
COLOMBIA

GENERAL SITUATION AND TRENDS

Socioeconomic, Political, and Demographic Overview

Colombia has a land area of 1,141,748 km²; its relief map is dominated by three branches of the Andean range (western, central, and eastern) separated by valleys and plains. The population in 1997 was estimated at 40,072,328 inhabitants: 49.5% males and 50.5% females. The population growth rate is 2.05% per year and the demographic density is 32.4 inhabitants per km². The urban population represents 71% and the rural population represents 29% of the total.

Internal migration flows mainly toward the Andean region. One of every four Colombians lives outside his or her native region. External migration is primarily to Ecuador, the United States of America, and Venezuela. According to the 1993 census, emigration exceeded half a million persons. However, this number represents only part of the exodus, because much of the migration is done clandestinely. The volume of immigrants from other countries represents 0.33% of the total population.

Colombia is a multiethnic and multicultural country, with diverse traditions and different languages. There are 81 indigenous groups (1.7% of all inhabitants) as well as a sizable population of African ancestry (25%) and of mixed race. This diversity produces not only cultural differences but also wide variations in living conditions and hence different types of diseases.

In general, the demographic indicators show steady improvement from 1970–1975 to 1990–1995. However, the statistics for the country as a whole obscure large differences among regions, between urban and rural areas, and among social levels. For example, in the period 1990–1995 the Pacific region, where the Colombian population of African ancestry predominates, had the worst indicators: life expectancy at birth was less than the national average by 2 years (64 years for men and 73 years for women), and infant mortality, at 37 per 1,000 live births, exceeded the national average by 20%.

There were also differences between the urban and rural populations: in the former, the overall fertility rate was 2.65 children per woman, whereas in the latter it was 4.41 children per woman. Mortality from communicable diseases was three times greater for the population with an index of unmet basic needs between 90 and 100 than for those with an index lower than 20.

The improvement of living conditions for the general population in the municipal seats (urban areas) has apparently had a positive influence on the demographic indicators. However, despite the encouraging trend observed between 1973 and 1993, the poverty gap between the municipal seats and the rest of the municipalities actually widened. In 1973 the number of people living in poverty (i.e., with at least one unmet basic needs indicator) was 1.5% higher in the municipalities as a whole (excluding inhabitants of municipal seats) than in the municipal seats. By 1993 that number had nearly doubled to 2.9%. The ratio of the population living in abject poverty (presence of two or more unmet basic needs indicators) in rural areas relative to those in the municipal seats increased from 2.2 to 5.0.

In the past 30 years the Colombian Government has taken great interest in extending the coverage of primary and secondary education, but the country's education deficits are still immense. In 1994, 2 of every 10 children between the ages of 6 and 11 were not attending primary school, and 5 of every 10 youths 12 to 17 years of age were not in secondary school. Of every 100 children enrolled in primary school, only 30 completed the ninth grade and only 7 managed to reach that level without having to repeat a year. In urban as well as rural areas, poor people receive the least education. In 1973, illiteracy in rural areas (22.8%) was more than three times higher than in urban areas (6.0%); variations within the country ranged from 3.0% in Bogotá to 25.11% in Tolima to 25.3% in Córdoba. As for number of years of schooling, in the urban population the figure (7 years) was double that in the rural population (3.2 years). The number varies widely from one

part of the country to another—4.2 and 4.3 years in Cauca and Sucre, respectively, and 8.1 years in Bogotá. In 1993 the rates of school attendance according to educational level were 36.9% at the preschool level (children aged 3 to 5 years), 79.1% at the primary school level (6 to 11 years old), and 54.1% at the secondary school level (12 to 17 years old); 8.7% of 18- to 24-year-olds pursued a higher education.

In addition to the deficits in educational coverage, there are also problems with the quality of education, especially in the public primary and secondary schools. In rural primary schools the children cover less than half the material prescribed in the curriculum; 25% of secondary school children in seventh grade rank at the lowest level in the language tests, and fewer than 20% in grades seven through nine manage to achieve the highest level.

Public expenditure on education as a percentage of gross domestic product (GDP) has remained almost unchanged: 2.85% in the 1970s, 2.99% in the 1980s, and 3.03% in the 1990s. As for the allocation of this spending, in 1994 the proportion allocated for primary schools was 33%; secondary schools, 29%; and higher education, 17%. Moreover, the distribution of these monies was unbalanced: at the primary level the poorest 40% of the population received 67% of the funds and at the secondary level the poorest 40% received 46% of the total; in higher education, the poorest 40% received only 15% of funds.

Coverage for basic services in the home increased significantly between 1985 and 1993, from 70.5% to 82.1% for water supply and from 59.4% to 69.0% for sewerage connections. Nevertheless, there are still between 6 and 10 million people who lack one or the other of these services. The situation is more critical in rural areas, where between 5 and 8 million people lack at least one of these services. The gaps are even greater when it comes to water quality. Only 62% of the urban population receives water that is fit for human consumption, and in rural areas the proportion is only 10%. The most significant advances in water supply and sewerage services have taken place in the 1990s. Investments made between 1991 and 1994 came to 25% of total spending in this area in the past 30 years. Even so, this expenditure represented only 0.3% of GDP and 2.7% of total spending on social services, which shows how little importance was given to this sector in the past.

The Colombian economy has experienced enormous changes in recent decades, constantly growing and diversifying. In the early 1990s it began to open up dramatically, with protectionist customs barriers falling in almost all sectors. However, in the past six years the economy's performance has been uneven and some sectors have benefited more than others. The GDP grew steadily from 1991 (2%) until 1994 (5.6%), but then it dropped to 4.5% in 1996. Inflation continued to decline until it reached 19% in 1995, but then it reversed and reached 23% in 1996.

Direct foreign investments went from US\$ 2,100 million in 1985 to US\$ 7,342 million in 1995, not including the mining and petroleum sectors. The foreign debt rose from US\$ 17,000 million in 1992 to US\$ 20,000 million in 1994, which corresponds to 34.5% and 30.7%, respectively, of the GDP.

Although the GDP increased at rates of 7.5% and 4.7%, respectively, in the first two quarters of 1995, during the same period in 1996 the growth rates were only 3.9% and 2.2%. This net loss is attributable to the liquidation of businesses, temporary shutdowns, and massive layoffs in the large cities, which produced an unemployed work force that for the most part could not be absorbed by other sectors of the economy, which were also affected by the extended recession. The loss of jobs was especially rapid in construction and in the manufacturing industry. On the other hand, jobs increased in the mining and quarrying sector, possibly because of activity in the petroleum industry.

As a result of these trends, the situation in the urban labor market deteriorated seriously and rapidly. In September 1996 the unemployment rate reached 12.1%, its highest level in 10 years. The situation was similar in almost all the large cities in Colombia: Pasto, 15.5%; Cali, 15.1%; Medellín, 13.6%; Manizales, 13.1%; Barranquilla, 12.2%; Bucaramanga, 10.8%; Bogotá, 10.4%. The rise in unemployment was matched by a sharp and almost equal drop in employment (-2.36%) between 1995 and 1996, the largest decline since 1990.

According to a 1994 report by the National Administrative Department of Statistics, informal employment represented 54.9% of total employment and had not changed since 1984. Small businesses accounted for most of this figure, and microbusinesses of five or fewer workers generated more employment than businesses with six workers or more.

There is a large informal subsistence economy in Colombia, and this situation constitutes a hindrance to the country's economic development. The goods and services produced by the informal sector are for domestic consumption. Three-fourths of the informal activities are concentrated in the trade and service sectors.

The recent opening up of the economy has added to the uncertainty of the market and to fluctuations in demand. In 1997 Colombian businesses were threatened by economic instability and had to face increased international competition, which forced them to lower costs and accelerate technological changes. This situation affected labor relations, because businesses had been forced to adopt more flexible working arrangements and to resort to different types of contracting agreements in order to lower costs (temporary and part-time employment, working at home, agreements with subcontractors). New businesses as well as those in crisis tended to rely increasingly on temporary labor.

Women with temporary jobs have much lower incomes than those with permanent jobs, and the gap between the two

groups tends to widen with higher levels of qualification: temporary laborers earn 2% less, temporary administrative employees earn 13% less, and temporary professionals earn 22% less than their permanent counterparts. The situation is different among men: temporary laborers earn 10% less and temporary professionals earn 5% less, but temporary administrative employees receive average salaries 10% greater than their permanent counterparts. Thus, the salary patterns are inconsistent.

Contrary to the unfavorable situation with regard to jobs, average earnings of those who are employed have increased in real terms since 1991, especially in the financial sector, while the wages of people working in the industrial and commercial sectors have remained within the national average, which indicates that although employment declined the productivity of workers improved. Although the Government's budget for social spending increased from 9.07% of GDP in 1990 to 15.14% in 1995, there were disparities between urban and rural areas in terms of education, basic services, and employment. This situation necessarily has direct or indirect repercussions on the health of the people because it affects living conditions and the accessibility of services, including health services. Health conditions are currently in a state of transition characterized by progressive but unequal improvements and the concurrence of communicable, chronic, and degenerative diseases, which particularly affect the poor (with notable differences according to sex). On the other hand, there has been an unusual preponderance of injuries and homicide in the overall epidemiological picture.

Mortality Profile

The crude general mortality rate during 1990–1995 was 6.57 deaths per 1,000 inhabitants. Underreporting of deaths in municipal seats was estimated at 15%, compared with 65% in the rest of the municipalities. Underreporting in the population as a whole was 34.0%, with rates of 46.6% for infants under 1 year old and 29.8% in the population aged 70 and over. With regard to men and women, underreporting was 34.8% for males and 32.5% for females. No major changes were noted during the period for either sex- or age-specific rates.

In 1994, circulatory diseases were the leading cause of deaths (168,568), followed by external causes, tumors, communicable diseases, and certain conditions that originated in the perinatal period. In terms of age distribution, 79.5% of deaths due to diseases of the circulatory system were in the population aged 45 and over, whereas 71% of mortality due to external causes was in the group 15 to 44 years of age, and communicable diseases occurred mostly in children under 5 years old. This situation is evidence of a mosaic of causes of age-specific death in the population.

Differences between the sexes were notable. Among women, chronic degenerative diseases were the most frequent cause of death; 35.3% of all deaths were due to diseases of the circulatory system and 17.7% of deaths were due to tumors. Among males, however, 36.8% of all deaths were due to external causes—in other words, males are at greater risk of dying from violent causes.

SPECIFIC HEALTH PROBLEMS

Analysis by Population Group

Health of Children

The main health problems in childhood are infectious diseases. In infants under 1 year of age, 43.5% of all deaths in 1994 were attributable to conditions that originated in the perinatal period, and 61.9% of the deaths in that age group were due to hypoxia. Thus the main cause of death is related to care during and shortly after birth.

In children under 5 years old, acute respiratory infections and diarrheal diseases are the leading reasons for consulting a health professional. In 1995, these reasons accounted for 37.4% and 14.0%, respectively, of all consultations. In addition to the specific health problems of children, there are other problems in Colombia that have not yet been quantified, such as orphanhood as a result of armed conflicts, participation of children in those conflicts, and child labor. On the other hand, at the root of the social problems and major inequities that exist among regions are the difficulties with access to education, especially for children in rural areas. In areas where there is armed conflict, the school dropout rate is nearly 100%.

Health of Adolescents

Colombia has made great strides toward the eradication of illiteracy, especially in the past decade. However, only 1 of 10 youths who begin a bachelor's degree program will graduate. According to data from the National Planning Department, 2.4 million youths (30% of the total adolescent population) neither work nor attend school. Thus, dropping out of school is one of the risk factors to which this population is exposed. Moreover, sexual activity begins between the ages of 11 and 18, and it is more common at younger ages among the population in the lower social strata in large cities. As a result, more than 10% of girls between the ages of 15 and 19 are already mothers. Statistics show that adolescents who are parents before the age of 19 are one-third as likely to graduate from a university.

The foregoing situation has led to the problem of juvenile delinquency. In 1994, 19,250 youths in Colombia between the ages of 12 and 17 had been sentenced and were incarcerated in correctional institutions. Recidivism in this group is nearly 85%, which has led to overcrowding in the correctional system. At the same time, the use of psychoactive substances is widespread among adolescents under the age of 18 in the upper and middle social strata; youths under 18 account for 15.2% of the population that consumes alcohol, and 6.8% of all cigarette smokers are young. Cocaine is used by 3.8% of the general population; 15.2% of the users are between 11 and 15 years old and 30.4% are between 16 and 18 years old. These factors contribute to the fact that external causes, especially homicides and traffic accidents, constitute the principal cause of death among adolescents.

Health of Adults

The main problems in the adult population are unemployment and underemployment, which create and reinforce precarious living conditions and hence exposure to social and environmental factors that affect health.

Rural poverty, among other factors, has been a factor in the displacement of large population groups to the outskirts of large cities. The effect of this migratory flow on the social life and mental health of the Colombian population is not yet fully known. However, it is worth pointing out that one-third of the households are headed by women.

In addition to the foregoing problems, 12.6% of the population over the age of 15 has high blood pressure, and an estimated 7% of the population over the age 30 has non-insulin-dependent diabetes mellitus, 30% and 40% of whom are unaware that they are ill. Second to traumatic injuries, the leading cause of morbidity and mortality in this age group is chronic degenerative diseases, and among women there is a high rate of illnesses associated with reproductive health.

Health of the Elderly

In studies conducted before 1993, it was found that 87.5% of the elderly were not beneficiaries of social security; 42.0% did not have a formal, regular income; 41.93% were living in a state of abject poverty in marginal areas; 11.0% were living in slums; 32.5% were illiterate; 8.7% had the benefit of some form of pension; 30.85% were engaged in remunerative work; and 39.05% worked at various trades in order to subsist. This age group accounted for about 50% of all deaths in Colombia, and cardiovascular disease caused about half of those deaths.

The Ministry of Health has launched the Health Program for the Elderly, which embodies the objectives of the national

social security policy—namely, comprehensive coverage of the needs of this group; reinforcement of the identity, self-esteem, and self-recognition of older persons; prevention and treatment of diseases; and improvement of health services.

Health of Women

In 1995, institutional coverage of pregnant women was 80%, each with an average of four checkups, 30% of which took place in the first trimester. In that same year, the coverage rate for institutional delivery was 77%, which means that about one-fifth of pregnant women did not receive any type of medical care. This situation was reflected in the coverage attained by health care programs for women of reproductive age. Of all women, 27% were of reproductive age, and 55% of these were married. Although there is widespread knowledge about contraceptive methods, only 72% of the women who were married or living in established unions used contraceptives; 29.4% of them were supplied by the public sector. Of all pregnancies, 24% were terminated by abortion and 26% resulted in unwanted births.

Abortion is the second leading cause of maternal death, accounting for 15% of all deaths associated with maternity, with the highest incidence in women from 20 to 29 years of age. This situation coincides with the unmet demand for contraceptives in the at-risk population. Of all pregnancies that ended in abortion in 1995, 24% were due to contraceptive failures and the rest were due to lack of access to contraceptives. Because abortion is illegal in Colombia, many women use unsanitary procedures to terminate unwanted pregnancies, which greatly endangers their life and health.

Analysis by Type of Disease or Health Impairment

Violence

The number one health problem in the Colombian population is injury due to external causes, the result of violence, which affects all of society. In 1994 the National Institute of Legal and Forensic Medicine created the National Reference Center on Violence under the directorate of Forensic Services to support social outreach activities for individuals and groups. The Center is responsible for planning and executing interventions against violence. In 1995 there were a total of 213,341 investigations of nonfatal injuries and 11,970 reports of sexual offenses in Colombia. These figures represent a 15% increase in the rate of nonfatal injuries (527 per 100,000 inhabitants in 1994 and 608 in 1995) and a 7.6% increase in the rate of sexual offenses (31.6 per 100,000 inhabitants in 1994 and 34.0 in 1995). The rate of nonfatal injuries in 1995, compared with the

previous year, reflects increases in public violence, family violence, sexual offenses, and traffic as well as other accidents.

Of nonfatal injuries, 163,230 (76.5% of all injuries) were personal injuries intentionally inflicted by others; 65.8% came under the heading of public violence (quarrels, holdups, settling of accounts, revenge, social purges, etc.), which represents a rate of 306 per 100,000 inhabitants; 26.3% were attributable to family violence (122 per 100,000); 0.5% to public disturbances; and 7.3% to sexual offenses (34 per 100,000). Most of the injuries were inflicted with blunt instruments (63.7%), followed by stabbing (18.5%). The highest injury rates were in San Andrés, Amazonas, Arauca, and Santa Fe de Bogotá. The areas with the highest rates of public violence are not the same as the regions that have the highest rates of homicide, which suggests that the two have different causes.

In 1995 the Institute reported 42,963 cases of family violence (child abuse, conjugal violence, and aggression among other family members), which represents 20.1% of all personal injuries investigated and is equivalent to a national rate of 122 cases per 100,000 inhabitants. The groups that suffered the highest rates of family violence were females 25 to 34 years of age and males 5 to 14 years old. Santa Fe de Bogotá, San Andrés, Arauca, Meta, Risaralda, Quindío, and Tolima had the highest rates of all forms of family abuse.

In 1995 there were 11,970 reports of sexual offenses, 87.8% of which were perpetrated against women, for a rate of 34 per 100,000 inhabitants; 55.3% of the victims were from 5 to 14 years of age, and in 77.4% of the cases the aggressor was a person known to the victim (9% were the father, 8.5% the stepfather, 11.3% another family member, and 48.6% an acquaintance). In 35.5% of the victims under 14 years of age, physical examination provided positive evidence. When there is no physical proof of a sexual offense, which is usually the case with abusive acts against minors, it is more difficult to conduct a judicial examination, to identify and charge the aggressors, and therefore to punish them.

Fatal and nonfatal injuries from traffic accidents have increased in the large cities. In 1995 a total of 7,874 autopsies were performed on persons who died in traffic accidents, which corresponds to a rate of 22 per 100,000 inhabitants. For every person who died, seven persons were injured in traffic accidents. Examinations were performed on a total of 52,527 victims of nonfatal injuries incurred in traffic accidents, or 150 per 100,000 inhabitants. Males, especially those between 25 and 34 years of age, were at greatest risk for nonfatal injuries (in which the pedestrian is usually the principal victim), whereas mortal injuries were most common in the population aged 60 and over. Various factors may be influencing the increase in traffic accidents, among them the larger number of vehicles on the road, the long distances being traveled, the high percentage of drivers under the age of 25 and their

easy access to alcohol, the lack of speed limits, and inadequate procedures for inspecting vehicles.

It is estimated that in 1995 there were a total of 1,450,845 years of potential life lost (YPLL) because of violent deaths, 67.4% (977,725) of which were due to homicide, 18.5% (268,303) to traffic accidents, 10.1% (145,988) to other accidents, and 4.1% (58,830) to suicide.

In 1995 the National Institute of Legal Medical and Forensic Sciences performed 43,800 autopsies in the entire country, 87.9% (38,483) of which were attributable to violent deaths. This is equivalent to a rate of 110 per 100,000 inhabitants, or a decline of 2% with respect to the previous year, when the rate was 112 per 100,000. Of all mortal injuries due to external causes, 65.7% were homicides, followed by traffic accidents, which represented 20.5%.

An analysis of the data by age and sex revealed especially significant differences between the sexes. The ratio for violent deaths in general is 7.7 males for every female; by type of violence, the figures are 14:1 for homicide, 3.3:1 for suicide, and 3.9:1 for each type of accident. In terms of age, 59.7% (22,977) of the violent deaths were in young persons 15 to 34 years old. In this age group the sex ratio (male/female) was 10:1 for violent deaths in general and 15.3:1 for homicide. Homicides were the leading cause of death for young Colombian males as well as the number-one cause of mortality and YPLL (67.4% of the total). In 1938 the homicide rate was 15 per 100,000 inhabitants; in the 1950s, despite the violence that marked this period, the rate was 55 per 100,000; in 1991 it reached 88 per 100,000; in 1994, 78 per 100,000; and in 1995, 72 per 100,000.

The phenomenon of violence in Colombia has been analyzed extensively taking into account various interpretations of its causes, principals, and scenarios. Notable among the hypotheses are the following:

- There is a culture of violent response to conflict. Indeed, Colombia has a long history of civil wars and guerrilla movements, which may have infused society with the tendency to resolve conflicts by force instead of by dialogue and consensus building.

- Violence is being unleashed by urban growth. It should be pointed out, however, that the homicide rate in Santa Fe de Bogotá, which has the highest population density in the country, is lower than in medium-sized cities such as Manizales, Cúcuta, and Bucaramanga, where it is around 100 per 100,000 inhabitants; some smaller cities have rates around 300 per 100,000. The highest rate (800 homicides per 100,000) is found in Apartado, a locality on the Pacific Coast where the Colombian population is predominantly of African origin.

- Violence is a response to poverty. Nevertheless, an analysis of cities by per capita income and frequency of homicides showed that there was no correlation, because the poorest cities were not the most violent ones.

- Colombians are violent by nature. This hypothesis is not supported by the wide variations between the different cities in Colombia, and genetics cannot explain the rapid rise that has occurred since 1980.

- Violence is related to illicit drug trafficking. Perhaps this hypothesis comes closest to an accurate explanation, because drug trafficking is the most important change that has taken place in Colombian society in the past 15 years. It is of interest that the areas with the highest homicide rates are Antioquia, Guaviare, Putumayo, and Valle del Cauca.

The possibility of risk factors that trigger or condition violent responses in society has been studied in some of the Colombian cities. Among the factors that have been identified are the following:

- Alcohol: In Santa Fe de Bogotá, blood alcohol levels were tested in 92.6% of homicide victims and 55.7% were found to be positive (ethanol levels above 15 mg/ml). According to studies conducted in Cali, 25% of homicide victims were intoxicated. Similar results, with a higher proportion of intoxicated victims, have been reported for Medellín as well as the rest of the country. Measures such as restricting the sale of alcohol in public places or “semi-dry” laws have had positive results in Cali and, more recently, in Santa Fe de Bogotá, where there was an 18% decrease in the proportion of persons who died violent deaths that tested positive for alcohol.

- Firearms: According to the Colombian Institute of Legal Medicine and Forensic Sciences, 80% of the homicides that occurred in Cali, Medellín, and the rest of the country in 1994 were attributable to firearms. That same year, according to data from the Prefecture of Santa Fe de Bogotá, 156,283 permits were issued to carry guns in that city. An evaluation of the gun control policy instituted in Cali in 1994 showed a significant reduction in homicides by firearms.

- Judicial system: Data from Desarrollo, Seguridad y Paz show that it was possible to identify the aggressors in only 6% of the homicides that took place in Cali in 1993, and only a few of them were punished. The National Police estimate that it was possible to apprehend the murderer in only 17.2% of homicides, which does not necessarily mean that they were convicted.

- Drug trafficking: This is an important factor that directly accounts for violence and also indirectly affects the other risk factors. Youth who are unable to attend school because the school system cannot accommodate them and who are unable to enter the tight, competitive labor market because of lack of education and work skills find an easy and attractive source of income for themselves and their families in the distribution and sale of drugs. Once they get involved in this business, violence becomes essential to survival.

An analysis of the scenarios and forms in which violence has occurred since the 1970s shows a picture of social disorder resulting from premeditated acts of revenge, the settling of accounts between drug trafficking leaders, terrorist plots, ordinary delinquency, confrontations over land rights, exploitation of emeralds, and other alarming manifestations of everyday violence.

This situation has displaced many Colombians who have been obliged to move away from their places of origin to protect their lives. Displacement, or involuntary migration because of violence, has caused grave consequences for individuals and families who are not directly involved in the conflicts but whose physical safety has been threatened. These groups are scattered throughout the country. Peasants have been uprooted because of common justice or private justice, and those living in abject poverty have been displaced because their situation becomes even more difficult in conflict-torn areas. It is estimated that guerrillas are responsible for 26% of the displacement; paramilitary forces, 32%; people’s militias, 16%; regular armed forces, 16%; and others, 10%. Displacement is accomplished mainly by threats (49%), followed by killings (15%), holdups (8%), and other methods (28%). The main reason for displacement, however, is political violence occurring in the form of armed confrontation between guerrilla groups and the State.

An investigation of the period 1985–1994 by the Episcopal Conference revealed that 1 of every 60 Colombians was forced to migrate because of violence. It was found that 586,261 persons, comprising 108,301 households, were displaced. Of these households, 6.7% had lost a spouse or one of the children through violence before they migrated, and 1,570 orphans, abandoned children, or youth had to assume responsibility for the family. Of this population, 52.4% were living in tenements or in slums—in other words, they were concentrated in outlying urban areas under living conditions that did not compare with the way they had lived in their places of origin. For example, 69.3% had their own homes before they were displaced, and this percentage dropped to 28.7% after displacement. Before, 40.7% were involved in agricultural production, either earning wages or as owners of small or medium-sized plots of land, and 10.0% had small or medium-sized businesses; after displacement, 22.5% had become street vendors, 12.9% had become laborers, and only 10.7% continued to be engaged in agricultural activities. This situation means that every day the Colombian population becomes increasingly drawn into the vicious cycle of poverty and disease. Access to health services is another serious problem that follows in the wake of forced migration: only 22.1% of the displaced households receive medical care.

The National Comprehensive Care System, which attends to the population displaced by violence, reports that in 1995, 1996, and the first four months of 1997 it was able to extend

care to 41,675 families. According to information from humanitarian organizations, during the period December 1995–1996, 53% of the displaced population were women and 54% were under 18 years of age. Women heads of families represented 36% of the total displaced population during this period.

The Government, aware of the magnitude of the internal displacement problem and its serious effects on human rights, created the National Comprehensive Care Program to attend to the needs of the population displaced by violence, and it supported development of a plan to address the factors that generate violence, thus facilitating the voluntary return of the displaced population to their places of origin. The Government also entered into the Rural Social Contract, which integrates public policies from various sectors with a view to improving the quality of life of the rural population, which is currently plagued by high levels of poverty and is largely excluded from the benefits of society.

Communicable Diseases

Vector-Borne Diseases. Since 1990 some 180,000 cases of malaria have been reported each year, and the numbers are rising. The cases are typically found in clearly established urban foci such as Buenaventura, in the Valle area, and Barranquilla, in the Atlántico area. Of the total, 38% have been attributed to *Plasmodium falciparum*. At the end of 1996, La Guajira, where *Plasmodium vivax* traditionally had predominated, had an increase in cases among males (20% of them Wayú Indians), 80% of which were attributable to *P. falciparum*.

Yellow fever has also increased in recent years. Two cases were reported in 1994 (in the Meta and Vichada areas); in 1995 there were three cases (in Meta and Guaviare); and in 1996 there were eight cases, all in males (Meta, Amazonia, and Caquetá).

Dengue affects all age groups, especially those aged 15 to 44. Hemorrhagic dengue and dengue shock syndrome have been diagnosed since 1989, and the number of reported cases has steadily increased, as the following figures show: 302 in 1993, 508 in 1994, 1,028 in 1995, 1,757 in 1996, and 1,702 as of week 25 of 1997. To date, however, serotype D3 has not been isolated. The areas most affected have been Santander, Tolima, Valle, Norte de Santander, Meta, and Huila.

In 1995 the Atlantic coast had the heaviest rainfall in years, which brought with it an increase in the population of *Aedes taeniorhynchus* and *Psorophora confinnis* mosquitoes, vectors that have been implicated in the equine encephalitis outbreak in Venezuela that affected around 75,000 inhabitants in the municipalities of Riohacha, Maicao, Uribia, and Manaure in the La Guajira district; a high percentage of the Wayú population were infected.

Although the recent increase in the incidence of these diseases can be explained in part by changes in weather that have provided favorable conditions for the vectors to reproduce, it is also related to decentralization and the decline in vector control programs within the framework of health sector reform.

Vaccine-Preventable Diseases. Among children under 5 years old there was a decline in diseases preventable by immunization in the period 1990–1994, as illustrated by the fact that there have been no cases of poliomyelitis since 1991. In 1994 the national committee for certification of the eradication of poliomyelitis reported that the circulation of wild poliovirus had been interrupted in Colombia, and epidemiological surveillance had been progressively developed to the point that an adequate average level had been reached in most of the geopolitical units in the country. Vaccination coverage in 1995 was 92%, and the number of reporting units increased from 868 in 1993 to 1,930 in 1996.

In 1991 a total of 11,127 cases of measles were reported; in 1994 the figure had fallen to 1,816, of which only 254 were confirmed in the laboratory; and in 1996 there were 1,070 cases, of which only 4 were confirmed. In 1993 Colombia made the commitment to eliminate measles, and in 1995 it introduced the use of trivalent viral vaccine. Coverage has consistently exceeded 90% during these years.

The Plan for the Elimination of Neonatal Tetanus, implemented in 1989, succeeded in reducing cases by 85% (from 171 in 1989 to 26 in 1996). The localization strategy was initiated in 1994, and 150 municipalities were identified as being either at risk or in the attack phase—most of them in rural areas where access was difficult or in urban locations with a sizable marginal population. Between 1993 and 1995, coverage in these areas ranged from 29% (in small municipalities with fewer than 1,000 births a year) to 75% (in cities with more than 3,000 births a year). The principal risk factors for the occurrence of neonatal tetanus continue to be the mother's negative vaccination history, home birthing, and poverty.

Cholera and Other Intestinal Diseases. There have been outbreaks as well as isolated cases of cholera associated with precarious living conditions in the population living on the Atlantic and Pacific Coasts and in the areas bordering on the two large rivers that traverse the country from south to north, the Magdalena and the Cauca. In 1995 a total of 1,989 cases were reported, and in 1996 there were 4,428. Most of the cases were on the Atlantic Coast, and the Wayú people were most affected (31% of the cases).

Chronic Communicable Diseases. Tuberculosis, which has been on the increase since 1993, reached a rate of 28 per

100,000 inhabitants in 1995. Extrapulmonary forms represented 10.1% of the total, and the districts of La Guajira, Atlántico, Quindío, Arauca, Vichada, Putumayo, Amazonas, Vaupés, and Guaviare, with rates in excess of 50 per 1,000, are considered to be at very high risk. In most of these districts a large proportion of the population is indigenous.

Rabies and Other Zoonoses. Human rabies declined during 1992–1994 (with seven, five, and three cases, respectively, in those years). In 1995, however, there were eight cases. Up until that year the cases had been transmitted by dogs, but the three cases that occurred in 1996 were transmitted by hematophagous bats. Since 1994, the cases have occurred exclusively in rural areas of the country.

Acute Respiratory Infections. These infections continue to be the principal health problem in children under 5 years old. In 1994 they accounted for 23.1% of all outpatient consultations.

AIDS. The program for the prevention and control of AIDS and STDs reported 933 cases of AIDS in 1992 and 1,042 in 1996, with a cumulative total of 7,776 diagnosed cases and a cumulative mortality of 41.5% (3,226 cases). Of all the cases diagnosed, 85% were in men, and 40.5% of those were in the group aged 25 to 34. Only 2.1% of the cases affected the population under 15 years of age. Heterosexual transmission accounted for 44.0% of the cases and homosexual transmission for 27.4%. The highest percentages of diagnosed cases were in Santa Fe de Bogotá (46.4%) and the district of Antioquia (15%).

Other STDs. There was an increase in diagnosis of congenital syphilis, from 322 cases in 1990 to 406 in 1995, under the Syphilis Surveillance and Control Program launched by the Ministry of Health. However, the monitoring of STDs in prostitutes was suspended, even though it had produced a 51.6% decline in diagnoses of gonococcal infections, from 39,089 cases in 1990 to 18,915 in 1995. In contrast, diagnoses of genital herpes increased 99.3% during this same period, from 2,231 to 4,446 cases.

Emerging Diseases. The prevalence of the surface antigen for hepatitis B (HBsAg) in blood banks remained stabilized, with levels of 0.73% in 1992, 0.87% in 1993, and 0.87% in 1994. Studies conducted in the past decade showed an overall prevalence of HBsAg carriers of around 5%, with transmission occurring within the household and primarily in the indigenous population. A plan for the control of hepatitis B was implemented in 1993, which involved vaccinating both the population under 5 years of age in the endemic areas and health workers. Since 1994, hepatitis B vaccine has been included in

the regular vaccination scheme for all infants under 1 year old throughout the country; hence coverage for this age group went from 36% in 1994 to 73% in 1995 and to 94% in 1996.

Noncommunicable Diseases and Other Health-Related Problems

Cardiovascular Diseases. These diseases are the leading cause of death in women, the second leading cause in men, and the primary cause of death in the group aged 45 to 64. In 1994, 44% of deaths attributed to this cause were due to ischemic heart disease, 93% of them were in persons aged 45 and older, and 56% were in men. Cerebrovascular diseases represented 28% of deaths from cardiovascular conditions, 91% of which occurred in the over-45 age group and 54% in women. Arterial hypertension is the most important risk factor for cardiovascular diseases. According to the 1987 national health study, the prevalence of arterial hypertension in Colombia as a whole was 11.6% in the population over 15 years of age. However, a study conducted in 1995 in the population of Quibdó revealed a prevalence of 35% in all persons over the age of 18 and a prevalence of 39% in the Colombian population of African ancestry—percentages significantly higher than those observed in the rest of the population (21%). The prevalence rates varied by age, from 10% in young persons to 50% in those aged 49 and over. No differences were noted according to sex. Only 16% of the persons surveyed said that they participated in some form of exercise in their free time. Somatometry showed that 50% were at least 10% overweight. A comparison between body mass index (BMI) means showed that hypertensive individuals were more obese than those who were not hypertensive ($P < 0.0001$).

Malignant Tumors. These are the second leading cause of death in the group aged 45 and over and in women. The order and types of cancer differ between the sexes. In 1994, stomach cancer was the most frequent form both in men (20.5% of all cases) and women (14.0%). The second most common site for men was the lung (13.4%), followed by the prostate (12.1%), and the lymphatic and hematic system (10.3%); for women cancer of the uterine cervix was the second most common site (11.1%), followed by the breast (9.9%) and lung (7.0%).

According to the records for 1989–1993 maintained by the National Institute of Cancerology (INC), which is the national reference center, about 70% of the diagnoses were made in the advanced stages—namely, stages III and IV. In the case of cancer of the uterine cervix, 80.9% of the cases were in stages higher than IIa, and with breast cancer 80.6% of the cases were in stages III and IV. Approximately 60% of the patients attended by the INC were from Santa Fe de Bogotá and Cundinamarca.

Among the recognized risk factors for lung cancer the most notable is the use of tobacco. The Survey of Health Knowledge, Attitudes, and Practices conducted by the Social Security Institute in 1994 showed that 33% of the adult Colombian population had smoked at some time and 21.4% were current smokers (29% of males and 14% of females). Of the current smokers, 84% smoked an average of 8.5 cigarettes a day on a daily basis. Tobacco use increases with age up to age 40, when it begins to decline. Males began to smoke at 17.3 years of age, and females at 18.2 years. Of the adolescents surveyed (12–17 years old), 19% had smoked at some time, and 13% were currently smoking an average of 3.1 cigarettes a day on a daily basis. Males began the habit at 15.1 years of age, and females at 13.8 years. The highest consumption patterns were observed on the Atlantic and Pacific Coasts and in the northern part of Antioquia.

Nutritional Diseases and Diseases of Metabolism. An indicator of improved health in the group under 5 years of age is the decline in overall malnutrition, which went from 10.1% in 1986 to 8.4% in 1995. The Pacific Coast region was most affected, with overall malnutrition at 17%. Chronic malnutrition declined from 16.6% to 15.0% during the same period; it is higher in rural areas than in cities (19% and 13%, respectively). The decline mentioned may be due to, among other factors, the campaign to encourage breast-feeding. The National Population and Health Survey found that 95% of all children under 5 years old had been breast-fed for an average of 14 months (13 months in urban areas and 10 months in rural areas) and 81.3% of infants under 1 year of age had been breast-fed from the day of birth (82% in urban areas and 80.1% in rural areas). The lowest percentage (77.2%) was in the Pacific region, and the largest percentage (83.3%) was in the Atlantic region. Despite this high coverage, however, exclusive breast-feeding through the fourth month of life is less than 10% and reaches 15% only if infants who also receive human milk and water are included.

RESPONSE OF THE HEALTH SYSTEM

National Health Plans and Policies

The 1980s saw the beginning of an active process of institutional transformation. Law 10 on the municipalization of health, drafted by the health sector, gave impetus to a series of changes aimed at strengthening the sector's territorial entities. Taking this initiative into account, the new Constitution of 1991 set out the fundamental points that gave rise to reform of the social security system. This mandate was enacted gradually under Law 60, which governs matters relating to the authority and resources of the various territorial entities, and

it culminated in the enactment of Law 100 of 1993, which created the social security system in general. This mandate covers standards governing the general system of pensions, professional risks, complementary social services, and the social security system as it relates to health.

The essence of the reform of the system is provision of coverage to persons under both contributory and subsidized regimens based on a partnership scheme of income redistribution that ensures universal benefits through protection of the insured, the spouse, and minor children as well as parents and other relatives. The guiding elements of the reform are efficiency, universality, solidarity, comprehensiveness, unity, and social participation.

The reform process initially was led by the Ministry of Labor and was intended to modify the country's pension plan. During discussions it was decided to incorporate changes in the delivery of services, which had been widely debated by all segments of society. The Ministry of Health had collaborated with a group of experts and contracted for a set of specialized studies to consolidate the proposal. Given the large number of participants—including international organizations and investment banks that will be financing some of the initiatives—it is difficult to know the exact cost of developing the proposal. Committees VII of the Assembly and of the House of Representatives, supported by the Ministry of Health, were responsible for negotiating the proposal.

The important role of promotion and prevention in the new system, the significant increase in the Government's financial contributions to health, the greater spending efficiency gained from competitive arrangements, the strong participation of upper-income groups, and the solidarity inherent in the system are all factors that are expected to contribute to major progress in the quality of health care, the coverage of services, and equity.

With regard to the degree of decentralization of health services, 17 departments and 4 districts have been decentralized and are directly managing more than US\$ 474 billion, which represents 70% of the national allocation, and 104 municipalities have been certified to independently manage their own fiscal budgets. The sum of US\$ 2,567 million has been allocated for 26 hospitals, health centers, and jobs in the health sector to improve care for the rural population.

Health sector reform currently faces a major problem with regard to access of the population, especially the very poor and the unemployed, to health services. One of the benefit plans proposed under the reform is the compulsory health plan POS-S, which is basically designed to respond to the needs of the poorest and most vulnerable members of the population. POS-S contains initiatives to benefit the individual, the family, and the community in general. Six of these initiatives are included under the basic plan and one is a form of reinsurance against high-cost diseases. In the

basic health care plan, all the actions are in the area of health promotion and disease prevention and are directed toward the community. The Government is responsible for the plan, which is territorially based, free to participants, and compulsory.

Organization of the Health Sector

Institutional Organization

To facilitate practical implementation, the general social security system for health has introduced a number of major administrative and operational changes in the sector. The new system reinforces solidarity by providing all Colombians with access to a comprehensive health protection plan, which aims to definitively achieve the goal of health for all by the year 2001. Universal and comprehensive coverage is a goal that should be met gradually by increasing benefits and expanding the base of beneficiaries. The organization of the new system is a mixed type that involves both contributory and subsidized funding. Its operation is based on four fundamental forms of support:

- The National Council on Social Security for Health, under the Ministry of Health, is a professional group that represents the main participants in the system. It is responsible for standardizing, regulating, controlling, and directing the system. The Ministry of Health relies on the sectional health services (one per department) to carry out its duties at the territorial level.
- The National Solidarity and Guaranty Fund is responsible for financing the system. It is made up of four subaccounts: compensation, solidarity, promotion, and catastrophic expenses. The law stipulates that all persons with incomes higher than the equivalent of two minimum wages are required to support the system with contributions, while the poor, the unemployed, and peasants are subsidized.
- The health promotion enterprises are the fundamental organizational nuclei of the system. They are responsible for the basic mobilization of financial resources, health promotion, and organization and delivery of medical services. These entities also have the related responsibility of managing the disabled and providing health services in the event of work-related accidents and occupational diseases as well as organizing complementary health plans, which may be public, private, partnership-based, or mixed and that compete for subscribers in the population.
- Finally, there are the institutions that provide health services—the hospitals, outpatient consultation offices, laboratories, basic health care centers, and other health service centers, plus all the professionals who, either individually or in

groups, offer their services through the health promotion enterprises.

As of June 1997, 104 of the 142 secondary- and tertiary-level hospitals (87%) had been turned into social enterprises of the State, and there were 165 health partnership enterprises, 67 family compensation funds, and 30 health promotion enterprises.

Organization of Health Regulatory Activities

Law 100 reaffirms the administrative, technical, and financial autonomy of the public hospitals originally established in Law 10 of 1990 and Law 60 of 1993, and for this purpose it stipulates that public hospitals will be turned into social enterprises of the State as a special type of decentralized public entity; that staff will be governed by the provisions of Law 10, and that private law shall apply in contractual matters. In addition, Law 100 specifies, as part of the Compulsory Health Plan, that initiatives executed by the local government to promote health and prevent disease must be provided free to the entire community and should respond to the needs expressed by the people. All the system's subscribers have the right to be covered under a basic plan, which includes emergency care, hospitalization, consultations, and medication.

Regulations are currently being developed for Law 100, especially with regard to increased coverage, basic packages, promotion and prevention, and financing. The National Health Authority has been an active participant in this process. Given the complexity of the model, it has been necessary to adjust the terms both of Law 100 itself and of this law in relation to other laws of importance for the health sector, such as Law 10 and Law 60. This situation has prevented the health sector from generating initiatives leading to its incorporation in the regional integration processes.

The legal framework continues to be supervised and evaluated by the various bodies responsible for this task at the national level, such as Committees VII of the Senate and the House Representatives. These law-making bodies represent the country in the Andean Parliament and other international legislative forums.

Health Services and Resources

Organization of Services for Care of the Population

Food. A Food and Nutrition Plan has been developed, which includes the following measures for sanitary regulation: a project to update sanitary legislation, implementation of techniques to analyze risks and critical control points, a

program for the epidemiological surveillance of foodborne diseases, strengthening of the laboratory network, updating of the food composition table, food safety, and programs for the prevention and control of micronutrient deficiencies, especially those of vitamin A, iron, and iodine.

Health Promotion and Community Participation. On October 1, 1996, the president of the Republic lent his support to the Healthy Municipalities for Peace strategy, calling on mayors, governors, council members, and other authorities, as well as on the community at large, the private sector, and other organizations to exert all their creative capacity to ensure that every municipality in Colombia will work for sustainable human development, conserve and protect the environment, facilitate the timely delivery of health care to the people, and guarantee the quality of care. These efforts are intended to reduce inequalities in health, and, with the participation of the community, to construct the Agenda for Local Development, Health, and Well-Being.

Environment and Sanitation. Health promotion activities come under the Basic Health Care Plan and are essentially carried out at the municipal level. Within this framework, the goal of the Plan for Environment and Sanitation for 1998 is to achieve 90% coverage with water supply systems and 77% coverage with sewerage systems, benefiting an additional 6.1 million inhabitants with safe drinking water and 6.2 million with cisterns for the disposal of wastewater.

Organization and Operation of Personal Health Care Services

According to statistical data from the Ministry of Health, the public health service network consists of 3,340 jobs in the health sector, 904 health centers, 128 health centers with beds, and 555 hospitals—397 hospitals at the primary level, 126 at the secondary level, and 32 at the tertiary level. In addition, the private sector has 340 clinics.

Under the health insurance system, the 10 public health promotion enterprises, together with the 20 authorized private and mixed enterprises, have the capacity to handle a total of 21.6 million persons. As of December 1996 a total of 13.9 million Colombians were covered, of which 66.9% (9.3 million people), according to the latest official report dated June 1996, were subscribers under the Social Security Institute, and the remaining 33.1% came under other health promotion enterprises. The subsidized program currently involves 236 entities: 18 health promotion enterprises, 49 family compensation funds, and 169 health partnerships, which as of December 1996 had 5.9 million subscribers. Of this total, 33.1% belonged to the health partnerships, 53.2% to the health promotion enterprises, and 13.7% to the family compensation funds.

Inputs for Health

Essential Drugs and Medications. One of the benefits of the reform has been seen in the area of drugs. Decree 677, promulgated in 1995, establishes a complete frame of reference for all matters related to the use and quality control of pharmaceutical products. The National Institute for the Surveillance of Drugs and Food (INVIMA) was established that same year, and a bureau of Pharmaceutical and Laboratory Services was created within the Ministry of Health with the responsibility of setting policy for the sector and promoting the development of services for pharmaceutical care and the rational use of drugs.

The list of essential drugs cited in the Compulsory Health Plan (about 300 principles and 435 presentations) has become an important element in managing the system, both from the therapeutical standpoint, by guaranteeing use of the best drug for each illness, and from the administrative perspective, by handling a moderate quantity of items throughout the entire pharmaceutical care chain. This list has resulted in some changes in the inventory of drugs used in Colombia; consolidated the production, sale, and prescription of essential drugs; and hindered the entry of other products (especially “novel” ones) on the national market that are less effective and safe as well as more expensive.

In November 1995, 2 years after the reform was initiated, essential drugs accounted for 70% of the drugs prescribed in the public hospitals, and more than 60% of all prescriptions specified the generic name. In that same year Colombia adopted the Good Manufacturing Practices (GMP) standards of the World Health Organization. The pharmaceutical laboratories, in turn, had to present INVIMA with a program of technological change that would guarantee complete retooling of their productive practices in order to bring them in compliance with GMP within a period of no more than four years. The various programs for controlling the quality of products on the market are still reporting rejection rates of nearly 4%.

Human Resources

In another positive response to the reform, a study was conducted and a national plan was prepared for the development of human resources in the sector. The study, carried out in 1994, showed the distribution of human resources by category as presented in Table 1.

However, with the passage of Law 30 and Law 115 of 1994, which authorized educational institutions to create new programs, there has been a haphazard proliferation of study programs and private vocational schools at the technical and auxiliary levels, which attempt to respond to the needs of the

TABLE 1
Human resources in the health sector,
by occupational category, Colombia, 1996.

Occupational category	Number	Rate per 10,000 population
Medicine	35,640	9.4
Nursing	16,560	4.4
Dentistry	21,240	5.6
Bacteriology	10,800	2.9
Physical therapy	3,744	1.0
Nursing auxiliaries	41,760	11.0
Health promoters	8,699	2.3
Total	138,443	36.5

Source: Colombia Ministry of Health, 1996.

sector. Some of these programs, especially the informal ones in technological areas, have an unclear curriculum and were created before regulations were in place to govern the practice of the new vocations.

The Ministry of Health offers training to develop health assistance in some of the priority areas. A study conducted in 1995 by the Expanded Program of Textbooks and Instructional Materials (PALTEX) of the Pan American Health Organization revealed that in general no prior assessment of training needs is made, nor is any evaluation done of its impact. This finding led to formulation of the National Human Resources Development Plan in 1996, which was intended to control the erratic growth of training programs, the lack of clear guidelines, and a series of other problems that might be considered to fall under three major headings:

- Imbalance between the availability of human resources in different occupational categories and the demand for their services, attributable in part to the absence of a clear policy of human resources planning and in part to the shortage and questionable reliability of information.
- Inconsistency between socioeconomic and epidemiological profiles, on the one hand, and occupational profiles, on the other, and incongruity between these profiles and pedagogical objectives, materials, strategies, and methods.
- Insufficient recognition of the importance of human resources management for productivity and quality of care and of critical areas such as job-relatedness, motivation, working conditions, performance evaluation, continuing education, and constructive supervision.

The National Council on Human Resources Development, created in 1977, is composed of representatives of the Ministries of Education, Health, and Labor, and it has working bodies at two levels—the National Executive Committee and

the Departmental Committees—which are responsible for proposing policies on basic formation, continuing education, and the dynamics as well as the distribution of human resources in the health sector. As of the end of 1996, this Council had regulated the basic formation of the following categories: health promoters, family and community health assistants, health assistants in dental offices, nursing assistants, assistants in dental hygiene, clinical laboratory assistants, administrative assistants, information assistants (health statisticians), environmental health promoters, pharmacy assistants, and assistants in oral health and dental mechanics.

Expenditures and Sectoral Financing

According to Law 60, enacted in 1993, the subsidized program relies on the following sources of funding: 15% of the municipalities' share of current national income, fiscal allocations to the departments, national income assigned to the departments, resources from ECOSALUD (gambling taxes), voluntary contributions from the municipalities and departments, royalties from new oil wells, contributions from the compensation funds, value-added tax destined for social programs, tax on firearms and ammunition, and copayments and prorated fees from the members and their families. If the contributions from private sector insurance schemes are added, the share that health represented in the gross domestic product (GDP), not counting private expenditures by families, increased from 2.07% in 1990 to 3.18% in 1994 and 4.71% in 1996.

Two more subaccounts have been incorporated into the social security system: the Compulsory Traffic Accident Insurance account, which receives payments from every automobile owner in the country and channels them into the emergency network to care for victims of hit-and-run accidents, and the Work-Related Accidents and Occupational Diseases account, which is fed by contributions from employers based on the degree of risk to which their workers are exposed.

During 1996 the health institutions continued to receive subsidies that were at least the same as in previous years. This per capita income, calculated on the basis of the uninsured population, represents considerably less than the value of the per capita unit of pay (PCP). Its calculation is based on a detailed analysis of family incomes over time. These funds are a potential source of fees for the health system. A study was conducted on the trend of the PCP over the past decade, and its composition was established on the basis of specific beneficiary groups and their distribution by age and geographic location. Perhaps the greatest challenge to the financial stability of the system is controlling fee evasion; the health promotion enterprises are responsible for membership and building up enrollment and not for controlling un-

derpayment of fees by higher-income members, who often underreport their income.

Private household expenditure on health was estimated at 3% of GDP in 1993, which means that in that year Colombians spent a little more than 6% of GDP on health. Of total private household expenditure, about 40% was for medication, 14% for office visits, 20% for hospitalization, 5% for diagnostic tests, and 20% for other items. Because essential drugs are included in the Compulsory Health Plan and must be referred to by their generic names, the private market has deferred to the institutional market of the health promotion enterprises and the health service delivery institutions. This means that the negotiated unit prices have fallen significantly. The hospital cooperatives, which cover about 80% of the public hospitals, have been very effective and efficient in organizing essential supplies for the public hospital system, offering average discounts of 79% on drugs and ensuring strict quality control of the products. Total social spending by the State as a percentage of GDP increased from 8.59% in 1990 to 10.65% in 1992 and 15.67% in 1996.

External Technical and Financial Cooperation

The nonreimbursable technical cooperation and funding for all sectors received by Colombia from multilateral and bilateral sources in 1990–1995 showed an uneven pattern, going from US\$ 88 million in 1990 to \$180 million in 1993 and then dropping to \$70 million in 1994 and \$80 million in 1995. During this period, the largest share of resources (27%) went to the agricultural sector for projects to eradicate unlawful crops; followed by 18% for environmental protection; 12% for health, basic sanitation, education, culture, and recreation; 11% for science and technology; 9% for industry; 6% for justice; and 5% for modernization of the Government.

Two factors have affected the level of priority that donors assign for providing nonreimbursable financial assistance, which have translated into smaller contributions: first, the financial situation of some of the cooperating organizations, in

particular the specialized agencies and other organizations of the United Nations, and second, the fact that Colombia has reached social and economic levels that allow it to be classified as a country with a medium level of development.

Of the US\$ 80.9 million in nonreimbursable technical and financial assistance received by Colombia in 1995, 56.6% came from multilateral sources. The largest amounts were received from the World Food Program (44.6%), the European Union (21.2%), and the United Nations International Drug Control Program (16.3%). Bilateral sources accounted for the remaining 43% received—from Germany, 19.6%; Spain, 12.47%; Canada, 4.98%; and other countries, 6.35%.

Pursuant to the priorities contained in the National Development Plan, social programs received 47% of the total contributions granted to the country in 1995, followed in order by the agricultural sector (16%), environmental protection (15%), and institutional development programs as part of the decentralization process (9%). With regard to the regional programs, the contributions were allocated, by order of importance, to education (24.3%), ethnic groups (24.2%), activities under the Alternative Development Plan (15.9%), and children (11.90%). Colombia has both received and contributed technical collaboration in the areas of health, tourism, science and technology, agriculture, institutional development, and management of international technical cooperation.

Since the end of 1994 the Government has assigned increasing importance to international cooperation, inasmuch as it is a key resource that contributes to economic and social development as envisaged in the National Development Plan. In March 1995 a policy document was issued, which called for international cooperation in institutional management by coordinating the demand for this cooperation, and which established priorities for the technical assistance the country receives from different sources. Areas identified as being of interest were social development, the elimination of poverty, and sustainable environmental development, to be carried out in tandem with territorial development and modernization of the Government.