Adolescent Pregnancy in Colombia: The Price of Inequality and Political Conflict

Mónica M. Alzate

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Abortion Colombia · Colombian adolescent pregnancy · Colombian fertility rate · Colombian maternal mortality rate · Contraceptive use · Catholic church · Sex education · Sexual and reproductive health · Prenatal · Partum and postpartum care

Introduction

For two decades, the reproductive behavior of adolescents in Colombia placed the country in the middle range among countries in Latin America, the Spanish-speaking Caribbean, Haiti, and Jamaica (Guzmán et al. 2001) in terms of adolescent fertility rates. This was due to an upwards tendency during the 1990s and 2000s. Since 2005, Colombia ranks in the lower range of AFR, along with Perú, mainly because the adolescent fertility rate in other countries of the region is higher (Flórez and Soto 2006). Despite a recent drop in the proportion of adolescent mothers, as will be described in this chapter, births to adolescents in Colombia continue to be a concern for the government, schools, researchers, service providers, and certainly for families. Although data on teen pregnancy's prevalence and variation according to several indicators are updated every five years through Demographic and Health Surveys (ENDS in Spanish), the sexual and reproductive information, these surveys' gather comes only from females. This methodological limitation exists as well in many other Latin American countries (Milosavljevic 2007). Even though fatherhood among male adolescents is much lower than among female adolescents in the Latin American region (Villa and Rodríguez 2001), males' reproductive experiences and choices obviously impact adolescent fertility. Consequently, their inclusion could fill many gaps in the current knowledge of adolescent pregnancy and birth.

To partially fill this void in Colombia, a few studies conducted in the largest cities have included male adolescents and used both quantitative and qualitative methodologies (Sandoval et al. 2008; Zuleta 2008; Florez 2005; Florez et al. 2004). Although these studies are not representative of the country and are urban-based, 75 % of the Colombian population lives in urban centers and 44% is under 25 years of age (Central Intelligence Agency [CIA], 2013). Those studies, as well as the latest ENDS, also reflect the pervasive effects of socioeconomic and

M. M. Alzate (✉)
Bilingual Therapist, HOPE Community Services, Inc. Oklahoma City, OK, 3824 Warrington Way, Norman, OK 73072, USA
e-mail: mmalzate@yahoo.com

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political factors on adolescents' reproductive behavior (see Profamilia 2011; Sánchez 2006).

According to DANE, the public office in charge of most population statistics, Colombia is the third most populous country in Latin America after Brazil and Mexico with 45,508,205 inhabitants in 2010; it is expected to reach 50 million by 2015. Most Colombians live in the north and western *departamentos* (states) while only 3 % of the population occupies 54 % of the territory distributed in the low lands of the eastern and southeastern states (US Department of State 2011). However, as much as ten percent of the population has been forcibly displaced by the internal armed conflict (CODHES 2010) and 1 in 10 Colombians lives abroad (Migration Policy Institute 2011). Forced and voluntary migration is the result of sociopolitical and economic problems, as well as the consequence of insecurity. For example, as of 2010, 27 % of all victims of landmines had not reached their 18th birthday (Díaz 2010). All these elements combined have prompted a humanitarian crisis in which millions of young people find little to no opportunities to better their lives.

Historical Context

Colombia's quandary has been labeled as a humanitarian emergency (see Väyrynen 2000) in which thousands of people have died and millions have suffered from war and displacement. This has been caused mainly by the internal armed conflict between guerrillas, paramilitaries, and the Colombian military, as well as by drug trafficking, kidnapping, massacres, attacks on civilians and infrastructure, and acute poverty (US Department of State 2002). During the last few years, some improvements have been made in terms of security to civilians, lower unemployment, and increased foreign investment. Despite this, Colombia still exhibits one of the highest levels of income inequality in the world (US Department of State 2011).

Much of Colombia's social and political instability has its roots in a period of internal conflict and civil unrest known as 'La Violencia' (The Violence), which began in 1948 after the assassination of the leader of the Liberal Party, Jorge Eliécer Gaitán, who was expected to become president following the 1950 election. The traditional political parties, the Liberals and Conservatives, fought a five-year armed conflict for power and landownership until 1953, when General Rojas Pinilla took control. Subsequently, in 1958, they formed a coalition government known as the National Front (Casa Editorial de El Tiempo 1999). This coalition excluded other political views, however, and consequently, several rural guerrilla groups formed during the 1960s.

After decades of deepening poverty and inequality, rising political corruption, and insufficient government services, drug trafficking evolved in the 1970s as a new economic alternative. By the 1980s, it had also become an additional source of violence. Extortion and violence by guerrillas who had survived from the 1960s were on the increase, and resentment was mounting among peasants and landowners due to a lack of state protection. Some large landowners and drug traffickers sponsored self-defense entities (Meertens 2001), which constituted the core of right-wing paramilitary groups (Amnesty International 2004). Most of these fell under the umbrella of the United Self-Defense Forces of Colombia (AUC). By the end of 2006, the AUC ceased to exist as a formal organization, after more than 31,000 former paramilitaries demobilized. During the paramilitary demobilization process, "…emerging criminal groups arose, whose members include some former paramilitaries" (CIA Fact Book 2011). Therefore, the legitimacy of this demobilization has been seriously questioned.

Currently, the two main guerrilla groups are the Revolutionary Armed Forces of Colombia (FARC) and the less powerful National Liberation Army (ELN). Both have used kidnapping and extortion to generate income. The former AUC and FARC derive finances for their operations through drug trafficking, an endeavor that has led to fights for strategic territories to cultivate and process illicit drugs. Some of these areas are also crucial for weapons smuggling

into the country. As the Global IDP Project argues, internal displacement is not just a consequence of war, but also a deliberate strategy (2004). Although illegal armed groups have weakened since the early 2000s, all have rural and urban cells that seek to control entire sections of towns and cities, causing intra-urban displacement, an overlooked aspect of the crisis that the internally displaced population (IDP) lives. Because most adolescents live in urban areas, or settle in urban areas after displacement, they have been uniquely affected by the armed conflict. Likewise, those who stay in their rural homes may be caught in the cross fire or simply continue to live with the traditionally limited educational, cultural, and health services that have characterized rural Colombia.

Next sections analyze the situation of Colombian female adolescents, paying particular attention to the effects of gender and economic inequality, ethnic/racial discrimination, and political conflict. Medical and legal issues are also analyzed with a focus on vulnerable adolescents. Although 90 % of Colombians are Catholic, no studies linking religion and sexual behavior, fertility, or contraceptive use among adolescents were found.

Colombia's Adolescent Birth and Fertility Rate

The adolescent birth rate in Colombia has fluctuated since 1990 when it was estimated at 70 per 1,000 15–19-year-old females. It experienced an upward trend and reached 89/1,000 in 1995; then it decreased to 85/1,000 in 2000 and went up again to 90/1,000 in 2005. Currently, the national birth rate among Colombian adolescents is at 84/1,000 (Profamilia 2011). Consequently, not only has there been no significant reduction in the national teen fertility rate in the last 10 years, but it is much higher than it was 20 years ago. As a comparison, the adolescent birth rate in the USA is 42.5/1,000; in the United Kingdom is 27/1,000; and in Switzerland it is 4.3, the lowest adolescent birth rate in the world (The National Campaign 2007). Fertility rates among adolescents in different Latin American countries are usually not released at the same time, which limits comparisons. In the Andean Region between the years 2000 and 2005, live births to 15–19-year-old adolescents were: 12.6 % in Bolivia, 10.1 % in Chile, 16.8 % in Colombia, 14.8 % in Ecuador, 11.7 % in Perú, and 20.6 % in Venezuela (Lora et al. 2009). In the year 2000, 20.2 and 25 % of births in Costa Rica and Nicaragua, respectively, were to 15–19-year-old girls (Milosavljevic 2007).

Adolescent Mothers by Region in Colombia

One in five Colombian adolescents has been pregnant at least once, and as of 2010, 15.8 % were already mothers; this represents a small overall national reduction from 16.2 % in 2005 (Profamilia 2011). Notwithstanding, the proportion of adolescents who are mothers varies depending on the state where adolescents live, including the capital of the country, Bogotá. The range goes from 12.2 to 26.9 % in the state of Putumayo (ENDS 2010) which has been for decades at the center of the guerrilla, paramilitary, and drug-trafficking violence. According to the latest ENDS (Profamilia 2011), the proportion of adolescents who are mothers increased in some regions of the country from 2005 to 2010, particularly in Orinoquía-Amazonía, one of the most rural, underserved, and underpopulated areas of Colombia with the highest concentration of indigenous groups. The Orinoquía region has also been heavily affected by drug trafficking and guerrilla activity. It comes as a surprise that in the state of Chocó, where 26 % of adolescents are mothers (the second highest after Putumayo), the percentage of pregnant adolescents decreased since 2005. Chocó is a state with one of the worst socioeconomic and health indicators in the country and with high internal conflict between guerilla, paramilitary, and the Colombian armed forces. It is also a state with a high concentration of Afro-Colombians. Paradoxically, the proportion of adolescents who were pregnant with their first child increased in Bogotá, where access to

health care and education is among the best in the country. It could be argued that these two unexpected findings of the 2010 ENDS may be due to the exodus of many of Chocó inhabitants and to the influx of internally displaced people into Bogotá as a result of the armed conflict.

Factors Associated with Adolescent Pregnancy

In Colombia, as in the rest of Latin America, several factors are associated with higher prevalence of pregnancy and birth among adolescents, such as area of residence (rural vs. urban), ethnicity (indigenous/African descent), socioeconomic status, and level of education (Guzmán et al. 2001). As expected, there are more adolescent mothers in rural Colombia (22.2 %) than in urban centers (13.8 %). However, total fertility rate (among all women 15–45 years old), as well as adolescent fertility rate, decreased in both rural and urban areas compared with 2005 levels (Profamilia 2011). Similar to the effect that it has on other demographic indicators, poverty increases the likelihood of motherhood among adolescents. Twenty-three percent of the poorest Colombian adolescents are mothers compared with only 5.5 % of the richest adolescents (Profamilia 2011). This effect of economic disparity in adolescent fertility rates is consistent with other Latin American countries and has originated the expression "the demographic dynamic of poverty" (Villa y Rodríguez 2001).

Several demographic surveys in Latin America have shown that adolescent women of different socioeconomic levels initiate sexual relations at a similar age; however, marriage or consensual unions and reproduction occur at younger ages among adolescent women of the lowest socioeconomic levels (Guzmán et al. 2001). While poverty is a risk factor associated with higher rates of adolescent fertility, the most influential aspect seems to be the level of education of a teenager at the moment of her pregnancy. Data from Latin America show that by the time of their first pregnancy, most girls have already abandoned school (Guzmán et al. 2001). Although the same pattern is observed in Colombia, one-third of very poor teenagers drop-out of school when they get pregnant (Flórez and Soto 2006). Therefore, pregnancy does impact the educational path of the most economically disadvantaged Colombian teenagers. Furthermore, as of 2002, 10 % of women younger than 20 years of age in Latin America interrupted their studies due to adolescent pregnancies (Gaviria cited in Profamilia 2011).

Among Colombian female adolescents with no education, 53.6 % have at least one child. This is the case for 41.5 % of those with only primary education. Among adolescents with secondary and tertiary education, the percentage of mothers is 14.2 and 7.7, respectively. Therefore, the more education a woman has, the lower her fertility. For example, women with no education have almost three more children, on average, than college-educated women (Profamilia 2011). Low levels of education and poverty appear to follow a dynamic that traps teenagers into a hopeless vicious cycle. Therefore, the lack of education, an essential right for claiming and enjoying reproductive rights, limits women's empowerment and that of their families and communities.

The Vulnerability of Very Young Adolescent Girls

Nowhere is lack of empowerment more evident than among very young teens (under 15 years of age) who get pregnant, most of the time by men who are 10 years older than them; the younger the teen, the older the father of her children. As Guzmán et al. (2001) argue, this is an indication of the unequal power structure of gender relations in Latin America. Table 1 illustrates the current situation among young Colombian adolescents, and Table 2 compares changes since 1990.

Among 15–19-year-old Colombian adolescents who had a live birth, 1.8 % had their first

Table 1 Pregnancy and fertility experiences of adolescents by their 15th birthday

Year	Already mothers (%)	Pregnant with 1st child (%)	Ever pregnant (%)
2010	3.1	2.1	5.2

(Profamilia 2011)

Table 2 Proportion (%) of adolescent mothers before their 15th birthday

Place of residence	1995	2000	2005
Urban	1.0	1.1	1.4
Rural	2.1	1.5	2.9
Total	1.3	1.2	1.7

(Flórez and Soto 2006)

child before their 15th birthday. Among urban adolescents, 1.5 % had this experience compared with 2.5 % of teens in rural areas (Profamilia 2011). This shows the higher vulnerability of and less availability of resources for rural adolescent girls.

The experiences of teenagers before their 15th birthday are described in Table 2 and classified by place of residence.

It is apparent that motherhood among very young adolescents has had a steady increase since 1995, and even more worrisome is its greater prevalence and escalation among rural adolescents from 2000 to 2005. This was the period when the controversial Plan Colombia, the United States billion-dollar package to Colombia, began to be implemented to combat narcotics and insurgency (Global IDP Project 2004). This led to an escalation of violence, as predicted by analysts (Nagle 2001). It is possible that more young adolescents in rural areas were victims of sexual violence by armed actors (guerrilla, paramilitaries, or the Colombian army) who took over their towns. They may also have fallen prey of relatives/acquaintances after the disappearance, assassination, or displacement of their parents. Unfortunately, the report of violence against women of any age is very low, and those least likely to report are young, single, from rural areas, with low or no education, and poor (Profamilia 2011).

According to statistics from the unit of sexual crimes of the Colombian *Instituto de Medicina Legal* (Institute of Legal Medicine), most sexual crime victims are girls between 5 and 14 years of age, but the official report of these crimes, and their prosecution, are rare. Most people do not believe in the judicial system, girls and families are ashamed of publicly admitting sexual victimization, and there is an under-registration of the prevalence of sexual crimes. This is more so when sexual crimes are related to the armed conflict; that is, when the perpetrator is a member of the Colombian military, paramilitary groups, or guerrilla (Sánchez 2006). The sexual victimization of very young teens may explain why, as of 2004, four thousand minors under the age of 15 were living with HIV. According to the Colombian Penal Code, if the minor is over 14 years old and found having sex with an adult, she/he could testify that the act was consensual and the adult is not prosecuted. This stipulation fragrantly ignores the power that adult men (especially armed men) exercise over minor's wishes and decisions and places minors in conflict affected areas in a deeply vulnerable state.

Prenatal, Partum and Postpartum Care

The latest ENDS (Profamilia 2011) revealed that only 3 % of pregnant women since January 2005 did not receive any medical help during delivery. Ninety-two percent were assisted by a doctor and 5 % by a nurse. Most women who received partum care by a medical doctor tended to be older than 20 years of age and live in an urban center. Ninety-eight percent of women with the highest educational levels and 97 % of women from the

highest socioeconomic strata received prenatal care. Women who did not have prenatal care tended to be younger than 20 years of age or older than 34, from rural areas, had more than three children, and were from the lowest socioeconomic strata. Except for slightly lower levels of depression and involuntary loss of urine, a greater proportion of women younger than 20 years of age experienced more postpartum complications ranging from vaginal bleeding, fainting, to breast infections than older women.

Despite the almost universal coverage of prenatal, partum, and postpartum care, 57 % of female adolescents who already have a child and 34 % of those who are pregnant lack health insurance (Barrera and Higuera cited in Carrillo 2007). Although partum care would be provided for free if the adolescent reaches a public health care facility, the fact that a teen lacks coverage suggests that her prenatal and postpartum care is not optimum.

Abortion

Access to adequate reproductive health services is one of the means by which women can enable themselves to decide whether to have children, and if so, how many, and when. According to Pallito and O'Campo (2004), many Colombian women have not been able to make such choices. For example, 55 percent of ever-married (or in unions) Colombian women aged 15–49 between 1995 and 2000 have endured at least one unintended pregnancy.

Information on abortion rates is generally very reliable in the industrialized world, but not so in the developing world, particularly where it is completely illegal or highly restricted. This is the reason why in most developing countries, adolescent pregnancy is usually measured by prevalence of adolescent mothers or adolescent fertility rate, instead of adolescent pregnancy rate. Due to the lack of reliable abortion statistics in Latin America and the Spanish Caribbean, it is not possible to determine how many pregnancies among adolescents end in abortion. Only in Cuba and Guyana, where abortion is not criminalized, accurate adolescent pregnancy and abortion rates may be established (Guzmán et al. 2001). Despite the fact that abortion in Colombia was illegal under any circumstances until May 2006, it has been widely documented as being available through clandestine channels (Guttmacher Institute 1996). Larger cities have clinics that perform safe procedures for a fee (Shepard 2000), and it has been known for years that in medium-sized cities, abortions take place in the privacy of a doctor's office at a high cost (Morgan and Alzate 1992).

After a Constitutional Court decision (C-355) on May 10, 2006, abortion in Colombia was decriminalized under specific circumstances: when the life or health of the woman is threatened, as certified by a medical doctor; in case of rape, incest, or involuntary artificial insemination, which requires the woman to present evidence of the report of the crime; and when the fetus has malformations that are incompatible with life outside the womb, as certified by a medical doctor (Corte Constitucional Colombiana 2006). In these situations, the universal health care system of the country is supposed to cover the cost of the abortion procedure. Health-insurance-paid abortions, then, would constitute the most accurate measure of the incidence of legal abortion. Unfortunately, five years after the historic Constitutional Court decision, most abortion procedures are still illegal (Redesex 2011). This is due to several factors: many women are not aware of all the circumstances in which abortion is legal (Profamilia 2011); many health care and legal professionals are either not informed of the specificities of the new law, or misinformed, or simply do not follow the law (Redesex 2011). Therefore, abortions that are not health-insurance covered, or performed at private doctor's offices, or by nonqualified personnel, whether they adhere to the law or not, are unaccounted for in official statistics of the incidence of abortion in the country.

The Court's decision, however, was instrumental to set a precedent as a result of the case of a 13-year-old girl who was raped and denied a legal abortion in Colombia. This young teen endured not only the denial of her constitutional

right, but also a complicated cesarean section as a result of a sexually transmitted disease contracted during the rape. She was also mistreated by health care professionals, and harassed due to her filing charges against her aggressor, and by giving up the newborn to adoption. All of these experiences led her to attempt suicide three times. The nongovernmental organization Women's Link Worldwide, based in Bogotá, took the case to the Inter-American Court of Human Rights, which, for the first time involving a legal abortion case, asked the Colombian government to protect the physical and mental health of this young teen and to issue all necessary protective measures (Women's Link Worldwide 2011). Due to the obstacles, many women found when requesting a legal abortion, the Constitutional Court issued a subsequent ruling in 2009, limiting the right of medical professionals to conscientious objection to abortion (Center for Reproductive Rights 2011).

The 2006 Court decision applies as well in the case of minors who are as young as 14 years of age; for those younger than 14, the Court allowed legislators to establish provisions of representation, protection or tutelage, but without impairing the minor's consent (Corte Constitucional Colombiana 2006). As the 13-year-old girl's case illustrates, there is a gap between the intention of the Constitutional Court judges and the reality that takes place in women's everyday lives and their navigation of the health and judicial systems. Notwithstanding, the decriminalization of abortion in such circumstances is a significant advancement in the promotion of women's health and rights.

Maternal Mortality

As long as the implementation of the new abortion legislation is uneven, poor, very young, and vulnerable women will continue to be affected by unsafe, illegal abortion, which still is the third cause of maternal mortality in the country (Castellanos 2008). Colombia's maternal mortality rate (MMR) up to the year 2002 (104 per 100,000 live births) increased among 15–19-year-olds between 1992 and 2002 (Boada and Cotes 2003). Currently, there is a discrepancy in terms of the latest official maternal mortality rate in the country. This is due to the lack of agreement between the statistics released by the Ministry of Social Protection—in charge of all health policies—and the office of Vital Statistics—in charge of the officially registered new births (Carrillo 2007). Therefore, different publications have different values for Colombia's MMR. According to a UNICEF (2011) report, Colombia's adjusted MMR for 2008 was 85 per 100,000 live births, the same value as for the entire Latin American and Caribbean region. In contrast, the MMR for all developed countries was 14. Therefore, for Latin American standards, Colombia has an average MMR, but compared with industrialized nations, it has a long road ahead. Sadly, most of these maternal deaths are related to the lack of quality reproductive health services and to women's precarious living conditions (Carrillo 2007).

Similar to the rates of teen fertility in the country, maternal mortality also varies according to several demographic indicators, such as percentage of population with unsatisfied basic needs, number of children per woman, number of women's years of education, and women's contraceptive use. Although these broken down statistics are from 1992 to 1996 estimates, it is interesting to note that the highest MMR among those variables was for women with 5 years of education or less: 150/100,000 live births (Carrillo 2007). Again, low education is a constant among the most vulnerable women. The high coverage before, during, and after pregnancy described previously is obviously not correlated with the high rates of Maternal Mortality. As Carrillo (2007) argues, it may be that many women in reproductive age are not affiliated to any health system (through their work or as a dependent), or the services they receive are very limited due to the poor conditions of many public facilities that may also be understaffed.

Among Afro-Colombian and indigenous women concentrated in some regions of the country, such as the states of Chocó and Amazonas, MMR has traditionally been more

pervasive (three times higher) than within the general population (WCRWC 2003; Guevara Corral 1997). Additionally, indigenous and Afro-Colombians are less likely to have health coverage (Carrillo 2007). Therefore, it is safe to affirm that Afro-Colombian and indigenous female adolescents may be the most affected by this largely preventable cause of death. MMR, then, embodies one of the negative consequences of inequality in Colombia and reflects what Rebecca Cook has labeled as "…a larger social injustice…" (1998, p. 357).

Contraceptive Use

Thanks to effective but discrete contraceptive campaigns and despite the opposition of the Catholic Church and other cultural forces, the Planned Parenthood Federation Affiliate—Profamilia—is largely responsible for the decline of Colombia's total fertility rate (TFR) from 1964 to 1990. During these years, the TFR decreased from 7.0 to 2.8 children per woman (Ramírez 1990). In addition to Profamilia, other nongovernmental organizations, especially women's health centers founded since the mid 80s, have contributed to the further decline of fertility among Colombian women. Currently, the TFR is 2.1 (Profamilia 2011). Furthermore, government policies and legislation have helped this decline through media campaigns and coverage of contraception through health-insurance plans, including male sterilization.

The latest ENDS (Profamilia 2011) found that 99.9 % of all Colombian women know at least one modern method of contraception and 68 % know about emergency contraception (70 % of urban women and 48 % rural women). Overall, there is no significant difference in the knowledge of modern contraceptive methods based on socioeconomic status, level of education, or rural or urban residence. Differences by ethnicity in terms of contraceptive knowledge were not included in the survey. Among all women, the most commonly used methods, at least once, were the condom and the pill; however, condom use is more prevalent among younger women and the pill among older women. In terms of current use of contraception, the preferred method among married women or in unions is female sterilization (48 %). Ninety-eight percent of sexually active adolescents (15–19 years old) have used a modern method at least once, 30 % have used emergency contraception, and almost 40 % currently use condoms. Nevertheless, 20.8 % of sexually active teens do not use any method.

Since lack of knowledge does not appear to be the reason for not using modern methods, it would be necessary to explore what factors keep them from doing so. As stated earlier, more than half of adolescent mothers and one-third of pregnant ones lack health coverage; thus, the inability to access services may help explain this situation. Even adolescents who have health insurance, through their families or guardians (up to 18 years of age), may find geographical, cultural, or economic barriers to obtain needed services (Sánchez 2006). Additionally, other obstacles related to access or sociocultural barriers are probably important considerations. For example, their partners may refuse to use condoms or may only use them sporadically, as studies with adolescents in one large city of the country have shown (Zuleta 2008). Furthermore, their parents' expectations and values may keep them from actively seeking contraception (Villa and Rodríguez 2001).

Socioeconomic Conditions and Education

Poverty and economic inequality are some of the most critical problems Colombia faces. As of 2004, 66 % of the total population and 78 % of women and children under 18 lived below the poverty line. This situation characterizes the country as one of the most unequal in Latin America (Sánchez 2006). The sources of this inequality have varied over time. During the nineteenth century and until the middle of the twentieth century, inequality was the result of transformations in the economy and long-time educational gaps. As a result of educational

advances in the 1960s, economic inequality diminished and increased again since the 1990s. This time, the causes of inequality were due to accelerated technological changes and the expansion of global commerce (Profamilia 2011). Additionally, for centuries, productive land has been concentrated in the hands of a minority who, in turn, have had the resources to increase their wealth through inheritance and entrepreneurship (US Department of State 2011).

Nevertheless, positive changes have occurred in economic terms. The poverty rate, which measures the percentage of households with one unsatisfied basic need, changed from 70 in 1973 to 20 in 2005. Likewise, the misery rate (two or more unsatisfied basic needs) decreased from 45 to 6 percent. These positive outcomes were reached despite mediocre results in terms of economic growth during the last decades (Profamilia 2011). Given the economic dependence of children and adolescents, these improvements have benefitted their quality of life in terms of satisfaction of basic needs.

In the education realm, the landscape is mixed. There has been a significant improvement in the number of youth enrolled at school and in the number of years of education per adult. Additionally, while in 1951 only 1 % of the population had a college degree, 12 % did so in 2005. At the same time, serious concerns exist about the quality of education. According to international standardized tests, Colombian students' scores are among the worst in the developing world (Profamilia 2011). The armed conflict has also left its mark on education. Children and adolescents in conflict affected areas face a different problem that truncates their educational path. The United Nations Special Rapporteur on Education found in 2003 that teachers of displaced children have been victims of violent threats (US Office on Colombia 2005), only six out of every ten internally displaced children enroll in schools, and of these, two finish elementary school and one finishes high school (CODHES, cited in El Tiempo 2003). The above-mentioned situations have a profound impact on the economic prospects of the young population as well as on the advancement of the society as a whole.

Legislation on Sex Education

In 1993, as a result of a decision of the Colombian Constitutional Court, the Ministry of Education required sex education at schools, public, and private. A law enacted in 1994 backed the National Project on Sex Education (NPSE) which established sex education as a pedagogical tool and as integral component of children's and youth's general education (Sánchez 2006). The NPSE involved the entire school system, from pre to the last grade of high school, and it was to be developed around four themes and twelve areas of emphasis. The themes were: person, couple, family, and society. The emphasis ranged from identity and dialog, to love sex, responsibility, and critical thinking. Both themes and emphasis were intertwined with processes of autonomy, coexistence, self-esteem, and health. The NPSE was successfully implemented until 1997 with the help of the Ministry of Health and nongovernmental organizations (Sánchez 2006).

Due to lack of resources and political will, the implementation of the NPSE has been significantly reduced. After a call for action from the mass media and the civil society in 2004, the Ministry of Education revised and ratified the NPSE. Along with the Ministry of Health, the Red Cross, and UNAIDS, the project "Escuchamos Propuestas" [We Listen to Proposals] was developed. It consisted upon the education of school youth leaders as peer educators in sexual health, and it was implemented in 60 cities and towns of 21 states (Sánchez 2006). According to Sánchez (2006), three categories of problems have been identified to continue the implementation of NPSE: (a) the Government's involvement; (b) the educational system; and (c) social representations of sexuality. Ideological pressure by some sectors of the government, a lack of resources assigned to the NPSE, and poor technical assistance to implement the project at the regional and local levels are among the first

category. The emphasis of coverage as opposed to quality in education, as well as a focus on cognitive functions in detriment of affective ones, is the main concerns in regard to the educational system. The third category has to do with cultural reproductions of sexuality as taboo, lack of dialog among generations, and inequality between women and men.

In the last few years, NPSE has limited its scope to promotion of information and services to help youth reach the necessary level of maturity to make responsible decisions, understand their sexuality, and learn how to protect themselves from undesired outcomes. Despite the intentions of the Ministry of Education, the implementation of the NPSE depends on the willingness of each educational institution, and as a result, Sánchez (2006) argues, sex education has almost disappeared from the school curriculum. This is a tragic outcome for a country where, as stated earlier, almost half of the population is below 25 years of age and adolescent fertility among the most socioeconomically deprived girls has increased.

National Policy of Sexual and Reproductive Health

As a result of poor indicators in several aspects of sexual and reproductive health, the Ministry of Social Protection issued the National Policy of Sexual and Reproductive Health (NPSRH) for the Presidential Period of 2002–2006. The main purposes of the NPSRH was to promote sexual and reproductive rights, reduce vulnerability factors and risky behaviors, stimulate protective factors, and pay particular attention to groups with special needs. The Ministry selected several priority themes in sexual and reproductive health that impact the development of the country. Such themes and their specific objectives were: safe motherhood (reduction in maternal mortality), family planning (coverage of unsatisfied demand of this service), adolescent sexual and reproductive health (reduction in adolescent pregnancy), cervical cancer (early detection and treatment), sexually transmitted infections—including HIV/AIDS—(prevention and provision of services), and sexual and domestic violence (provision of services to victims). Each theme incorporated a research component in order to collect necessary information to design and guide future policies and services. The Ministry based this policy on the agreements reached through the different United Nations Conferences, such as the Conference on Population and Development and the Fourth Conference on Women, as well as decisions of the Colombian Constitutional Court (Ministry of Social Protection 2003).

As has been described in previous sections, one may conclude that the NPSRH of the previous Presidential administration fell short in its attempts to accomplish most of its specific objectives.

The Case of Medellín

The second largest city of Colombia, once known as the “murder capital of the world” during the times of infamous drug trafficker Pablo Escobar, is the only place in the country whose local government has actively launched a program to reduce pregnancy and prevent HIV transmission among youth 10 to 19 years of age. This segment of the population (total youth 353,000) represents 17 % of the total inhabitants of the city. The program, entitled *Sol y Luna* [Sun and Moon], was funded by the Inter-American Development Bank (68 %) and the local administration of the city of Medellín with a total cost of $ 1,106, 000 (one million one hundred and six thousand dollars) to be implemented in two years. The proposal was supported by the Mayor and First Lady of the city and the result of the work of 45 individuals from several organizations, public and private, academia, the media, as well as individual experts that created the *Red Para la Prevención del Embarazo Adolescente en Medellín* [Network to Prevent Adolescent Pregnancy in Medellín] (Alcaldía de Medellín 2004), the only such functioning network in the country. The Network was coordinated by the Office of the First Lady of the city.

In 2002, there were 7,021 pregnancies among 10–19-year-olds and 4 % of them occurred among 10–14-year-old girls. In that year, 21.6 % of all deliveries were among adolescents and the fertility rate among 15–19-year-olds in the city was 74.72/1,000. This was double the total fertility rate of the country in 2002 (Alcaldía de Medellín 2004). The highest rates were observed in the poorest neighborhoods of the city, while the richest neighborhood presented a rate similar to that of Switzerland. The specific goal of the project *Sol y Luna* was the reduction in adolescent pregnancy by 25 %. Project *Sol y Luna's* philosophical foundation was based on relevant United Nations Conventions that emphasize sexual and reproductive rights, as well as the United Nations Millennium Development Goals. In 2005, it was found that 1 in 100 pregnancies among 10–19-year-olds occurred among 10–14-year-olds. By 2006, there was an increment of births to adolescents: 25 % of all births were among 10–19-year-old adolescents.

After data gathering, the Network determined the causes of adolescent pregnancy and the reasons why previous prevention programs had not worked. The causes were classified as:

Structural: family violence, armed conflict, displacement, marginalization from services, social exclusion at school, and sexual exploitation.

Individual: myths/misinformation about sexuality, identity search, need of approval by men and peers, overvaluation of motherhood, and men's lack of involvement and responsibility in sexual and reproductive health.

Institutional barriers: crisis in the family, lack of positive role models, domestic violence, sexual violence, single mothers, lack of supervision, early adoption of adult responsibilities, lack of knowledge of sexual and reproductive rights.

The main reasons for the failure of programs were the lack of coordination of services among providers and unfriendly environments. Then, a pilot project with a control group in Medellín and in Cali (third largest city in the country) determined the effectiveness of the intervention. The project included the sustainability component through services to be administered by the different organizations of the network and impact evaluations to be carried out by researchers that belonged to the network. In 2007, *Sol y Luna* began to be implemented in ten government-run sites in the most marginalized areas of the city and continued even after a new Mayor was elected. This is an accomplishment by itself considering how volatile social policies may be when they are the result of temporary administrations and are not mandated by the law. Today, *Sol y Luna* is implemented in 33 sites throughout the city, and it involves mainly nurses, but also medical doctors, social workers, psychologists, and other health care professionals (Bermúdez 2011).

The new administration continued the efforts and implemented *Servicios Amigables Para Jóvenes* [Friendly Services for Youth], an initiative of the *Plan Andino Para la Prevención del Embarazo Adolescente* [Andean Plan for the Prevention of Adolescent Pregnancy]. Plan Andino is an agreement among the Ministries of Health of Bolivia, Chile, Colombia, Ecuador, Perú, and Venezuela, and it is considered an international public law treaty. Through *Servicios Amigables Para Jóvenes*, other local projects such as hands-on workshops, as well as guaranteed access to health services for adolescents, the birth rate among 10–19-year-old girls in Medellín dropped to 42.9/1,000 girls in 2007 and to 39/1,000 in 2011. Therefore, the city has become an example for Colombia and the Andean region.

A Focus on Internally Displaced Adolescents

More than half of all internally displaced persons in Colombia are women and children, one-third are Afro-Colombians—although they represent 25 % of the Colombian population— and 11 % are indigenous, who are just 2 % of the total population of the country (Gónzalez Vélez and de la Espriella 2002). Despite the lack of accurate statistics according to ethnicity, it may be concluded that ethnic minority adolescents

are overrepresented among internally displaced persons.

As stated throughout this chapter, adolescents affected by the armed conflict are particularly vulnerable to pregnancy, diseases, violence, and exploitation. According to Pacheco Sánchez and Enríquez (2004), 81 percent of young, sexually active displaced individuals, male and female, do not use contraception. As a result, by 2005, thirty percent of displaced adolescents (13–19 years old) were mothers or pregnant (Profamilia 2005), and there is no current statistical information on abortion or maternal mortality rates among IDA.

Of particular, concern is the sexual exploitation of IDA, both male and female. Based on research conducted by this author (see Alzate 2008), IDA often falls prey to adult male displaced leaders who demand sexual "favors" as a precondition for helping their families. Furthermore, to support their families in their new urban location, male and female minors have turned to prostitution (El Tiempo 2003). For IDA girls and young women in tourist sites, the best way to make ends meet is through prostitution; while for IDA boys and young men gangs provide a source of income (Arcieri 2004). Thus, a gendered behavior is revealed. Young displaced men prefer to engage in violence or illegal activities, such as drug trafficking, while young displaced women become involved in prostitution. It is obvious that both women and men exposed themselves to danger, trauma, disease, and even death, but how they exposed themselves reflects the unequal power relations based on cultural gender norms. Sexual exploitation, then, exposes the exacerbated deprivations of this at risk group.

Sexual violence is also common among IDA, particularly rape by relatives, neighbors or acquaintances. In a study with internally displaced women, Vergel (2003) found that the parents of adolescents do not respect adolescents' wishes about what action to take if pregnancy occurs in such cases (see Vergel 2003).

The Future of Adolescent Pregnancy in Colombia

Currently, this is the general panorama regarding sexual and reproductive health among adolescents that impact efforts on pregnancy prevention:

Except for recent success stories, such as that of the city of Medellín, many adolescents are not aware of the few public sexual and reproductive health care services available.

Most existing services target mainly adults and married or cohabiting couples, leaving adolescents and unmarried/non-cohabiting women with few or no alternatives, depending on where they live.

Many governmental health care providers, unfamiliar with sexual and reproductive rights guaranteed by Colombian legislation, censor information on emergency contraception or the provision of information to young, unmarried people.

To overcome these obstacles, the following concrete actions to prevent pregnancies among adolescents and improve their overall sexual and reproductive health may be implemented.

Inclusive coalitions of organizations or networks, similar to the network in Medellín, should be among those planning and implementing programs.

Public and private organizations must offer specific sexual and reproductive rights and health outreach programs to rural, marginalized, displaced, and ethnic and sexual minority adolescents.

Materials must be made available to promote sexual and reproductive rights and health, gender equity, and pregnancy prevention. These must be appropriate with regard to the gender, age, ethnicity, and sexual orientation of the adolescent receiving services, as well as to his/her literacy level.

Personnel who work with internally displaced adolescents must be trained to recognize their particular plight and to be sensitive to their needs.

Health care and human services workers must be trained in sexual and reproductive health and rights, cultural competency, and internal displacement legislation.

Special attention and consideration should be given to very young adolescents (under 15 years of age) and assessment of sexual violence should be made. Additionally, the age of consent (currently at 14) should be increased.

Special attention and services should be provided to adolescent victims of domestic or sexual violence.

Confidential information on the diversity of adolescents seeking services should be recorded. This includes gender, age, socioeconomic level, urban/rural origin, ethnicity, and level of education, among others.

Colombia has made great advancements in its legislation regarding rights to adolescents, including sexual and reproductive rights; the general intention of public policies is to empower adolescents and improve their sexual and reproductive health. Unfortunately, despite progressive rhetoric, intentions have been greater than actions at the national level and more political will and pressure from the civil society are necessary in order to reverse the current fertility trend among adolescents and help design the future that they deserve. Furthermore, gender and economic inequality, which significantly impact human development and the peaceful progress of the Colombian society, must be greatly reduced in order to offer adolescents true opportunities for social mobility and self-realization.

At the family level, it is necessary to create and promote interventions to prevent domestic violence, educate family members about women's and men's rights and responsibilities within the family, the rights of children (Colombia has ratified the Convention on the Rights of the Child), and gender equality. By doing this, household and care-taking responsibilities may not only fall on female adolescents, but their brothers as well. Likewise, less female adolescents may be inclined to establish relationships with older adolescents and men, and thus, maintain more equal personal interactions.

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