ADOPTION EDUCATION LLC

SPECIAL REGIONAL CONSIDERATIONS

COLOMBIA

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COLOMBIA

Introduction [1]

Colombia is a country of 45 million people located in northwestern South America. Colombia is bordered to the east by Venezuela and Brazil; to the south by Ecuador and Peru; to the north by the Caribbean Sea; to the northwest by Panama; and to the west by the Pacific Ocean. Colombia also shares maritime borders with Venezuela, Jamaica, Haiti, the Dominican Republic, Honduras, Nicaragua and Costa Rica. Colombia has the 29th largest population in the world and the second largest in South America, after Brazil. Colombia has the fourth largest Spanish-speaking population in the world after Mexico, the United States, and Spain.

Colombia is very ethnically diverse, and the interaction between descendants of the original native inhabitants, Spanish colonists, Africans brought as slaves and twentieth-century immigrants from Europe and the Middle East has produced a rich cultural heritage. The majority of the population (58%) is Mestizo, (a mixture of European and South American Indian ancestry). Approximately 20% of the population is of European ancestry (predominantly Spanish, partly Italian, Portuguese, and German). Fourteen percent of Colombia's total population is of mixed African and European ancestry, with 3% being of mixed African and Amerindian ancestry, and 4% having primarily African ancestry.

Colombia's diversity has also been influenced by its varied geography. The majority of the urban centers are located in the highlands of the Andes mountains, but Colombian territory also encompasses Amazon rainforest, tropical grassland and both Caribbean and Pacific coastlines. The population is concentrated in the Andean highlands and along the Caribbean coast.

The government of Colombia is a liberal democracy with separation of powers into executive, judicial and legislative branches. Its legislature has a congress, its judiciary has a supreme court, and its executive branch has a president. The citizens of Colombia cast votes concerning their government, and they employ a *public* sector office for an inspector general to oversee the public interface of the government. Colombia has "control institutions" which mix government and public officials, who work alongside one another.

In spite of the difficulties presented by serious internal armed conflict, Colombia's market economy grew steadily in the latter part of the twentieth century, with gross domestic product (GDP) increasing at an average rate of over 4% per year between 1970 and 1998. The country suffered a recession in 1999 (the first full year of negative growth since the Great Depression), and the recovery from that recession was long and painful. However, in recent years growth has been impressive, reaching 8.2% in 2007, one of the highest rates of growth in Latin America.

Colombia has four major industrial centers--Bogota, Medellin, Cali, and Barranquilla, each located in a distinct geographical region. Colombia is rich in natural resources, and its main exports include petroleum, coal, coffee (fourth-largest producer of coffee in the world) and other agricultural produce, and gold. Colombia is also known as the world's leading source of emeralds, while over 70% of cut flowers imported by the United States are Colombian. It has the largest coal reserves in Latin America, and is second to Brazil in hydroelectric potential.

Around one third of the people in Colombia have been affected in some way by armed conflict there. Those with direct personal experience make up 10% of the population, and many others also report suffering a range of serious hardships. In total, 31% have been affected in some way – either personally or due to the wider consequences of armed conflict. Trade unions in Colombia have been particularly affected as trade unionists have been targeted by paramilitaries and state security forces. As a result Colombia has been the most dangerous country in the world for trade unionists for decades, with over 2800 murders between 1986 and 2010.

Due to widespread corruption, economic instability and high unemployment over the last century or so, Colombia has developed a huge rift between two economic classes (Low and High) with an almost nonexistent, but increasing middle class, particularly in the Bogotá and Medellín areas. Colombia has one of the strictest stratified social systems in the world and has been extensively used by the government as a reference to develop social welfare programs, statistical information and to some degree for the assignment of lands. The last CEPAL* report includes data about extreme poverty in 45% of the general population and 17% homelessness, with an estimated 9,654,722 homeless people. In comparison, the average figures in Latin America as a whole are 18% and 5%, respectively. Colombia has the highest rate of unemployment in Latin America, and a work market dominated by informal jobs, with no significant prospects for the creation of new work opportunities.

Colombia's Gini coefficient (a measurement of inequality in wealth distribution) was 0.51 in 2000 and 0.56 in 2006, making it the second-most unequal country in terms of wealth distribution, after Brazil. By 2009, Colombia had reached a Gini coefficient of 0.587, which was the highest in Latin America. This means that 10 percent of the wealthiest homes have incomes 30 times higher than the 10 percent of poorest homes. Over 60.1% of Colombian homes are below the poverty threshold.

Education in Colombia includes nursery school, elementary school, high school, technical instruction and university education. Basic education is compulsory by law. The basic goal expected for the average citizen is to study through 11 grades (elementary school plus some high school). Public education in Colombia is free while private education in Colombia is more reliable than public education, but is more expensive. The current index of illiteracy in the country is 7.6%, with areas such as Chocó Department and Sucre Department having a 16% level. These rates show a worsening of the illiteracy index, compared with those 20 years ago, when in the same areas the rate was 13.5%.

The family is, as it is with nearly all of Latin America, a highly important institution to Colombians as engraved by the traditional Roman Catholic Church teachings. Members of the extended family are close and children rarely move far away from their parents. There is a deep sense of familial responsibility that stretches through many generations. Traditionally, men were usually the head of the household, in charge of earning most of the family's income while women were responsible for cooking, housework and raising children. However, today the majority of families (regardless of economic class) have two working parents due to the need of an income to sustain a family.

Sex roles in Colombia, especially in some segments of population, are rigidly defined. Few men take on housekeeping or child-rearing duties, which are reserved for women. Economic instability has increased the number of single, female-headed families, and gender discrimination in wages and hiring has lead many single mothers and their daughters to turn to prostitution. Abortion is legal in some cases, and divorce was legalized in the past decade.

Colombia's cuisine, influenced heavily by the Spanish and Indigenous populations, is not as widely known as other Latin American cuisines such as Peruvian or Brazilian. Along with other cultural expressions of national identity, Colombian cuisine varies among its many distinct regions. But to the adventurous traveler there are plenty of delectable dishes to try, not to mention fruits, rum, and especially Colombian coffee which is well known for its high standards in taste compared to others.

Note - The Economic Commission for Latin America (ECLA) - the Spanish acronym is CEPAL

History of International Adoption

In 1968 answering the problems such as the nutritional deficiency of the disintegration and instability of the family, and the loss of values of the abandoned childhood, the *Institute Colombiano Bienestar de Familia (Bienestar of ICBF*) was born in order to strengthen the integration and the harmonic development of the family, to protect and guarantee to the children, girls and adolescents their rights. The ICBF is present in each of the departmental capitals, through its regional and sectional. Additionally, it has 200 zonal centers, which are points of service to serve the population of all municipalities. Currently about 10 million Colombians benefit from their services. [2]

In Latin America, and Colombia in particular, the orphan boom came in the wake of civil conflict of the late 1970s and 1980s. Adoptions in Colombia have been taking place under the current system since 1979 and the process is extremely stable. The success of this program lies with the cooperation of the Colombian government, the stability and consistency of the program, and the comparatively good health of the children. While Colombia has threats of travel warnings from the US State Department, several hundred adoptions happen each year from this country.

Law 1098/2006, the Code of Infancy and Adolescence defines the Adoption Program in Colombia. It regulates the Adoption Program as a means of re-establishing rights to those girls, boys and adolescents having had a positive ruling regarding their adoptability, their parents consent or an authorization from the family ombudsman. Likewise, the law is clear in stipulating that ICBF and all institutions authorized to process adoption will prefer (in equal conditions) requests presented by Colombians when they fulfill the requirements established in the Code of Infancy and Adolescence. [3]

NUMBER OF IMMIGRANT VISAS ISSUED TO ORPHANS COMING TO THE U.S. FROM COLOMBIA

FY 2009	238
FY 2008	306
FY 2007	310
FY 2006	344
FY 2005	291
FY 2004	287
FY 2003	272
FY 2002	334
FY 2001	407
FY 2000	246
FY 1999	231
FY 1998	236
FY 1997	233
FY 1996	255
FY 1995	350
FY 1994	351
FY 1993	426
FY 1992	404
FY 1991	521
FY 1990	631

SOURCE – US Department of State, *http://www.travel.state.gov/pdf/MultiYearTableXIII.pdf*

NOTE: All statistics given correspond with the U.S. Government fiscal year, which begins on October 1 and ends on September 30.

Logistics [4]

Colombia is a party to the *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (the Convention) and with which the Convention is in force for the United States. Because Colombia is a Convention country, adoption services must be provided by an accredited agency, temporarily accredited agency, approved person, supervised provider, or exempted provider.

Colombia's Central Authority for adoptions, the Colombian Family Welfare Institute (ICBF), is the only means of adopting a Colombian child; Colombian law prohibits private adoptions. Please note ICBF does not allow for a Colombian child to travel to the United States to be adopted. Therefore, prospective adoptive parents must obtain a full and final adoption under Colombian law before the child can immigrate to the United States. Adopting parents are required to be physically present before a "family judge" at the time of adoption. No exceptions are made to this requirement.

Special transition provisions apply to adoptions initiated before April 1, 2008. Additional information can be found here - http://www.adoption.state.gov/hague/overview/transition.html.

WHO CAN ADOPT

Adoption between the United States and Colombia is governed by the Hague Adoption Convention. Therefore to adopt from Colombia, you must first be found eligible to adopt by the U.S. Government. The U.S. Government agency responsible for making this determination is the Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS).

In addition to the U.S. requirements for prospective adoptive parents, Colombia also has the following eligibility requirements for prospective adoptive parents:

- **Residency Requirements**: There are no residency requirements for intercountry adoptions from Colombia.
- **Age Requirements**: Both parents are required to be 25 years old. In practice, newborns are assigned to younger couples and older children to older couples.
- **Marriage Requirements**: Colombian law allows adoptions by a married man and woman and common law spouses of more than three years. Single men and women are only allowed to adopt children over the age of seven on a case-by-case basis.
- **Income Requirements**: Prospective adoptive parents are required to submit documentation confirming their ability to provide for the adopted child. This requirement may be met by only one parent.
- **Other Requirements**: Gay or Lesbian individuals or couples may not adopt children from Colombia. In addition, according to Colombian law, both parents must be found "physically and emotionally capable" to adopt.

WHO CAN BE ADOPTED

Because Colombia is a member of the Hague Adoption Convention, children from Colombia must meet the requirements of the Convention in order to be eligible for adoption. For example, the Convention requires that Colombia attempt to place a child with a family in Colombia before determining that a child is eligible for intercountry adoption. In addition to Colombia's requirements, a child must meet the definition of a Convention adoptee for you to bring him or her back to the United States.

Children being placed for adoption range in age from infancy through early teens. There are many sibling groups available, as well as special needs children. First-time adopters cannot choose whether to adopt a boy or girl.

HOW TO ADOPT

Colombia's Central Authority for adoptions, the Colombian Family Welfare Institute (ICBF), is the only means of adopting a Colombian child; Colombian law prohibits private adoptions. Once prospective adoptive parents decide that Colombia is the nation from which they wish to adopt, they must first contact the ICBF in order to obtain a list of adoption service provider in the United States, nearest to the couple's place of residence, that are accredited by both the Colombian and U.S. Governments.

Once the U.S. Government determines you "eligible" and "suitable" to be an adoptive parent, you or your adoption service provider will forward your information to ICBF in Colombia. The Central Authority will review your application to determine whether you are also eligible to adopt under Colombian law. Once the ICBF approves the package of documents, it will be in a position to inform prospective adoptive parents, through their adoption service providers, about the availability of children in need of a family placement and the amount of time it is likely to take to complete an adoption.

If both the United States and Colombia determine that you are eligible to adopt, and a child is available for intercountry adoption, the Central Authority in Colombia may provide you with a referral for a child. ICBF will inform the parents, through the adoption service provider, once a child has officially been assigned to them. Medical, social, psychological, and nutritional assessments are provided to the prospective adoptive parents, as well as photographs of the child. Prospective adoptive parents are given two months to make a decision as to whether to adopt that particular child. Each family must decide for itself whether or not it will be able to meet the needs of the particular child and provide a permanent family placement for the referred child.

After you accept a match with a child, you will apply to the USCIS for permission to adopt that child (Form I-800, Petition to Classify a Convention adoptee as an Immediate Relative). USCIS will determine whether the child is eligible under U.S. immigration law to be adopted and enter the United States. After this, your adoption service provider or you will submit a visa application for to a Consular Officer at the U.S. Embassy in Bogota. The Consular Officer will review the child's information and evaluate the child for possible visa ineligibilities. If the Consular Office determines that the child appears eligible to immigrate to the United States, he or she will notify the ICBF (Article 5 letter). For Convention country adoptions, prospective adoptive parent(s) may not proceed with the adoption until this takes place.

At this point, you may travel to Colombia to begin the legal process with Colombian authorities. The ICBF or the Colombian adoption agency will assist with obtaining the documents needed to complete Colombian legal procedures.

There is no set time frame for completing an intercountry adoption from Colombia. There are many factors that determine how long the adoption and visa process takes, including paperwork approval times, desired sex and age of the child, and the age of the prospective adoptive parent(s). Adoptive parents have reported the entire process taking 18 to 30 months.

You will need to apply for several documents for your child before he or she can travel to the United States:

1. You will first need to apply for a new birth certificate for your child, so that you can later apply for a passport. Your name will be added to the new birth certificate. In Colombia, this should be processed at the same time as the adoption decree.
2. Your child is not yet a U.S. citizen, so he or she will need a travel document or passport from Colombia. The court will authorize a new passport, containing the information from the new birth certificate, when issuing the adoption decree.
   Note: *As of July 2010, The Colombian Ministry of Foreign Affairs now requires eight business days to issue a new passport. A temporary, three-month validity emergency Colombian passport may be issued sooner, but the fee is higher, about 200,000 Colombian Pesos, or about USD $100.*
3. After you obtain the new birth certificate and passport for your child, you also need to apply for an U.S. visa from the U.S. Embassy in Bogota for your child. After the adoption is granted, visit the embassy for final review and approval of the child's I-800 petition and to obtain a visa for the child.

This immigrant visa allows your child to travel home with you. As part of this process, the Consular Officer must be provided the Panel Physician's medical report on the child if it was not provided during the provisional approval stage.

Note: *Visa issuance after the final interview takes at least one business day, and it is not possible to provide the visa to adoptive parents on the day of the interview. Adoptive parents should allow at least one business day after the interview before making final travel arrangements.*

General Health Issues of the Population [5, 6, 7]

Colombia is the only Andean and South American country with ports and long coasts on both the Atlantic and Pacific oceans. Extending over both sides of the equator and the Andes, from sea level to permanently snow-covered peaks of nearly 19,000 feet, Colombia has a wide variety of landscapes, climatic conditions, peoples, and types of settlement and economic activity.

DEMOGRAPHICS, MORTALITY AND MORBIDITY

Colombia's population in 2007 was 43,926,034, of which 72% of the population lived in urban municipalities. It is a multiracial, multicultural country with a tradition of democratic stability and, since 1999, steady economic growth. Colombia is vulnerable to natural disaster such as earthquakes, hurricanes, floods, landslides and volcanic eruptions. For over 40 years, it has endured a domestic conflict between the Government and armed illegal groups, more recently involving drug traffickers—a situation reflected in high indices of mortality from violence and of displaced populations that hinder the country's economic and social growth.

One of the most serious effects of economic development has been the deterioration of natural resources, especially water, soil, and air. Poor water quality and variations in the water cycle are having a negative effect on health. The pollution of groundwater by domestic and industrial effluents and solid waste of all kinds is threatening not only the supply of water available for human consumption and production but also the nation's flora and fauna. One of the worst pollutants is oil, which has leaked into the soil and water sources as a result of attacks on the country's petroleum infrastructure.

According to the Ministry of Development, barely 5% of Colombia's 1,076 municipalities treat their wastewater before they dispose of it. This situation has turned the Cauca and Magdalena river basins essentially into sewers, as they receive more than 80% of the nation's wastewater. According to the Ministry of Health, 60% of the inhabitants in the municipal seats run a medium to high risk of contracting diseases because of the poor quality of the water. In 2000, 76% of municipalities did not have potable water. Very few urban areas in Colombia have adequate facilities for the disposal of solid waste. In rural areas, this waste is usually dumped in open fields or burned or buried on household property. The use of organic solid waste for productive purposes has not been sufficiently studied, and recycling programs lack continuity.

Colombia is experiencing demographic changes as well as changes to its epidemiological profile typical of transitional societies. These demographic changes include population aging, decreasing fertility, rapid urbanization, while the change in the epidemiological profile emphasizes the persistence of communicable diseases with a concomitant increase of noncommunicable diseases. Life expectancy at birth had increased to 73 years (2008) while fertility dropped to 2.4 children per woman (2005).

While significant achievements have been made in lowering the maternal mortality rate, in 2005 it is still high (130/100,000 live births, estimated) due to poor access to prenatal and institutional obstetric care. Domestic violence is a high-priority problem. Forty-one percent of women who ever lived with a partner declared they had been physically abused by their partner (and an additional 20% by another relative). An additional, thirty-four percent had been threatened by their partner.

In 2000, infant mortality rate was 21/1,000 live births, ranging from 17 in Bogotá to 29 in the coastal area. By 2008 the infant mortality rate had dropped to 16.5.

In 2005, this age group represented 10.3% of the total population. In 2003, the under-five mortality rate was 21/1,000 live births, with the prevalence of chronic undernutrition at 13.5%; diarrhea, 13.9%; and acute respiratory infections (ARI), 12.6%. ARI are one of the leading causes of morbidity and mortality in this age group, even though mortality from pneumonia fell from 51.0 per 100,000 population in 1988 to 34.1 in 1998. In 2008, the under-five mortality rate decreased slightly to 20/1,000 live births. Mortality from pneumonia continued to fall to 12% and diarrhea fell to 4%.

The prevalence of chronic undernutrition was 13.5% in children under 5, with 2.8% at risk for severe undernutrition. The prevalence of exclusive breastfeeding through the fourth month of life was 23%, and through the sixth month, 12%.

The age group 5-9 age group represented 10.8% of the population, according to data recorded by the National Administrative Department of Statistics for 2002. There were 1,537 deaths in 1998 (36.9 per 100,000 males and 26.7 per 100,000 females); more than 65% were due to external causes. In 2002, 1,449 deaths were registered in this group, for a rate of 30.6 per 100,000 population (60% males and 40% females). Leading causes of mortality were motor vehicle accidents, followed by acute respiratory infections and diseases of the blood (malignant neoplasms of lymphoid, hematopoietic, and related tissue).

In 1998, there were 7,864 deaths in the adolescent population (133.4 per 100,000 males and 47.9 per 100,000 females). In young men aged 15-19, violence accounted for 69% of the deaths; there were 13 male deaths for each female death in this age group. Data from a national survey on juvenile drug use showed that among the population surveyed, alcohol and marijuana continued to be the most consumed drugs; 15.2% of all persons who drank alcohol and 6.8 % of cigarette smokers were under 18 years of age. The prevalence of cocaine consumption in the general population is 3.8%.

By 2002, deaths registered for the 15-19 age group numbered 6,738 (156.5 per 100,000 population), a decrease from 1998 figures. Of these,67% were violent deaths, the majority caused by firearms; for each female mortality, there were six male mortalities.

During the 1990s, the proportion of pregnant women aged 15-19 years almost doubled, from 10% in 1990 to 19% in 2000. The proportion of pregnant women aged 15-19 years continued to rise at a slower rate to 20.5% in 2005. The number of adolescents aged 15–19 who have had one or more pregnancies has nearly doubled over the past 15 years, increasing from 10% in 1990 to 19.7% in 2005.

In 2000, the adult population (20-59 years of age) in Colombia numbered 26 million. There were 78,820 deaths for this age group in 1998 (406.3 deaths per 100,000 males and 168.9 per 100,000 females). At the end of the 20th century, the adult population aged 15-44 saw an increased burden, especially among males, attributable to the rise in homicides and in AIDS as causes of death. Every year, there are thousands of cases of severe trauma and hundreds of deaths due to exposure to physical and chemical hazards in the workplace. The artisanal industries do not provide adequate health conditions for their employees.

Between 1990 and 2003 assaults (homicides), ischemic heart diseases, and cerebrovascular diseases retained their positions as the first, second, and third leading causes of mortality, respectively, for all age groups. In relation to age and gender, communicable diseases appeared among the first five causes of death only in the male and female population under age 5. Above that age, both sexes showed a progressive increase in causes associated with transport accidents, homicides, intentional self-harm, malignant neoplasms, and diseases of the circulatory system. In the population aged 45 and older, diabetes mellitus replaced external causes as one of the leading five causes of death.

COMMUNICABLE DISEASES

1. MALARIA

Malaria poses a serious public health problem for Colombia. It is estimated that 18 million people live in areas where malaria is transmitted. Transmission is highest in the upper Sinú River and lower Cauca River regions, in Urabá and on the Pacific coast. Males aged 15–44 were the most affected population group. In 1998, there was an epidemic with 240,000 confirmed cases. In 2000, there were 141,047 confirmed cases - a figure consistent with the endemic level observed over the preceding decade - and 41 deaths. In 2008, the number of reported malaria cases decreased to 79,230 and the number of reported malaria deaths fell to 22.

2. DENGUE

Another serious public health problem in Colombia is dengue. Around 65% of the urban population faces a high probability of becoming infected with dengue and dengue hemorrhagic fever (DHF). In 1998, a total of 57,985 cases of dengue were documented, including 5,171 cases of DHF. In 2005, there were 43,257 reported cases (187 per 100,000 population); 4,322 were dengue hemorrhagic fever (17 per 100,000 population), with 48 deaths. In recent years, circulation of all four dengue virus serotypes has been confirmed. In 2005, the population age groups most affected were those 45–84 years old (48%) and 5–14 years old (26%).

3. YELLOW FEVER

There are jungle yellow fever infection foci, mainly in the Amazon, Catatumbo, and Orinoco river basin areas and the foothills of the Sierra Nevada de Santa Marta. The high index of Aedes aegypti infestation in many municipalities poses a serious risk factor for the urban transmission of yellow fever, and jungle yellow fever continues to be active in Colombia. In the 1990s, there was an average of 4 cases per year. Over the last five years, 179 cases have been reported, with a 47% case fatality rate. In 2003, there was an epidemic with 102 cases, which in particular affected the Norte de Santander department. Most cases appeared in male agricultural workers 15–44 years old.

4. LEISHMANIASIS

There were 15,000 cases of leishmaniasis reported in 2004 and 22,000 in 2005; 99% of the cases were cutaneous leishmaniasis. Almost 80% of the cases occurred among the 15–44-year-old population segment, with male farmers being the most affected group.

VACCINE PREVENTABLE DISEASES

The eradication of poliomyelitis in 1991, the elimination of measles in 2002, and the elimination of neonatal tetanus and diphtheria as public health problems, as well as the current initiative to eliminate rubella and congenital rubella syndrome by 2010, place Colombia among the first Latin American countries to reach these regionwide goals.

1. MEASLES

In 1993, Colombia joined a regional partnership for the elimination of measles by the year 2000; successive national campaigns in 1993, 1995, and 1999 achieved coverages of 97%, 95%, and 90%, respectively, in children under 5 years old. Reports of suspected cases increased from 632 in 1997 to 1,267 in 2000, while the number of laboratory-confirmed cases fell from 308 in 1995 to 0 in 2000, and the number of clinically confirmed cases dropped from 473 in 1995 to 34 in 1999 and to 1 in 2000. Coverage with measles vaccine was 80% in 2000. Rubella was added to the measles surveillance system in 2000, and that year, 679 suspected cases were reported, 155 of them laboratory confirmed and 4 of them clinically confirmed. The reports included outbreaks among military personnel and sanitation workers.

2. HEP B

Vaccination against Haemophilus influenzae type b was introduced in 1998. There has been a decline in meningitis caused by H. influenzae type b among children under 5 years, from 306 cases (6.4 per 100,000)

in 1998 to 163 cases (3.4 per 100,000) in 1999 and 119 cases (2.8 per 100,000) in 2000. Most of the reported cases of pertussis occurred in Antioquia (181 in 1998, 255 in 1999, and 264 in 2000). Also, in 2000, there was an outbreak of 46 cases with 7 deaths in indigenous population. Reported cases of hepatitis B numbered 1,354 in 1998, 1,490 in 1999, and 1,283 in 2000; most of the cases were in endemic areas (Orinoquia, Amazonia, and Santa María). In 2005 there were 19 cases of *Haemophilus influenza* type b meningitis reported.

CHRONIC COMMUNICABLE DISEASES - TUBERCULOSIS

Incidence rates for all forms of tuberculosis were 26.2 per 100,000 population in 2001, 26 in 2002, 28.5 in 2003, 24.8 in 2004, and 22.5 in 2005. On average, Colombian households are made up of 4.2 persons. Almost four of five people (79%) live in houses and 19% live in apartments. Overcrowding in large city centers, inadequate housing conditions, and poor ventilation in settlements with precarious infra-structures all provide a favorable environment for the disease. The average percentage of deaths due to tuberculosis between 1991 and 2000 was 0.7%. Among HIV/AIDS patients, tuberculosis deaths averaged 10.8% during the 1997–2001 period.

HIV/AIDS

There were 17,163 cases of HIV/AIDS registered between 1983 and March 1999, of which 11,381 corresponded to carriers of HIV infection and 5,782 to patients with AIDS; 85% were males. During the same period, 3,441 deaths were reported (90% in males). In 2000, it was estimated that 67,000 persons were carriers of HIV. Sexual transmission accounts for 96% of cases reported. In 2001 it was estimated that 140,000 adults and children were living with HIV, whether or not they had developed symptoms of AIDS. This number increased to 170,000 in 2007. It was estimated that 5,800 adults and children died of AIDS in 2001. This estimate increased in 2007 to 9,800.

ACCIDENTS AND VIOLENCE

The last 30 years have seen an increase in accidents and violence. The mortality rate from homicides and harm intentionally inflicted by another person was 72.6 per 100,000 population; 16.1 from transport accidents; 10.7 from accidents, excluding transport; and 5.5 from intentional self-harm and suicides. There are no data disaggregated by gender. In 2004, there were 203,438 cases of nonfatal wounds from external causes and, compared to 2003, there was an increase in sexually related and accidental injuries (1.6%). There has been a proportional reduction in common interpersonal violence (42.5%) and an increase in sexual crimes (8.8%); nonfatal injuries from domestic violence amounted to 29.4%. Mortality caused by violent, illegally armed groups decreased from 28.2% in 2003 to 15.1% in 2004.

MENTAL HEALTH AND ADDICTIONS

Two out of five persons (40.1%) experience at least one mental disorder during their lives, with anxiety disorder being the most prevalent form (19.3%). The most frequent disorder in men is alcohol abuse (13.2%). In women, it is major depression (14.9%). The prevalence of lifetime substances abuse (of all types) was higher in men; following alcohol abuse as leading disorders are alcohol dependence (4.7%), nicotine dependence (2.9%), and drug abuse (2.1%). Lifelong prevalence for suicidal ideation was 12.3%. The median age for the appearance of affective disorders in a major depression episode was 24 years.

Special Considerations for Children Adopted from Colombia

Before the Adoption

Licensed private adoption houses offer support to birth mothers considering adoption. A pregnant mother may stay in these maternity homes during and after her pregnancy where she receives counseling and pre/post-natal care, as well as job training. She gives birth in a hospital and her child is cared for in the agency nursery or foster care.

Most of the children available for adoption have been voluntarily placed in orphanage due to poor economic conditions in their families of origin. Many children are abandoned by single parents who simply cannot afford to feed them, or who must work to survive and cannot afford child care while they work. Others come from families where they have been neglected or mistreated and their parent's parental rights have been taken away from them. Many of these orphanages are public and approximately 2/3 of the children are from the Bogotá area. As of this writing, Colombia has over 4,000 children waiting for families who are either older (age 9 and older), part of sibling groups, or who have special needs.

The medical and background information on children from Colombia is usually accurate and thorough. When a child is assigned, generally, photograph(s), a general health report, results of certain blood tests (including a test for Hepatitis B and HIV), and brief written social/developmental description of the child are provided. Overall, children from South America have been considerably healthier than children from certain other areas of the world.

After the Adoption [4]

Colombian law does not currently have any post-adoption requirements.

Many adoptive parents find it important to find support after the adoption. Take advantage of all the resources available to your family -- whether it's another adoptive family, a support group, an advocacy organization, or your religious or community services.

SOURCES

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