

The context of family planning in Colombia

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Official family planning policies in Colombia are relatively recent; however its use privately and individually dates from pre-Hispanic times. In historical accounts of autochthonous, Colombian cultures, birth control is referred to as being crucial as a mechanism for survival, which is why, in these ethnic societies, sex is considered to be taboo, a sinful act. It has been reported that when the Spaniards arrived, the density of the population on the high plains of Cundiboya, where today's capital city is located, was not very high (approximately 400,000), because the need to maintain a natural balance which would permit the subsistence of the community, gave rise to a variety of different practices for spacing births.

Subsequently, the history of medicine and health practices is limited to reporting advances in terms of care afforded to pregnant women, to the birth and to gynecological pathologies, but family planning and birth control have, like all sexuality-related topics, been taboo for many decades.

In 1960, the birth control pill called Enevid was the first to be sold in the country, but at that time there was no public family planning policy or private facilities openly offering these services. In the same decade, the Colombian Association of Medical Faculties (ASCOFAME), began to conduct the first population surveys and studies, including one study in which worrying figures were shown concerning hospital discharges on account of abortion.

The first initiative to introduce family planning programs came from Dr. Fernando Tamayo Ogliastris based at his private practice, who in 1965 founded the Colombian Family Welfare Association, PROFAMILIA. This institution, affiliated to the International Planned Parenthood Federation since 1967, ended up covering, for many years, up to 70% of the demand for family planning services in the country.

The first population policies were decreed four years later, around 1969-1970, when from the government of Carlos Lleras Restrepo, a set of proposals was

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prescribed for policies related to fertility levels and the growth of the population linked to the promotion of responsible parenthood and the health of mother and child, prompted by the high maternal and infant mortality recorded at the time.

Subsequently, presidential development plans from 1974 to 1990 have gradually promoted the broadening of family planning coverage and a reduction in maternal and infant mortality, but with no clearly defined State family planning policy. Only in 1984 were norms issued that would govern family planning actions, specifying the responsibility of the State to provide birth control services, including sterilization. At that time, 80% of health services were provided by the State, 10% by the Institute of Social Security that cared for affiliated workers, by means of employee and employer contributions and the remaining 10% that corresponded to supplementary healthcare plans and special rules for those having greater financial means. Nevertheless, at that point in time, it was PROFAMILIA that continued to be the institution leading the way with surveys, training, education and birth control services.

In December 1993, law 100 was proclaimed which intended to achieve universal healthcare coverage for the country under the principles of comprehensiveness, decentralization, compulsoriness, solidarity, efficiency and quality. It was intended that these services should achieve this coverage in a gradual fashion, until they reached 100% of the population, to be met through the contributory regime (self-financed by employee-employer contributions) or the subsidized regime (subsidized by contributions of fiscal origin and parafiscal contributions). This goal has still not been achieved some 16 years later.

A personal and individual healthcare benefits plan has been established which includes interventions, activities, procedures and inputs (including drugs), for promotion, prevention, treatment and rehabilitation, including sexual and reproductive health. These benefit plans differ according to whether the regime is contributory or subsidized. The subsidized regime for the poorer population includes far fewer services. For the contributory regime, the benefits plan has, since its inception, included family planning education and advice, oral contraceptives (primarily macrodose), injections, the IUD and sterilization. Subsequently, non-oral hormones and emergency birth control were included. As for the subsidized regime, the same services are included with the exception of male sterilization which was only brought in 2007.

The Sexual and Reproductive Health Policy introduced by the Ministry of Social Protection 2002 - 2006 defines the following as its priority topics: Sexually transmitted diseases including HIV/aids, family violence, cancer of the uterine cervix, maternity care, sexual and reproductive health in adolescents and family planning.

Since 2003, the country has signed up to the celebration of the world day for unplanned teen pregnancy and is promoting the creation of amicable health services for this age group, the former due to the rise in the number of pregnancies in the teen population over the last decade. In a separate field of activity, the UNFPA and the Ministry of National Education have implemented the National Education Program for sexuality and citizenship building, which includes the promotion of sexual and reproductive rights and the prevention of teen pregnancy.

During the last 40 years, Colombia has recorded a marked change in its fertility rates, moving from an average of 5.5 children per woman to 2 children per woman. However, these averages mask big differences. Despite the efforts made by PROFAMILIA to get out to the more remote urban areas and rural areas, and in spite of the government's efforts through national policies, law 100 and public health plans, illegal abortion practiced in insalubrious conditions continues to imperil women's health and inequality continues to be prominent. Demographic and health surveys conducted in 1986 and at intervals of five years since 1990, show that there continues to be a great inequality in the country's hinterland in terms of access to services and rates of unsatisfied demand.

Unsatisfied demand for Family Planning services is higher amongst the poorest women, women in rural areas and those who have a lower standard of education. This situation is reflected in the General Fertility Rates reported in both the surveys and the census figures. According to the reconciled census data for 2005, the average General Fertility Rate (per 1,000 women) for the country, dropped from 112.6 to 81.4 between 1996 and 2006, however this same indicator was 92/1,000 women in 1996 and 62.30/1,000 in Bogotá, below the national average. Very similar figures were seen for the departments with the highest health coverage and for the largest urban populations. In the poorest and least educated areas of the country, the numbers are very different, such as in the region of Amazonia and Chocó where in 2006, general fertility rates of 147.3 and 144.5 were recorded, respectively.

