

IDP health in Colombia: needs and challenges

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Providers of reproductive health care to displaced communities in Colombia need to plan not only for the immediate needs of IDPs but also for their longer-term needs.

Situations of protracted displacement require a shift in mindset from immediate, crisis-based humanitarian action to sustainable service provision – and preferably some degree of local integration. The notion of local integration may be uncomfortable for governments and IDPs alike as both groups may fear that even short-term integration will preclude eventual return for displaced people, yet it can offer a welcome route to stability and dignity without eliminating the possibility of return, should it become feasible.

Profamilia – Colombia’s foremost provider of sexual and reproductive health (SRH) education and services – endorses the concept of

local integration as being about “realizing and protecting rights during displacement, about building self-reliance and self-sufficiency.”¹ For more than 40 years, Profamilia has provided family planning services and education in Colombia; it now reaches 65% of the country’s population via 33 centres. In 1997, Profamilia extended its reach to include groups of displaced people, and its current work with this population includes joint projects with USAID, Mercy Corps and the RAISE Initiative.

Access to health services

Colombia’s five-decade-long conflict has displaced between two and three million Colombians, making it

home to the world’s second largest population of IDPs, second only after Sudan. Colombia has no camps for IDPs; rather, the displaced are dispersed throughout the country, with most concentrated in urban settings. Whether they live in rural or urban areas, displaced Colombians’ access to health services is sharply limited, and they face stark health challenges. Immunisation coverage is extremely low in rural areas and one study showed that more than 60% of the population presented symptoms of clinical depression.²

Compared to non-displaced Colombians, IDPs also experience a disproportionate rate of SRH problems. For example, although domestic violence is prevalent throughout Colombia, 52% of displaced women have experienced domestic violence, including sexual violence, as opposed to 41% of non-displaced women.³ Displaced women aged 40-49 have an average of 5.8 children, which is much higher than the national average of 3.1 children and suggests dramatically reduced access to contraception. Furthermore, displaced women aged 13-49 have a rate of unintended pregnancy that is 40% higher than non-displaced women.⁴ One third of displaced adolescents are pregnant or parenting, compared to about 20% of non-displaced adolescents. Sexually transmitted infections (STIs) are as common as respiratory infections amongst displaced Colombians but few displaced people are familiar with common symptoms of an STI.⁵

In rural areas, IDPs’ health issues are exacerbated by a lack of access to services. IDPs are widely dispersed and, in the Pacific region especially, the health service infrastructure is minimal. Afro-Colombians and indigenous Colombians comprise a disproportionate number of the displaced. Recognising that these populations in particular lack economic resources and are almost entirely cut off from access



Profamilia staff providing sexual and reproductive health services to displaced communities in Colombia

to health services, Profamilia sends regular mobile health brigades (MHBs) to these communities. Profamilia's workers first discuss the community's health needs with community leaders. If the leaders are interested, Profamilia creates an MHB customised to the needs of the community. MHBs visit each community at least four times per year to ensure that clients have adequate supplies to complete a year-long contraceptive cycle.

Urban contexts present different challenges. Although IDPs are eligible for the national health system, displaced people may not be aware of this, or of how to access it, or they may be afraid that the armed groups will discover them if they seek services. Profamilia helps displaced Colombians to navigate the bureaucracy of the national health system so that they can gain sustained access to health services.

Tensions between IDPs and host communities are not uncommon in urban settings. IDPs who receive special services based on their status as forcibly displaced people may evoke resentment from the area's non-displaced, but likewise impoverished, urban residents. Aware that NGOs can exacerbate disparities by neglecting the communities that host IDPs, Profamilia works closely with host communities to offer services to more established residents as well as to newcomers, an effort that is key to the philosophy of local integration.

Comprehensive services and education

Profamilia centres and MHBs offer a range of contraceptive methods. Profamilia also offers antenatal care and refers pregnant women to the national health system so that they can give birth in high-quality health institutions.

Although Profamilia's focus is SRH, this may not always be the foremost health priority for men and women when displaced. Adults in displaced communities are far more likely to seek medical attention for their children than for themselves. In recognition of this, Profamilia has expanded the scope of its services for IDPs to encompass general medical consultations, including a dispensary with a wide range of medicines (as

well as contraceptive supplies). As the general health needs of children are met, their parents – who may never have seen a doctor in their lives – are then able to address their own health concerns, including SRH.

Profamilia only delivers SRH services to clients who attend an educational session. Such sessions are supplemented with written material and individuals are also offered private assessment sessions so that they can ask questions they might not be willing to ask in public. The educational sessions also help the community health workers understand what kinds of SRH services people need or expect, so that they can tailor their work accordingly.

Profamilia charges a nominal fee for its services and products, believing that it is important to promote the concept that health has a value and believing that a modest fee encourages people to expect and demand high-quality services. Where individuals cannot afford the payments, the community as a whole will often try to raise the small amount of money needed; ultimately, however, if clients cannot afford to pay, Profamilia will not refuse to provide services to them.

Instituting best practices

In scenarios of protracted displacement, organisations should make every effort both to protect the human rights of and cultivate self-sufficiency among IDPs. To do this:

- **Institutions must work very closely with the communities** they intend to serve in order to meet their needs. This requires coordination with local leaders, local authorities and community members; flexibility in approach; and individual tailoring of programmes.
- **Alliances are vital.** A single organisation cannot possibly meet the population's high demand for health services and providers must build local partnerships with other health organisations, both private and governmental.

- **Humanitarian actors must be forward thinking and willing to advocate** for the future needs of IDPs, whether the ultimate goal is return or permanent integration into the host communities.

In Colombia, for example, rural people displaced to urban areas may be reluctant to return to their homes even if the conflict ends, as the agricultural areas are neither protected nor subsidised, and the lack of infrastructure impedes the ability of farmers to sell their crops. Those who do return may face starvation unless they are willing to grow illegal drugs. Yet people who remain in urban areas may lack the skills that will ultimately allow them to permanently integrate into those communities. Humanitarian actors have a unique perspective on the range of both current and future challenges that IDPs face – a perspective which they must share when working with health organisations and communities facing protracted displacement.

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1. Expert Seminar on Protracted IDP Situations 21-22 June 2007 <http://www3.brookings.edu/fp/projects/idp/conferences/20070622.pdf>

2. WHO 'IDPs in Colombia' www.who.int/disasters/repo/7301.doc.

3. Human Rights Watch (13 October 2005) 'Colombia: Displaced and Discarded: The Plight of Internally Displaced Persons in Bogota and Cartagena' <http://www.hrw.org/en/node/11574/section/5>

4. IDMC (17 October 2008) 'Colombia: Rate of new displacement highest in two decades - A profile of the internal displacement situation. <http://tinyurl.com/IDMCCol2008>

5. F Castano, S Ward and E Hill (2007) 'Light at the End of the Tunnel: HIV Prevention for Colombia's Internally Displaced Youth' Margaret Sanger Center International at Planned Parenthood of New York City <http://tinyurl.com/ColLight>