise of the cocaine drug-trade in the 1980s.

The human rights violations have increased with the continual deterioration of Colombia's internal conflict.[9] Violence in Colombia is disabling to women, because it has inhibited and prevented their full participation in social, cultural and political life; inflicted economic hardships; and caused the displacement of families and communities. Sexual violence against girls and women in Colombia is a tactic of war.[10]

d. Economic Context

Colombia managed to escape the 1980s debt crisis that debilitated many other Latin American countries. In the 1990s, the Colombian government introduced liberalization policies that consisted of cuts in public spending (including health and education), decentralization of state functions, liberalization of labor markets and removal of price controls.

Nevertheless, at the end of the millennium Colombia experienced a deep economic crisis. Foreign debt already constituted a third of the country's gross domestic product (GDP) in the mid-1990s and is still on the rise. GDP contracted by more than 5 percent in 1999.[11] Approximately 20 percent of Colombians are unemployed, and the underemployment rate is 33.4 percent, indicating that more than half the population is subsisting without a formal job.[12]

Colombians' economic opportunities are shaped by one of the world's least equitable land and wealth distributions. Almost 80 percent of the land is in the hands of a mere 5 percent of landowners while 92 percent of national financial resources are controlled by just four economic groups.[13]According to figures from the Latin America and Caribbean Economic Commission (CEPAL), 23 percent of the population (approximately 9 million people) do not have the income for one proper meal a day.[14]

e. Internally Displaced Population

[8] Relief Web, Norwegian Refugee Council, Internally displaced people: Global Survey 2002
[9] Thematic Group on Internal Displacement, International Displacement Situation Report, August 2001.
[10] United Nations, Consulta con Mujeres Desplazadas sobre Principios Rectores del Desplazamiento, Bogotá, May 16-18, 2001, p. 13
[11] Pan-American Health Organization/World Health Organization (PAHO/WHO), 'Country Health Profile – Colombia,' http://www.paho.org, December 2001.
[12] DANE (Colombian Department of National Statistics), 2001, in: Colombia Solidarity Campaign, *Colombia Solidarity,* No.3, December 2001, p 29.
[13] Save the Children UK, 'Emergency Updates – Colombia,' http://www.savethechildren.org.uk , December 2001.
[14] CEPAL, 2001, in: Colombia Solidarity, op.cit.

Internally displaced persons (IDPs) are those who are forced to abandon their place of residence, their land, their property and belongings, their jobs, and in many instances their families and communities, but who do not cross an international border. Colombia has one of the largest internally displaced populations of any country in the world. According to the US Committee for Refugees' 2001 Report, Colombia had more IDPs than any countries but Sudan and Angola.[15] Although no official census of the displaced population has taken place, various estimates exist. According to local NGO sources, more than 2.1 million Colombians have been forcibly displaced by violence since 1985, and their numbers have been increasing markedly since 1995.[16] Although Colombian government estimates differ and tend to be much lower, they also indicate a sharp increase in the late 1990s and agree that the humanitarian crisis has escalated.

The majority of IDPs in Colombia come from the countryside. Prior to displacement, most IDPs worked in agriculture. As the UN Secretary-General's representative on IDPs, Francis Deng, stated, the situation in Colombia is "among the gravest in the world…Displacement in Colombia is not merely incidental to the armed conflict but is also a deliberate strategy of war."[17] At the heart of this strategy is the armed factions' ability to gain control of large tracts of land, forcing people off their property.

While the flow of displaced people crossing the borders to Ecuador, Panama and Venezuela is steadily growing, the great majority head for urban areas within Colombia, fleeing individually or in small family groups. Contrary to other countries' experiences, only 22 percent of Colombian IDPs have fled in larger groups, due to a high level of insecurity and continuous lack of protection.[18] These reasons also discourage Colombian IDPs from concentrating in camps, leading them to spread themselves among slums in the cities and to change their location often.

Women and girls account for more than 55 percent of the displaced population and together with male children account for nearly 72 percent of the IDPs in Colombia.[19] Much of the violence is directed at men, resulting in a high number of female-headed households in conditions of displacement, reportedly between 49 and 58 percent, a significant proportion of whom come from the Afro-Colombian and indigenous minorities.[20]

Following displacement, families typically experience an abrupt drop in living conditions. Due to the economic recession in Colombia since 1999 and the lack of employment opportunities in urban areas for people with farming skills, income generation outside of the informal sector becomes very difficult, particularly for single mothers. The assessment team often heard reports from IDPs and others that discrimination against the displaced, because they come from a different area, or they lack ability to pay for health services and school fees, for examples, is widespread.

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[15] US Committee for Refugees, World Refugee Survey 2001.
[16] Codhes, *Desplazados: Rostros Anónimos de la Guerra* (The Displaced: the Anonymous Face of the War)*,'* Codhes Informa, No. 38, Colombia, June 2001.
[17] Human Rights Watch, 2001, in: Global IDP Database, 'Colombia - Causes and Background of Displacement,' http://www.db.idpproject.org, December 2001.
[18] Codhes, op.cit.
[19] Thematic Group on Internal Displacement, *Internal Displacement Situation*, Colombia, August 2001.
[20] Social Solidarity Network (*Red de Solidaridad Social*), 2001, in: ibid, p. 13.

Conditions in IDP settlements, such as Ciudad de la Paz, are very basic.

The poor and crowded living conditions that many IDPs endure (often more than one family in a single room) were reported to the assessment team to negatively affect household relations, increasing stress, tension and domestic violence, of which women are the primary victims. Traditional support networks are broken as a result of the major social and economic changes caused by displacement. For example, IDP men experiencing unemployment may suffer from low self-esteem and fall into alcohol abuse. Some may also abandon their families. Consequently, young displaced women often are challenged with new or increased family responsibilities and a change in gender roles.

According to Save the Children UK, over a million children, 800,000 of whom are under the age of 14, have fled their homes.[21] Apart from the deterioration in their quality of life, IDP children in Colombia often suffer from emotional trauma. An estimated 63 percent of displaced children have at least one family member who has been murdered or has been a victim of an attempt on his/her life.[22] Moreover, the number of IDP children going to school is minimal due to high costs, the lack of available space in local schools and stigmatization. Child labor among Colombian IDPs is common, as are prostitution and criminal activities among displaced adolescents.[23]

f. The Colombian Government's Response to Internal Displacement

National authorities have the primary duty and responsibility to provide protection and humanitarian assistance to internally displaced persons within their jurisdiction.
Guiding Principles on Internal Displacement, Principle 3 (1)

An early period, commonly called The Violence (*La Violencia*) (1954–1964), caused the first displacement from the Colombian countryside to the cities on the Andean range and the Atlantic coast, forcibly displacing approximately 2 million people. This problem of displacement only began to gain

[21] Save the Children UK, op.cit.
[22] IACHR (Inter-American Commission on Human Rights), 1999, in: Global IDP Database, 'Colombia - Issues of Family Unity, Identity & Culture,' op.cit.
[23] Ibid.

recognition in 1995 when the Catholic Church (*Conferencia Episcopal*) published a study on *La Violencia.*

Facing mounting pressure, the Colombian government, under the Samper and Pastrana administrations, produced laws and decrees (e.g., Law 387/1997, Law 589/2000, Decree 2569/2000, 3057/2001) addressing forced displacement. Public policies addressing internal displacement issues tend to have a strong link to specific presidents, thus affecting the sustainability of such policies across administrations. Government measures moreover attempt to apply standardized models of assistance, with little recognition of the heterogeneity of the displaced population and their basic needs (e.g., women, children, indigenous and Afro-Colombian minorities).[24]

The government under President Pastrana (1998–2002) relied on the Social Solidarity Network (*Red de Solidaridad Social - RSS*) to sub-contract local organizations to provide direct assistance to IDPs. Since the RSS's establishment, Colombia's response to the internally displaced has improved. Only a small portion of this response, however, has concentrated on efficient decentralization, implementation and coordination of programs and policies among the government's different branches and local municipalities. Government health officials told the assessment team that regional and local authorities often do not have the resources to assist IDPs adequately. However, even when resources do exist, government officials often evade their responsibility toward the displaced population.

According to RSS, government assistance lasts for 90 days (occasionally up to six months), is available to individuals and families displaced only in the past three years, and depends on a bureaucratic registration process. IDPs told the team that many choose not to register for fear of reprisals from armed groups and mistrust of the government. UN representatives said that many IDPs lack knowledge of their rights. Others told the team that to register for government assistance, IDPs without documentation have been asked to return to their original village or town to obtain new documents, a practice that places IDPs' lives at serious risk.

Less than one in four (22 percent) IDPs are registered and receive government assistance, according to Colombian NGOs.[25] Three successive UN missions have recommended that the government modify registration procedures for IDPs, but on the whole, the Colombian government's response to IDPs has suffered from chronic under-financing.

This lack of registration with the Social Solidarity Network is likely one factor that blocks IDPs' access to local health services. The Pan American Health Organization (PAHO) estimates that only 22 percent of displaced households receive medical care.[26] According to the Profamilia 2001 study, 73 out of 100 women do not know where to receive authorization certifying their displaced status, and a high percentage of women are not familiar with the benefits of receiving such certification.[27] Even when the

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[24] Codhes, '*Guerra y Diaspora* (War & Diaspora),' Codhes Informa, No. 39, Colombia, November 2001.
[25] Ibid.
[26] PAHO/WHO, op.cit.
[27] Profamilia, '*Salud Sexual y Reproductiva en Zonas Marginadas – Situación de las Mujeres Desplazadas'* (Sexual and Reproductive Health in Marginal Areas – The state of Displaced Women), Profamilia Survey, Colombia, 2001.

displaced qualify for services, their needs may be ignored due to the stigma attached to their displacement. In addition, hospitals and clinics may not be adequately equipped and financed to cope with the additional burden of an increasing displaced population.

Internally displaced persons (…) shall be protected in particular against: rape, mutilation, torture, cruel, inhuman or degrading treatment or punishment, and other outrages upon personal dignity, such as acts of gender-specific violence, forced distribution and any form of indecent assault.
Guiding Principles on Internal Displacement, Principle 11 (2. a)

People displaced from conflict, as unarmed civilians, have the right to be protected by the state and its security forces (Guiding Principles on Internal Displacement, International Humanitarian Law, Protocol II, Art. 3). Protection should be provided before displacement (as a form of prevention), during displacement and during return, resettlement and reintegration. Protection should be provided to IDPs and those who bring them assistance or lobby for their rights.

In Colombia, the magnitude of violence, including gender-based violence, is difficult to determine, and for the most part goes unreported. State protection against the targeting of civilians, IDPs and humanitarian and human rights NGOs (whether local or international) is negligible and thus undermines the accurate collection of information.[28]

Update

The reproductive health assessment team visited Colombia in November 2001. During 2002, the situation for IDPs worsened further.

Targeted by armed groups, the numbers of IDPs surged dramatically throughout 2002. It is estimated that 173,320 people were displaced in the first half of 2002 compared to a total of 190,437 IDPs in 2001. On average, 772 people were displaced every day in 2002 compared to an average of 472 IDPs per day in 2001. In addition, a new campaign of terror in Colombia, in which rural villages are besieged by armed groups and people are cut off from access to their survival needs and humanitarian assistance, has been recognized by the United Nations System (UNS).[29]

The report of the UN Special Rapporteur on Violence Against Women was released in early March 2002, with findings from her mission to Colombia just prior to the assessment team's visit in November 2001. The report documents the effect of the internal conflict on the human rights of women, including the widespread, systematic and overlooked gender-based violence perpetrated by armed groups with impunity in Colombia. Among the recommendations of the UN Special Rapporteur on Violence is increased protection for women, particularly with regards to GBV, a call to include gender perspectives

[28] Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings: A Global Overview,* pgs. 105-109, 2002.
[29] United Nations System Thematic Group on Internal Displacement, Humanitarian Action Plan 2002-2003 Colombia.

in policy development and programming, increased monitoring and documentation of incidents of sexual violence, and the prosecution of perpetrators of GBV.[30]

At the end of May 2002, independent presidential candidate, Alavaro Uribe Velez, was elected with 53 percent of the electoral vote. He took office on August 7, 2002 with a mandate from the Colombian population to focus on the country's violent internal conflict and to re-establish security both in the cities and in rural areas. While the president appears to have a great deal of popular support, the country's economic situation has gone from bad to worse and the health sector appears to have low priority for the scarce resources available. It is, however, interesting to note that Mr Uribe was the Health Minister responsible for Ley 100, which reformed the Colombian Health System. It still is not clear how the new administration will address IDPs' poor access to reproductive and other health services.

In November 2002, the UNS Thematic Group on Internal Displacement in Colombia (TGID), [31] presented a collaborative strategic planning framework entitled the Humanitarian Action Plan (HAP) 2003 for Colombia. The overall goal of the HAP is "to promote respect for, access to, and enjoyment of the human rights and basic humanitarian principles of the population affected by the humanitarian crisis caused by the armed conflict."[32] UN agencies are intending to double the resources committed to Colombia to implement the plan for a total of U.S.$62 million.[33]

Specific plans of action within the health, education and family welfare sector include:

- "Strengthening, through technical cooperation and training, the local and regional capacity for timely and efficient response, with special emphasis on vaccine-preventable disease, sexual and reproductive health, mental health, emerging diseases, nutritional improvement and upgrading of information on the health situation.
- Promoting the creation and development of strategic partnerships for comprehensive health care.
- Supporting communities with organizational skills and capacity-building to promote the right to health, and enable them to engage in monitoring, follow-up and control activities."[34]

Improved access to sexual and reproductive health services for displaced populations, particularly adolescents, is one of the three major objectives in the United Nations Population Fund (UNFPA) reproductive health subprogram for 2003–2007. Activities will include training and institutional capacity building of organizations working with IDPs to educate IDPs about their reproductive rights and to implement integrated sexual and reproductive health services with particular emphasis on adolescents. [35]

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[30] Commission on Human Rights, Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women, March 11, 2002.
[31] The Thematic Group on Internal Displacement consists of representatives of 12 United Nations System agencies present in Colombia: UNHCR, OCHA, FAO, UNFPA, UNDCP, IOM, UNHCHR, PAHO-WHO, UNIDO, UNDP, UNICEF and UNIFEM.
[32] United Nations System Thematic Group on Internal Displacement, Humanitarian Action Plan 2002-2003 Colombia.
[33] ReliefWeb, UN Country Team in Colombia, November 2002.
[34] Ibid.
[35] Executive Board of the United Nations Development Programme and of the United Nations Population Fund, United Nations Population Fund Country Programme for Colombia, October 2002.

3. Reproductive Health Context

a. National Reproductive Health Situation

The Ministry for the Environment and Population, responsible for the formulation of public policy on population and health, has not yet developed a national population policy.[36] While the 1991 Colombian constitution did include an article on the human right to family planning, health and family planning expenditures were delegated to local municipalities as a measure of self-determination and decentralization. In 1993, the Colombian government and the Ministry of Health began restructuring the health system by introducing a General Social Security System (Law 100). Under this system, mayors are responsible for formulating a plan to ensure local health services, including reproductive health services, to every citizen.

Since 1993, the public health sector has experienced major difficulties in reaching much of the population, especially the very poor and the displaced. In a number of municipalities, institutional weaknesses and limited administrative and technical capacities have hampered the progress of change in the health system. As a result, government family planning services are marginal. A good majority of family planning services are provided instead by Profamilia, which is subcontracted through the Social Solidarity Network.

Profamilia provides, through its 42 clinics in 32 cities and mobile health projects, about 70 percent of the reproductive health and family planning services available in Colombia.[37] Profamilia received the 1988 United Nations Population Award.

In general there are marked disparities in reproductive health status between urban, rural and conflict-affected areas in Colombia. And, while some technical areas of reproductive health have steadily improved, such as maternal and infant health status, others such as gender-based violence, unwanted pregnancies, knowledge about sexually transmitted infections and the needs of adolescents remain inadequately addressed.

Profamilia's efforts have contributed to the improved reproductive health indicators that Colombia has achieved over the last 30 years. Apart from Cuba, Argentina and Chile, Colombia has the best reproductive health indicators in the Latin American region.

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[36] UNFPA, op.cit.
[37] Profamilia, *Salud Sexual y Reproductiva en Colombia* (Sexual and Reproductive Health in Colombia), National Demographic Health Survey, Colombia, 2000.

The table below provides important health indicators for Colombia.

INDICATORS	Colombia
Maternal mortality ratio maternal deaths per 100,000 live births	71
Infant mortality rate per 1,000 live births	13.5
Total fertility rate	2.6
Annual growth rate (%)	1.8
Women aged 15–19 giving live-births each year (%)	9
Women aged 15–19 using contraception - all methods (%)	72
Women aged 15–19 using contraception – modern methods (%)	59
Women aged 15–49 using contraception – all methods (%)	76
Women aged 15–49 using contraception – modern methods (%)	70
Births attended by trained personnel (%)	87

Sources: PAHO/WHO Colombia Health Profile 2001, Profamilia ENDS 2000, IPPF Colombia Profile.

Family Planning (FP)

Due to the increase in female education and family planning use, Colombia's birth rate has dropped by more than half over the last 35 years. While women in 1965 were having an average of 7 children, in 2000 the total fertility rate was 2.6 children. Major regional and rural/urban differences, however, remain hidden by national averages. For example, women in rural areas and uneducated women in urban areas tend to have more children. In the cities, the fertility rate is 2.3 children per woman, while outside of the cities the rate is 3.8 children.[38] Colombian women on average wait 37 months before having their next child (40 months in urban areas, 33 in rural areas). The average age at the time of the first birth is 22 years.

Knowledge about contraception is high: almost all Colombian women of reproductive age are aware of at least one contraceptive method. About 84 percent of sexually active women were using a family planning method in 2000. The region with the lowest rate of family planning use was the Atlantic region (71 percent), while the Eastern region (83 percent) and Bogotá (81 percent) had the highest rate.

Abortion in Colombia is illegal unless a woman's life is at stake. However, Colombian women with unmet family planning needs often resort to unsafe abortions to terminate their unwanted pregnancies, greatly endangering their life and health. An estimated 337,000 abortions are performed every year in the country. [39] In Colombia, 15 percent of all deaths associated with maternity are abortion-related, making it the second leading cause of maternal death, with the highest incidence among women from 20 to 29 years of age.[40]

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[38] Profamilia survey, 2000, op.cit.
[39] Profiles for Family Planning and Reproductive Health Programs. The Futures Group International, 1999.
[40] PAHO, Colombia, Health in the Americas, 1998 Editions, Volume II.
http://www.paho.org/English/HIA1998/Colombia.pdf

Safe Motherhood (SM)

The estimated maternal mortality ratio in Colombia is 71 maternal deaths per 100,000 live births. However, discrepancies in mortality rates between regions still exist, with the Pacific Coast's maternal mortality rate three times higher than the national average. According to UNFPA, the main causes of maternal mortality are toxemia, complications from abortions, hemorrhages and complications before, during and after labor.[41] The Colombian Ministry of Health has identified 150 municipalities with the highest maternal mortality rates in the country, which range between 207 and 570 deaths per 100,000 live births. One hundred of these municipalities lie in departments characterized by significant social inequities, violence and population displacement (Bolivar, Cauca, Cesar, Cordoba, Nariño, Sucre).[42]

Trained personnel attend about 87 percent of all births. Almost all regions in Colombia have shown a decrease in infant mortality rates during the 1990s. A high proportion of women (91 percent) who had children between 1995 and 2000 confirmed to Profamilia that they received antenatal care, although in some rural areas like Pacific Coast and among uneducated women the situation is more precarious. Profamilia also found that a high proportion of deliveries are carried out in a health facility (88 percent) in the presence of a doctor (83 percent). [43]

STIs/HIV/AIDS

Infectious and tropical illnesses cause 10 percent of deaths in Colombia.[44] Although a general decrease has been reported, illnesses such as malaria, tuberculosis, cholera, hepatitis B and HIV/AIDS continue to be an important public health concern, especially in the marginal areas around the largest cities, the Atlantic and Pacific Coasts, the Oriental and Amazonian planes and the Magdalena and Cauca valleys. Knowledge of the existence of AIDS is almost universal (99 percent), but knowledge of the modes of transmission is low. According to UNAIDS, less than one percent of Colombia's adult population (aged 15–49) were living with HIV/AIDS at the end of 1999. The number of deaths due to AIDS for the same year was an estimated 1,700. Seventy-eight percent of reported cases were due to sexual transmission, 1.6 percent was mother to child transmission (MTCT) and 0.6 percent of cases were due to blood transmission. In 19 percent of cases no mode of transmission was recorded. [45] In an increase since 1994, about 14 percent of people living with HIV/AIDS are women, most of whom are heterosexual women in stable relationships. A Profamilia 2000 survey found that almost half the population (42 percent) has no knowledge of STIs.[46]

Gender-based Violence (GBV)

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[41] UNFPA, 'Recommendation by the Executive Director – Assistance to the Government of Colombia,' http://www.unfpa.org, December 2001.

[42] Ibid.

[43] Profamilia, ENDS 2000, op.cit.

[44] PNUD/UNDP Colombia Office, '*Salud – Indice de Desarrollo Humano* (Health – Human Development Indicator),' http://www.pnud.org.co, Dicember 2001.

[45] UNAIDS, 'Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections – Colombia,' http://www.unaids.org, December 2001.

[46] Profamilia, ENDS 2000, op.cit.

During the past few years, the Colombian government has attempted to reduce domestic violence through the creation of legal institutions and legislative changes for the penalization of violent partners. Nevertheless, in 2000, Profamilia found that a significant proportion of women experienced verbal violence (experienced by 65 percent of women) and physical violence (41 percent) in the home. Education levels did not seem to influence the extent of GBV. Only 22 percent of all female victims of GBV have reported the violence.[47] According to the Colombian National Reference Center on Violence, the groups that suffered the highest rates of family violence in 1995 were females aged 25–34 and males aged 5–14. In the same year, there were 11,970 reports of sexual offences, 88 percent of which were perpetrated against women, which gives a rate of 34 per 100,000 inhabitants. In 77 percent of the cases the aggressor was a person known to the victim. Due to a serious lack of data, the exact impact of the violence associated with armed conflict on women in Colombia is unclear and difficult to estimate.[48]

Adolescent Reproductive Health

Sexual activity in Colombia typically begins between the ages of 11 and 18, and is more common at younger ages in the large cities and among the lower social strata. On average, five percent of 15–19 year-old females are single and sexually active. Women in Colombia tend to marry at a young age, with an average age at first marriage of 21 years, and 14 percent of women between 15 and 19 are currently married. Since 1985, fertility among women aged 15–19 has increased throughout the country, particularly in Bogotá and in the Oriental departments. In 2000, Profamilia found that 19 percent of adolescents were either pregnant or already mothers.[49] Births among adolescents also seem to be higher in the rural areas and among less educated women. Moreover, approximately 45 percent of pregnancies among adolescents under the age of 19 are terminated by abortion.[50] In Colombia, sex education is mandatory by law in both primary and secondary schooling. Nevertheless, there is an ongoing challenge in reaching youth through formal education, as public programs addressing adolescent sexuality are scarce.

Adolescent girls are at risk of gender-based violence, including rape. Many adolescent girls are already mothers.

[47] Ibid.
[48] The Center for Reproductive Law and Policy, *Women's Reproductive Rights in Colombia, A Shadow Report*, December 1998.
[49] Ibid.
[50] UNFPA, op.cit.

b. IDP Reproductive Health

Special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care, as well as appropriate counseling for victims of sexual and other abuses.
Guiding Principles of Internal Displacement, Principle 19 (2)

Special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons.
Guiding Principles of Internal Displacement, Principle 19 (3)

In 1999, the Women's Commission for Refugee Women and Children found that "while reproductive health care services are more or less available to Colombian women through the national health system and the services of organizations like Profamilia, displaced women suffer from a lack of access to this particular area of health care, just as they lack access to health care in general."[51] In 2001 there is still little institutional presence, and a great need and demand for attention to the sexual and reproductive needs for women in marginalized zones. According to Profamilia, education campaigns that include the fundamentals of sexual and reproductive health are minimal.

In a discussion with the assessment team members, Ministry of Health (MOH) officials provided a lengthy description of the current health care system and an analysis of IDPs' lack of access to services but did not address any specific programming for IDPs. Representatives explained that IDPs should be given priority for health services. The MOH officials acknowledged the gap between policies and services but had no recommendations to address the problems. The decentralized system requires municipalities to provide services to IDPs but the municipalities are not supported with resources or technical assistance to do so. Moreover, officials explained, some host municipalities do not want to provide solutions or make things too comfortable for IDPs as it might encourage them to stay.

MOH representatives said that it was easier to manage health services for people displaced in large groups than it was to support individuals. They explained that during the initial emergency of a mass displacement there are a lot of resources and NGOs to assist the IDPs.

The MOH does not hold health coordination meetings or have a tracking system of who is doing what with IDPs and where they are working. The MOH has recently initiated coordination with some groups. However, they reported that some NGOs begin their work without even meeting with the MOH or local officials.

UNFPA reports that the following local and international organizations are supporting reproductive health in Colombia:

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[51] Women's Commission for Refugee Women and Children, *A Charade of Concern: the Abandonment of Colombia's Forcibly Displaced,* US, 1999.

Local:
Si Mujer: Cali
Serfam: Medellín
Fundación Mujer y Futura: Barrancabermeja
Cami: Cali
Casa de Mujer: Bogotá and Putumayo
Profamilia: Profamilia's coverage is in large cities.

International:
Engenderhealth
Save the Children UK

UNFPA said it is important to reach smaller and more rural municipalities. They would also like to support reproductive health training in the demilitarized zone.

There is very little information available about the specific health situation of IDPs. Profamilia therefore conducted a study in 2001 that for the first time tried to quantify the reproductive health status of marginalized women in Colombia. In the Profamilia study, marginalized women are defined as "the IDP and host populations." Of the total number of women interviewed in the Profamilia survey, 37 percent had been displaced due to armed conflict. The overall findings of the Profamilia study revealed that the reproductive health status of marginalized women in Colombia (including IDPs) was poorer than the national average.

Family Planning
Although national registries appear to indicate a general desire of Colombians to limit family size, the 2001 Profamilia survey revealed that women displaced by armed conflict and who live in marginalized areas plan less and have more pregnancies and larger families, making their subsistence more difficult. [52] Marginalized women had an average of 5.3 living children as compared to a national average of 3.4 and a rural average of 4.8. Nearly half (47 percent) of the women who were pregnant at the time of the Profamilia study did not receive any antenatal care.[53] The survey also shows that two out of every five women interviewed who were pregnant did not want their pregnancy. Approximately 30 percent of displaced and marginalized women aged 15–40 who are in a union do not use any family planning method.[54] Among women interviewed by Profamilia, the average number of live births per woman was 2.7 and the average number of live births the women thought would be ideal was 2.4. [55] The MOH reports that all family planning is free and it is not an issue of access, but of demand. However, the assessment team found that public health centers did not have family planning supplies. Profamilia introduced emergency contraception in Colombia in 2001 with significant resistance from the Catholic Church.

[52] Profamilia survey, 2001, op.cit.
[53] Ibid.
[54] Ibid.
[55] Ibid.

UNFPA reports that in the demilitarized zone the Revolutionary Armed Forces of Colombia (FARC) force women to use contraception and abortion. There have been subsequent problems with pelvic inflammatory disease. [56]

Safe Motherhood
As with other areas of reproductive health, safe motherhood services are limited in the country in general, and even less accessible for those who are displaced. Services are overstretched. UNFPA reports that the situation for IDPs at hospitals is precarious; deliveries and miscarriages take place at hospital doors. IDPs' inability to pay for services gives rise to discrimination by service providers. Hospitals refer emergency obstetric cases to other hospitals when IDPs cannot pay, delaying life-saving care for women. According to UNFPA, one medical director left his position of direct service provision because of the ethical dilemmas that he faced in not providing assistance to those in need. [57]

Displaced women often face discrimination when attempting to access services, or they lack the necessary medical insurance or coverage to obtain treatment. For example, IDPs receive less antenatal care during pregnancy than do Colombian women overall. Even when comparing women displaced by armed conflict to the host population or other migrants, 56 percent received no antenatal care as compared to an average of 47 percent among the marginalized group. Twenty-seven percent of displaced women who were surveyed experienced either a miscarriage or a stillbirth. Of these, 37 percent received no treatment or medical care. [58]

STIs/HIV/AIDS
STIs, including HIV/AIDS, are the reproductive health issues of greatest concern according to the UNFPA representative with whom the assessment team spoke.[59] Little is known about the problem because there are no statistics for IDPs. UNFPA has noted a high occurrence of male-to-female and MTCT of syphilis, with subsequent congenital syphilis. They have found it difficult to treat men from indigenous communities and have resorted to supporting the hospitalization of indigenous women to prevent them from becoming re-infected and to prevent MTCT.

The majority of marginalized women (97 percent) interviewed by Profamilia in 2001 reported knowledge of AIDS.[60] However, while one in every three females feels that she could contract HIV, half of the women did not know where to get tested for the virus. Among those with the lowest knowledge of AIDS are women displaced by armed conflict and adolescents aged 13–14. Although STIs are as common among the displaced as other conditions such as malnutrition, respiratory illnesses, diarrhea and parasitic diseases, the Profamilia study found that 28 percent of women are unable to identify any symptom of an STI.[61]

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[56] Interview with UNFPA representative responsible for IDP projects, Bogotá, November 15, 2001.
[57] Ibid.
[58] Profamilia survey, 2001, op. cit.
[59] Interview with UNFPA representative responsible for IDP projects, Bogotá, November 15, 2001.
[60] Profamilia survey, 2001, op. cit.
[61] Ibid.

There is severe stigmatization and human rights abuses by armed groups against people perceived or known to be HIV-positive. UNFPA reports that in the demilitarized zone, FARC test men and women for HIV. Recently, three women were killed because they were HIV-positive. The FARC have also burned the houses of suspected gay men. UNFPA representatives described the situation of a 16-year-old mentally disturbed boy who was known to be HIV-positive. Many groups worked to support him in an institution for his protection. However, he did return to his family and was horrifically abused by paramilitaries.[62]

Gender-based Violence (GBV)
The majority of displaced women in Colombia face an extraordinary amount of violence due to armed conflict or other physical, emotional or sexual abuse from their partners/spouses, strangers, friends, ex-husbands, fathers-in-law or step-fathers. Half the female respondents to the 2001 Profamilia survey reported physical attacks, 50 percent of which were perpetrated by their partners.[63] One in every five displaced women reported having been a victim of sexual violence and 24 percent reported having been raped.

UNFPA also reports that gender-based violence is a serious problem. In fact, three young girls were killed the day before the team's interview with UNFPA in Barrancabermeja. According to UNFPA, some young people apparently formed a resistance movement and the girlfriends of the boys in the resistance movement were killed.

While Colombia has one of the most modern and progressive frameworks for gender-based violence, there is a huge gap between legislation and action. There is a total mistrust for reporting and consequences. Domestic and sexual violence are invisible and very few lawsuits are adjudicated.

UNFPA is working on norms for all agencies to support an integrated response to sexual violence that addresses protection, health/medical care, including forensic evidence, justice and mental health. UNFPA is currently considering proposals for training workshops for providers.

According to one women's rights activist in Puerto Asis at Mocoa, the military operate and live in a girls' school. Many girls and women live with paramilitaries in the community and use their positions to threaten other girls and their families. They live in a climate of fear. For some girls, initiating sex with the paramilitary is at first an honor, but girls are often abandoned afterwards. Paramilitaries have also gone to the families of girls in Puerto Asis requesting their daughters to go with them for a weekend as a "community service." The consequence of refusal can be murder. Some girls are kidnapped for cooking and cleaning and are systematically raped by paramilitaries. Two months prior to this interview, a 14-

[62] Interview with UNFPA representative responsible for IDP projects, Bogotá, November 15, 2001.
[63] Profamilia survey, 2001, op. cit.

year-old girl who lived with the paramilitary and whose sister who was a guerrilla was murdered in Putumayo because she was suspected of spying. This activist also said that women are unwilling to report GBV and its consequences due to a total mistrust of authorities. She also explained that while Colombia has one of the most modern and progressive legal frameworks, there is a huge gap between legislation and action.[64]

In September 2001, the working group on armed conflict in Colombia decided to collect information about violence affecting women and girls. It called on many organizations to work together to bring it to the attention of the international community. Four regional workshops were conducted, information was compiled and reports were prepared and presented to the UN special rapporteur on human rights and violence. The reports describe the types and extent of violence by armed actors, including direct killing of women as a form of punishment, killing men and women so children are without a family, forced recruitment of boys and girls for domestic servitude, sexual exploitation and forced abortions.

News coverage on the findings of the UN special rapporteur on human rights was extensive. The findings exposed issues that provoked debate. However, the country and newspapers were not open to a subsequent visit weeks later by the UN special rapporteur on violence.

The Colombian Institute of Family Welfare (ICBF) is responsible for programs for children affected by armed conflict, including IDPs. The assessment team met with the director of ICBF. He felt that ICBF has been able to make domestic violence a high priority on the national agenda and that domestic violence reports have increased dramatically. The director did not think gender-based violence against female combatants by paramilitaries was a problem, in contrast to reports the assessment team heard from women and human rights representatives of sexual violence toward girls by paramilitaries. Instead he said that girls are "initiated by combatants" and described the situation as sexual exploitation implying that such behavior was acceptable. Reproductive health is not addressed in programs for ex-combatants.

Adolescent Reproductive Health

The situation of displaced adolescents is critical. They have the highest pregnancy rates in the country and confront serious problems in their sexual and reproductive lives. Displaced adolescent females also have crucial family planning needs, as 30 percent of these adolescent girls are already mothers or pregnant with their first child. Of those women aged 13–19 who were pregnant, over half would have liked to have postponed pregnancy and 20 percent did not want to get pregnant.[65]

4. IDP Findings by City

Specific findings from focus group discussions and interviews with key informants conducted by the assessment team follow. The information is reported by city, and by site within each city.

[64] Interview with representative of Working Group, Women and Armed Conflict, Bogotá, November 14, 2001.
[65] Profamilia survey, 2001, op. cit.

a. Barranquilla, Atlanticó[66]

The assessment team visited two of four internally displaced settings in Barranquilla, Ciudad de la Paz and La Esperanza.

Ciudad de la Paz

Ciudad de la Paz was established in December 2000 and currently houses 167 permanent and additional temporary families who arrived from at least six other regions in the country.

Discussions with 20 male and female adolescents in Ciudad de la Paz revealed that similar to their tradition at home, most youth are not formally married but either live alone, with their parents or in common-law unions. Most of the adolescents were not in school and did not have jobs, although many of them already had children. Participants reported discrimination, including verbal abuse and refusal of health services because people believe displaced persons are guerrillas. In spite of the discrimination, they reported feeling more secure then they did at home. Knowledge about HIV/AIDS among participants was very basic and simplistic: "Just don't have sex with people with AIDS." Project peer educators expressed enthusiasm for their training and work because it enables them to increase their knowledge about reproductive health and share it with others.

Focus group participants in Ciudad de la Paz.

In the discussion with 20–25 adults in Ciudad de la Paz, the adults also reported that health services and medicines generally were not available to them and appealed to Profamilia to intervene on their behalf. One man said, with the concurrence of others, that it was difficult to adjust to the change from independence as a rural farmer to a new situation where they have nothing and are completely dependent on others who treat them poorly. Despite this, as with the adolescents, they also said they felt much safer in Barranquilla than at home. The adults spoke of the violence they experienced at home and how it continues to impact their everyday lives.

At the start of the Profamilia project in Ciudad de la Paz, some opposition by adults in the community to the project's focus on young people arose. Profamilia responded by hosting meetings with the adults to explain the project. The adults in this group were now receptive and supportive of the project although

[66] Trip Report, Therese McGinn, Colombia, November 2001.

they believe that young people's care and education is the parents' responsibility. They also expressed a desire for additional reproductive health services for adults.

La Esperanza

La Esperanza is a more established setting, housing both displaced and local poor families. An estimated 89 percent of the residents are displaced and began arriving six years ago. A range of services is available in La Esperanza, including education and micro-credit programs.

Approximately 15–20 young women, most under 20 years of age, participated in a group discussion with another 12–15 girls observing. Many of the young women had two or three children and were living in non-formal unions; only a few were formally married. Non-formal unions are more common in this community because they can be dissolved with relative ease. The young women said "machismo" is strong; men insist on making household decisions and rarely support their children when separated from their girlfriends or wives. In addition, the women reported that their boyfriends refuse to use condoms. (However, it was not clear that the women were particularly interested in condom use either.)

The young women in La Esperanza were also forthright about induced abortion, reporting that they knew many tried it and many failed. The recent death of a young girl was attributed to unsafe abortion.

Following a prompted question by the discussion leader, women excitedly shouted that drugs of every kind were everywhere and used by everyone. They denied use of drugs themselves but said men and women, young and old, used drugs. They did not elaborate on the types of drugs and their vague responses may suggest a lack of real familiarity with the drug situation in the area.

The young women reported that domestic violence seemed to have increased since their displacement. They also noted that rape was not a problem.

The young women recounted positive experiences with the health care they received at the local government clinic, explaining that they were not discriminated against. They were also very satisfied with the services at Profamilia, expressing positive views of the project, although they did comment on Profamilia's distant location.

Later in the discussion, the young women were asked about the benefits of having children. They immediately grew very animated and remarked that having children was great. It gave them someone to love, relieved their loneliness and brought financial and emotional support from their families and friends (though not necessarily their boyfriends). The young women's emotional response to this topic was quite strong.

b. Cartagena, Magdalena[67]

The assessment team visited the Nelson Mandela IDP camp in Cartagena where it held discussions with adolescents and adults. During this visit, the team interviewed the director of Profamilia's center in

[67] Trip Report, Therese McGinn, Colombia, November 2001.

Cartagena who expressed her concern about the increase in pregnancies among young women. The director believed that the internally displaced have greater numbers of children because they are from rural areas and have less access to information on family planning. In addition, the director reported that HIV and STIs are more common among the urban population, and the internally displaced are at risk because they are not aware of prevention measures.

Nelson Mandela

Nelson Mandela is an established area outside the center of Cartagena that houses both the displaced and local poor. Profamilia estimates 9,500 families live there, some 40 percent of which are displaced. Displaced people started arriving in Nelson Mandela about five years ago, and continue to arrive. As services were offered to the displaced, there was some conflict with the local urban poor. In addition to Profamilia, many service agencies work in Nelson Mandela, including government, NGOs and church-based groups. Last year, the agencies conducted a joint planning exercise in an effort to coordinate their activities. Profamilia's services are available to both residents and the displaced.

The assessment team met with a group of young people and a group of adults in the Nelson Mandela settlement. They spoke with a group of eight young men and six young women, aged 14 to 22, all of whom are project peer educators. Both the men and women participated actively in the discussion. Almost all were in school, although some of the men were working full or part time (as bus fare collector, pizza maker, fruit vendor). Unlike participants in the other groups, no one in this particular group had babies with them, although a few were parents. Only a few of the young people were married.

Houses in the Nelson Mandela settlement are makeshift.

Participants said they became peer educators to learn about sex, to avoid mistakes themselves and to share information with others. They were interested in the topics of family planning, self-esteem and myths about STIs. The young adults felt that the project has made it easier for them to talk about sex and has made clinic visits less intimidating.

When asked about condoms, the responses – mostly from the men – were what have become typical: they don't like them; you can't feel the "meat"; they're too much trouble; there are too many other things to do during sex; they don't know how to use them; asking your partner about condoms means you don't trust them; wanting to use condoms means you have a disease. Participants said they would

consider using condoms with someone they don't know well, as a means of preventing HIV transmission.

The group appeared to agree that pregnancy is a women's problem. Moreover, men spend little time with their children and give little financial support.

The group characterized men as possessive. They argued that since a wife or girlfriend could be taken by someone else if she went out with her partner, it would be better for a man to leave his girlfriend or wife at home and go out with someone he didn't care about.

A discussion of domestic violence provoked an active exchange, with a range of different ideas expressed. The male participants said that women may become angry at men for any number of reasons, so the men may hit them to calm them down. (Here, some young men in the group gave examples of arguments using high voices to imitate the women's part. They appeared to be ridiculing and expressing anger at the women in the process.) The men also stated that women hit men out of jealousy when they see them with other women. Others disagreed, saying women are submissive and allow men to get away with anything because of a lack of an alternative, although they acknowledged that women are less likely to be submissive these days. When asked about their thoughts of a woman leaving a man because of abuse, one female participant replied that not only should a woman leave but she should also press legal charges against the perpetrator since women are equal to men and have that right. (The male participants laughed at this idea while the women remained passive.) A young man stated that women should not abandon men except for good reason, such as domestic violence; just having a bad day and not having money should not be cause for leaving a boyfriend or husband.

They reported that alcohol is used for entertainment, not for escape, noting that men are expected to drink.

In response to questions about reasons young people have sex and have children, participants reported that young people want to experiment with sex and sex is seen as a love test. Children are a means to extract money from the boyfriend (although previous comments suggested this was not common) and to get out of the parental home. In addition, a young childless woman may feel left behind when all her friends have children, and a child can provide friendship and security for their old age. They thought adolescent pregnancy is more common now than in their home communities but these perceptions may be affected by the participants' relative ages then and now.

After the discussion, some of the participants performed a mimed drama about domestic violence. In the play a woman had several sexual partners, including one who beat her. When she became pregnant, no one accepted responsibility. One kind male friend then took her to Profamilia.

The comments of young people in Cartagena were considerably different from those of the two groups of young people in Barranquilla. For example, the Nelson Mandela group was familiar with concepts such as equality and women's rights; indeed, the participants raised these issues themselves.

The assessment team spoke to a second group in the Nelson Mandela settlement, composed of eight women and three men, all community leaders and active participants in the discussion. The adults strongly supported Profamilia's project in Nelson Mandela and wanted it to continue. The program is needed, they said, because there has been a loss of values. Young people do not act responsibly – the adults believed this was more true now than in their own youths. Young people are bored because there is nothing to do – unlike in their rural homes – and therefore turn to sex, drugs and prostitution. They identified a need for additional activities, such as entertainment and micro-credit, and also indicated that these needs were the same for everyone, not just the displaced. Initially, however, life was harder for the newly displaced.

The adults also noted that girls are treated poorly at home and are not given affection, leading them to turn to boyfriends. Some parents do not fulfill their responsibility to care for their children, letting them roam around the area very late at night. The focus group participants felt strongly that mothers are responsible for educating their daughters about sex, yet they also recognized that communicating with their daughters about the topic is difficult, since their own mothers did not do so. The project is trying to address these issues by helping parents develop better communication skills.

The group made interesting observations on the differences between the displaced and local poor residents of Nelson Mandela. Participants stated that sometimes the displaced are more motivated to change their circumstances because they have different expectations and are less willing to put up with substandard conditions. The local poor, on the other hand, see the current situation as the norm, and so do not think it possible to change. All participants agreed that the government does not care about their predicament.

Participants reported "many" cases of rape of young girls and boys, but none of adults. (This may be due to a perception that adult women cannot be raped.) Domestic violence was not discussed, but participants agreed that "machismo" was prevalent among young and old men.

Although there are a number of services available in Nelson Mandela, the group indicated that there is poor coordination among service providers. Participants were dismissive of the "tourist" agencies, i.e., those organizations or individuals who come to conduct surveys or other limited tasks and then leave without assisting the community. The adult community leaders clearly took their responsibilities very seriously.

c. Bogotá, Cundinamarca

The largest number of IDPs, approximately 400,000, have fled to the poorest urban barrios of Bogotá. Most of them come from rural communities. They have lost their independence as subsistence farmers and suffer from the loss and/or death of family members, the breakdown of their communities, and the lack of traditional social and cultural supports. In Bogotá, IDPs struggle amidst stigmatization and unfamiliarity with urban survival to obtain basic necessities of life – security, shelter, food, water, health, education and livelihood.

The reproductive health assessment team met with IDPs in two sites and a first-level hospital near one of the sites. The following sections report the findings and perspectives raised during each of the team's meetings.

IDPs and representatives of organizations in Bogotá

The assessment team met with IDPs who were living outside the Defensoría del Pueblo Ombudsmen Office (Office of the Public Advocate) to protest the conditions for IDPs. Three women reported that they were all registered with the Social Solidarity Network (RSS) and that they do have access to reproductive health care through Profamilia and area hospitals but they lacked money to pay for medications. For example, despite problems with cystitis caused by their lack of access to a toilet, the women did not have the money to obtain medicine for treatment.

One woman who appeared exhausted told the assessment team that she had 12 children. When the woman was asked about gender-based violence she pointed and said that when she begs at the nearby traffic lights, men would offer her money for sex. She was concerned about the safety of her daughters. Her 12-year-old daughter was almost attacked by a man the previous day but fortunately found refuge in a church. The woman wished she could send her four daughters away to a safer place because they are at risk of gender-based violence.

The assessment team also met with women from the National Association of Rural and Indigenous Women of Colombia (ANMUCIC). Established in 1985 to improve the quality of life for rural women through agricultural reform and participation in civil society, ANMUCIC has been crippled by the ongoing conflict. Actual and threatened violence, including displacement and the murder of 30 active members, has severely impacted their participation and leadership throughout the country and their capacity to fulfill their mission. ANMUCIC members and some of their remaining family shared tragic stories of displacement and gender-based violence.

> ***My name is Elena. I lived in a rural farming community and was a community leader. I had three children, two of whom are now 12 and 14. In December 1999 my daughter, who was then 13 years old, went to another area/department to stay with my sister on school holiday. She was in the sixth grade. She was caught in the crossfire between the guerrillas and the paramilitaries in front of my sister's home. My daughter was shot but not killed. But as she lay seriously wounded, she was raped and then killed by army soldiers. I spent nine hours trying to prove that my daughter was not a guerrilla so that I could see and get my daughter's body. I tried to report my daughter's murder, but I was told that I would probably be killed by the time that was done because my own life was at stake. So I could not denounce the rape and murder of my daughter. To protect my life, I left my home and my other two children so they could continue school. I moved to another small village in the area. In July 2000 the paramilitaries burned our house down. My two children and I moved to Bogotá. My two children have told me that they want to commit suicide. They ask, "What is the reason for living?" In Bogotá***

we moved into a farmhouse belonging to the president of ANMUCIC, and being around cows has lifted my children's spirits. My children are not in school.

Profamilia in Bogotá

Profamilia manages four centers in Bogotá and initiated its first IDP project with funds from the Reproductive Health for Refugees Consortium small grants program with technical support from Marie Stopes International (MSI). Since then, Profamilia has secured funding from the British National Lottery Fund ($400,000 for two to three years) and is now funded by USAID ($1.5 million 2001; $2.5 million per year from 2002–2004) to provide services and education to IDPs.

Claire Morris of Marie Stopes International (left) with staff of Profamilia.

Profamilia provides services to everyone and 99 percent of its services to the displaced are subsidized. Profamilia charges 500 pesos ($0.27) for a family planning consultation; 1,000 pesos ($0.54) for general medicine and 2,000 pesos ($1.08) for female/male sterilization (the most common family planning method in Colombia). Profamilia's perception is that health sector reform has led to a major financial crisis in the public health system. Profamilia does not distinguish IDPs from their general beneficiary population, including the urban poor, and is committed to the contributory system they worked hard to establish to sustain reproductive health services, to which all Colombians have a right.

Profamilia refers emergency obstetric cases to hospitals. The director of Profamilia said that no emergency cases, such as survivors of sexual violence, are turned away if they cannot pay; an emergency fund supports these cases.

Profamilia works closely but quietly with local churches. However, Profamilia has been in conflict with the Church over the last year because they introduced and began social marketing of emergency contraception, selling 120,000 doses in 2001.

Profamilia staff also discussed the demise of sex education in the schools. They said that Colombia had an excellent sex education program in the schools until 1993 when the program was undermined by the intervention of religious groups. They correlate the rise in the rate of adolescent pregnancy with the lack of sex education and believe that national sex education has failed.

Soacha

Many IDPs have settled in Soacha, a large urban area on the outskirts of Bogotá in Barrio el Progreso, in the department of Cundinarmarca. There is a 90 percent concentration of IDPs living in makeshift shelters of scrap wood with dirt floors and tin roofs. Generally, IDPs do not own the land they settled on and some pirate electricity. Water is available to the community three half-days per week via a garden hose attached to community roof-top water tanks provided by Médicos sin Fronteras (MSF – Doctors without Borders). Most homes use outdoor latrines and open sewage water drains into paths to a ravine.

Profamilia implements a mobile project to assist IDPs in Soacha. Profamilia initiated the project three years ago following an evaluation analysis and meetings with community leaders. Their findings revealed IDPs' problems with transport and access to Profamilia clinics in Bogotá. Profamilia responded by working with the community to establish health committees and community sites to provide mobile services.

Profamilia currently provides mobile services once a month to approximately 25 sites in Cundinarmarca, including some community members' homes. Mobile services include general medicine, gynecology, pap smears, antenatal care, family planning and health education workshops.

Focus group in health committee leader's home

The assessment team met with 16 focus group participants, including women, men, adolescents and children who had arrived in the community from five months to eight years ago, in the health committee leader's home.

This health committee and its leader have been proactive on the community's behalf, contacting government agencies and NGOs to provide them with assistance. MSF was contacted by the community health leader to provide water and nutrition services. MSF conducts growth monitoring of children and supplementary feeding for children and pregnant and lactating women. In addition, the health committee contacted the government to ensure that everyone in the community was registered with SISBEN, a system where evaluation census places those most in need and enables them to receive services from public sector providers. Out of fear of reprisals, no participants were registered as displaced.

Profamilia provides reproductive health services via a mobile clinic once per month while some people also receive services at the government hospital. Participants reported that it cost them 11,400 pesos ($5.50) for each antenatal visit and 50,000 pesos or ($25) for delivery services at the government hospital. The community arranges taxi service to the hospital for emergencies. Although there have been no problems in the community with transport in the event of medical emergencies, participants reported

that they often went to the hospital between 2:00 and 5:00 a.m. to avoid waiting all day for assistance. Some participants have been unable to get emergency services due to a lack of funds.

Participants reported that although some people had lived in union, marriage was more common in the past. Since their displacement, however, things had changed and more young people saw no need to marry. Consensual union is easier because IDPs lack documents they would need for an official marriage. Participants reported that people either marry or live in union starting from 13–14 years of age and it is more common now for young girls to get pregnant to feel stable. While participants denied social stigma for an unmarried girl/woman who has a baby, it is a problem because grandmothers end up looking after the children of these very young mothers.

Most of the focus groups participants said they knew one woman who had died due to maternal causes; all of the incidents occurred in the rural areas they had come from. Breastfeeding is common, although some also add bottle feeding when their babies are four months old.

Participants expressed mixed desires for family planning. The health committee leader said that most couples want two or three children, but have four or five. One man said, "You get the ones God gives you." A woman expressing her desire for one child said, "The problem with too many children is a lack of money for food and education." One man with five children said he wanted twelve. To prevent or postpone having children, participants reported two modern methods of family planning, sterilization and intrauterine devices, from Profamilia.

In the event of an unwanted pregnancy, participants said the woman takes herbs and calls someone from the community. One woman became infected after an abortion and almost died. Participants also mentioned Citotech, an over-the-counter medicine for gastritis easily obtained in pharmacies, as a method used to induce abortions.

Most members of the group had heard of HIV/AIDS and reported being worried about the disease. To prevent HIV/AIDS, participants said you should use a condom and have only one partner. Condoms are available in the pharmacy or from Profamilia when they make their monthly visit. Participants denied that men have sex with men in their community stating, "That only happens on television or in Bogotá, an out of control, degenerating society."

In response to questions about gender-based violence, participants said that there are a lot of problems with domestic violence. One comment from the group was, "It happens a lot to plenty of women."

> ***One five-year-old girl told her mother that she wanted to throw herself out of the window because of the fighting between her mother and father.***
>
> *Community health leader, Soacha, Bogotá*

Another participant said that some men get women pregnant and then abandon them and that there are many women on their own who need additional support. Sexual exploitation and violence were also

reported problems. There have been three cases in their community of women working as prostitutes at brothels.

> ***Some parents without work do what they have to do and prostitute their own children — girls 12 to 13 years old. Boys are also exploited all over. Some children get caught when they are begging for money and food.***
>
> *Participant, Community Meeting, Soacha, Bogotá*

Another participant said that this was very serious and something that affects the whole community while putting the women and their children at risk.

> ***Her brother-in-law raped her 16-year-old sister. They went to the authorities and to the hospital but were not able to pay for the laboratory analysis which cost $50.00. Without this, the investigation ended. My sister, she said tearfully, is now six months pregnant.***
>
> *Participant, Community Meeting, Soacha, Bogotá*

One participant said that there was an NGO called Feathers in the rural area she came from that provided training in sexual violence prevention. She said that here they are too afraid to report cases of sexual violence and they don't believe anyone can do anything and that there is no justice.

A priority concern among focus group participants is the problem of adolescents who are often not in school and do not have jobs. School is difficult to get into and there is no community day care. The few children who go to school are sometimes stigmatized when others ridicule them for being from the countryside.

Adults reported that adolescents who are idle often get into trouble with drugs such as marijuana, ecstasy pills and alcohol. Adolescents using drugs get involved with gangs, threaten and rob the community. The participants would like the assistance of an organization to develop productive programs with young people in their community. They also agreed that sex education for children and adolescents is important.

The group reported that they would also like assistance to find work for adults, especially men who are idle all day, as well as help for women on their own.

First-level hospital Mario Gatian Yanguas de Soacha

Members of the assessment team visited the social services department at Mario Gatian Yanguas hospital following the focus group meeting. The two social workers with whom the assessment team met reported that the hospital has provided services to IDPs for the past two years and serviced 1,042 families, with an average of five members per family, in 2001. They receive an average of 25 certificates per week from RSS.

The lead social worker said: "I think it is terrible that we have to certify someone who is violently displaced but we also have to think about people who are displaced by poverty. There is a man here now who is very sick and he has his initial declaration but he doesn't have official certification so he has to pay under the sliding-scale system of *vinculado*. We often see IDPs with their initial declaration but without official certification. We review their claim to see if they are on the list from RSS. We know enough is not being done and we cannot give all of the services that we want, although we try to provide services to everybody, especially for an emergency. We do this by justifying the paperwork, although we encourage them to go to RSS. The displaced come here and have nothing, there are big belts of misery."

The social workers reported that gangs are developing and moving violence from one place to another, from the rural areas to, for example, Soacha. One social worker explained that there are different groups among the IDPs. Some, she said, are fighting for the IDPs and others have their own agenda. Local militias are trying to get rid of IDPs and, she said, they came to her office once to look at the list of IDPs.

According to the social workers, domestic and sexual violence are also a significant problem for IDPs. They said many women have been sexually abused and tortured. They described the case of a woman whose jealous husband burned her genitals with a hot iron for talking to a neighbor woman.

The lead social worker said young girls were taken by paramilitaries from Soacha in May or June 2000. In addition, three young IDP girls were suspected and tested for STIs after being sexually abused by the paramilitaries. While these tests were negative and they have not had any cases of IDPs with HIV, the hospital is in the process of conducting sensitization and awareness raising on HIV/AIDS. Because, the social worker reported, "now, anyone with HIV would be marginalized."

The hospital does not receive support from international NGOs. According to the social workers, the organizations working with IDPs are all involved with their own work. At this first-level hospital in Soacha, the social workers seemed very overworked and stressed but were clearly aware of the needs of IDPs, the obvious injustices and the lack of resources to assist them.

d. Quibdó, Choco

Located on the western coast of Colombia, Quibdó is the capital of Choco. Choco is one of the poorest states in Colombia with among the lowest literacy levels and the worst health indicators. It is a small city in the jungle with limited access to the rest of the country. There was no electricity in Quibdó during the assessment visit. Military and police were highly visible. The assessment team visited an IDP settlement, met with groups of young people and women and visited a local women's organization and a local hospital.

Villa Esperanza IDP settlement

This settlement was built in 1999 by the Spanish Red Cross to house IDPs who had been living in a sports center or *coliseo* from 1997 to 1998. There are not enough houses for all of the IDPs in Quibdó

and some remain in the *coliseo*. Housing, water and sanitation were available in this remote settlement. Access to schools, work and shops is difficult due to lack of transport.

The assessment team met with a group of 22 adolescents, 13–21 years old, in the settlement. The group was articulate and outspoken, particularly the older boys, about their situation and needs. Generally the group felt they were much better off in their home villages before they were forced to leave. They fled from threats, violence and massacres by numerous armed groups, especially the paramilitary. In their villages they would never go hungry and could go to school. Now they do not have the money to pay for school, uniforms and books and feel ashamed. They also said teachers discriminate against them for not paying fees. Less than half the group was in school.

The adolescents talked about discrimination and insults as they sought opportunities for work. In the wake of increased robberies and crime in Quibdó they have been called thieves and told that IDPs are destroying the town. One 18-year-old mother with children ages two and four said she left her job because her employer persisted in accusing her of being a thief. They have been told outright that that won't be hired because they are IDPs. The adolescents feel strongly about the need to work. Unable to go to school, find jobs, participate in social or prevention projects, or even get a football for recreation, they said, there is no support to avoid doing things wrong. Children who are from the host community also reject them and it is difficult to make friends.

While some IDPs reported adequate experiences with health services, others described bureaucratic, financial and discriminatory obstacles to care. Among the problems were the refusal of some hospitals and health centers to see IDPs, particularly for emergencies, the cost of transport to reach a hospital, difficulties in getting papers to register, requirements to pay up to 5,000 pesos ($2.13) for laboratory analysis forms and a consistent lack of medicines in stock. One young man who was unable to get emergency care reportedly died on the steps of the hospital. One young woman said that she had to wait to deliver her baby because she was an IDP and she had her baby alone in the delivery room. Others said they were left alone after their deliveries with no food to eat.

The youth lacked awareness and knowledge about reproductive health although some reported they had sex education in school about family planning and disease prevention. The young women said they were not ready to become mothers, especially in their displaced situation, but they didn't know about family planning. Some adolescents begin having babies at the age of 12 to 14. Some believed there is an increase in adolescent pregnancies because adolescents are unable to attend school. Also, girls must leave school if they become pregnant. A couple of boys said that they could always wear condoms to avoid disease. Condoms were known to be available from pharmacies or Profamilia at 100 pesos ($.04) each. They also said they don't like condoms and feel they don't know enough although they are aware of STIs, including gonorrhea.

Some of the adolescents have formed a youth group called "Nueva Imagen en Unión" (New Image in Union) in order to forget what has happened to them. They are a group of nine boys and one woman. The group is seeking to establish recreational opportunities, promote their goal of becoming better integrated into the community at large and to support one another. They are also trying to meet up with

other groups and have an idea to organize a national gathering of displaced youth in Colombia. They have no plans to return home because they are too scared.

Profamilia – Women's Group
The assessment team met with a group of 20–25 IDP women of reproductive age who have participated in Profamilia programs. Many of the women were registered with the RSS but said most IDPs were not, and that they were required to re-register every time they needed to go the doctor and that medicines were often not available. If people do not have a letter of registration, hospitals would let them die, they said. The women shared their feelings of humiliation about asking for help and the social injustice of the situation for IDPs. They also discussed the mental health problems of family members that result from the violence and the lack of any help to deal with it.

The women believed the number of pregnancies has decreased since Profamilia began working with them. Many had tubal ligations, and believed this access to information and services was a benefit to life in Quibdó. In general the women felt they received good attention from Profamilia for family planning, pap smears and STIs.

Emergency contraception was unknown to the women. However, the women said that Citotech was readily available and used for early abortions. The women were not aware of STIs or HIV in their community and complained that men did not want to use condoms.

The women's most significant concern was unemployment. One said, "Kids, especially girls shouldn't be sent out onto the streets." The women were concerned about the risk of gender-based violence for young girls and said it is difficult to prove cases of abuse and rape. They said young girls from 12 years had boyfriends among the armed groups because the men have money or because they are afraid of the consequences if they do not go out with them. They mentioned a girl who was killed by her paramilitary boyfriend. However, the group felt that IDP men had learned more about equality in Quibdó and there was less domestic violence.

Meeting with AMUNCIC in Quibdó
The assessment team met with 10 women, some of whom were IDPs and some of whom were not, in the ANMUCIC office in Quibdó. The women said the situation was already difficult in Choco and that displacement has only made things much worse. In general, IDPs are restricted in the city because they have no land and no way to earn money.

Prostitution was the only way IDPs could make money, the women said. They also shared that young people are not in school and have nothing to do. They have seen an increase in teenage pregnancy among girls as young as 13 and believe IDP girls become pregnant because it gives them security if the father is a local. According to the women, HIV/AIDS is a time-bomb waiting to happen and they inquired about programs to address HIV/AIDS. The women also said that people often hide when they are ill and need to recognize that health is their right.

Hospital Ismael Roldan

The assessment team first met with the hospital administrator and a social worker. The hospital is a level-one hospital and patients requiring specialists or surgery are referred to the large public hospital (San Francisco). They reported that the hospital would only help IDPs if they had a letter of registration from the RSS. They said they would like to help but that the government does not pay them for those they do serve and they have a cash crisis. The forms they are required to submit for reimbursement are complicated and often returned to them. Overall the hospital is owed 730 million pesos ($310,638) by various insurance programs.

The hospital director joined the meeting and said that all IDPs were treated, especially if it is an emergency, and that no one is refused service. He claimed that IDPs did not understand the timetable and the need to book appointments, which is why they are turned away. The director said that all providers recognize an IDP patient. He also said that they have a very low stock of medicines and are unable to provide what people require.

The director explained the change to a different system for health care providers serving IDPs. Prior to 2000, specific hospitals were contracted to provide services to IDPs and were advanced 50 percent of their contract. A change was instituted for all hospitals and centers to provide services that would increase IDPs' access to services but provider bills are now paid on a cost reimbursement basis. Bills submitted to the state might not be paid for six to seven months and then they are often only partially paid. It is a frustrating bureaucratic mess to keep up with the forms, he said, which are often returned to the hospital for resubmission. He feels the municipality from which IDPs have come from should make a contribution. The hospital is not receiving assistance from international or nongovernmental organizations.

When the team inquired about reproductive health and family planning he said that people preferred to go to Profamilia so they "didn't really bother." They have however seen an increase in STIs, including gonorrhea and syphilis, in postpartum women. He said that in such cases both the woman and her child are treated. The hospital does not have the facilities to test for HIV, but, based on anecdotal evidence, the hospital director believed it was increasing. The social worker and doctor also note an increase in pregnancy rates among young (13–14 years) adolescents.

e. Puerto Asis, Putumayo

Putumayo is located in the southern part of Colombia. The focus of the US-supported Plan Colombia anti-narcotics program is in the department of Putumayo and it is an area of significant conflict. The assessment team was limited in their activities in Putumayo due to the security situation. The team met with UNHCR staff, attended a UNHCR-supported two-day workshop for women in Puerto Asís and conducted a focus group with 10 women.

UNHCR in Puerto Asís

The UNHCR community services officer explained that UNHCR plays a catalytic role between the people and the authorities. She stated that there is an important lack of understanding among IDPs and the authorities and subsequent social disruption between them. Therefore, UNHCR is trying to help

people to express and acknowledge their situation and learn their rights to pressure the government to support them.

As described by the community services officer, UNHCR is working to infuse indigenous culture with a gender focus. It is doing this by bringing indigenous women's groups together and providing training and capacity building for them. The UNHCR project currently supports 139 families or approximately 800 people. In the UNHCR-supported project the team visited, the national NGO, Casa de la Mujer, conducted a two-day workshop for women in Puerto Asis. Approximately 25 women ranging in age from 25–50 years attended the workshop. The workshop addressed women's rights, self-esteem and empowerment. Casa de la Mujer distributed materials on community rights, legislative issues and organization as important support for decision-making.

Domestic violence was also addressed at the workshop. Casa de la Mujer conducted a series of activities for women to get in touch with themselves physically and emotionally. While the facilitator instructed the participants to touch their body (eyes, ears, lips, hips, etc.) with their eyes closed, she recited affirming messages. The purpose of the exercise is to support self-esteem building among the participants.

Focus group with workshop participants in Puerto Asís

The focus group included 10 women of reproductive age. In response to questions about their access to health care, the women reported that visiting a specialist is a problem because they don't have the money to pay for services. For example, they said, if an IDP woman has breast cancer, public services do not cover the cost. There are no community outreach workers. If people have a health problem they must go to the hospital. The participants explained that the law says they are not supposed to pay for medicines, but they are in fact required to pay.

Traditionally, the women said, marriage is not a strong custom and most people live in union once they are 18, though some 13-year-olds also live in union. People don't get married because there is more responsibility. They said that if there is a problem with a relationship that both men and women have a right to establish other relationships. However, it is more difficult for women to do this. Many people have more than one relationship at a time.

Participants said that some women deliver at the hospital while others deliver at home. Women from rural areas tend to have traditional midwives deliver their children at home. The discussion became animated and emotional when women started sharing stories of their hospital experiences. One woman said that some women have had to deliver at the door of the hospital. Sometimes, she said, the doctors and nurses were sleeping and they had to scream for help. In general, participants said it was difficult to access services. The participants also felt that women tend to die at the hospital, citing two cases of maternal deaths.

If a young woman is pregnant outside of union or marriage, it is not a problem because the community will assist. Most women breastfeed, although one woman reported using bottle milk the first three days after the baby was delivered. The women said that some babies are given oil and water in the first days after birth.

There was a mixed demand for family planning, with some women desiring more children while others did not want more. Together, group members were able to cite all of the modern methods of family planning. However, there was little knowledge of the timing of a woman's reproductive cycle: the focus group participants thought you should avoid sex five days before and after menstruation. They said if a woman was raped or had unprotected sex and did not want to get pregnant, she could drink strong coffee or use lemon juice. There was no knowledge of emergency contraception.

Participants said that if a woman had an unwanted pregnancy she would have an illegal abortion or give the baby up. An abortion is induced, the women said, by introducing something into the vagina. "It happens a lot and there are many deaths."

Overall the women felt that domestic violence was the biggest problem for them.

5. Conclusions

Overall

The assessment team findings indicate significant reproductive health needs among the IDP population with an alarming and unconscionable dearth of services available to them. The reproductive health problems most commonly expressed to the team were gender-based violence, adolescent pregnancies, inadequate childbirth services, particularly for complications of pregnancy and childbirth, and a lack of money for medicines and essential care.

The decentralized health system and universal health care, both instituted in Colombia in the early 1990's, are faltering between policy at the national level and services to the population, particularly IDPs, at decentralized levels. The inadequate three-month emergency assistance package, ostensibly available to IDPs, does not include the minimum initial service package (MISP) of reproductive health services or supplies. With the exception of Profamilia, which must charge user and medication fees, albeit minimal, and a few NGOs, little is being done to ensure that reproductive health services are provided to IDPs. Profamilia plans to significantly extend their RH services for IDPs over the next three years.

The assessment team also frequently heard that when IDPs sought health care, they were stigmatized for being IDPs, felt humiliated and degraded and were required to pay or go without medicines and services.

Minimum Initial Services Package (MISP) of Reproductive Health Services

There was no UN or other focal point person to coordinate the MISP and no plan for implementing it by UNFPA or others. Currently there is no distribution of MISP kits, including clean delivery supplies to pregnant women or safe delivery kits to hospitals. A number of women told assessment team members stories of being turned away from hospitals for childbirth, including for emergency services. There was no evidence of programs to prevent gender-based violence or manage it.

A woman who was raped and sought care at a government hospital in Bogotá did not receive clinical care, including emergency contraception, or appropriate documentation of the offense due to a lack of money to pay for the services. She was six months pregnant at the time of the focus group. Condoms were not free and readily available for the prevention of HIV.

Gender-based Violence

Representatives of UN agencies, human rights groups and IDP women themselves described numerous incidents of gender-based violence, including sexual exploitation, sex to meet survival needs and sexual violence, including rape followed by murder, by the guerrillas, paramilitaries and state actors. Armed actors also force girls to use contraception and to undergo abortion. Frequently, victims are afraid to file reports and the rapes of women who are then murdered are not noted. In a culture of impunity, most sexual violence in Colombia is followed by silence without any legal, social or medical redress. In discussions with women, they often described domestic violence as a major problem. Machismo and high levels of intrafamilial stress were described as contributing factors.

Family Planning

There is a significant problem of adolescent pregnancies and psychosocial issues are major contributing factors. Young adults engage more in sexual activities because they are idle. Young girls reported the desire for children and babies to fulfill needs for personal security, recognition, love and safety. Young boys are not interested in supporting the babies and their mothers.

There appears to be a mixed demand for family planning among IDPs, with some people wanting more children while others do not. IDP women's knowledge about family planning is limited. While women could name the modern contraceptive methods, their understanding of how their reproductive system and how modern contraceptive methods work, was limited. No IDP women the assessment team queried had heard of emergency contraception. Some women were following periodic abstinence incorrectly. Women also lacked access to contraceptives because they were not available or believed to be too expensive.

STIs, including HIV/AIDS

Given the acute poverty, dependence for survival needs, ongoing conflict, frequent displacement and mobility, and the large presence of armed actors, the situation among IDPs in Colombia is conducive to an explosion of STIs, including HIV/AIDS. UN agencies, health providers and IDPs themselves felt STIs were a serious unchecked problem but there are no data available. In some settings, among indigenous groups particularly, pregnant women are hospitalized for STI treatment because it is difficult to treat men.

There was little apparent HIV/AIDS information, education and communication to sensitize communities about HIV/AIDS. Some adolescents had heard about HIV/AIDS in school but they were largely uninformed and did not practice preventive measures. The FARC were reported to test men and women for HIV and seriously discriminate against people with HIV/AIDS, including killing people known to be HIV/AIDS-positive.

Safe Motherhood, including Emergency Obstetrics

The maternal mortality rate among IDP women is unknown. Profamilia does not provide delivery or emergency obstetric services so IDPs are dependent on the government health system for them. Pregnant IDP women face discrimination and rejection for delivery, including emergency obstetric services, at government hospitals. Basic clean delivery supplies are not made available to pregnant IDP woman for home deliveries in rural areas nor are midwife delivery supplies made available at referral centers and hospitals.

Some IDPs reported knowing of many girls or women who die from trying unsafe abortions. Traditional and local methods are sometimes used to prevent pregnancy and induce abortion. For example, some women use an over-the-counter medicine for gastritis called Citotech for early abortions and it is reportedly very effective, while others were reported to insert something into the vagina, which resulted in many deaths.

Adolescents

Another frequently cited concern of community members and parents surrounds the situation of IDP adolescents. Prior to displacement, most adolescents attended school and worked around the home. Displaced adolescents frequently lack access to school, jobs and recreation, and are unfamiliar with their new urban environment. The few who currently attend school said they were discriminated against by administrators and teachers and ridiculed or neglected by non-displaced classmates.

With the loss of their home communities, family and socio-cultural norms, many adolescents are insecure, idle and vulnerable to conscription by armed actors, recruitment by drug dealers and sexual exploitation. They also succumb to drug and alcohol abuse and delinquency.

GBV, including rape, exploitation and prostitution, compounds IDP adolescents' risk for unwanted pregnancies, unsafe abortions and STIs, including HIV/AIDS. Both young people and adults with whom the assessment team spoke said that the desperate situation of some families forced parents to exploit their own children to obtain survival needs.

6. Recommendations

The Colombian government should provide significantly more financial and technical support for health care, including reproductive health care, to IDPs, particularly at the local level and at referral hospitals for IDP women suffering from obstetric emergencies.

The Ministry of Health should collect and disseminate comprehensive information on who is doing what and where for IDPs and convene representatives of key organizations to improve the coordination of services.

The MOH and humanitarian assistance providers should increase funding and institute data collection and monitoring mechanisms of IDP health services at major health centers and hospitals.

The UN should undertake efforts to promote human rights awareness and knowledge and demand for services among the IDP population.

UNFPA should support hospitals and health centers by providing MISP kits, including safe delivery supplies, emergency contraception, condoms and essential medicines. UNFPA could also provide MISP kits to Profamilia to facilitate the MISP activities in their community outreach to IDPs.

The MOH and humanitarian assistance actors should raise awareness about gender-based violence, including sexual violence, by promoting community information and education about GBV and ensuring documentation and verification of incidents to identify and address these widespread human rights violations.

The government, UN agencies and NGOs should seek to ensure medical, legal and social services are available for IDP survivors of gender-based violence.

The government, UN agencies and NGOs should initiate multisectoral efforts to mobilize and support IDP adolescents and their parents. Programs should be implemented to provide health, including reproductive health services, educational opportunities, recreational activities, income generation projects and family support groups to address household stress and domestic violence.

Greater efforts must be made by the government, UN agencies and NGOs to conduct community outreach to educate IDPs, especially adolescents, about reproductive health, including family planning and emergency contraception.

Appendices

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c. Project Document List

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d. Focus Group Summaries

Focus group summaries and other notes are available upon request. Please contact:

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