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Access to Health Services and Health Seeking Behavior Among Former Child Soldiers in Manizales, Colombia

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Access to Health Services and Health Seeking Behavior Among Former Child Soldiers in Manizales, Colombia

by

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts
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ABSTRACT

Through the Colombian Institute for Family Welfare (ICBF), the Colombian government aims to provide comprehensive reintegration for children demobilized from the country’s various armed groups. The reestablishment of rights, including the right to health (guaranteed by the Colombian constitution), is a key factor in successful reintegration. This thesis explores the topic of access to health care and health seeking behavior among former child soldiers in Manizales, Colombia who are over the age of 18 and were previously in the Hogar Tutor program (foster care-based youth reintegration) in Manizales. This thesis utilizes semi-structured interviews (n=9) and body mapping (n=9) with former child soldiers, key-informant interviews, participant observation, and a review of archival and secondary sources, including survey data, which is used to complement this research. This research is focused on understanding the barriers participants are experiencing in accessing health care, how participants understand and experience health and the health care system, and how health is handled within reintegration programs. Findings illustrate the incompatibility of transitional justice and the right to health within a neoliberal health system. This research suggests that former child soldiers face significant barriers in access to health care, experience persistent health conditions related to the conflict, and may be insufficiently aware of their rights as both citizens and victims of the armed conflict. These challenges likely affect the ability of former child soldiers to successfully reintegrate. This thesis provides recommendations for future research, as well as for the implementation of- and changes to- health education efforts within the ICBF and the Colombia Agency for Reintegration (ACR).
CHAPTER 1: INTRODUCTION

CHAPTER OVERVIEW

This chapter will provide an introduction to this research, beginning with a brief explanation of how it contributes to anthropology and public health. I will then give an overview of the issues explored in this research and the research design. This will be followed by an explanation of the theoretical framework employed in this study and a description of the research setting. Next, I contextualize the research and give an explanation of why I decided to pursue the issue of health care access among this particular group, despite an awareness of broad systemic issues within the Colombian health system. Finally, I conclude with a brief overview of each chapter.

SITUATING THIS RESEARCH WITHIN ANTHROPOLOGY AND PUBLIC HEALTH

Utilizing an anthropological perspective, this study explores the realities of reintegration and transitional justice for Colombia’s former child soldiers, specifically focusing on their health and access to health care. This study aimed to contribute to both the fields of anthropology and public health by allowing participants to speak for themselves and share their experiences, while simultaneously seeking to better understand the health concerns this population is experiencing and beginning to explore ways to improve the overall health of former child soldiers during and after youth reintegration.

This study draws from critical medical anthropology in an effort to critically evaluate health policy and its impact on the targeted individuals. This research both draws from and contributes to the anthropological literature on childhood and child soldiering by providing qualitative accounts of participant experiences in an attempt to avoid the use of a paternalistic perspective. This research also contributes to the public health literature on child soldiers and reintegration, as well as the limited body of
literature on the physical health of former child soldiers. The qualitative and exploratory nature of the research allowed for investigation into a number of different issues, enabling a better understanding of how reintegration programs can serve to improve the health outcomes of this population, mainly through improved health education and communication. In addition, the utilization of body mapping contributes to the use of visual methods in health research both as a way to promote discussion with participants and to understand how individuals understand and categorize their own health problems.

OVERVIEW OF STUDY

Child recruitment to guerilla and paramilitary groups in Colombia has been common practice throughout the internal armed conflict, which has lasted over 50 years. The majority of youth recruited to armed groups come from rural areas, as well as poor urban neighborhoods, with factors such as domestic violence, child labor, and a lack of access to basic services or opportunities being contributing factors to recruitment (Downing, 2014). A direct violation of international law, children in armed groups experience profound physical, sexual, and psychological violence. Challenges faced by this population do not end at the time of demobilization, but simply “change shape” as they begin the difficult transition back into civilian life (Denov & Marchand, 2014, p. 332).

As of 2014, over 12,000 children had demobilized from Colombia’s armed groups (Downing, 2014). Through the Colombian Institute for Family Welfare (ICBF), the Colombian government aims to provide a comprehensive reintegration program for former child soldiers. However, despite an average demobilization age of 17.5, under the current mandate, participants in reintegration programs are only considered to be child soldiers until the age of 18 (Naeve, 2012). Once participants are older than 18, they are labeled ex-combatants and their reintegration becomes the responsibility of the Colombian Agency for Reintegration (ACR), leaving them without the protection and support provided by the ICBF programs (Naeve, 2012; Thomas, 2008).

Excluding research focused specifically on mental health, research on the health of child soldiers in general, and specifically in Colombia, is limited. In 2006, the Colombian Ministry of Social Protection
published a report on the effects of violence on children in Colombia, briefly discussing the health impact of adolescent participation in the armed groups. It reports that 29% of participants were diagnosed as “healthy”, while 71% had health problems (Strauch, 2006). After removing health problems common among adolescents and those with no apparent relation to age or participation in an armed group, 55.4% were found to have health problems related to their participation in the violence, indicating a fairly high impact on health (Strauch, 2006).

Verhoef (2008, p. 30) reports that upon arrival to ICBF programs, former child soldiers are often in “critical physical condition”, having experienced malnutrition and a lack of hygiene that exposes them to a variety of diseases and with measles, diarrheal diseases, and skin disorders being common. While many are injured upon arrival to ICBF programs, immediate medical attention is credited with preventing more permanent handicaps, and most appear to be in “good physical condition” upon turning eighteen and exiting youth reintegration programs.

While in ICBF programs, former child soldiers in Colombia receive guidance and assistance in accessing health services, which are required. However, once they are out of these programs they lose this assistance and are likely subject to similar challenges in health care access as other victims or marginalized groups, such as the country’s many internally displaced persons (IDPs) – whose challenges in accessing health services have been better documented. To understand the barriers this population is experiencing in accessing health services, there must also be an understanding of how, when, and why former child soldiers are trying (or not trying) to access them. In order to achieve this goal, this research focuses on former child soldiers who have aged out of government protection programs (specifically the Hogar Tutor program in Manizales, Colombia) and how they experience and perceive health and health services. This research aims to assess and understand the challenges and barriers former child soldiers face in accessing health care, their own awareness and understanding of their rights, and their health beliefs or perceptions and how they may promote or prevent health-seeking behavior. To better understand these factors, this exploratory research employed the use of interviews and body maps with nine former child soldiers who were previously in the Hogar Tutor program in Manizales. Other methods
utilized include key informant interviews, participant observation, and a review of archival and secondary sources. This research was conducted in cooperation with Centro de Estudios sobre Conflicto, Violencia y Convivencia Social (CEDAT), a research center at the Universidad de Caldas in Manizales, Colombia.

**Theoretical Orientation**

Franco (2003) argues that violence is in and of itself a public health problem; the primary public health problem in Colombia. To address this, he promotes the use of a social-medical perspective that accounts for the interactions between structural and transitional factors. Health policy can serve to reproduce structural violence and in-turn, despite the goal of improving health, may further harm it (Singer & Castro, 2004). Thus, one of the roles of anthropology in health policy is to encourage the creation of “healthier” health policy that works to help level the playing field by critically reviewing its impact on the lives of those targeted (Singer & Castro, 2004). This research utilizes a critical medical anthropology (CMA) framework in its examination of health policy and the “sufferer experience within a framework of hegemony and resistance” while accounting for the intersections of class, race, and gender (Singer & Baer, 1995; Singer & Castro, 2004). While avoiding the use of a narrow, top-down perspective, CMA explores the ways in which social conflict and oppression are experienced and somatized, with illness becoming the arena for “resistance and political conscientization” (Singer & Baer, 1995, p. 62; Singer & Castro, 2004).

This research uses CMA to analyze the ways in which political and economic forces work together to shape the experiences of former child soldiers in regards to health and health care. This includes recognition of the “medical-industrial complex” and how the state legitimizes the for-profit activities of corporations in regards to health, as well as power and the contradictions between the purpose of medicine and its organization (Singer & Baer, 1995). By accounting for multiple dimensions and including the voices of those affected by macro-level processes, CMA allows for research that “speaks truth to power”, which in this case means going beyond the superficiality of a “comprehensive”
reintegration program and universal health care to understand how these programs and policies interact with structural and individual factors to create lived experiences and realities (Pfeiffer & Nichter, 2008).

Nordstrom (1996) discusses the invisibility of children (particularly girls) in political and media accounts of war, but also warns against the “othering” of violence against children:

“Rather than seeing ‘war abuses’ or ‘child (s)exploitation’ as ‘outside’ the rules and boundaries of ‘average’ or ‘normal’ society, perhaps we should be asking instead what it is that makes such behaviors possible wherever they are found, and what patterns of in/tolerance link them” (Nordstrom, 1996, p. 20).

Nordstrom explains that the distinctions between zones of war and peace are blurred – with multinational linkages and processes making these abuses possible across both social and political settings and boundaries. She emphasizes that children must be allowed to tell their stories through access to media and organization, rather than being silenced or “spoken for” as they have in the past, which fails to acknowledge their “well-developed moral, political, and philosophical understanding of the events in their lives and the world” (Nordstrom, 1996, p. 43).

In order to avoid a victimizing and paternalistic perspective that reinforces Western-ideals of childhood and, as Rethmann (2010) explains serves to re-marginalize the ex-combatants while simultaneously maintaining the “status-quo” and government control by pathologizing violence in the body of the individual, rather than in socio-historical processes and structural issues, this research also draws from literature on the anthropology of childhood and its “multiplicity” (Nordstrom, 1996; Rosen, 2007). To do this, there must be acknowledgement of the “Straight 18” position, or the use of a universal definition of childhood, and how it can be used to further agendas without taking into account social and cultural challenges (Rosen, 2007).

In addition, this research utilizes a ‘vector of rights’ approach that takes into account intersectional human rights frameworks. Conklin and Meier (2008, p. 65) describe the vector of rights in terms of female child soldiers, arguing that the vulnerabilities they face are not just additive (not just “sexism in one context and age-related prejudice in another”), but rather are complex and overlapping. The authors argue that a comprehensive and intersectional “vector of rights” framework is necessary to
address the myriad of overlapping human rights violations experienced by female child soldiers. In this research I expand upon Conklin and Meier’s (2008) approach to understanding intersectional vulnerability, as inclusive of both male and female child soldiers – particularly in regards to what could be perceived as a dual role in being victims of displacement (as described by Denov and Marchand (2014)), as well as forced recruitment, but also in terms of other forms of vulnerability, such as those based on racial discrimination.

Research Setting

This study was done at the Universidad de Caldas’ Centro de Estudios sobre Conflicto, Violencia y Convivencia Social (CEDAT) in Manizales, Colombia. Located in the coffee region and known as “the City of Open Doors,” Manizales is the largest city in- and the capital of- the Department of Caldas with a population of 388,525 (Infi-Manizales, 2015). Compared to other regions of Colombia where the conflict has been more pronounced, the coffee region is generally associated with an image of “peace and prosperity”, though this perception has often denied recognition of its role in the conflict and in the displacement crisis (Palacio Valencia & Cifuentes Patiño, 2005; Rettberg, 2010). In the early 2000s, armed activity in the coffee region, as well as drug trafficking, increased from relative lows in the 1990s, which Rettberg (2010) argues was related to a decline in international coffee prices, followed by increased poverty in the region and the National Coffee Federation’s inability to compensate for State shortcomings in the provision of social services and economic stability.

Manizales is not known for being a city with a strong history of social movements or social inclusion and this, combined with the desire to cling to the fantasy of “peace and prosperity,” has resulted in stigma and exclusion for those who arrive in the area seeking refuge from the conflict, and in-turn, low visibility and a lack of social services. Those who arrive in the city are seen as “others” or “outsiders” and are often perceived as having easier access to limited institutional services due to their status as displaced
or victims. Thus, this population is often seen as being responsible for issues of unemployment, increased crime, and insecurity in the region (Palacio Valencia & Cifuentes Patiño, 2005).

![Map of Colombia by region with the department of Caldas highlighted](https://commons.wikimedia.org/wiki/File:Map_of_Colombia_by_region_with_the_department_of_Caldas_highlighted.jpg)

**Figure 1.1: Map of Colombia by region with the department of Caldas highlighted**

CEDAT was created in 2001 as a research center at the Universidad de Caldas in Manizales. The focus of CEDAT is on understanding issues of violence, conflict, and coexistence through a combination of research and social programs. CEDAT’s work is focused on victims, with programs specifically targeting people forcibly displaced by the armed conflict, child and young adult combatants, and the families of victims or survivors of extrajudicial killings and state crimes. CEDAT aims to utilize their work as a way to generate a current understanding of the issues at hand and to use that knowledge to make proposals for action. Their work in recent years has emphasized the current social and political dynamics in the country and the role of victims in the peace-building process (Dr. Maria Rocío Cifuentes Patiño, personal communication, January 13, 2015).
Between 2006 and 2013, CEDAT was responsible for management of the Hogar Tutor program in Manizales. Hogar Tutor is a project that was initially overseen by the European Union and ICBF, and then transferred entirely to ICBF. Hogar Tutor is responsible for providing reintegration and rehabilitation services to demobilized child soldiers from any armed group and any region of Colombia. Their responsibilities include identifying and training potential families to act as guardians for the children, working with the families and the children to help integrate them into their home lives and civil society, working for the restoration of the rights of the children, and – when possible – helping them to locate and contact their families of origin. While CEDAT no longer manages the Hogar Tutor program, they do maintain contact and do some work with the program (Dr. Maria Rocío Cifuentes Patiño, personal communication, March 25, 2015).
Despite rhetorical affirmations “guaranteeing” the right to health for all Colombians, as well as preference for the most vulnerable, it was evident throughout the research process that in reality, these guarantees do not go far. When I first arrived in Manizales, I did not intend to focus my research specifically on access to healthcare; my interest in the topic was spurred by an initial review of the surveys later utilized in this research. I was aware of difficulties in access to healthcare among the general population, and even more so with the displaced, and thus found it unusual that such a significant number of survey participants reported not having problems with affiliation or access. I began to wonder if there was truly such ease in access, if there were simply few attempts at access, or if differing opinions regarding what constitutes a problem were to blame.

The body of research on the topic of access to health services (excluding mental health) among former child soldiers in Colombia is virtually non-existent. Naeve (2012, p. 35) very briefly touches upon the topic among ACR participants, indicating that 68% of interviewees report participating in ACR-provided health care and there is reasonable belief that the rest “simply have not sought health care while participating with the ACR.” I have been unable to locate any other sources that discuss the topic more in-depth.

Throughout my time in Manizales, as I discussed the issue of healthcare with local people, I was given the impression that opinions of the system were so negative that my interest in the topic as it pertains to this group was comical – the system is bad for everyone so why would or should it be any better for them? It was a question I could never answer, with healthcare being a guaranteed but unachieved constitutional right for all. Feelings toward child soldiers complicated the topic, as they tend to elicit a mixed reaction: sentimental feelings towards children often clashing with negative feelings towards ex-combatants.

However, these begrudging feelings are not exclusive to former child soldiers, with victims as a whole being seen as “outsiders” with easier access to services (Palacio Valencia & Cifuentes Patiño, 2005). Memorably, one evening when I began to discuss the topic with a friend, he talked about how he
had overheard a displaced person who had been in Manizales for years trying to use their victims’ status as a way to get an appointment. He viewed it as them trying to work the system and exploiting their status as victims. The conversation brought to light a general lack of knowledge regarding the rights of victims and an overall misunderstanding of their experiences. The issue of access to health services among the displaced has been further explored in the literature and thus it will be used to supplement discussion of this research, acknowledging both the similarities and differences between the two groups.

Over and over, I would discuss my research with friends I made in the city, many of whom were students at the university, only to find that they themselves were not affiliated to an EPS (an insurer within the public health system) because there was “no point” or to hear stories of waiting months or years for treatment. However, rather than deter me from the subject, it justified it on the grounds that if educated individuals with stability and social support cannot navigate the system, or are simply denied timely and quality treatment, the situation can only be more difficult for those who lack the same support and resources. Furthermore, it can be inferred that the health effects of the conflict predispose many, or even most, former combatants to needing a higher degree of medical attention than the average citizen.

It was with this mindset that I began to explore the topic of access, both in youth reintegration programs and following independence. As expected, the challenges experienced by participants are - in large part - larger systemic issues that can only be touched upon within the scope of this research, and are not specific to this group. What is specific to this population are some of the unique challenges they face and how those challenges often clash with policy, as well as the effect that these issues may be having on their ability to effectively reintegrate. With recent developments in the Colombian peace process and impending mass demobilization, it is important to acknowledge and understand the intricacies and interrelatedness of these experiences.

**SUMMARY**

This research explores the interactions between individual experiences and health and reintegration policy among former child soldiers in Manizales, Colombia. Through the utilization of a
qualitative approach and a critical medical anthropology framework, this study contributes to the current anthropological literature on childhood and child soldiers. By focusing on the health of this population and the identification of shortcomings in health policy and reintegration, this research also contributes to the public health literature on child soldiers and reintegration.

This chapter provides a brief introduction to this research. Chapter 2 will provide more in-depth background and a review of the literature. In Chapter 3 I will describe the research design and methodology, as well as discuss my positionality as a researcher and some of the ethical concerns in doing this research. Chapter 4 will present the results of this research. Chapter 5 will analyze and discuss the results. Finally, Chapter 6 will present the final conclusions of this study and present recommendations for future research and improved health education within reintegration programs.
CHAPTER 2: BACKGROUND

INTRODUCTION

While the scope of this research does not allow for in-depth analysis of the larger structures and processes that have ultimately shaped the experiences of former child soldiers in Colombia, these processes are inseparable from this research and must be acknowledged to allow for a holistic perspective. Thus, in this chapter, I aim to contextualize this research by providing background on relevant subjects through a review of the literature. First, I provide background on the Colombian conflict and the global issue of child soldiers. Next, I provide an overview of child soldiers in the Colombian context, the health of child soldiers, and girl soldiers (for the purpose of this thesis ‘girls’ is used to refer to females under the age of 18, while ‘young women’ refers to those over the age of 18 or those who have left youth reintegration). This is followed by an overview of reintegration and relevant policy in Colombia, transitional justice and victims’ rights, and healthcare in Colombia.

CHILD SOLDIERS

In March of 2000 the United Nations (UN) General Assembly adopted the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (OPACCRC), which specifies that any person under the age of 18 is a child and may not be recruited into armed forces. This increased the minimum age at which persons may be recruited and participate in hostilities from 15 years, as originally determined by the Rome Statue of the International Criminal Court (ICC), which was adopted in 1998 (Vautravers, 2009).

Despite broad international acceptance of the requirements set forth in the OPACCRC, there are an estimated 250,000 to 300,000 child soldiers globally (Milne, 2015). Child soldiers participate not only
on the front lines, but also as spies, messengers, cooks, suicide bombers, porters, and mine detectors, or to provide sexual services. Children at the greatest risk of recruitment are generally those who live in combat zones and those experiencing population movements; the recruitment of children from refugee camps is a serious and persistent issue. Children who have been separated from their families are also especially at risk, as are those who lack educational opportunities (Commission of the European Communities, 2008).

While it is not a new phenomenon, the issue of child soldiers has only truly begun to receive attention and enter the political agenda in recent years. Largely spurred by a rush of popular media focused on the subject, including blockbuster films, documentaries, and campaigns like “Kony 2012,” the increasing attention to the subject is largely based on the contemporary, Western understanding of children as innocent or defenseless, and fails to address the multiplicity of childhood, or to acknowledge the well-established participation of children in conflict throughout history (O'Driscoll, Loots, & Derluyn, 2013; Rosen, 2007). Furthermore, despite broad acceptance of the aforementioned international laws on paper, by both governments and armed groups, reality shows that in many instances age limits are not adhered to, with parental consent being sufficient for enlistment under the age of 18 in many countries, including the United States (O'Driscoll, Loots, & Derluyn, 2013).

Rosen (2007) discusses international humanitarian and human rights initiatives to end the use of child soldiers, which have resulted in efforts to establish a universal definition of “childhood” or the “Straight 18” position. Rosen (2007) argues this is an example of how political goals or agendas can be furthered by representing them as new cultural norms, without taking into account the social and cultural challenges in restructuring age categories. The argument builds upon previous anthropological literature that contributes to the understanding of the multiplicity of childhood and its determining factors such as age, history, and location. Ethnographic data is presented to discredit the portrayal of children as irrational and apolitical decision makers and calls for a more nuanced understanding using ethnographic approaches to determine more effective and culturally-specific solutions.
THE COLOMBIAN CONFLICT

For over 50 years Colombia has been engaged in a civil war that has become the Western Hemisphere’s longest running armed conflict (Correa, 2015). The conflict began in the mid-1960s when left-wing guerrilla groups (the Revolutionary Armed Forces of Colombia [FARC] and the National Liberation Army [ELN]) gained financial power through illegal activities such as kidnapping and narco trafficking and began attacking both the Colombian government and civilians. The effects of the war have been drastic with more than 6 million people being displaced and over 300,000 murdered or disappeared (Correa, 2015). The populations most affected by the conflict have been the most vulnerable and include Afro-Colombians, indigenous, and peasant populations (Summers, 2012). Areas affected by the conflict are lacking in public services, including access to health and education, in addition to facing widespread loss of livelihoods (Berents, 2014).

It is important to note that the present conflict began only shortly after the conclusion of a period known as La Violencia (1940s-1960s) - a civil war centered on issues of inequality and land conflict between large landholders and peasants – and is just one in a series of violent periods spanning most of the country’s history (O'Driscoll, Loots, & Derluyn, 2013). Similar to La Violencia, inequality has been a key issue in the current war, with land reform being one of the main demands of the left-wing rebel groups, particularly the FARC, which was born of the remnants of guerrilla groups from La Violencia (United Nations Development Programme [UNDP], 2003). However, the political beliefs of the groups have grown less influential throughout the course of the conflict, as they began competing for control of the country’s drug-producing and resource-rich regions, where State presence is weak (Grajales, 2011; Summers, 2012).

Complexity is added to the conflict by the involvement of right-wing paramilitary groups, such as the United Self-Defense Forces of Colombia (AUC) (now demobilized), who joined the fighting in the early 1980s with funding from drug cartels and landowners (Grajales, 2011). Control of legal business has also become a motivator in the conflict, with corporations relying on paramilitary assistance to further
their financial interests (Gill, 2007; Summers, 2012). There is some debate as to whether or not paramilitaries in their original form still exist, however, it is well established that a significant percentage of demobilized paramilitary members have formed criminal gangs that are similar to paramilitaries – particularly in relation to their participation in narco trafficking (O’Driscoll, Loots, & Derluyn, 2013). The involvement of the State as a perpetrator of extensive human rights violations must also be acknowledged in order to illustrate the complexity of the conflict and the extent of the violence, while avoiding a narrow perspective that limits the perceived roles of the actors involved to that of either perpetrator or victim.

CHILD SOLDIERS IN COLOMBIA

In 2004, Colombia was ranked fourth in the world for the highest use of child soldiers behind Myanmar, Liberia, and the Democratic Republic of the Congo (Watchlist, 2004). Child soldiers have been utilized by all of the armed groups involved in the internal conflict in Colombia and it is estimated that over the course of the conflict, tens of thousands of children have been recruited to the country’s various armed groups (Denov & Marchand, 2014; Naeve, 2012). Estimates from recent years suggested 5,000 to 14,000 (with some suggesting up to 18,000) children in armed groups at the time, and that as much as 30% of armed groups and 60% of urban militias are children (Berents, 2014; Denov & Marchand, 2014; Watchlist, 2012). For example, in Bogota, 51% of demobilized combatants are under the age of 25 (Rethmann, 2010). Data suggests that child soldiers come from throughout the country. Specifically, youth in government reintegration programs have come from 27 of the country’s 32 provinces, indicating how widespread the problem is. However, this same data suggests 95% of those who enter government youth reintegration programs come from rural backgrounds – a fact that is not unrelated to the lack of public services and economic opportunities in these areas (Lugo, 2014; Rethmann, 2010; Berents, 2014).

Child soldiers are underrepresented in government reintegration programs, with data showing low rates of participation among demobilizing youth. Between 1999 and 2006, only 20% of youth leaving armed groups participated in the program; research from 2008 shows 32% (O’Driscoll, Loots, & Derluyn, 2013). Reasons for low participation include large numbers of youth demobilizing informally, either
because of perceived danger in declaring themselves, distrust of the government or the system, or fear of discrimination. Other reasons include rerecruitment to other armed groups or reorganization as criminal gangs. Finally, many of the minors may have been murdered, as evidenced by mass graves (O’Driscoll, Loots, & Derluyn, 2013).

The involvement of children in Colombia’s armed groups is not a sudden or unforeseeable event, “…but rather the result of processes which lack a clearly identifiable onset” (Muñoz D., 2014, p. 122). While forced recruitment is certainly an issue, the armed groups themselves are not always directly involved. As Naeve (2012) explains, the Colombian conflict is unique in that, rather than being kidnapped, 84% of child soldiers have joined voluntarily. Common explanations for joining armed groups include threats to them or their families; revenge against another armed group; familial problems; a lack of opportunities. Established preconditions for participation in an armed group include living in areas where they coexist with armed actors, living in low socio-economic and/or female-headed households, and exploitation of child labor (Muñoz D., 2014).

Cifuentes Patiño (2015) concludes that the search for power and recognition combined with “conditions of existence,” such as poverty and social exclusion, has led to the recruitment of children and adolescents. Chamorro (2012) and O’Driscoll, Loots, and Derluyn (2013) also emphasize the search for power as a motive for participation in an armed group, specifically in reference to female child soldiers who seek a reprieve from assigned gender roles and the everyday violence of a patriarchal society. This is a commonality in many areas, as revolutionary groups are often based on Marxist-Leninist ideologies that encourage greater equality for women, which is attractive to female combatants (Nilsson, 2005).

Unlike most conflicts in which demobilization occurs post-conflict, the Colombian demobilization process thus far has occurred during the ongoing conflict. Denov and Marchand (2014) discuss the implications this has had for former child soldiers who have been going through the Demobilization, Disarmament, and Reintegration (DDR) process – most notably their displacement during the process. The ongoing violence and the threat of re-recruitment make it unsafe for demobilized
youth to return to their communities, so they are relocated to other parts of the country. Using qualitative interview data, Denov and Marchand found that the implications of forced migration were a key theme among research participants. They suggest that while there has been extensive research on forced migration, there is a gap in the literature on the forced displacement of child soldiers.

**GIRL SOLDIERS**

An estimated 40% of child soldiers worldwide are girls, some of whom join voluntarily in an attempt to avoid gender-based violence, such as early marriage or exploitation, while others are recruited similarly to boys (Commission of the European Communities, 2008; Nilsson, 2005; Pillai, 2008). Narratives presented by Muñoz (2014) support the notion that girls in the Colombian context often find greater equality within the armed groups, in terms of roles and responsibilities, though this does not hold in the narratives of girls from paramilitary groups, where typical sexual divisions are reproduced. In any context, this perceived equality does not account for the additional sexual responsibilities expected by many girls within armed groups and unsurprisingly experiencing sexual violence during childhood is a significant risk factor for participation in an armed group (Muñoz D., 2014)

Girl soldiers are often less visible than boys, being hidden by armed groups and classified as ‘wives’ rather than combatants. They are also often reluctant to come forward on their own, knowing that they will face extreme discrimination (Commission of the European Communities, 2008; Nilsson, 2005; Save the Children, 2005). Thus, despite evidence showing that they are a fundamental part of the “war machine,” the roles played by girls are often seen as insignificant and less of a security threat, leading to a degree of invisibility that has led to the exclusion of girls from both local and international efforts to demobilize and reintegrate child soldiers (Denov, 2008; Nilsson, 2005).

Focusing on the African context, Tonheim (2010) identifies gaps in the literature pertaining to female child soldiers. Among these is the way in which females are presented, using concepts such as ‘bush wives,’ ‘sex slaves,’ or ‘forcibly involved girls;’ terms with an underlying implication that
participation was involuntary, despite research showing that some girls do voluntarily join armed groups. Other gaps Tonheim (2010) discusses include the lack of inclusion for females in reintegration programs and research on the topic, as well as research on the wellbeing of the ‘at-risk’ children of child soldiers and their mothers.

Tonheim (2010) identifies a need for research that seeks to understand how families and communities receive former girl soldiers, who are perceived as having strayed from their gender roles through violence (as opposed to males who may be viewed as having strengthened their gender roles), contributing to the likelihood of experiencing rejection and stigma in reintegration. Denov (2010) echoes these concerns in her research done with child soldiers in Sierra Leone, where girl soldiers are ostracized not only for their affiliation with rebels, but also as victims of sexual violence, which affects their ability to marry, and thus their options for securing economic security and protection. Similarly, Chamorro (2012) analyzes the experience of female child soldiers in the context of Colombia’s patriarchal society, suggesting that participation in armed groups provides a space for girls to abandon their gender roles and acquire new forms of power. However, through their participation, young girls are often prostituted, at which point their body ceases to be their own and becomes a weapon of war; rape being used as a tool “of war against the bodies of women and girls” (Berents, 2014, p. 364; Chamorro, 2012). Thus, within the armed groups girls remain subject to the patriarchy and may need to masculinize themselves in order to survive and to rise in the ranks of a hierarchy designed for men. Following their demobilization, girls become subject to scrutiny and judgment from society as they are expected to assume their assigned gender roles of “good mother” or “good woman” (Chamorro, 2012, p. 128).

HEALTH ISSUES FOR CHILD SOLDIERS

Excluding research focused specifically on mental health, research on the health of child soldiers is limited. Denov (2010) touches on the physical health of children involved in the armed conflict in Sierra Leone, noting that the majority of participants reported being injured, with many being left disabled or experiencing ongoing pain from injuries, or gynecological problems as the result of sexual
violence. In 2006, the Colombian Ministry of Social Protection published a report on the effects of violence on children in Colombia, a chapter of which is dedicated to the health impact of adolescent participation in the armed groups. It reports that 29% of participants were diagnosed as “healthy,” while 71% had health problems. The most commonly reported health problems were gunshot wounds, fungal infections, headaches, scabies, influenza, and lower back pain (Strauch, 2006). After removing health problems common among adolescents and those with no apparent relation to age or participation in an armed group, 55.4% were found to have health problems related to their participation in the violence, indicating a fairly high impact on health (Strauch, 2006).

Similarly, Verhoef (2008, p. 30) reports that upon arrival to the Colombian Institute for Family Welfare (ICBF) programs, former child soldiers are often in “critical physical condition,” having experienced malnutrition and a lack of hygiene that exposes them to a variety of diseases, with measles, diarrheal diseases, and skin disorders being common. High rates of sexually transmitted diseases, sexual abuse, forced contraceptive use, and forced abortions among youth in armed groups are also reported (Verhoef, 2008). O’Driscoll, Loots, and Derluyn (2013) note that injuries from anti-personnel mines, gunshot wounds, and back problems are common, leaving the youth with physical burdens and bodies marked for life.

Narratives constructed with or by former child soldiers, such as those published by Lugo (2014) provide some insight on health conditions experienced by this group, as well as on their experiences of health care during reintegration. Some of Lugo’s participants discuss illnesses such as “el pito” or Chagas, from which many youth ex-combatants have scars, while others describe experiencing snakebites that were cured by “healers.” Lugo’s (2014) narratives also include the story of a girl who was captured and taken to the hospital to be fed intravenously following her refusal to eat, illustrating her fear and confusion during her time at the hospital and her unfamiliarity with this type of medical attention.

Verhoef (2008) and others report high rates of addiction, as well as tobacco, alcohol, and marijuana use among child combatants. In 2002, Colombia’s Defensoria del Pueblo and the United

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Nations Children’s Emergency Fund (UNICEF) published the results of a descriptive study conducted with 86 demobilized youth in the care of the ICBF. The study found that on average, participants began using psychoactive substances at 13 years old. Alcohol and cigarettes were consumed at higher rates during the time associated with an armed group, while the consumption of other substances, such as cocaine, was lower at that time. Cigarettes and alcohol were the two most commonly used substances at 73.26% and 43.02%, respectively. While cigarette consumption most commonly began in the armed groups (58.7% of users) - as opposed to in the barrio, at home, or in reintegration - alcohol consumption most commonly began at home (54.07% of users) at an average age of 12.3 years (Defensoría del Pueblo & UNICEF, 2002).

While many are injured upon arrival to ICBF programs, immediate medical attention is credited with preventing more permanent handicaps, and most appear to be in “good physical condition” upon turning eighteen. However, Verhoef (2008, p. 32) explains that it is unclear whether this is due to good medical care in ICBF programs or the result of ex-combatants being “ashamed” to admit that they continue to suffer from disease or injury. The only group that reported regular hospital visits was pregnant women, who commonly experience pregnancy related health problems.

A characterization of children and adolescents demobilized from armed groups in Colombia found that when asked about access to sexual and reproductive care within ICBF programs, 68.4% of women and 48.3% of men report having received at least one medical consultation relating to the avoidance of unplanned pregnancies; 81.3% of women reported having at least one Pap smear; 64.2% of men reported a medical visit in which their genitals were examined (Defensoría del Pueblo & UNICEF, 2006).

REINTEGRATION OF CHILD SOLDIERS

Drumbl (2012) gives an overview of the reintegration phase of DDR, describing it as the “trickiest step;” centered upon reuniting the demobilized children with their families, which Denov and
Marchand (2014) explain is often not possible in the Colombian context of ongoing conflict. Drumbl goes onto explain that the goal of reintegration is to reinsert the demobilized “into civilian life with sustainable employment” (2012, p. 167). Achieving successful reintegration is difficult in any situation, but particularly during conflict where the process is less structured and predictable, with many children being informally discharged and not participating in formal DDR programs. Drumbl (2012) also critiques the reintegration process for its failure to encourage ownership in the process by individuals and communities, and for not building local capacity.

Lugo (2014) argues that former child soldiers cannot be reintegrated into civilian society because they were not integrated before entering armed groups and continue to be marginalized following their demobilization. Thus, she suggests that “transition to civilian life” is a more appropriate description and uses narratives from youth in government reintegration programs in Manizales, Colombia to better understand this “transition,” reconstruct experiences of before, during, and after the war, and to understand importance of social relations during the transition to civilian life (Lugo, 2014, p. 18). The Canadian International Development Agency (CIDA)(2005) states that at minimum, reintegration assistance for child soldiers must aim to improve health status and economic well-being, while providing opportunities for recreation and personal development. In the report, CIDA also explains that reintegration is a process that requires time, with participants being monitored for years so that interventions can be implemented for problems that may emerge related to health or social relations.

One of the critiques Drumbl (2012) gives of the reintegration component of the DDR process and its effectiveness is the low participation rate among females and a lack of attention to their needs. Pillai (2008) argues that DDR programs lack sufficient research regarding the experiences of children who have participated in these processes. Specifically, she draws attention to the lack of evidence regarding female participation in these programs and their status afterwards, citing statistics that show female participation in DDR programs worldwide to be as low as 2%, despite the fact that as many as 40% of child soldiers are girls. Pillai explains that many girls are left out of formal DDR programs because involvement identifies them as combatants, which has negative repercussions for their reintegration to society. A
Watchlist (2012) report showed that in Colombia, between 1999 and 2011, of the 4,811 children assisted by the government reintegration programs, only 28% were female.

Nilsson (2005) calls reintegration a “theoryless field” and draws attention to the lack of research pertaining to the reintegration process and what makes it successful, explaining that reintegration is based on statements and assumptions from experiences of attempted reintegration, rather than scientific evidence. He argues that reintegration should be defined as “a social process aiming at the economic, political, and social assimilation of ex-combatants and their families into civil society” and identifies three central themes around which the process revolves: finding substitutes for the benefits of war, healing the wounds of war, and dealing with the contextual factors that make reintegration a challenge (Nilsson, 2005, pp. 92-93). In discussing the reintegration of demobilized combatants in Colombia, Theidon (2007; 2009) argues that DDR should be a part of the transitional justice process and that the separation of DDR from transitional justice contributes to the reintegration phase continually being the weakest link in the DDR process.

**Colombian Reintegration Policy**

In 2002, Ley 782 recognized demobilized child soldiers in Colombia as victims of political violence, which in turn gave way to the creation of a program to attend to the needs and vulnerabilities of this population, focusing on their well-being and quality of life, while providing them the necessary opportunities for growth and development (Caicedo, 2012). Article 8 of Ley 782 states that the ICBF would design and implement the protection program for minors who have taken part in the hostilities or been victims of political violence (in the context of the internal armed conflict), with priority assistance being given to those without family or whose family is unable to care for them (Caicedo, 2012). ICBF utilizes subcontractors (NGOs and other organizations, such as educational institutions) to handle parts of the reintegration program. Some of these organizations are financed directly by ICBF while others receive funding from various sources, while still under the direction of ICBF (O'Driscoll, Loots, & Derluyn, 2013).
The ICBF program, which was started in 1999, has limited capacity for family-based or foster care, with 60% of children going into institutional programs (O’Driscoll, Loots, & Derluyn, 2013; Watchlist, 2012). For those who enter institutional reintegration, there are two main types of care: Hogar Transitorio (Transitory Home) and Centro de Atención Especializada (specialized care center) (CAE) (Caicedo, 2012). An individual generally remains in the transitory home for around 45 days depending on their needs, during which they are provided with 24-hour care and evaluated on social, emotional, health, and educational aspects. They are then referred to a CAE where they generally remain for eight months to a year while receiving more personalized attention and preparation for reintegration. Finally, they may enter a third phase of institutional reintegration – a Casa Juvenil or youth home – where they are expected to begin utilizing the skills they have learned, enabling them to cope with reentering civil society while exercising their rights and autonomy as independent adults (Caicedo, 2012).

Those who do not enter institutional care may enter the Hogar Tutor (foster home) program, where they are placed with foster families while receiving support from a psychosocial team. Those who enter the Hogar Tutor program are typically between 12 and 17 years old and time spent in the program varies. The final form of reintegration is Hogar Gestor, in which the youth are returned to the care of their immediate family, where they will receive both financial and psychosocial support (Caicedo, 2012).

Through these ICBF efforts the Colombian government aims to provide a comprehensive DDR program for former child soldiers. However, despite an average demobilization age of 17.5, under the current mandate participants in reintegration programs are only considered to be child soldiers until the age of 18 (Naeve, 2012). Once participants are older than 18, they are labeled ex-combatants and their reintegration becomes the responsibility of the Colombian Agency for Reintegration (ACR), leaving them without the protection and support provided by the ICBF programs (Naeve 2012; Thomas 2008). O’Driscoll, Loots, and Derulyn (2013) call for greater clarity regarding what happens after the age of 18, arguing that it is impossible to put a time limit on the process and that there are fundamental differences between older adults and 18-year-olds that are not recongized in the adult reintegration process.
Caicedo (2012) identifies other policy gaps in the reintegration process, specifically pertaining to the homogenization of approaches to reintegration and limitations in the care of those with special needs, including cognitive disabilities. Similarly, Weierstall et al. (2013), argues for the consideration of individual variation in motivation for violent behavior and demobilization, as well as the impact of traumatic stressors, in the approach of DDR programs and how they handle the reintegration process and therapeutic interventions. O’Driscoll, Loots, and Derulyn (2013) are especially critical of institutionalization and call for greater family integration or foster care.

Rethmann (2010) analyzes the ways in which the Colombian reintegration process, through the “problematization of children and youth in armed conflict” and the portrayal of child soldiers as innocent and apolitical victims, serves as a tool for the government to delegitimize the guerrilla groups, while “economizing” the youth whose reintegration focuses on entering the workforce. Rethmann (2010) argues that the focus on victimization and the use of a reductionist perspective that accepts paternalistic, Western ideals of childhood, serves to re-marginalize the ex-combatants while simultaneously maintaining the “status-quo” and government control by pathologizing violence in the body of the individual rather than in socio-historical processes and structural issues, which then legitimizes state intervention.

TRANSITIONAL JUSTICE AND VICTIMS’ RIGHTS

Often misinterpreted as a diluted form of criminal justice, transitional justice seeks to reestablish the necessary conditions for a functioning social contract, while making sure that the rights of victims’ are taken seriously in attempts at repairing trust between the state and its citizens (Seils, 2015). In 2011, Colombia passed the Ley de Víctimas or Victims’ Law (Law 1448), which provides victims with rights to reparation, truth, and justice, as well as the establishment of accountability for perpetrators. Both ambitious and unique, the law reinterpreted transitional justice as a process that can occur during a period of conflict, rather than following the end of a conflict, as has been the norm (Correa, 2015; Summers, 2012). The law provides all victims of the conflict - anyone who has suffered human rights violations due to the conflict since 1985 - with “rights to damages, restitution of prior living conditions, a range of social
services, and special protection in legal proceedings” (Summers, 2012, p. 225). In its ambition, the Victims’ Law combines - and blurs the lines between - reparations, humanitarian assistance, and social policy, through the creation of multiple programs and the notion of ‘comprehensive reparations’ (Correa, 2015).

In a report from the International Center for Transitional Justice, Correa (2015) outlines some of the challenges and shortcomings in the implementation of the Victims’ Law, arguing that the ambitiousness of the law, combined with lack of recognition of the State’s shortcomings, creates risk of the law becoming no more than rhetorical affirmations. One of the challenges identified is the exclusion of members of illegal armed groups in the registering of victims. While members of these groups may be eligible for victims’ benefits in some instances, such as if they were captured and tortured by the state, allowing those who committed serious crimes to receive benefits is a complex issue, especially during ongoing conflict. The Constitutional Court has argued that the law does not presently deny victim status to these individuals, only specific benefits which have been established by law for certain victims “who were not members of illegal armed groups” – this in turn creates almost insurmountable obstacles for these individuals in attempting to be recognized as victims and eligible for benefits as such (Correa, 2015, p. 4).

Victims of certain kinds are eligible for ‘administrative compensation’ in the form of a one-time payment. Included in this are victims of illegal recruitment, who receive an amount of approximately USD $6,218, which if they are under age, is placed in a trust fund until they reach the age of 18 (Correa, 2015, p. 12). The Victims’ Law also guarantees health care and education for all child victims, as well as ‘rehabilitation’ (legal, medical, psychological and social services) to all victims. Correa (2015) explains that this is focused on only short-term rehabilitation and lacks sufficient funding to ensure that local services can provide the necessary levels of care and support. Shortcomings in the provision of health and education, combined with socio-economic challenges, can result in victims using their compensation to pay for access to these basic services, limiting their ability to use the funds in other ways that would benefit their long-term quality of life (Correa, 2015).
HEALTHCARE IN COLOMBIA

In 1993, as a response to challenges in quality and equity in the provision of health services, the Colombian government reformed the state-dominated health care sector, replacing it with a regulated competition approach. This approach to healthcare is unique in the Latin American region and is based on increasing the participation of private insurers, which they hoped would lower cost while improving quality, with state involvement ensuring equity (Gaviria, Medina, & Mejía, 2006; Trujillo, Portillo, & Vernon, 2005; Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012). Colombia’s state health insurance program has three tiers:

a. **Contributory regime** – financed by mandatory payroll tax

b. **Subsidized regime** – targets low-income/disadvantaged groups; financed by general tax

c. **Basic medical services for the uninsured** – publicly financed

In addition to the public health system, for those who want and can afford it, there is a private, premium-based insurance market (Gaviria, Medina, & Mejía, 2006; Trujillo, Portillo, & Vernon, 2005; Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012).

The main device for determining which regime an individual is eligible for in the subsidized program is a proxy means test, *Sistema de Selección de Beneficiarios para Programas Sociales* (SISBEN). SISBEN is a crude welfare index that ranks families according to “a set of household characteristics, human capital endowment, and reported income level” (Trujillo, Portillo, & Vernon, 2005). Using the survey results, families are ranked into six levels, with only levels 1 and 2 being eligible for the subsidized regime\(^1\). As there is no guarantee that municipalities will be provided sufficient funding for all eligible individuals, priority is given to rural and indigenous populations, pregnant women,

\(^1\) In theory, anyone earning above a specific threshold is required to be affiliated with the contributory regime, however there are loopholes and it is common for individuals to get around the regulations – particularly if they are self-employed. These loopholes result in low-income families being excluded while high-income families receive the subsidy. As a deterrent to this, there are “costs” to the subsidized regime, such as wait times, and the coverage is less comprehensive than contributory coverage (Trujillo, Portillo, & Vernon, 2005).
children under 5, female-headed households, senior citizens, and handicapped individuals (Trujillo, Portillo, & Vernon, 2005).

Switching from a model based on subsidizing supply, to one subsidizing demand, the 1993 health reform began the practice of providing subsidies to individuals for healthcare provided by private insurers, which are known as EPSs or Empresas Promotoras de Salud (Gaviria, Medina, & Mejía, 2006; Pacheco, 2009). The EPSs are responsible for arranging the provision of health services through various public and private health care providers (Montenegro & Bernal, 2013). The health reform was based on Structured Pluralism and the concept of health as a commodity influenced by market forces, rather than health as a right. Thus, the country’s insurance system is run in large part by private companies who manage both the government provided subsidies for the subsidized regime and the premiums paid by employees in the contributive regime. This contradicts the Colombian constitution and a Constitutional Court decision of 2008 (T-760), which declare health a basic right rather than a service. Neoliberal ideology and the context of war create complexity in efforts to guarantee the right to health (Pacheco, 2009).

While coverage in Colombia has improved vastly since the 1993 health reform and subsequent legislation, inequities have persisted alongside questions of sustainability and issues of responsiveness (Montenegro & Bernal, 2013; Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012; Webster, 2012; Zambrano, 2008). Limited private sector expansion outside of large urban areas has allowed for persistent challenges in access to health services, with a large percentage of rural enrollees in the subsidized regime having only one provider available in their area. The country’s millions of internally displaced persons also pose a challenge in the provision of care, with an estimated 30% lacking access to government provided services in 2012 (Webster, 2012). This is attributed in large part to “red tape” and the requirement for the displaced to show their documents in order to access care, delays in transfer of affiliation, and the lack of a mechanism guaranteeing access anywhere in the country (Mogollón-Pérez & Vázquez, 2008; Webster, 2012).
Until 2011, financial supervision of health plans and providers was non-existent - a fact which a senator, Jorge Enrique Robledo, argued would lead to total financial collapse of the health system (Montenegro & Bernal, 2013; Webster, 2012). Webster (2012) argues that high rates of coverage and spending on health care are misleading, distracting from issues of high pharmaceutical costs and rampant insurance fraud. In recent years those insurers found to be ineffective have been absorbed by stronger EPSs and in 2011, Law 1438 was enacted in an attempt to address structural weaknesses within the system (Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012). Vargas-Zea et al. (2011) call for the incorporation of patient participation and "real-world" evidence and experience in efforts to improve Colombian health policy.

**SUMMARY**

The experiences of child soldiers are shaped by various historical, political, and socioeconomic structures and processes. Anthropology – particularly critical medical anthropology - is well suited to exploring these issues as it allows for recognition of individual experiences and realities within the larger context of these processes. This chapter focused on providing an overview of the processes most relevant to this research, while serving to contextualize the results and discussion presented in chapters 4 and 5.
CHAPTER 3: METHODOLOGY

CHAPTER OVERVIEW

I will begin this Chapter by briefly discussing my positionality as a researcher and the ways in which my status as a Colombian-American influenced this research. Next, I provide an overview of the research design and the methodology employed in data collection and analysis. To conclude this chapter, I highlight some of the limitations and ethical concerns in doing this research.

POSITIONALITY

Awareness of one’s own positionality, or measures of privilege or disadvantage, is an important aspect of ethnographic research that allows for recognition of power and enables the ethnographer to situate his or herself “inside and outside their research site” (Schensul & LeCompte, 2010, pp. 30-31). As a Colombian-American I am, in a sense, both an insider and an outsider in Colombia. While I was born and raised in the United States, I have close familial and cultural ties to Colombia. My familial connections within the country played a large part in enabling me to locate an appropriate research site and secure an internship, and also provided me with a place to live throughout the duration of my research. My Colombian background ensured greater ease in speaking and understanding the language, as well as comfort and familiarity with mannerisms and customs. Learning that I was an American with a Colombian mother often seemed to put interview participants more at ease in communicating with me.

However, while my identification as “part Colombian” helped lessen the degree to which I was “othered” in some ways, it also served to reinforce power dynamics—particularly in terms of ethnicity, class, and education (Sultana, 2007). My whiteness prevents me from being able to blend in well in Colombia and reinforces power disparities, in a country where whites have the highest mean income and
people with darker skin are at a disadvantage (Bailey, Saperstein, & Penner, 2014). My duality as both Colombian and American also contributed to this, as while I can visit Colombia with ease at any time and return to the United States at will, the same cannot be said for participants – some of whom mentioned a desire to visit or live in the United States – for financial reasons, but also likely due to visa restrictions. Finally, my position as a highly educated researcher, particularly one educated abroad, may have served to further the power differential between participants and myself.

Cognizant of the differences in power between participants and myself, I attempted to frame this research in a way that allowed for participants to teach me rather than to be “studied” and to convey their knowledge and experience in relation to a subject, which I do not have any personal experience in. I aimed to make this research more about the health and reintegration systems and how they serve participants, rather than about the participants themselves as “subjects”, thus allowing for a more participatory approach to the research.

RESEARCH DESIGN

Attempting to understand how former child soldiers in Colombia experience and understand health and health care after leaving youth reintegration programs necessitates the examination of various micro- and macro-level factors and how they are interrelated. In order to help guide this research and shape analysis, a three-pronged approach is used that looks at the issue within the contexts of: (1) individual factors, (2) reintegration programs, and (3) policy and systemic issues. This research is an exploratory study, based on the following research questions and aims to identify relevant themes and issues and build a foundation for future research and intervention in the subject area:

1. What barriers to health care access are participants currently experiencing?
2. Do participants know their rights in relation to health care?
3. How do participants perceive the concept of health?
4. How do participants perceive and experience the health care system?
5. How was/is health care handled within the Hogar Tutor program and how has that shaped participants’ experiences since leaving government protection?

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<thead>
<tr>
<th>Research Question</th>
<th>Methods</th>
<th>Data Collected</th>
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<tr>
<td>1. What barriers to health care access are participants currently experiencing?</td>
<td>Participant observation; literature review; review of secondary (survey) data; informal and semi-structured key informant interviews; semi-structured interviews</td>
<td>• Individual and structural barriers participants are facing&lt;br&gt;• Barriers created by policy and systemic issues&lt;br&gt;• Background on health care system and health policy</td>
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<tr>
<td>2. Do participants know their rights in relation to health care?</td>
<td>Participant observation; informal key informant interviews; semi-structured interviews</td>
<td>• Participants’ knowledge and understanding of the health care system and their rights in relation to health&lt;br&gt;• Participants’ utilization of health services</td>
</tr>
<tr>
<td>3. How do participants perceive the concept of health?</td>
<td>Participant observation; informal key informant interviews; semi-structured interviews; body mapping</td>
<td>• Participants’ perceptions of what “health” is&lt;br&gt;• How participants classify “health problems”, “illness”, “injury”, etc.&lt;br&gt;• Participants’ health priorities&lt;br&gt;• When participants seek out health services</td>
</tr>
<tr>
<td>4. How do participants perceive and experience the health care system?</td>
<td>Participant observation; review of secondary (survey) data; informal and semi-structured key informant interviews; semi-structured interviews; body mapping</td>
<td>• Participants’ opinions of the health care system&lt;br&gt;• Participants’ perceptions of problems or barriers in health care access&lt;br&gt;• Observations and anecdotes of participants’ experiences with accessing health services&lt;br&gt;• Key informants’ perspectives and experiences related to how participants’ feel towards- and utilize, health care</td>
</tr>
<tr>
<td>5. How was/is health care handled within the Hogar Tutor program and how has that shaped participants’ experiences since leaving government protection?</td>
<td>Review of secondary (survey) data; informal and semi-structured key informant interviews; semi-structured interviews</td>
<td>• How participants’ opinions and utilization of health services have changed since leaving reintegration programs&lt;br&gt;• Key informants’ experiences working with youth in Hogar Tutor in relation to health and health care&lt;br&gt;• Key informants’ and participants’ accounts of how health education and the health care system/policies are taught in Hogar Tutor</td>
</tr>
</tbody>
</table>

Research was broken into two phases over the course of approximately 3.5 months from May to September 2015, during which I completed an internship at CEDAT under the supervision of Dr. María Rocío Cifuentes Patiño, director of CEDAT and social work professor at the Universidad de Caldas.
Table 3.2: Research Plan

<table>
<thead>
<tr>
<th>Phase/Length</th>
<th>Objective</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Phase 1/</td>
<td>• Learn from- and collaborate with CEDAT/key informants to identify research questions</td>
<td>• Participant observation</td>
</tr>
<tr>
<td><em>Approx. 1 month</em>)</td>
<td>• Identify preliminary themes to develop research focus and solidify design</td>
<td>• Informal key informant interviews</td>
</tr>
<tr>
<td></td>
<td>• Familiarization with: organizational structure of CEDAT; current Colombian policy related to reintegration of child soldiers and victims’ rights; Colombian health care system</td>
<td>• Literature review</td>
</tr>
<tr>
<td></td>
<td>• Begin data collection and identify preliminary themes</td>
<td>• Review of archival and secondary data</td>
</tr>
<tr>
<td></td>
<td>**Phase 2/</td>
<td></td>
</tr>
<tr>
<td><em>Approx. 2.5 months</em>)</td>
<td>• Data collection and preliminary analysis</td>
<td>• Participant observation</td>
</tr>
<tr>
<td></td>
<td>• Continue familiarization with policy based on issues emerging during data collection</td>
<td>• Informal and semi-structured key informant interviews</td>
</tr>
<tr>
<td></td>
<td>• Situate participant experiences within policy framework to find solutions and identify shortcomings</td>
<td>• Semi-structured interviews</td>
</tr>
<tr>
<td></td>
<td><strong>Methods</strong></td>
<td>• Body mapping</td>
</tr>
</tbody>
</table>

**METHODOLOGY**

**Participant Observation**

Participant observation, the “foundation of cultural anthropology”, allows for the researcher to learn through exposure to and involvement in the research setting, while building relationships and gaining an intuitive and intellectual understanding of organization, relationships, and social and physical boundaries (Bernard, 2011; Schensul, Schensul, & LeCompte, 2013). The process of participant observation involves immersion, followed by the researcher removing oneself from the immersion each day to intellectualize their observations (Bernard, 2011). Participant observation began upon my arrival in Colombia during May 2015 and lasted throughout the duration of my stay, which ended in September 2015. My experiences as a participant observer were vast and varied, serving a variety of purposes.

As an intern at CEDAT, I was immersed in the daily life of the center. During the beginning of my internship I alternated between an office shared with Dr. Cifuentes and CEDAT (both are on the same
Universidad de Caldas campus, but are located on different floors), however, I quickly began to spend the majority of my time in CEDAT, as it allowed for greater immersion in the research site and an opportunity to build rapport with the students and employees. I was also able to familiarize myself with their various projects and the victims’ populations with whom they are working.

I spent a large amount of time in CEDAT on a daily basis, often while doing archival research and reviewing secondary data, which allowed for constant participant observation. My presence also made me available to join others in visiting their research sites, to observe various activities done as part of their respective projects, or simply for a cup of coffee. While the events I participated in were not always related to my own research, they were invaluable in building rapport and in familiarizing myself with CEDAT’s work, other victim populations in Manizales, and with the city itself. Early participant observation during Phase 1 was integral to the design of the research. Notably, observing a corporality exercise conducted by a social work student with a group of ex-combatants is what inspired the body mapping method I utilized in my research.

**Data Collection**

Observations were recorded mainly in the form of field notes. Depending on the situation, notes were written immediately in a notebook or on an iPhone or they were typed following my return to the university or home at the end of the day. In one instance, while observing an ACR meeting on health care, I audio recorded the meeting so that I could later reference it to ensure accuracy in my analysis of the information presented.

In order to clearly and concisely describe the types of data collected as a participant observer, I have broken data collected via observation into three categories outlined in Table 3.3: (1) organizational structure, (2) building rapport, (3) realities of policy.
Table 3.3: Participant Observation

<table>
<thead>
<tr>
<th>Category</th>
<th>Types of observation</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational</strong></td>
<td>• Day-to-day observations and immersion in site (internship)</td>
<td>• Understand the structure of the site (CEDAT) in order to better understand how the it has shaped the reintegration experiences of participants</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>• Attended meetings with CEDAT’s “grupo de investigación”</td>
<td>• Understand the roles of individuals within CEDAT</td>
</tr>
<tr>
<td></td>
<td>• Accompanied students to observe their fieldwork (in the community and at the University)</td>
<td>• Understand the role of CEDAT within the community</td>
</tr>
<tr>
<td><strong>Building Rapport</strong></td>
<td>• Day-to-day immersion</td>
<td>• Build rapport with participants and key-informants</td>
</tr>
<tr>
<td></td>
<td>• Informal outings in small to large groups: lunch, coffee, movies, flying kites, etc.</td>
<td>• Get to know participants more informally and “off the record”</td>
</tr>
<tr>
<td></td>
<td>• Get to know participants more informally and “off the record”</td>
<td>• Allow participants the opportunity to get to know me as more than a researcher and ask me questions</td>
</tr>
<tr>
<td></td>
<td>• Understand the relationship between CEDAT and participants on a more informal level to better grasp the role played in their lives and its value as a resource for participants</td>
<td></td>
</tr>
<tr>
<td><strong>Realities of Policy</strong></td>
<td>• ACR/health system meeting for ex-combatants</td>
<td>• Understand how policy plays out in reality</td>
</tr>
<tr>
<td></td>
<td>• Lunch in the home of a Hogar Tutor foster mother</td>
<td>• Get a glimpse of what reintegration programs are like before (Hogar Tutor) and after (ACR) age 18</td>
</tr>
<tr>
<td></td>
<td>• Extensive observation (and some participation) of CEDAT’s attempt to assist a participant in seeking attention for an ongoing medical condition</td>
<td>• Observe real interactions between participants and the health care system, rather than relying solely on second hand information and the perceptions of participants</td>
</tr>
</tbody>
</table>

**Data Analysis**

Field notes were compiled and coded to identify emergent themes. Field notes were used to supplement data collected via interviews and body mapping, providing a more complete picture of the setting and participants’ experiences. Field notes were especially useful in identifying contradictions or bias in participant’s responses (i.e. saying or believing that they do not have “problems” accessing health services, while field notes provide an account of my observations of problems experienced.)
**Key Informant Interviews**

Key informant interviews were a combination of informal and semi-structured interviews conducted with 14 individuals, some of whom I interviewed multiple times. During Phase 1 the majority of key informant interviews were informal and used to gain insight on informants’ experience, which helped to identify issues and guide the research. As the research progressed into Phase 2, key informant interviews became more tailored to topics that arose during observations and interviews. Interview guides were developed prior to semi-structured interviews but were specific to the interviewee and the topic being addressed in the specific interview. Key informants included a madre tutora, an employee of the public health system in Manizales, and two individuals who were working with the current Hogar Tutor program in Manizales. In addition, I interviewed one social work student from CEDAT who had been working with former child soldiers and nine professors and researchers from the University of Caldas including psychologists, social workers, a lawyer, and two individuals working in public health. The professors and researchers interviewed worked with the Hogar Tutor when it was managed by CEDAT and the majority has continued to work with former child soldiers.

**Data Collection**

During informal interviews notes were occasionally handwritten during the interview, but most often were typed up following its completion. A few informal interviews (generally those where a large amount of policy-related information was being conveyed) were audio recorded with permission from the interviewee, in addition to written notes being taken during the interview. Semi-structured interviews were audio recorded in addition to handwritten notes being taken during the interview.

**Data Analysis**

Notes from informal key-informant interviews were coded and used to support other data. Semi-structured key-informant interviews were transcribed and coded and translated to English.
Archival and Literature Review

Primarily during Phase 1 of the research, I conducted an extensive review of the literature and of archival data provided by CEDAT. My position as an intern at CEDAT allowed me to utilize their guidance in accessing literature that was not previously available to me, as much of the relevant literature on child soldiers in Colombia has been published internally. I was also able to review archival and secondary data sources including Hogar Tutor files (youth and “madre tutora” files, and various files on health and related subjects) from when the program was managed by CEDAT and life histories collected by CEDAT with former child soldiers. I was also able to utilize survey data collected in 2014, which is important to this research and is explained in further detail below.

The review of archival and secondary sources was particularly important in that it provides a foundation for the research and background knowledge on the subject, particularly in terms of the histories of former child soldiers. This allowed me to focus my interviews on their current experiences which serves the dual purpose of avoiding sensitive subject matter and repetition, as well as to allow for research that focuses on current issues this population is experiencing, while still accounting for their histories.

Surveys

CEDAT provided me with survey data collected during Fall 2014. Surveys were done with 28 former child soldiers who have aged out of youth reintegration programs, not restricted by current place of residence. Surveys cover a range of topics including extensive demographic questions and a portion on health and health care. Survey data were entered into Microsoft Excel and basic descriptive statistics were conducted.

Survey data was used to compliment the data collected and illustrate various issues and concepts on a larger scale than the interview data. Responses from the health portion of the survey were used to frame the research questions, particularly the question, “Have you had difficulty connecting to or using health services?”
Interviews

Participants

A total of nine former child soldiers (four female, five male) participated in this research. Participants were required to be over the age of 18 and to be former child soldiers who are graduates of the Hogar Tutor program in Manizales. Recruitment was guided by CEDAT, with all participants having maintained a relationship with CEDAT since leaving the program. All participants were currently residing in the Manizales area at the time of the study. Participants were not chosen based on factors such as race, ethnicity, the armed group with which they were involved, economic status, employment, or education level. One individual scheduled an interview through CEDAT but did not show up. No reason was given and the interview was not rescheduled.

Interview Guide

The interview guide was developed based on my initial observations and findings (from extensive literature review, archival research, and key informant interviews) during Phase 1. I created the initial interview guide, which was then approved and translated by Dr. Cifuentes, with some minor changes made to the wording based on her expertise. Dr. Cifuentes and I went over the final interview guide together prior to beginning the interview process to ensure that the questions were clear and the translations accurate.

Interviews began with close-ended demographic questions regarding age, marital status, children, employment, and current living arrangement. The remainder of the interview was comprised of more open-ended, semi-structured questions so that while each participant was asked the same question (with an additional question on reproductive health only asked of females), follow-up questions were tailored to the individual. Four participants were asked additional questions (specified in interview guide Appendix A), which were added based on questions that emerged during the research process. Questions relate to
how participants interact with and experience health and the health care system. Some questions were
straightforward, addressing how often or if they have accessed health services while others were
intentionally more vague and open-ended, asking participants to describe their feelings or experiences.

Towards the end of the interview, a list of questions based on scenarios was asked based on the
focused ethnographic study method (FES) (Bernard, 2011). The scenarios prompt participants to explain
what they would do in a theoretical situation (“You have had flu-like symptoms for two days”). Due to
the short period of the research (approximately three and a half months), the FES-based scenarios
provided a form of rapid assessment that explores how participants may respond to health-related events
within the time constraints of the research.

Collection

Interviews were conducted during Phase 2 of the study. Oral consent was granted prior to each
interview. Permission to record interviews was requested and granted for all but one of the nine
interviews. The one unrecorded interviewee granted permission for handwritten note taking. Interviews
lasted anywhere from twenty minutes to an hour depending on the willingness of the participant to
elaborate and share their stories.

Dr. Cifuentes or another CEDAT researcher accompanied me for all or part of many interviews,
though some were done unaccompanied. It was discussed and determined prior to the interview if I
should be accompanied. The presence of individuals from CEDAT during interviews seemed to provide a
degree of comfort and familiarity, which in turn created more openness in the interviews than I may have
achieved independently with those participants. While those accompanying me did not speak fluent
English, they were able to help clarify question or responses in certain instances. Unaccompanied
interviews were done mainly towards the end of my internship when I was more comfortable with the
interview process, familiar with participants, and there was less of a language barrier. The quality of
responses and the perceived comfort of participants did not seem to be affected in the interviews
conducted independently. This is likely due to my having interacted with these participants prior to the time of the interviews, as well as the personalities and experiences of the individuals themselves.

Analysis

Audio recordings from interviews were transcribed, coded, and translated. Codes reflect themes that emerged during the interview process and are used to address the study’s research questions. A codebook was created in Microsoft Excel for demographic data from close-ended interviews.

Body Mapping

Guillemin (2004, p. 287) argues for the use of visual methods (specifically drawing) as a way to gain further insight into how “participants interpret and understand their world.” In response to critiques of the use of visual methodologies in research on illness, Guillemin (2004) argues for their validity based on using not only analysis of drawings, but also the participant’s own interpretation of the drawing. It is suggested that the usefulness of visual methodologies is limited when used independently but that they can be valuable when used in conjunction with other methods, as they allow participants an alternative method for expressing their understanding of the subject.

This body mapping method was first inspired by a corporeality exercise I observed, which was conducted by a social work student at CEDAT with a group of ex-combatants. Participants were asked to trace an outline of each other’s bodies on a large sheet of paper and then each person was asked to draw things such as “hope” or “suffering” on their respective outlines. After observing the exercise I began researching the use of visual methods and body mapping in health research.

This body mapping activity is based loosely on Tarr and Thomas’ (2011) Mapping Embodiment: Methodologies Representing Pain and Injury. Using analysis of a body mapping project done to understand the socio-cultural contexts of dance injuries and gain insight into how dancers distinguish between pain and injury, Tarr and Thomas (2011) suggest that body mapping can be a useful tool for promoting awareness of “embodied experiences” including pain, which may escape conscious perception.
Tarr and Thomas’ study views pain as a “bio-psycho-social phenomenon” rather than simply an emotion and used body mapping as a way to encourage participants to think further about pain and injury. The research used three-dimensional body scans and had participants map things such as pain, injury, strength, weakness, and former injury using varying colors on their respective bodies (or a generic blank body when done offsite). In comparing the body mapping results to questionnaires, there were much higher rates of pain or injury reported during body mapping. For example, of the 46 participants who reported only having one injury during the questionnaire, 32 mapped more than one site on their body map.

In adapting Tarr and Thomas’ (2011) method to suit this research, I created generic female (Figure 3.1) and male (Figure 3.2) templates and altered the categories accordingly (pain, illness, injury, former injury, other health problems). The body mapping activity was designed to supplement the semi-structured interviews and was used as a way to promote further discussion regarding health related issues and how they are understood and experienced.

Figure 3.1: Female Body Mapping Template
Figure 3.2: Male Body Mapping Template

Collection

Body mapping was done at the end of the semi-structured interview with all nine participants. Prior to beginning this research, I completed my own body map, which was used as an example to aid participants in understanding the body map. This also served the purpose of allowing participants to ask questions about my body map, thus making them more comfortable about sharing their own sites of pain or illness. Participants were provided a variety of colored pens and markers and were instructed to select a different color for each category and draw or mark each on the body. Participants who were hesitant were given more guidance while others completed the exercise more independently and based on their own interpretation. In some cases participants were prompted with questions (i.e. “Have you ever broken a bone?”) to encourage further thought and reflection. Regarding the category for “other health problems” participants were encouraged to include things such as smoking or wearing glasses. Audio was recorded during the body mapping so as to capture any discussion. Participants were asked to explain what they drew, with the depth of their explanations being determined by their own eagerness and comfort levels.
Analysis

As body maps were mainly used as a way to elicit further discussion, relevant audio from body mapping was transcribed, coded, and used to supplement interview data. The body maps were scanned and are used as a visual supplement to the data.

LIMITATIONS

This research was limited by its short length, which made it difficult for me to spend a greater length of time as a participant observer, observing interactions between participants and the health care system. The short length of the research required me to rely on the existing relationships between individuals from CEDAT and participants, though their relationships and roles as gatekeepers did enable me to get further in building trust and relationships with participants than would have been otherwise possible. Research done with those from CEDAT as key informers served as a way to fill in the gaps created by the briefness of my stay – substituting their experience for my own. However, the inherent bias created by informants’ personal and political histories serves as an additional limitation.

IRB APPROVAL AND ETHICAL CONSIDERATIONS

This study was approved by the University of South Florida’s Institutional Review Board (see Appendix B) and the risks associated with participation in the study were minimal. The nature and purpose of the study was explained to participants and the voluntary nature of the study was emphasized both during recruitment and before beginning the interview. Written consent was waived to ensure confidentiality for participants. Oral consent was granted by participants following the review of an IRB-approved document that included contact information for the principal investigator and USF IRB.
Beneficence (Do No Harm)

This research was low-risk and took all possible measures to avoid doing harm to participants. The voluntary nature of the study was emphasized and it was explained to participants that they were able to withdraw from the study at any time or choose to not answer certain questions or discuss certain topics. CEDAT recognizes that while many of the former child soldiers they have worked with are very willing to participate, they tend to “come and go,” sometimes preferring to avoid anything that reminds them of their experiences (Dr. Maria Rocío Cifuentes Patiño, personal communication, March 23, 2015). Interviews were semi-structured to allow for flexibility and sensitive topics about their past were avoided (i.e. which armed group they were in or whether they have regained contact with their family of origin) unless the information was offered by the participant. Measures were taken to avoid encouraging participation that is not truly voluntary (i.e. no compensation) (Whiteford & Trotter, 2008).

Justice

Individuals who met the criteria for participation (over the age of 18, have aged out of government protection programs for former child soldiers, and have an established relationship with CEDAT) were given equal opportunity to participate. An effort was made to have participants as close to 50% male and 50% female as possible but were not otherwise chosen based on factors such as race/ethnicity or social/economic status. Participants were not given any sort of compensation aside from refreshments during the interview, as deemed appropriate by CEDAT, to ensure that participation was truly voluntary and not based on the prospect of financial compensation, so as to not unequally target those with lesser financial security (Whiteford & Trotter, 2008).

Autonomy

Prior to beginning any research, the process and focus of the study was clearly explained to participants. The voluntary nature of the study was emphasized, as was the fact that they could decide to discontinue participation in the study at any time with no negative consequences or repercussions. It was
also emphasized that participants could chose to not answer particular questions or participate in certain aspects of the study. In addition to the measures taken by CEDAT to protect their research participants, all participants gave oral informed consent after speaking individually with myself and select CEDAT researchers (Whiteford & Trotter, 2008).

Confidentiality

Interviews were conducted with only myself and, in some cases, CEDAT researchers present to help maintain confidentiality. No names or identifying characteristics were recorded. CEDAT handled the scheduling of all interviews. Each participant was assigned a pseudonym so that they cannot be identified. Prior to the beginning of the interview, participants were asked if they agree to have their interviews audio recorded. If participants did not grant permission for audio recording, data collection was limited to handwritten notes. After the interview, all audio recordings and notes were password-protected and deleted from the audio recording device (Whiteford & Trotter, 2008).

SUMMARY

This study utilized a qualitative approach centered on semi-structured interviews with nine former child soldiers, over the age of 18, who were previously in the Hogar Tutor program in Manizales, Colombia. Interviews were supplemented with body maps done with the nine interview participants, as well as by key informant interviews, participant observation, and a review of secondary and archival sources, including a survey conducted by CEDAT with former child soldiers. These methods combined allowed for investigation into the experiences of former child soldiers, as they relate to health and health care, during and after youth reintegration. The results of this research are presented in the next chapter and discussed in Chapter 5.
CHAPTER 4: RESULTS

INTRODUCTION

The following chapter will present the results of this research, beginning with participant characteristics including demographics, as well as data on recruitment, demobilization, and mobility. Survey data were collected during Fall 2014 by CEDAT and provided for secondary data analysis. Survey data is used to provide a larger context for the themes presented in the interviews and as a comparison population. Demographic information of interview and survey participants are compared in Table 4.1, showing consistency between the two and suggesting that the small sample of interview participants may be representative of the larger population of former child soldiers who have aged out of youth reintegration programs.

Next, I present a case study on Simon, whose story is used to personify the themes to follow, as his experience embodies these in a tangible manner. Following the case study, I present results related to health in Hogar Tutor, as experiences within the program play an important part in shaping participants’ introductions to the health care system and how health and health care are experienced following their transition to independence. Results discussing the transition to independence and the emergent themes of responsibility and self-efficacy, followed by results illustrating pain, illness, and injury, including individual body maps will also be presented. Finally, I present themes related to health care access after leaving Hogar Tutor including frequency, quality, affiliation, and time. In closing this chapter, I present results related to alternate routes of attention and reliance on self-care. Results are presented largely in the form of illustrative quotes in order to retain the voice of participants.
SAMPLE CHARACTERISTICS

Of the nine interview participants, four (44.4%) were female and five (55.6%) were male. Ages range from 20 to 25 years with the average age being 22.5 years. Eight participants (88.9%) were single and one (11.1%) was in a free union. Six (66.7%) were employed, two (22.2%) were unemployed, and one (11.1%) was a student. Five participants (55.6%) had children. Self-reported years in Hogar Tutor range from one to nine with an average of 4.7 years.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Marital Status</th>
<th>Self-Reported Years in Hogar Tutor</th>
<th>Employment Status</th>
<th>Children (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erika (1)</td>
<td>F</td>
<td>21</td>
<td>Single</td>
<td>4</td>
<td>Unemployed</td>
<td>Y</td>
</tr>
<tr>
<td>Simon (2)</td>
<td>M</td>
<td>22</td>
<td>Single</td>
<td>1</td>
<td>Employed</td>
<td>Y</td>
</tr>
<tr>
<td>Esperanza (3)</td>
<td>F</td>
<td>24</td>
<td>Single</td>
<td>6</td>
<td>Employed</td>
<td>Y</td>
</tr>
<tr>
<td>Mateo (4)</td>
<td>M</td>
<td>24</td>
<td>Single</td>
<td>9</td>
<td>Unemployed</td>
<td>N</td>
</tr>
<tr>
<td>Sofia (5)</td>
<td>F</td>
<td>25</td>
<td>Single</td>
<td>2</td>
<td>Employed</td>
<td>Y</td>
</tr>
<tr>
<td>Marisol (6)</td>
<td>F</td>
<td>23</td>
<td>Single</td>
<td>9</td>
<td>Employed</td>
<td>N</td>
</tr>
<tr>
<td>Fabian (7)</td>
<td>M</td>
<td>20</td>
<td>Single</td>
<td>4</td>
<td>Employed</td>
<td>N</td>
</tr>
<tr>
<td>Gabriel (8)</td>
<td>M</td>
<td>24</td>
<td>Free union</td>
<td>4.5</td>
<td>Employed</td>
<td>Y</td>
</tr>
<tr>
<td>Juan (9)</td>
<td>M</td>
<td>20</td>
<td>Single</td>
<td>2.5</td>
<td>Student (High school)</td>
<td>N</td>
</tr>
</tbody>
</table>

Secondary data analysis was conducted on survey data collected by CEDAT from 28 former child combatants, 27 of those participants had previously been in the Hogar Tutor program in Manizales, and one had been in a Centro de Atención Especializado (CAE) in Manizales (most participants had been in other types of youth reintegration programs in addition to Hogar Tutor). Survey participants were 60.7% (17) female and 39.3% (11) male. 67.9% (19) were single, 28.6% (8) were in a free union, and 3.6% (1) were separated. The average age of survey participants was 22.5 years, with ages ranging from 19 to 26. Participants reported an average of 3.6 years in Hogar Tutor with a range of 0.17 to 8 years. 67.9% (19) of participants were employed and 32.1% (9) were unemployed. 46.4% of participants had at least one child. Unlike interview participants, not all survey participants were residing in Manizales at the time of the survey. Of the 28 survey participants, 16 (57.1%) were residing within the department of Caldas, with
11 of those (39.3% of all participants) residing specifically in Manizales. The remaining 42.9% (12) were residing in other departments of Colombia.

**Table 4.2: Survey and Interview Demographic Comparison**

<table>
<thead>
<tr>
<th></th>
<th>Survey (28)</th>
<th>Interviews (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>60.7%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Male</td>
<td>39.3%</td>
<td>55.6%</td>
</tr>
<tr>
<td><strong>Age (in years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>22.5</td>
<td>22.5</td>
</tr>
<tr>
<td>Range</td>
<td>19 – 26</td>
<td>20 – 25</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>67.9%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Free Union</td>
<td>28.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Separated</td>
<td>3.6%</td>
<td>--</td>
</tr>
</tbody>
</table>
| **Self-Reported Years in Hogar Tutor**
|                      |             |                |
| Average              | 3.6         | 4.7            |
| Range                | 0.17 – 8    | 1 – 9          |
| **Employment Status**|            |                |
| Employed             | 67.9%       | 66.7%          |
| Unemployed           | 32.1%       | 22.2%          |
| Student              | --          | 11.1%          |
| **Children**         |             |                |
| Yes                  | 46.4%       | 55.6%          |
| No                   | 53.6%       | 44.4%          |

*Only 27 of 28 survey participants responded*

Comparison of survey and interview demographics (Table 4.2) shows much similarity between the two groups, which can likely be attributed in-part to participant overlap. Average age between the two groups was very similar, as was employment status. The few notable differences between survey and interview participants include gender distribution, with survey participants being 60.7% female, compared to 44.4% among interview participants. This suggests overrepresentation by females among survey participants. Interview participants were also more likely to be single than survey participants (88.9% compared to 67.9%) and had a slightly higher average number of self-reported years in Hogar Tutor.

**Recruitment and Demobilization**

Of the 28 survey participants, 57.1% (16) were in the FARC, 32.1% (9) were in the ELN, and 10.7% (3) were in the AUC. Survey participants were in their respective armed group for an average of 3.39 years, ranging from 16 days to 14 years. The average age at mobilization was 11.29 years with ages
ranging from 2 to 14 years. The average age of demobilization among survey participants was 14.59 years, ranging from 12 to 18 years. The majority of survey participants (24) reported that recruitment was voluntary (85.7%), while one participant (3.6%) reported forced recruitment; one “by deceit;” one unknown; one did not respond. Regarding demobilization, 33.3% (9) of participants demobilized voluntarily/escaped; 33.3% (9) were captured; 33.3% (9) surrendered or were in a group that demobilized (this includes the three participants who were in the AUC); one participant did not respond.

Table 4.3: Survey Results - Recruitment and Demobilization

<table>
<thead>
<tr>
<th>Survey</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Armed group</strong></td>
<td></td>
</tr>
<tr>
<td>FARC</td>
<td>57.1%</td>
</tr>
<tr>
<td>ELN</td>
<td>32.1%</td>
</tr>
<tr>
<td>AUC</td>
<td>10.7%</td>
</tr>
<tr>
<td><strong>Time in armed group</strong></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>3.39 years</td>
</tr>
<tr>
<td>Range</td>
<td>16 days – 14 years</td>
</tr>
<tr>
<td><strong>Age at recruitment</strong></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>11.29 years</td>
</tr>
<tr>
<td>Range</td>
<td>2 – 14 years</td>
</tr>
<tr>
<td><strong>Recruitment</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td>85.7%</td>
</tr>
<tr>
<td>Forced</td>
<td>3.6%</td>
</tr>
<tr>
<td>“By deceit”</td>
<td>3.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3.6%</td>
</tr>
<tr>
<td>No response</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Age at demobilization</strong></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>14.59 years</td>
</tr>
<tr>
<td>Range</td>
<td>12 – 18 years</td>
</tr>
<tr>
<td><strong>Demobilization</strong></td>
<td></td>
</tr>
<tr>
<td>Escape/voluntary</td>
<td>33.3%</td>
</tr>
<tr>
<td>Captured</td>
<td>33.3%</td>
</tr>
<tr>
<td>Surrendered</td>
<td>33.3%</td>
</tr>
<tr>
<td>No response</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Mobility

Survey participants originated from 12 of Colombia’s 32 departments, with Antioquia being the most common (6), followed by Caquetá (4) and Tolima (4). Only two survey participants were originally from Caldas. 50% were originally from rural areas and 50% originated in urban areas. Survey participants reported relocating (changing cities) an average of 1.9 times since leaving Hogar Tutor. 28.6% (8) of
participants had not left Manizales, 53.6% (15) had relocated between one and three times, and 17.9% (5) had relocated four or more times, with one participant having relocated eight times at the time of the survey. Of the 28 participants, ten (35.7%) were living in their department of origin, with three of the ten living in their city of origin (10.7% of total).

Frequent relocation, as demonstrated by the high mobility of survey participants, was also an issue among interview participants. Juan said during the interview that he had had changed cities often since leaving Hogar Tutor. Simon told me on multiple occasions that he had to leave the city where his son lived because “they wanted to kill [him].” Since the culmination of my time in Manizales, Simon has informed me that he relocated once again but that he was not happy; that he has “enemies everywhere.”

CASE STUDY: SIMON

Simon is a 22-year-old Afro-Colombian male. He is tall and walks with a slight limp; talks with a slight stutter. Between his height and his skin color, he stands out anywhere he goes in Manizales. Anytime I accompanied him outside of the university, I was acutely aware of the stares, the suspicious glances, and the sudden need to search our bags in places where it had never been requested of me alone – or with anyone else. In reality, I found Simon to be friendly. He often seems younger than his 22 years, enjoys singing and dancing, and is always eager for company. He is single, lives alone, and has a young son who he rarely sees because he lives in another city. Simon reported having been in Hogar Tutor for only one year, and prior to that was in a “CAE” or centro de atención especializado for young ex-combatants. Unlike the foster home model of Hogar Tutor, CAEs are an institutional setting which house multiple youth.

Of the participants involved in this research, Simon is the one whom I was able to spend the most time getting to know. He was working nights at the time and did not sleep much, so he would spend many of his days at CEDAT, passing time on the computer or chatting with whoever was around. Simon’s interview barely scratched the surface - his answers were generally vague and hard to understand - yet I
was able to get to know him relatively well in more informal settings, through time spent together at the university and outings with other ex-combatants or a university psychologist, who can likely be considered Simon’s closest friend. Despite the fact that I often struggled to understand him due to his thick accent and tendency to speak quickly, Simon was always eager to talk and patient with me and my need for him to constantly repeat himself. His willingness to share his thoughts and experiences provide a concrete example of many of the themes that emerged throughout this research. Since my departure from Colombia, I have remained in regular contact with Simon via online messaging and have been kept updated on his life and continued experiences as they relate to this research.

Simon told me over coffee one afternoon that he had stopped going to school in 7th grade and that he did not want to go back. His lack of education is often obvious, yet in the same breath he can show a level of self- and political awareness that is rare in any population, but particularly for a 22-year-old with limited education. Memorably, in one sitting he asked for an explanation of what the solar system is and then proceeded to comment on Colombian politics, drawing connections between his personal history and the actions of the former president, Álvaro Uribe, in a complex and decidedly insightful manner. Simon is also a poet. He writes about his past and about his dreams, though he says that it stresses him out to write so he does not like to do it often. He allowed me to read a collection of poems that he had compiled with the help of a student from the university, as well as some new poems. His writing is impressive and it seems hard to believe that the words on paper came from the same person who seems to stumble and stutter his way through the Spanish language, with an often-undecipherable accent.

Though I had already spent some time getting to know him prior to the interview, Simon’s was one of the first interviews conducted and was done with a psychologist from the university, who served mainly as a translator. During the recruitment process, individuals at CEDAT explained that Simon would make an ideal participant as he had a problem with one of his legs and was resistant to seeking medical attention. They hoped that participating would motivate him to see a doctor. From the beginning, in an effort to avoid sensitive topics, I refrained from asking Simon for much detail regarding the origin or nature of the condition of his leg and the information he volunteered on the subject was often vague.
and piecemeal. During the interview, when asked if he was experiencing any health problems he only said, “Yeah, well... I have a sick leg with varicose veins… it gets cramps.” I already knew bits and pieces of the story. His problems with his leg began before he entered reintegration. He was hospitalized at some point years before but felt he did not receive proper treatment for his condition and remembered his time there unfavorably, mentioning his dislike for the food in particular. Those who worked with him in Hogar Tutor told me that he was receiving treatment when he was in the program, but had not continued on his own.

In the interview, I asked Simon how often he went to the doctor and he replied, “When I feel more pain.” He said that the last time he had been to the doctor was the year before because “the doctors sent me for some tests for the surgery for my leg, so I stopped going because of that.” By the time I interviewed Simon, we had already talked about why he didn’t want to go to see a doctor about his leg. He tended to avoid the topic, but a few days prior to the interview, he told me that he had been to the doctor a year or two earlier and that they had suggested the possibility of amputation. He said that he was scared; he did not want to lose his leg, and that is why he did not want to go back. I asked if he had requested to see another doctor for a second opinion and he said he had not.

In the interview, I asked if he was experiencing any other health conditions, particularly any chronic issues, and he replied “Well no. The truth is... I do not know. I still do not know.” Later in the interview, when explaining what he would do in response to the listed scenarios, he described having digestive discomfort and stomach pain.

“Well, sometimes … it is too strong and the problem is that they say ‘no Simon, take something because, well, you cannot work like that’ and well, then I take something like, for example … an Alka-Seltzer. I take one and I go back... I can work normally again.”

“Sometimes it hits me like this [inaudible] and well, very strongly … I have to lay down in special positions.”

The psychologist sitting in on the interview asked him what he would do for stomach pain and at first he said “Go the to the EPS” but quickly admitted “...but no, not really… when I take something it goes
away again.” Over time it became clear that Simon’s stomach pain was a chronic issue that frequently caused him pain and discomfort.

Prior to that point in the interview, Simon had already told me that he had SISBEN (subsidized health care) and was affiliated with an EPS; yet he had not been to the doctor recently and went on to speak vaguely and often incoherently during the interview about difficulties with the EPS. He said that he would go to the doctor more often if it were easier to get an appointment, but described the long waiting period:

“You have to make an appointment in advance. The minimum is one month before so that they see you more or less the same month you go. Other times they say they do not have any spots so… sometimes you have to wait.”

He also described challenges in seeking attention from specialists:

“Yeah, sometimes I have encountered problems because you go … and well, you go to the doctor and the one you need is not there because they are not in the country because they are traveling. So you have to wait… you have pain until they come back again.”

A few weeks after the interview Simon told me that he had gone to the EPS to ask for an appointment. He was very fond of his job, despite the fact that it was a lot of work, and had been encouraged by his boss to see a doctor. After his first therapy appointment, he sent me a message saying that it hurt more after the appointment and that was why he did not like going. Following his next appointment, he seemed more optimistic but needed to see a specialist. He went to make an appointment with the EPS but was informed that his referral from the previous year was no longer valid. An employee of CEDAT spent the better part of a day calling the EPS, without any success in getting a response, but was eventually told that they could not make an appointment without first getting another referral.

Not long after, before being able to see another doctor to get a referral, Simon hit his leg and was unable to sleep that night because of the pain. He was frightened the next morning so he called CEDAT and was accompanied to the emergency room. After waiting more than half of the day he was seen, though the person who accompanied him told me that the wait would have been longer, except that they had a cousin working there. He was given medication and a referral to a vascular surgeon, labeled by the doctor as “urgent.”
Despite the fact that Simon could barely walk and is reliant on public transportation, they were informed that he would need to go to the EPS in person to “actualize” the referral. Someone from the university contacted an employee of the health system (one of the key informants in this research) who works with victims for guidance and was told that after he went to the EPS with his referral he would receive a response in four days and then would be able to make an appointment. Two weeks after they went to the EPS with the referral Simon still had not received a response. Eventually someone from CEDAT accompanied him to the EPS to ask about the referral. He was given a code, which he was instructed to use to make an appointment with the specialist. The next day a CEDAT employee called multiple times with no answer, trying to make the appointment. Finally, after being put on hold, someone answered and said that there were no vascular appointments available. She tried to explain the situation and that the referral was urgent but the call was ended abruptly.

I continued to speak with Simon regularly after leaving Colombia but it was not until two and a half months later that he told me he had an appointment for his surgery. He said that he was happy but a little scared. However, when I asked him about it at a later date he told me he did not know when it would be and has not volunteered much information on the matter since. It is unclear whether he decided against going; having lost the momentum gained from the pain he was experiencing at the end of my time in Colombia, or if he was still waiting on an appointment. Later I learned that Simon’s referral had expired and he had not yet restarted the process.

**HEALTH IN HOGAR TUTOR**

Near the beginning of my time in Manizales, I spoke informally about the health of young ex-combatants with some key informants who have been involved in working with participants since their time in Hogar Tutor until now, following their transition to independent life. Regarding physical health prior to- and as a result of their time in armed groups, informants discussed the issue of poor childhood nutrition and stunted growth, and listed some of the health conditions common among demobilizing
youth: digestive problems, tropical diseases (specifically Chagas disease or trypanosomiasis), various injuries, muscle pain, and back pain. One informant described youth combatants as having “strong, resilient bodies” from their time in the armed groups, but suggested that there are implications of discontinued activity following demobilization.

A key informant who was previously responsible for health care related issues for youth in Hogar Tutor described the resistance that many youth – particularly those of indigenous background - had to seeing the doctor upon their arrival to the program, and often throughout the reintegration process. She emphasized the irony of the idea that youth who had been in the war could be so afraid of doctors and voiced her concern that once out of the program, without assistance in making appointments and keeping track of them, they do not continue to go to the doctor because they do not want to. Interestingly, another informant explained that many of the female ex-combatants had expressed interest in becoming nurses, as they had learned basic healing practices and botanical knowledge, complimented with “magic and rituals” during their time in the armed groups.

One of the informants also discussed the issue of mental health among former child soldiers and the tendency to pathologize them; they explained that most have been diagnosed with some form of mental illness and that this is not without consequence as, among other things, it adds an additional “classification” (i.e. ex-combatant, campesino, indigenous, mentally ill) and another basis for stigma.

**Difficulties with the EPS and Affiliation in Hogar Tutor**

Correspondence between CEDAT and the Secretary of Health from 2013 describes challenges experienced in working with Caprecom - an EPS with whom many youth in Hogar Tutor were affiliated. CEDAT explained in the correspondence that obstacles to accessing services caused by Caprecom did not allow for youth to be guaranteed attention in a “timely and quality” manner. The correspondence describes delays in receiving authorizations for specialists and tests, followed by finding at the time of requesting appointments, that providers were no longer contractors of Caprecom. This resulted in expired
authorizations and having to restart the process. The official response to the correspondence explains that the delay in receiving authorizations was related to the EPS lacking sufficient human resource management to ensure “speed and timeliness” in the delivery of requested authorizations.

Madre tutora and youth files also present instances in which there were problems associated with accessing health services for youth in Hogar Tutor and other reintegration programs, based on issues related to the health care system or affiliation, examples of which are presented below in Table 4.4.

Table 4.4: Difficulties in Accessing Health Care (Hogar Tutor Files)

<table>
<thead>
<tr>
<th>MT-1</th>
<th>“This week he had pain in his testicles but did not go to the health center because of difficulty with the health card.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT-15</td>
<td>“For the youth the health system is very inefficient and sometimes poses little support from any technical staff with health emergencies.”</td>
</tr>
<tr>
<td>Y-2</td>
<td>“The youth has not yet had a medical or visual assessment due to difficulties in processing insurance papers. This must be resolved as soon as possible or the situation must be put into the hands of the ‘defensor de familia’ so that health coverage is assumed as a reestablished right for the youth.”</td>
</tr>
<tr>
<td>Y-3</td>
<td>“…The social worker tried to make a dental appointment … they called the health center and they said that there are no appointments for this year.”</td>
</tr>
<tr>
<td>Y-4</td>
<td>“…Continues to present a rash, without medical supervision due to lack of healthcare coverage.”</td>
</tr>
<tr>
<td>Y-5</td>
<td>“The youth has presented a toothache in recent weeks, however, it has not been possible to get a dental appointment by phone which is why a letter was requested … guaranteeing the right to health by the appropriate entity.”</td>
</tr>
</tbody>
</table>

Interviewees: On Health in Hogar Tutor

During interviews participants were asked about their feelings towards going to the doctor - if it is “usually a good experience” or if it makes them feel “nervous or uncomfortable.” Participants were also asked if their feelings towards seeing the doctor have changed since they were in Hogar Tutor. The majority of participants simply responded that they do not have a problem with going, that it is fine, and that their feelings towards going to the doctor have not changed; they never had a problem with it. However, this was not the case with all participants. Three individuals indicated that they initially did not
like going to the doctor as it caused shame or discomfort. Fabian described his first memory of going to the doctor, when he arrived at Hogar Tutor as being uncomfortable:

“The first time was an experience… well, I was very young. I was 13 and I do not remember going to the doctor before that. … I went to the doctor and they examined my whole body, asked me questions. I was very young. You arrive in a new city, to a new climate, different people, to different languages – well, not a different language but a different tone of voice- and well, you feel uncomfortable. … I was a child and I had to answer the questions they asked me because I was already there, I did not want to so it can be uncomfortable. But for the first time.”

Despite his initial discomfort and sudden introduction to seeing a doctor, Fabian explained that he relaxed and became accustomed to asking questions and telling or showing a doctor what hurt and where. Similar sentiments were echoed by two other participants – that if it were up to them they would not have gone or that it gave them “the most horrible shame,” but that they got used to it and now feel comfortable.

In addition to their feelings related to going to the doctor, four participants were asked about how they learned to use the health care system and if they feel they have a good understanding of how it works, with follow-up questions focusing on who taught them and if health education was formally provided in the Hogar Tutor program. The overall consensus among participants was that anything they have learned about the health care system was the result of them seeking out the information themselves or was taught to them by a madre tutora. Participants noted that the madre tutoras were not required to teach them about the health care system and instead did it of their own volition. For example, regarding knowledge of the healthcare system, Fabian feels that while he now has a clear understanding of how the system works, it is due to experience and his own efforts and interest in learning rather than being formally taught about the health care system or someone having explained it to him.

“Explained… no. Because when we arrived to the program what happened? … They take you to the doctor, take you to school, take tests … right? So you listen and they are saying things and you begin to realize what the system is like, how it operates, what is public health, private health. You begin to figure it out but they do not explain because you are very young and it does not interest you at that time…” -Fabian

However, Fabian did explain that his madre tutora helped him learn how to make appointments, encouraging him to be independent. He recalled his madre tutora giving him the number and telling him to call and make appointments himself and said that after the first two times he went to and requested
appointments on his own. Fabian felt that it helped him to have a madre tutora who taught him to be autonomous.

Gabriel described a similar experience as Fabian. When asked if someone taught him how the health system worked or how to request appointments, he explained, “directly from the program, no” but went on to describe the assistance he received from his madre tutora:

“…The madre tutora … accompanied you … but it was more that the madre tutoras - I think – that more than by mandate of the program they did it by their own initiative. For example, there were some madre tutoras that did not do it. Mine did it because it was always a good home. Because of that I never changed homes, I was always in the same one.”

Gabriel went on to explain that the social worker would take care of the process to get them affiliated with a health card and that was it. From that point forward the madre tutora or Gabriel would request appointments. Similarly, Marisol said that when she was in Hogar Tutor her madre tutora or the university typically made her appointments, but that sometimes she would do it herself. She said that her madre tutora told her that she needed to learn to make appointments and was also the person who explained to her what her rights were.

INDEPENDENCE

A portion of the interview was dedicated to discussing the transition from youth reintegration to independence, with participants being asked to describe the transition, as well as who helped them through the process and what the greatest challenges were. Most participants emphasized the difficulty of the transition from Hogar Tutor to independence, with only one participant stating that the transition had been easy. When asked who helped them with the transition only one participant stated that nobody helped them. Other responses mentioned include: CEDAT (4), the ACR (4), the familia tutora (1), and family of origin (1). Participants described the difficulty of the transition in different ways with common themes including the challenge of entering an environment they are unfamiliar with, as well as not having the necessary skills to enable a smooth transition to independence.

“I think one of the hardest things is regaining independence, because … it was like we were a species of mice in a laboratory. In what sense? In that logically, the program put us in a bubble
and then let us go. It is like if I have a hamster in its ball and then I let it go at the critical moment that it is going to have to face the predator and the daily reality of living.” –Gabriel

“It was hard at the beginning; it was really hard … I believe that all of us said, if they asked us ‘Do you want to come back?’ we would go back. Now I am happy but it was very hard.” – Esperanza

“You arrive at a center- for example, where I was I got very accustomed to being there and when it was time to exit [the program], once you are of age, they say ‘no, now you need to go’ and I did not want to leave… since you get very accustomed … you leave and miss those who are in [the program] very much … I always miss it…” - Simon

“[The transition] was very complicated because I did not know how to read or write but thank god [I] took advantage of everything and am very well… well, now.” - Marisol

Gabriel emphasized the challenge of transitioning to independence in an environment different than where they are from and the difficulty of learning to adapt to life in a city, noting how in the country things are more informal and “words have value” - a dichotomy that obliges them “…to be like chameleons, to camouflage ourselves among them to be able to rise in society.” Gabriel goes on to describe the challenge of transitioning to independence:

“The issue of transitioning to independence was not easy for me and for many peers it was not easy. … You leave with a very different reality than you had before. These little birds were wild birds that were in the country and flew from tree to tree. They were captured - let’s say in one way or another they entered an artificial life, which is the program. Later they leave that artificial life halfway… and it is not yours. So were are no longer able to fly tree to tree; now we fly from sidewalk to sidewalk, stoplight to stoplight; from block to block. You find a reality much different than the previous one.” –Gabriel

The age at which participants leave the program was a common theme discussed in the interviews and was identified as being part of what makes the transition challenging, with some participants explaining that at 18 they had not developed the necessary skills to be independent. However, while the official age of removal from the youth programs is 18, some participants indicated that they were in the program until as late as their early 20s. A key informant from CEDAT informed me that while the norm is 18, exceptions are sometimes made for those who are in school, have young children, or are mentally handicapped. They explained that when CEDAT was managing the Hogar Tutor program in Manizales,
they based it more upon the reestablishment of rights and whether or not they were prepared to assume independence, which accounts for the varying ages reported by participants.²

**Responsibility**

In discussing the transition from Hogar Tutor to independence, the concept of responsibility emerged as a common theme, though one that is understood in different ways. Some participants discussed the concept of responsibility in relation to their transition to independence, with most explaining that the need to be responsible for oneself made the transition difficult, though this was not the case for all participants. For example, Erika felt that the transition to independence was “easy” because she was “responsible” - a sentiment that she repeated throughout the interview. However, generally participants felt that the transition to independence was harder because of the need to act responsibly. As one participant stated:

“I lived with a family and then I went to live alone. So I had more independence, I was more autonomous. The most difficult…is the responsibility. I think that is the hardest and most important.” –Fabian

Responsibility was also a common theme in relation to accessing health services. Multiple participants discussed how their feelings towards- and actions in relation to going to the doctor have changed since they were in Hogar Tutor because of the need to be responsible. However, the feeling of needing to be responsible appears to be synonymous with the feeling of lacking a support system. In other words, they now go to the doctor because if they don’t take responsibility for themselves, nobody will. Mateo and Marisol explain that while they would have preferred to not go to the doctor while in Hogar Tutor, now that they are independent, they must be “responsible”:

“For whatever little thing they take you … if it was up to me, I would not go. … Now, yes. I have to be responsible.” –Mateo

² Based on an interview done with a current Madre Tutora, it seems that the program is now less flexible regarding the age of independence. When I spoke with her she was fostering an ex-combatant who was in his last year of high school but would be turning 18 in the middle of the school year. She said she had tried to get approval for him to stay in the program longer so that he could finish school but that the request had been denied.
“I remember that before I could not be bothered to go because ugh… In comparison now I am responsible, I have to be more concerned. [In Hogar Tutor] I did not feel like going but now I know that I have to be responsible because I am not going to have anyone…” – Marisol

Self-Efficacy and Rights: Gabriel and Fabian

Gabriel and Fabian were two participants who stood out from the rest, but shared many similarities with one another. Both individuals are light-skinned males who discussed having good madre tutoras during their time in the program. Both were employed at the time of the interview and had at least a high school education. The contrast between them and the other participants was most evident in discussing topics such as their understanding of their rights and the health care system. These two participants were perhaps the most aware and critical of the flaws in the system, while attributing their success largely to their personal desire to learn and help themselves, suggesting a ‘bootstrapping’ mentality among both individuals.

When I asked Gabriel if anyone had ever explained to him what his rights are in relation to health (e.g. the services he is guaranteed), he explained that they had not and emphasized the importance of knowing one’s rights and the difficulty of doing so – a significant theme throughout both his and Fabian’s interviews. For example, Gabriel stated:

“How does one learn? In the march – when you are denied service, when they tell you do this or do that, in daily practice. One learns because … for example, you’ll be thinking of doing a procedure when …[suddenly] they cut the procedure. Or when you realize that there is corruption in the EPS … because the EPS does not pay, because they are closing the EPS for corruption, they closed the EPS because it went bankrupt, different things … Really the health system is a bit uncertain. If one does not know the law then really they do not know the health system and really, in Colombia much of the population does not know their basic rights.”

Both Gabriel and Fabian, credited their success in independence to the things they have learned as the result of their own efforts to teach and help themselves, while emphasizing a personal interest in rights and education.

“I believe many of the young [ex-combatants] do not know what I know. Or I do not know what I am talking about because they are different experiences. I know that I am rich in knowledge because I talk a lot, because I inquire, because I like to make mistakes…. So that has helped me...
Gabriel explained that since he arrived in Manizales he has enjoyed learning and “experimenting,” so he has made an effort to make acquaintances and enter social circles, becoming involved with political issues and learning many things in the process, while developing “such skills as knowing how the health system works.” Gabriel once again related this to his immersion and interest in the topic of rights, noting the value of his education:

“...Since I left, or since I was in the armed group, I have always focused on the issue of rights. ... I studied judicial administration and that has helped me a lot to know and further explore the topic of rights ... and I love how that opens so many doors. ... In comparison many peers, when they were in the program, [they] dedicated themselves to partying or stayed home and watched television ... and when [they] left the program and] entered reality, unfortunately, they felt as if the current had taken them...”

Similarly, after being asked if he felt that he understood how the health system worked, prior to attending an informational ACR meeting on health, Fabian explained that he believed he did understand how it “works and operates,” as he enjoys the topics of “public, social, economic and political relations.” However he went on to explain that health in Colombia is “very difficult” and that the country lacks both “good education and good ethics.”

PAIN, ILLNESS, AND INJURY

During either the interview or body mapping activity, the majority of participants indicated experiencing pain, injury, or illness of some kind. However, during the interview, when initially asked if they were experiencing any health problems, many participants said no. Instead, many described their health conditions in relation to their experiences with the health care system, or seemed to suddenly “remember” them during the list of scenarios provided later in the interview or during the body mapping.

Only one interview participant, Juan, did not mention any type of pain, illness, or injury during the interview or the body mapping activity, though he did explain that he smokes cigarettes to relieve a lot because … reality is learning to get up, learning to correct those errors and, like all humans, have a life of mistakes, right? But, I think every day I am one of those who gets up and thinks and corrects them and tries to better myself.” –Fabian

“I learned more through the habit of watching other people … Detailing and analyzing what others say … and differentiating if it is good or bad or if I can do it…” –Gabriel
stress. Of the various conditions identified during interviews and body mapping combined, headaches were the most common and were reported by five participants. Headaches were also the most commonly mentioned health condition among survey participants with two participants stating that they were currently receiving treatment for headaches/migraines and four listing headaches as their most frequent motive for seeing a doctor.

Each interview participant’s descriptions of his or her respective health conditions are presented alongside their body map on the following pages. Participant’s categorization of each issue is identified by the corresponding color in the key, though not all were done correctly. Participants did not always include conditions they had discussed during the interview on the body map and vice versa.

Figure 4.1: Erika’s Body Map

Erika is a 21-year-old, single female with a young daughter who does not live with her. Erika reported spending four years in Hogar Tutor and at the time of the interview was unemployed and living with her boyfriend. On her body map (Figure 4.1), Erika indicated that she had an unidentified bump on
the inside of her lip. She reported that the bump had been there for around eight months but that she had not seen a doctor for it because she was not affiliated to an EPS. The bump caused her pain and discomfort and was a continually open sore that had trouble healing because it would reopen when she ate. She said that she could not eat “hard foods like chicharrón” because it would irritate it further. Erika did not report any other health conditions and said that she was healthy. She does not smoke, exercises, and stated, “I eat healthy – a lot of fruit”.

Figure 4.2: Simon’s Body Map

Simon is a 22-year-old, single male who reported one year in Hogar Tutor. Simon was employed at the time of the interview and has a son that lives in another city with his mother. As is described in Simon’s Case Study and indicated on his body map (Figure 4.2), he has an injured leg that requires surgery. Simon described it as, “I have a sick leg with varicose veins… it gets cramps.” He also had stomach pain and digestive discomfort for which he had not seen a doctor. Simon explained that the stomach pain sometimes hits him so strongly that he must “…lay down in special positions.” He
explained that at work he is encouraged to take something, like an Alka-Seltzer, as he cannot work with the pain.

Figure 4.3: Esperanza’s Body Map

Esperanza is a 22-year-old, single female with a young daughter. Esperanza reported spending six years in the Hogar Tutor program and now works as a nail technician. When I asked if she had any chronic health conditions, Esperanza replied, “I suffer of asthma and rhinitis” (Figure 4.3). She explained that she has had asthma for as long as she can remember and has always been treated for it – but had never had to go to the emergency room because of it until her arrival in Manizales. Esperanza said that she is from hot weather and that when she moved to Manizales it made her asthma worse. Her rhinitis also began when she arrived in Manizales and due to challenges in getting an appointment with an ENT she had not yet received treatment for it. Esperanza also reported experiencing headaches.
Mateo is a 24-year-old, single male. Mateo reported spending nine years in the Hogar Tutor program. At the time of his interview, Mateo had recently become unemployed. In addition to knee injuries from playing soccer, Mateo described an arrhythmia that had been detected during a visit to the emergency room after he fainted at work (Figure 4.4).

“…They did an exam and detected an arrhythmia. That was in March and it was in April that they give me the appointment. …I was working one day and had to go to the emergency room because I blacked out …and I went to the clinic so they took my vital signs and some came out good, others came out that no…”

Mateo had received a referral to see a cardiologist but had been waiting months for the appointment at the time of the interview.
Sofia is a 25-year-old, single female who reported spending two years in Hogar Tutor. In addition to having a four-year-old daughter, Sofia was cares for her eight-year-old nephew. Sofia indicated that she is a smoker and that she has pain in her ribs and neck, both of which she attributes to work and her posture (Figure 4.5). She works as a seamstress, seated all day and making repetitive movements. When I inquired as to what she was doing to address the pain she replied, “I am applying creams and improving my posture at the [sewing] machine.” Though not indicated on the body map, Sofia discussed experiencing headaches the previous year, for which she made various trips to the emergency room. She believes that the headaches were caused by her birth control and had seen a doctor for them. She explained that since receiving treatment the headaches did not occur as frequently.
Marisol is a 23-year-old, single female with no children. She reported nine years in Hogar Tutor and works as a nail technician. Marisol did not identify any notable injuries or illnesses, though she does wear glasses, which she classified as illness on her body map (Figure 4.6). However, she did note that she sometimes gets bad headaches, for which she had a consultation scheduled.
Fabian is a 20-year-old single male who is self-employed and reported spending four years in Hogar Tutor. Fabian indicated that he had a broken nose, back pain, and reoccurring headaches (Figure 4.7). He explained that his headaches are not particularly strong but they last many days “once a month.” He also described having almost constant back pain, which he attributes to having had bad posture:

“In this moment my back is not hurting but I believe that when I was younger I had much worse posture, position of my body … when I am standing for a long time it starts to hurt or on a day that I work very hard my back hurts and I don’t do anything for it. … Nothing, nothing, nothing. I don’t do anything. That is the truth and I have it all the time, almost always. Almost every day my back hurts.”
Gabriel is a 24-year-old male in a free union, with a young son, and reported four and a half years in Hogar Tutor. Gabriel explained that he is in constant treatment for gastric problems, which have recently worsened but he has had to delay seeking treatment due to being transferred to a different EPS (Figure 4.8).

“I was almost finished with the Hogar Tutor process when I began to detect intestinal problems … I began to vomit blood and … they had to take me to the emergency room … I was incapacitated for a week and in the process they realized that I had the pylori bacteria and … like seven types of gastritis … It always bothers me in the early morning so I always have to keep something to eat early in the morning- three or four o’clock. It does not bother me the whole night but by 5:30 in the morning I can’t stand the pain. I always have buscapina, metronidazole, Mylanta and omeprazole…”

Gabriel also described experiencing long-lasting migraines that began the year before. He described having been to the doctor after experiencing a “migraine crisis” that left him exhausted and explained that he is now very careful when his head begins to hurt because that incident was so bad.
Figure 4.9: Juan’s Body Map

Juan is a 20-year-old, single male with no children. At the time of the interview he described himself as a high school student and reported 2.5 years in Hogar Tutor. Juan stated that he did not have any health problems and explained the lines drawn on his body map as being “scars” though he did not say what they were from (Figure 4.9). Juan was by far the most soft-spoken and least forthcoming in providing personal information during the interview and I was careful not to press him for more. However, he did explain that he smokes cigarettes to help him relieve stress. This information was readily volunteered without prompting from me, which came as a surprise and caused me to wonder about the degree to which stress is affecting him and his mental health, as well as how it manifests itself in his physical health due to the use of smoking as a coping mechanism.
ACCESSING HEALTH SERVICES

“... In Manizales ... we do not have a sufficient service network to serve the general population and much less by the victim population.”

-Key Informant (Secretary of Health)

Frequency

Survey participants were asked how often they go to the doctor. Of 27 responses, five participants (18.5%) stated that they see a doctor every two months or more often, however all five of those explained that they were receiving treatment for a health condition at the time of the interview. Two participants (7.4%) said that they go every four to six months and one (3.7%) said that they go once a year. Four participants (14.8%) said that they go when they are sick but some elaborated and added: “Almost never”; “But why go so that they give me acetaminophen?”; “I do not go to the doctor. I am almost never sick.” Ten participants (37%) responded that they go to the doctor rarely, irregularly, or occasionally. Some elaborated: “When I am sick”; “Only when they tell me I need to go”; “It has been two years” Other responses included: for check-ups (1); only to take their child (1); and “It has been a long time since I have been” (1).

Interview participants were also asked how often they go to the doctor (Table 4.5) and reported varying frequencies with which they access the health care system or see a doctor/dentist. Only one participant stated that they never go to the doctor, with the most common response being that they go when they feel sick and others reporting regular intervals. However, many participants followed these statements with discussion of how they prefer to not go, they cannot see a doctor due to problems with affiliation, or they experiences challenges in getting appointments. Participants were also asked if they go to the doctor more or less than they did in Hogar Tutor, with answers showing little consistency between participants. However, when asked if they would go to the doctor more often if it were easier to get an appointment (Figure 4.6), they majority of participants (7) stated that they would.
Table 4.5: Frequency A

“How often do you go to the doctor?”

<table>
<thead>
<tr>
<th>Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erika (1)</td>
<td>“Never”</td>
</tr>
<tr>
<td>Simon (2)</td>
<td>“When I feel more pain.”</td>
</tr>
<tr>
<td>Esperanza (3)</td>
<td>“Asthma maintenance is every three months … and the others almost never.”</td>
</tr>
<tr>
<td>Mateo (4)</td>
<td>“Every time that I feel bad… every time I feel bad because the rest of the time, no…”</td>
</tr>
<tr>
<td>Sofia (5)</td>
<td>“Every six… eight months.”</td>
</tr>
<tr>
<td>Marisol (6)</td>
<td>“Well… like I go when I am a bit sick or sometimes when I need exams but the rest of the time, no. It’s that I’m not motivated to go just so that they give you the same thing you can buy, why bother?”</td>
</tr>
<tr>
<td>Fabian (7)</td>
<td>“I go very often … every six months and I go any time I have the flu or … he sends me something or calls me … the last time I went was four months ago, more or less.”</td>
</tr>
<tr>
<td>Gabriel (8)</td>
<td>“Well, it depends. When I feel good I go more or less every three months, which is prevention. When I’m not very well then I have to go to the emergency room … but in that respect let’s say that it is not much. In general, yeah, every three months or two.”</td>
</tr>
<tr>
<td>Juan (9)</td>
<td>“Every time I feel something.”</td>
</tr>
</tbody>
</table>

Erika was the only participant who said that she never goes to the doctor or dentist and has not recently accessed any health services. When asked if she had accessed any reproductive health services, she replied “No, not for many years.” She said that she does not have problems with access, she just does not go because she is not sick and stopped going immediately after leaving Hogar Tutor, despite having gone two to three times per year while in the program. Marisol, Juan, and Simon all replied that they go when they are sick, however, Simon also stated that he had not recently utilized any health services, with the most recent time having been more than a year earlier. Simon said that he goes less now because he has left the program and “If I do not want to go then now I do not go.” Like Simon, Juan said that he goes to the doctor whenever he “feels something” but also explained that he was unaffiliated and had not had the option to go.

Gabriel described going to the doctor regularly because of existing medical conditions that require maintenance, but not without difficulty. Beyond his maintenance appointments, he expressed that he often prefers to not deal with the challenge of seeking care.
“You go to the doctor because you feel like you have one foot in the cemetery and the other outside, but for the rest you do not go to the doctor.”

“In the event that an emergency occurs then it is very complicated. When you have to wait in the emergency room and there are three chairs to wait in … I am affiliated to EPS SURA, but SURA hires a contractor who operates the clinics … When you want you can pass by and from the street you will see the three chairs. There are three chairs … it is one of the clinics that is used the most in Manizales and there are three chairs for waiting. For example, the last time I was sick I had to wait in the street and it got windy and started to drizzle, and you get sicker when you wait outside … So I prefer to go home because at home I can be lying down, covered, taking some medicine in the meantime and not be at the disposal of the environment, that sort of thing. It makes you unmotivated.”

Similar to Gabriel, Esperanza explained that she frequently sees the doctor for asthma maintenance, but infrequently for other reasons. However, she did add that she had recently been to doctor for varying reasons and at the time of the interview only needed to see the dentist.

“I rarely go … [but] in the last six [months] I have had everything… pelvic exam, birth control, general, asthma… all those. I am missing the dentist, there was no appointment and I need to call [again]…”

Fabian was the only participant to reply that he goes to the doctor frequently, however, he does not utilize the health care system. He explained that this is due to his own “lack of interest” since he prefers go to a friend of his and pay in part for services.

When asked if they go to the doctor now more or less than they did in Hogar Tutor (participants reported varying frequencies in Hogar Tutor, between one and three times per year) participants had varying responses. Sofia said that she sees the doctor with the same regularity as she did in the program. Fabian and Mateo said that they go to the doctor now more than they did in Hogar Tutor.

“…I am requesting appointments more frequently. … Well, for health. So yeah, for referrals … to avoid some type of illness or something.” –Mateo

Fabian explained that his feelings towards going to the doctor have changed since he was in Hogar Tutor:

“I express what I feel, I get to the doctor and I tell him if it hurts here or here and if he does not understand I show him so he can give me what I need … I do not go to the doctor with shame, I do not go with anxiety that I had [before].”

However, Marisol and Esperanza report going to the doctor less now than when they were in the program.

Marisol said that it was because in the program they made the appointments for them. Esperanza says that
she now goes less than she did in Hogar Tutor due to the challenges of being a single mother without the assistance of her madre tutora.

“Now… because it is hard to go there with a daughter … well, complicated. Independent life takes a lot of my time. Before it was just the girl and that was it. Well, because of that, now I have to do everything, so now with the girl it is more difficult, before the madre tutora could request [the appointment] or she could take the girl for me and take her to the appointment. Everything was much easier.”

The majority of participants (7) stated that they would go to the doctor more frequently if it were easier to get an appointment, with Sofia and Marisol being the only exceptions (Table 4.6). Sofia already reports going to the doctor approximately twice a year and does not feel that she has had any problems accessing services, so she would not change her current frequency. Marisol explained that she goes to the doctor as necessary, because she knows she needs to be responsible, but generally does not care for or feel like going (“me da pereza”) to the doctor, so she would not go more often even if it were easier.

Table 4.6: Frequency B

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erika (1)</td>
<td>“Yes”</td>
</tr>
<tr>
<td>Simon (2)</td>
<td>“Well yes…yes, if it was easier, yes.”</td>
</tr>
<tr>
<td>Esperanza (3)</td>
<td>“Yes…let’s say for rhinitis, ugh. There are times when…no, let’s say the dentist – I called last week and it was horrible. They were closed when I called but there is never anyone to call. You get bored.”</td>
</tr>
<tr>
<td>Mateo (4)</td>
<td>“Yes, of course.”</td>
</tr>
<tr>
<td>Sofia (5)</td>
<td>“Well no, I have not had problems with the appointments so no.”</td>
</tr>
<tr>
<td>Marisol (6)</td>
<td>“Well…since I go when I am a bit sick or when I need to get an exam but the rest of the time it is that I do not feel like it…”</td>
</tr>
<tr>
<td>Fabian (7)</td>
<td>“Of course, yes! Sometimes it would make things easier, save more money… and if I could save that time – that is my problem – sometimes I work a lot …and sometimes …it distracts from one’s health.”</td>
</tr>
<tr>
<td>Gabriel (8)</td>
<td>“Yes, logically.”</td>
</tr>
<tr>
<td>Juan (9)</td>
<td>“Yes, of course.”</td>
</tr>
</tbody>
</table>
EPS: Quality and Affiliation

Participants were asked about problems they may have experienced in accessing health services, with specific appointments focusing on issues such as long waiting periods to get appointments or challenges in seeking referrals for specialists. Overall, participants expressed varying levels of dissatisfaction with, and understanding of, the Colombian health care system and the EPS’. Problems with affiliation to the EPS’ were the most common issue identified among participants, though some participants also emphasized shortcomings in the quality of care provided. For example, Fabian stated, “[the health system] is the worst here in Colombia” and Gabriel expressed dissatisfaction with the quality of care:

“...It gives you a certain kind of anger to go a lot of the time because the great majority of doctors review you [and] … never explain what you really have. They do not lower the medical terms to the level of the user to explain it … At one time I thought that it is not their fault but the fault of the system, which only allows like, 7, 10, 15, 20 minutes with each patient and they have to be systematic. They are systematizing all the time and not … diagnosing the user, the patient. So for that reason it is tedious. There are very few doctors who attend to one well, who explain step by step and … make them feel like a friend and accepted.”

Gabriel discussed his perception of the controversial Ley 100 de 1993, which extended health care coverage to the country’s population, as well as his negative view of the system and the quality of care – feelings which he relates to his negative views of the former president, Álvaro Uribe.

“It is not a secret for anyone that the Ley 100 that the ex-president Uribe left us finished in the health system in this country … to me it seems supremely depressing that a sick patient has to wait between 4, 6 hours to be reviewed, to see whether they are worthy of medical attention … so unfortunately I think the Ley 100 finished.”

“...Citizens become customers and health becomes a product and that product is inadequate to ensure the connection to the right to life. So really in Colombia it is sad when people die in the doors of clinics, in the street, because they did not get the proper attention. There are some rights that, unfortunately, our founding fathers did not want to see and that have been influenced by some politicians with power and here in Colombia that is Uribe.”

I asked Gabriel, who has a young son, if he felt that the health care system was better at attending to children than to adults and he explained that while children below the age of five are supposed to have priority, in reality, this is not always the case.

“Usually within the Colombian health system there is supposed to be priority for children until age five, priority for pregnant women, and priority for seniors/older adults. But … I have seen
children there in the clinic… babies waiting three hours for attention. After three hours the nurse reviews them and decides if they do or do not pass to the doctor, so really you do not notice a lot of difference even if the paper is- and should be there- it is logical. But in reality it is practiced very little … I take my son to the doctor and he has to wait hours because… he looks five … he is big so they make him wait a lot.”

Issues related to affiliation were at the root of participants’ difficulties in accessing health services, though this ranged from a complete lack of affiliation to subtler challenges. Among survey participants, 23 (82.1%) responded that they were affiliated, three (10.7%) were unaffiliated, and one (3.6%) did not know (one participant did not respond). Erika was not affiliated to an EPS. She explained that she had previously been affiliated but had lost her affiliation when she became unemployed. She stated that she is not sick so she does not try to access health services, but was quick to explain that her daughter (who lives with her father) is affiliated through her father’s EPS. The relationship between affiliation and employment was also seen in the case of Mateo, who had contributive health care and had been waiting months for an appointment with a cardiologist. Mateo had lost his job just days before the interview and explained that he had one month to become employed and retain his current health care – or have to re-affiliate and face losing the appointment he had been waiting on.³

Juan was also unaffiliated but in the process of re-affiliating with Caprecom, a public EPS providing subsidized coverage.⁴ He explained that he had lost his affiliation after leaving Hogar Tutor but that he had changed cities multiple times in the two years since leaving the program. Because he had moved so frequently he had not gone through the process of affiliating each time. At the time of the

³ After speaking with an employee of the health care system, I learned that individuals whose employment status changes, and therefore must change from contributive to subsidized health, may notify their EPS and request an application to switch to subsidized health without having to change EPS’, allowing for continuity of care. This is based on the guarantee of “movilidad” as determined by Decreto 3047 of December 27, 2013 (Ministerio de Salud y Protección Social 2014). However, Mateo, as well as other key informants I spoke to were unaware of this.

⁴ Based on Decreto 2519, liquidation of the public EPS, Caprecom began in January 2016. The EPS provided subsidized coverage to 2.2 million Colombians who were transferred to 15 different EPS’ (El Tiempo, 2015). At minimum, of the 9 interviewees, at least 3 (Marisol, Esperanza, and Juan) were affiliated to Caprecom and would have been required to transfer to another EPS. Among survey participants, 3 reported that they were affiliated with Caprecom at the time of the survey. According to a key informant, youth currently in the Hogar Tutor program were also affiliated to Caprecom.
interview, Marisol was also in the process of transferring to Caprecom following a switch to subsidized coverage:

“Today I was doing the transfer … I was affiliated to Salud Vida and they withdrew me from there.”

Fabian explained that while he was technically in the system, at the time of the interview he did not have the card he needed to access health services:

“[I have] subsidized health… it is that I do not have the card but I appear in the system and everything. … Well, if I were to have an emergency today I can go without a problem. What I need to get is the card …”

He explained that he had Salud Cóndor but that customers of that EPS had been switched to another EPS, Salud Vida. He said that he had been without the card “more than a year - around two years, more or less.” Due to his dissatisfaction with the health care system, Fabian had been utilizing a private practitioner. Gabriel described how he was presently in need of constant treatment for a chronic condition, but because of problems related to EPS’ changing he had not had the procedures he needed.

“At this moment I am continually receiving treatment because in 2009, more or less, I had the beginning of gastric cancer so I constantly have to go to the doctor … for example I’ve also had to go lately because everything I eat comes back up … In general lately … I eat lunch and I am in the bathroom. So I have to go to the doctor again… Why have I not done it? Well, because I had a transition from one EPS to another EPS. I was removed from the EPS where I was and they moved me to another. So for that reason I have to wait some time to be able to have some procedures performed.”

Survey participants were asked whether they had experienced difficulties in affiliating or using health services. 67.9% (19) of participants said that they had not experienced any difficulties, while 25% (7) said that they had, and 7.1% (2) did not respond. Participants’ explanations of the difficulties they had experienced included: problems making appointments, issues related to documentation, emergency care, affiliation, “no attention,” and discrimination.

Confusion related to affiliation was illustrated during a meeting held by the ACR on health at the university. Ten ex-combatants attended the meeting, approximately half of which were former child combatants.

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5 Salud Cóndor was liquidated in 2013 and its 36,000 users in Manizales were transferred to Salud Vida. Prior to the liquidation Salud Vida had 20,000 users in Caldas but with the addition of Salud Cóndor’s users it increased immediately to 56,000 (La Patria, 2013).
soldiers (four were participants in this research: Mateo, Fabian, Erika and Juan). While the bulk of the meeting was dedicated to health professionals presenting information on routes of care and attention pertaining to specific topics such as sexual and domestic violence, the latter part of the meeting allotted some time for participants to ask questions. The questions asked were largely related to affiliation, as they sought clarification on their status due to events such as EPS transfers and employment changes. While individuals were not quick to speak at first, Fabian began to discuss the challenges he was experiencing, which in turn encouraged others to explain their own situations. The overwhelming confusion among those in attendance seemed to be indicative of a larger problem. While the meeting provided an opportunity for attendees to seek guidance, it was not the main purpose of the meeting and only a small segment was allotted for this purpose. Furthermore, as the meeting was for all persons affiliated with the ACR, not only former child soldiers or those granted victim status, the information did not cater specifically to victims, but rather to the larger population of adult ex-combatants. Despite this, the meeting seemed to be beneficial for those in attendance. Fabian explained that after meeting with the ACR he wanted to “…resume [using the EPS] because they said it was important to acquire and use something that the state gives us and that we deserve.”

Time

Of the obstacles participants discussed in relation to accessing health services, issues related to time were the most common. The issue of time was discussed in three different ways: (1) making appointments; (2) waiting for appointments; (3) time lost going to the doctor/waiting in the emergency room. This was corroborated by discussions with key informants and is personified by my observations of Simon’s experience in seeking appropriate medical attention with the help of CEDAT.

“It also makes you lose your patience because human nature is not to be patient. The vast majority of humans are not patient about sitting and waiting, and even more so when you are sick.” – Gabriel
Time lost making appointments was due to the difficulty of the process, which often requires calling multiple times or going to the EPS in person. Esperanza, a single mother who works full-time and lives alone with her baby, described having recently called repetitively for a week to get a dentist appointment without any luck. She could not get an answer or found that they were closed when she called. I asked her if she has to wait a long time to get an appointment:

“Depending what appointment it is, yes, a lot. There are times when it is one, two months. There are other times when it is 20 days. It is very complicated. Other times I go and they give me one right away.”

She finds it difficult to secure an appointment with a general practitioner; though, notably, she has no trouble getting appointments for asthma maintenance:

“In relation to the problem of asthma, I go and they attend to me immediately. It is very hard to ask for an appointment with a general practitioner. Horrible. … For asthma I can ask for an appointment there directly. In contrast, with a general practitioner, well, you have to put up with something else. You have to call and there are no appointments, they never answer. But, in relation to asthma, it is super good.”

As seen in Simon’s case study, making appointments with specialists, in particular, was one of the most notable challenges participants faced in relation to time. The challenge is two-fold in that they must go through the process of seeing a general practitioner for a referral and then try to get an appointment with a specialist. Gabriel explained the process:

“It is even worse still because in general you always have to wait for the appointment with the general practitioner which takes on average 20, 30 days. The doctor orders it and then comes the authorization to see a specialist and that can be a bit later – between one and almost two months more. It is more or less a process that takes three months for a specialist.”

Esperanza has rhinitis for which she has never been treated. She explained that it previously took her a year to get an appointment with a specialist but when she was finally able to see the doctor, she was unable to be treated.

“The ENT … They saw me when I was pregnant so they did not do anything to me because I was pregnant. They are horrible. After I had to return to ask for an appointment, and ask for an appointment… it is horrible. Horrible. … One year. All that and they did not treat me when I went because I was pregnant and they could not do anything.”
At the time of the interview Esperanza’s daughter was over a year old and she still had yet to see a specialist or receive treatment for rhinitis. Another participant, Mateo, describes the extensive wait time for him to see a cardiologist:

“Yes, I have an appointment they gave me in… in April. Yeah, it is for September, but it does not take too long … Yeah… four months [laughing] and it is ‘priority’ … because they did an exam and detected an arrhythmia. That was in March and it was in April that they gave me the appointment. … I was working one day and had to go to the emergency room because I blacked out … and I went to the clinic so they took my vital signs and some came out good, others came out that no…”

While the issue of time was a common theme among all participants, there is variation between responses. Some of the variation appears to be dependent on the specific EPS. For example, Sofia described satisfaction with the EPS, Salud Total:

“No, well here Salud Total is very good. I call so that they will give me an appointment and I ask ‘can you give me an appointment for this week or the soonest you have’ and they give it to me for the same week or the next. It is very fast so for that reason I like it, Salud Total seems very good to me. There are people who complain but it seems good to me.”

Mateo, who was also affiliated with Salud Total, reported, “An appointment … takes about eight days. The only thing is like, for a specialist, it is slow.” Unlike Mateo, however, Sofia’s positive evaluation of Salud Total applied to specialists as well:

“No it is the same as well, I call like if I am going to the doctor, the doctor refers me and that’s it. They give you another appointment to go there to a specialist and the date … No, to me Salud Total does not appear so complicated. They give the appointments quickly; the specialists are good. There are people who tell me ‘no but that Salud Total is very bad’ and it does not seem that way to me because they give you the appointment there at once, so no.”

However, Sofia also discussed an extensive wait time for an operation she wanted to have so that she would not be able to have more children:

“I went and there in Salud Total I put in the papers and everything to have the operation. I have the implant in my arm. Yeah, but well, for family planning I want to have an operation to not have more children. So I put in the paperwork and I have to wait a year so that they give me a response. Horrible. One year so that they give me a response and then after that they plan the surgery because many women are waiting to have operations. I go, I ask for the appointment and I take the papers and I already did, like, the petition for the operation so now I have to … they told me to wait a year and it has been seven months now. Around October, November I have to return to see how the process is going, how the petition is going, if they are going to give it to me or not.”
Similar to Sofia, Gabriel is waiting for a vasectomy. However, Gabriel and his wife wanted to have another child. He explained that due to the long wait for the operation, if his wife was not pregnant prior to his operation, then he planned to go ahead with the surgery prior to having another child:

“…On the subject of family planning … the issue of getting a vasectomy, which I have placed myself in the process to get one … My wife and I decided to wait this semester and see if our second child suddenly arrives, otherwise I will be having the surgery in mid-December to not have any more family.”

Gabriel explains that the issue of time also lies in time lost to see the doctor. Free time is limited and it can be difficult to see a doctor due to employment related issues that may arise.

“I usually work from Monday to Friday. I work from seven in the morning to six, seven at night … Usually I manage a company separate from work in the evenings, I work weekends…for example, Saturdays [I work] until six in the morning and the next day I … continue studying… But when I’m not [studying] I am managing the business on the weekends or doing politics. There is an election going on right now and the little time I have left I try to enjoy with family…”

“For someone to go to the doctor, it is that they almost have to have nearly one or two days to go … So it is very complicated because, for example … you have to create a labor issue, that they are not going to fire you for being at the doctor, right? So one prefers to guarantee and keep working on getting permission to go to the doctor, for example.”

Participants who mentioned going to the emergency room described it as being slow or time consuming:

“No, that is a bit slow because they have many sick people there and so I have to wait … if you arrive very delicate then you are treated quickly, but there are hardly exceptions. It is always very slow to enter the emergency room.” –Sofia

“… The last time I had to go to they emergency room they did not attend to me. I was there 6 hours waiting for them to do the triage and they did not attend to me. I had to go home and at dawn I had to return to the clinic and then after two hours I could go in.” –Gabriel

Alternate Routes and Self-Care

Rather than a reliance on the health care system, some participants identified alternate routes that they utilize in seeking care. Participants also discussed self-reliance and the ways in which they are able to help or treat themselves. In the case of one participant, Erika, she was hoping to use her boyfriend’s affiliation with an EPS to seek treatment for a persistent health issue she had been experiencing, as she
herself was unaffiliated. Erika was also reliant on her boyfriend for birth control injections, which he purchased at the pharmacy.

Another participant, Fabian, who finds the health care system unsatisfactory explained that he preferred to go to a friend who is a doctor, and pay “in part for services” than to utilize the EPS:

“I give tennis lessons to some friends – a couple – the man is a doctor and his wife is a nurse. If I get sick I go to them … if I need an appointment, an injection, flu or whatever, I almost always go to them.”

“Do I have to wait much? No, he expects me before … He almost always waits for me. That is what I like and that is why I work with him … I go there because I called him and he said ‘Come, I have space’. So I don’t have to wait, I don’t have to call for an appointment and wait on the phone.

When presented with possible scenarios and asked what they would do in response to each situation, answers frequently involved purchasing something available over-the-counter - most commonly acetaminophen, as a general “cure-all.” When asked what he would do if he began to experience severe and frequent headaches, Gabriel replied, “Here in Colombia, generally one takes an aspirin or an ibuprofen or an acetaminophen.” This was a sentiment echoed by participants over and over in response to the different scenarios. In various instances participants said that they would not go to the doctor because the doctor would just give them acetaminophen or something similar that they could buy themselves. When asked what they would do in response to having flu-like symptoms for two days, only Fabian and Gabriel said that they would go to the doctor (Table 4.7). Fabian specified that he would go to a specific doctor (his friend), while Gabriel said that he would wait 72 hours, but added that they usually just send you acetaminophen.
Table 4.7: FES Responses (17b)

“What would you do if you had been experiencing flu-like symptoms for two days?”

<table>
<thead>
<tr>
<th>Name</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erika</td>
<td>“Rest, stay at home and try to not get worse.”</td>
</tr>
<tr>
<td>Simon</td>
<td>“I take a pill to not be … one of the flus, I believe, one of the flus is like that so I would see how if it continues...”</td>
</tr>
<tr>
<td>Esperanza</td>
<td>“I would go to the pharmacy.”</td>
</tr>
<tr>
<td>Mateo</td>
<td>“Ha! Ay… What is the Colombian thing? Folk medicine. Syrups. … Noraver … aspirin. All there is … some mixture for the flu…”</td>
</tr>
<tr>
<td>Sofia</td>
<td>“No, I do not go … I have a drink and some pills and then it calms like I don’t know… My family, well, we do not think the flu is so delicate and no… The flu since you take care of yourself well, it is not much … it passes and it is good. … It is not so delicate as to go to the emergency room.”</td>
</tr>
<tr>
<td>Marisol</td>
<td>“The truth is I do not go to the doctor because why go so that they send you acetaminophen? Buy something for the flu.”</td>
</tr>
<tr>
<td>Fabian</td>
<td>“I do not wait two days … I go to a particular doctor… He gives me an injection or he sends me pills for the symptoms. If I continue that way or it gets worse he sends me the usual - syrup and he gives me an injection and 2, 3 days I take care of myself… I don’t get wet … and well, almost always within 3, 4 days I don’t have symptoms.”</td>
</tr>
<tr>
<td>Gabriel</td>
<td>“If I have flu-like symptoms for 2 days… well, I’d wait until it had been 72 hours and then go to the doctor … through the emergency room if I need urgent or prompt medical attention but in general they just send you acetaminophen … that sort of thing.”</td>
</tr>
<tr>
<td>Juan</td>
<td>“I would buy something like for the infection…”</td>
</tr>
</tbody>
</table>

SUMMARY

This chapter served to characterize the sample population and present the themes that emerged during this research. These results show that former child soldiers in Colombia experience a myriad of obstacles in accessing health services, beginning with their time in the reintegration programs and continuing into independence, following their exit from the programs. While some of the obstacles that emerged in this research can be related to population characteristics and the unique challenges this group faces, barriers are largely the result of systemic flaws. This is illustrative of broader issues within the Colombian health care system, as well as the incompatibility of a neoliberal health system with the transitional justice process.
CHAPTER 5: ANALYSIS AND DISCUSSION

INTRODUCTION

This chapter will analyze and discuss the results presented in the previous chapter, in an effort to elaborate upon findings and their significance. Results are related to observations from my time in Colombia and discussion with key informants, while being situated within the larger context of existing literature. Guided by the objectives of this research, discussion is focused on understanding challenges participants are experiencing in relation to health and access to health care, perceptions of health, and health seeking behavior.

To begin, sample characteristics will be discussed and compared to those of the larger population of former child soldiers in Colombia, as seen in the literature. Next, I will discuss the results pertaining to health and the issue of stigmatization and discrimination. Following this I will discuss findings on the obstacles this population faces in accessing health care and their perceptions of the health care system.

SAMPLE CHARACTERISTICS

The average number of years in Hogar Tutor for both survey and interview participants is high in comparison to overall youth participation in ICBF programs – 60% are in ICBF programs for 18 months or less (Thomas, 2008). Furthermore, the self-reported years in Hogar Tutor do not reflect the additional time most participants spent in other ICBF programs, indicating that on average, both survey and interview participants benefitted from more time spent in ICBF programs than is the norm.

It should be noted that gender distribution among both survey and interview participants was considerably different than the overall distribution of youth who have gone through ICBF programs (26% female; 74% male), with females being disproportionately represented (Thomas, 2008). It is likely,
however, that the gender distribution is closer to that of the true male to female ratio of Colombia’s child soldiers, based on global estimates (40% female) and due to the invisibility of girls and their lack of inclusion in reintegration programs – often resulting from their misclassification as ‘wives’ or their reluctance to come forward (see Chapter 2).

Employment status among both interview and survey participants was high compared to findings from Naeve’s (2012) study of 112 demobilized child soldiers in Colombia, which shows 57% unemployment. However, this may be attributed in part to the differences in population samples: Naeve’s interviewees were currently participating in ACR reintegration and while all were child soldiers, not all participants demobilized prior to the age of 18 and thus were never under the care of the ICBF. While not statistically significant, Naeve (2012) suggests that those who demobilized as youth and were in ICBF reintegration were more likely to be employed, which may explain the lower unemployment rates among participants in this study (32.1% survey; 22.2% interview).

Interestingly, Naeve (2012) found that women were half as likely as men to be employed, which is similar to survey findings showing 41.2% unemployment among women, compared to 18.2% among men. This may be due to women staying home with their children or due to their boyfriend or spouse preferring that they do not work outside of the home; three of the nine unemployed women surveyed listed ‘housewife’ as their occupation.

Recruitment and Demobilization

Survey results regarding affiliation with armed groups (See Table 4.3, page 47) are relatively consistent with ICBF statistics and findings from previous research. Between 1999 and 2011, of the 4,811 former child soldiers assisted by the ICBF, 59% (2,838) were with the FARC; 22% (1,058) with the AUC; 15% (721) with the ELN (Watchlist, 2012). It is possible that the difference in survey results (specifically the percentage affiliated with the AUC and ELN) and ICBF participation from 1999 to 2011 can be attributed in part to the increase in AUC combatants entering reintegration following the demobilization of the AUC from 2003 to 2006, whereas recently demobilized youth are more likely to
have been with the FARC or ELN (Watchlist, 2012). More closely aligned with survey findings are findings from Naeve (2012) - though not limited to those who were in ICBF programs, in a sample of former child soldiers in the ACR, Naeve found that 65% were FARC, 22% ELN, and 12% AUC.

Survey findings related to age at recruitment and demobilization are fairly consistent with the Office of High Commissioner for Human Rights in Colombia’s estimate of 11.8 years being the average age of recruitment in 2009 - down from 13.8 years in 2002 (Watchlist, 2012). The average age of demobilization among survey participants (14.59 years) is low in comparison with the general population of child soldiers who enter ICBF programs – 40% of those who enter the programs are 17 years old; 68% are between the ages of 16 and 17 (Thomas, 2008). The difference may be attributable to the fact that all but one of the survey participants were in Hogar Tutor, as those who are placed into foster care tend to be younger ex-combatants (Verhoef, 2008). Type of demobilization among participants is fairly consistent with findings from Defensoria del Pueblo and UNICEF (2006) indicating that escape (45%) was the most common type of demobilization, followed by capture (35%), and various types of surrender (i.e. voluntary or mass demobilization).

**Mobility**

Survey and interview findings echo previous findings by Denov and Marchand (2014), which suggest that ongoing threats to the safety of demobilized child soldiers often require them to relocate multiple times, hindering their ability to reintegrate successfully. Rejection and stigma of demobilized combatants also contributes to their perceived safety and security, in-turn encouraging frequent relocation (Denov & Marchand, 2014; Denov & Marchand, 2014).

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6 It should be noted that participation in government reintegration programs does not reflect the true number of child soldiers that were involved with the AUC, as government officials failed to enforce the handover of child soldiers by the AUC. Despite the fact that an estimated 20% of paramilitary groups are children, only 391 children were formally released (compared to 31,671 adults) from the AUC. Many of the children who were in the AUC joined other paramilitary groups after AUC demobilization Watchlist. (2012). *No one to trust: children and armed conflict in Colombia*. Watchlist.
Thomas (2008) suggests that demobilized youth may see mobility restrictions within the programs as a form of imprisonment. Lugo (2014, p. 188) explains that the majority of youth ex-combatants in reintegration programs want to leave; they lack a sense of belonging that results in an itinerant life. This is made worse by repetitive movements within the program - from family to family in foster care or from foster to institutional care - due to trouble adapting to conventional family life. This raises questions as to how feelings of imprisonment or limited mobility, combined with repetitive movements that work to prevent feelings of belonging, may affect their desire to relocate after the transition to independence.

HEALTH CONDITIONS

Among survey participants, when asked if they suffered from any illness that required monitoring or treatment, 64.3% (18) said no, 32.1% (9) said yes, and 3.6% (1) did not respond. This is not consistent with findings from the interviews and body maps, as only one participant did not identify any type of pain, illness, or injury. However, it should be noted that by asking only about illness which requires monitoring or treatment, the survey fails to take into account what participants feel are conditions worthy of medical attention, or if they can or want to seek medical attention.

The health conditions listed by a key informant as common among youth arriving to Hogar Tutor are consistent with those found in the literature, as presented in Chapter 2 (O’Driscoll, Loots, & Derluyn, 2013; Strauch, 2006). They are also similar to those identified by participants, suggesting that in many cases, the conditions they are experiencing are not problems that are easily solved or ‘cured’, but rather long-term conditions that will remain with the individual, requiring continued attention following their departure from the program. This is especially true in the case of those such as Simon, who continue to deal with the pain of injuries acquired during their time as combatants.

Headaches and stomach pain are also common among child soldiers in other regions and are generally understood as psychosomatic complaints associated with trauma and PTSD (Buchanan, Al-Mashat, Cortes, Djukic, Jaghori, & Thompson, 2013; Haer & Böhmelt, 2016; Schauer & Elbert, 2010;
Wessells, 2006). What is not seen in the literature is in-depth discussion as to how these psychosomatic symptoms affect the everyday lives of these individuals, as well as how they are being treated for the associated physical pain. Key informants in this research lamented the lack of mental health services available to former combatants, suggesting that once regular access provided to youth in the Hogar Tutor program is discontinued, psychosomatic conditions, such as headaches and stomach pain, are likely to persist untreated – aside from self-treatment which, according to the results of this research, is likely to be based on the use of acetaminophen or other over-the-counter pain relievers.

**Sexual and Reproductive Health**

Naeve (2012) found that just over half of participants had children, with age at birth of first child revealing that demobilized child soldiers were over three times more likely to be teenage parents than the general Colombian population (Naeve, 2012). This is consistent with results from this research. Participants were not asked specific questions regarding their sexual health, however, it has been established that “Many of the girls receiving assistance under the government’s program for demobilized children have become pregnant as a result of sexual abuse…” (Watchlist, 2012). A 2004 report from Watchlist states that the Ombudsman found that among young women in Santander who were former members of guerilla groups, approximately 70% had sexually transmitted infections. Furthermore, girls associated with the FARC are typically denied medical assistance, even during pregnancy, and forced, unsafe abortions are not uncommon (Lugo, 2014; Watchlist, 2012). Documents reviewed in the Hogar Tutor files recount experiences among youth who were in the program and are consistent with the literature in regards to sexual health and experiences of sexual violence (Denov, 2010; Verhoef, I have a hard time sleeping: About the reintegration of child soldiers in Colombia, 2008).

As pregnancy is not allowed in the guerilla groups, girls are forced to use contraception (generally injections or implants) (Lugo, 2014; Watchlist, 2004; Watchlist, 2012). According to UNICEF and Defensoría del Pueblo, in 2005, of a sample of 525 youth in the government reintegration program, 90.5% of girls and 82.8% of boys were forced to use contraception in the armed groups, but once in the
program – when given a choice – there was a drastic decline in the use of contraceptives (9.5% of girls and 10.3% of boys) (Thomas, 2008). This was not mirrored in the small sample of this research, which may be indicative of efforts to promote the use of contraceptives among youth in the programs in the decade following the report. Interestingly, a key informant from the current Hogar Tutor program in Manizales explained that the young women who were in the armed groups for longer periods are more willing to use birth control than those who were in the groups for brief periods, as they are accustomed to it.

Participants in this research – especially young women – are likely to have experienced the militarization of sexuality and attempts to constrain or control it, as well as the repercussions of these experiences in terms of both physical and mental health (Lugo, 2014). Despite awareness of these experiences and their effects, my conversations with participants and key informants indicate that there is little to no mandatory or standardized sexual health education in Hogar Tutor. A key informant explained that while some young women have “more problems” that need to be addressed, efforts in the program are currently focused on the use of birth control among females.

As previously described in Chapter 2, a 2006 characterization of demobilized youth showed that within ICBF programs, 68.4% of young women and 48.3% of young men report having received at least one medical consultation relating to the avoidance of unplanned pregnancies; 81.3% of women reported having at least one Pap smear; 64.2% of men reported a medical visit in which their genitals were examined (Defensoría del Pueblo & UNICEF, 2006). The characterization does not account for reasons why some youth would not receive these services during their time in government care. Particularly concerning is the low rate of young men who reported receiving consultation on the avoidance of unplanned pregnancies.

A key informant who was charged with handling health among youth in Hogar Tutor in Manizales explained that under the subsidized regime (the tax-financed tier of the state health insurance program that targets low-income and disadvantaged groups), Pap smears are covered every 3 years so depending on age of entry to the program; some young women may have only one or none during their
time in the program. Another key informant working with Hogar Tutor explained that beyond the mandated yearly doctor appointment and bi-annual dentist visits, there are no requirements for preventative care – including sexual and reproductive health care. While youth and their madre tutoras may request appointments, the onus falls on them to seek attention.

When asked about current access to sexual health services, participants largely associated this with access to birth control, which can be acquired relatively easily and independently from other sexual health services. Erika, for example, was unaffiliated and reported that she “never” goes to the doctor, but was able to obtain birth control injections that her boyfriend purchased for her at the pharmacy. Upon further discussion with the other three female participants, it was evident that they are receiving sexual/reproductive health services regularly: Sofia and Marisol reported yearly pap smears and Esperanza stated that she had received a pelvic exam during the previous six months. Due to the small sample size of this research, it is impossible to judge whether these young women are the rule or the exception among the larger population of former child soldiers.

Based on the high rates of sexually transmitted infections among this population and the lack of a mechanism guaranteeing that all youth in reintegration programs receive sexual and reproductive health care and education, future research should aim to gain an understanding of this population’s access to sexual and reproductive health services. This will be particularly important as the population of youth who have aged out of reintegration programs reach the age at which there is an increased risk of cervical cancer, especially considering the co-factors that combined with HPV increase the risk of cervical cancer: tobacco use, high parity, long-term use of oral contraceptives, and past infection of herpes simplex type 2 or Chlamydia (Muñoz & Bravo, 2012).

STIGMATIZATION AND DISCRIMINATION

The presence of injuries or scars has been explored in the literature as a contributor to stigmatization and discrimination; “stigma symbols” that can potentially reveal an individual’s participation in an armed group (Denov & Marchand, 2014, p. 237). Injuries and scars have also been
touched upon as constant reminders of a traumatic past: Watchlist (2012, p. 24) quotes a female victim of illegal recruitment and sexual violence stating, “It was a childhood I do not wish for anybody. Every time I shower, I see the scars and I remember everything.” While Juan did not offer a story behind his scars, they were the only marks on his body map (Figure 4.9). Simon cannot hide the discomfort he experiences from his leg, or the disability that comes with it, but in all of our conversations he never offered a full explanation of it. The daily forms of discrimination Simon experiences are undeniable but it is unclear to what degree this is made worse by his noticeable limp or the scarring on his leg.

Something missing from the discussion of discrimination – real or perceived – is the effect it has on the willingness of former combatants to seek medical attention, as well as the quality of the care they receive. How willing to describe or explain the origins of his injury to a doctor can Simon (who experiences daily discrimination based on factors much more superficial) possibly be when it is so intricately tied to his identity as an ex-combatant? The avoidance of the topic may serve to deter Simon from seeking medical attention, and when he does, if he is not forthcoming with details regarding his medical history, it may hinder his treatment. This could possibly be remedied by access to a single primary care doctor, with whom familiarity and trust could be established, but this is not the model of the public health system.

In an interview with a key informant from the Secretary of Health, as well as one from the university, we discussed the issue of access and how this is affected by the population’s high degree of mobility, as previously discussed in this chapter. While “movilidad” addresses frequent changes in employment, there is not presently a mechanism for handling frequent geographic movement. Despite this, victims are theoretically guaranteed medical attention anywhere – if they declare their victims’ status and the insurer (the EPS) is able to verify it. Other challenges aside, it was explained that this population is often wary of disclosing their status as victims, which increases the likelihood of them not seeking medical attention, even in cases of emergency based on possible discrimination, as well as safety concerns stemming from the past involvement with armed groups. Safety concerns contribute in large part to high mobility, thus they simultaneously create both the need for guaranteed medical attention in any
part of the country and the unwillingness to utilize this guarantee. The desire for concealment or selective disclosure is consistent with Denov’s (2010) findings among former child soldiers in Sierra Leone.

Of course, there is also the possibility of discrimination by medical professionals, which may in turn reinforce the desire to avoid seeing a doctor, as well as affect the quality of care; of the survey participants who reported having difficulties in utilizing health services, one explained it as “discrimination”. While this is not to suggest that in general, a doctor would intentionally provide lesser care to an ex-combatant based on their past association with an armed group – there are certain generalizations that can be made about feelings of mistrust or dislike towards former combatants, as well as an overall lack of understanding among the general public. It is also possible that poor quality of care can be perceived as discrimination; Abadia and Oviedo (2009, p. 1159) report “a lack of care and humanity in clinical practice” in Colombia but suggest that it may be due to restrictions imposed on the autonomy of physicians by the insurance companies. This is consistent with Gabriel’s frustrations with the quality of care, as he acknowledges both the limitations of the system and poor treatment by doctors.

My field notes recount numerous conversations with individuals outside of CEDAT - including a medical doctor - showing overwhelming skepticism and difficulty in separating feelings of resentment and disapproval towards the armed groups, from their vague understanding of child soldiers as victims. Of course, this is further complicated when the image of the “voiceless” child victim is replaced by that of an adult with a violent past. Interestingly, the person outside of the university setting who was most open to- and understanding of the challenges and discrimination this population faces, as well as the importance of working with them, was the maid in the household where I was living during my time in Manizales. This brought to mind questions of class and socioeconomic background and how this may bring individuals closer to the conflict and the structural issues that often lead to becoming a victim. The daily realities of the conflict being so far removed from cities like Manizales, as well as from the upper classes, may create a difference in perception compared to those from rural areas or barrios, where the conflict is a lived reality. Inferring that Colombian doctors are likely to come from more affluent and
OBSTACLES TO ACCESSING HEALTH SERVICES

In an assessment of the Colombian health care system, Abadia and Oviedo (2009) illustrate a lack of access among all societal groups, showing that the number of people insured is neither representative of access nor of success in providing health care. Going beyond the constitutional guarantee of health as a right for all citizens in Colombia, former child soldiers are guaranteed access to health care as part of the reestablishment of rights based on their classification as victims and as an integral component of the reintegration process. However, the present health care system in Colombia, particularly pertaining to affiliation with an EPS and in the absence of affiliation - the need to claim and prove victimhood - clashes with some of the key challenges faced by this population: stigmatization and discrimination, high mobility, and security concerns.

Frequent changes in employment can also be considered a contributing factor, despite the provision of ‘movilidad,’ which allows for continuity of care when users change from subsidized to contributive health care (or vice versa). The current system requires a seemingly endless stream of paperwork and ‘movilidad’ is no exception. While users can remain with the same EPS, simply changing regimes to guarantee continuity of care, they are required to notify the EPS and fill out the relevant paperwork for it to go into effect. Furthermore, because the individual is responsible for notifying the EPS and initiating the process of changing regimes they must be aware of ‘movilidad’ in order to utilize it. Throughout the research process it was evident that neither participants nor key informants were aware of ‘movilidad’, with multiple individuals discussing the challenges associated with loss of affiliation due to changes in employment. Thus, while ‘movilidad’ has the potential to be very useful in guaranteeing continuity of affiliation, this research suggests that its effectiveness is currently being hindered by a lack of awareness. Similarly, when an EPS is liquidated and users transferred, the individual must be aware of
the liquidation and follow through with the transfer process to ensure that their affiliation remains current, as seen in the case of Fabian.

The meeting I attended with the ACR and former combatants illustrated the high level of confusion regarding the healthcare system, affiliation, and accessing care. In fact, the information presented in the meeting and the style of delivery seemed to embody the larger health care system: so thorough it lacks the necessary degree of user-friendliness. Slides from the meeting presented in Figure 5.1 and Figure 5.2 show routes of attention and illustrate the complexity of seeking care. While the slides themselves are difficult to understand, it is partly due to the presentation style and the provision of unnecessary information, but also largely because the processes themselves are complex.
Similar to these findings, Mogollón-Pérez and Vásquez (2008) explain that among Colombia’s internally displaced, barriers to access include: the requirement of the declaration of displaced status; loss of affiliation when changing municipalities due to delays in the transfer of complex documentation and the lack of a mechanism to guarantee attention anywhere in the country; excessive paperwork. Abadia and Oviedo (2009, pp. 1153, 1159) argue that the Colombian health care system “has created complex bureaucracies that delay and limit care through cost-containment mechanisms, which has resulted in harmful consequences for people’s lives” and that “institutions profit from creating administrative access barriers given that they do not incur treatment costs.”

The amount of red tape involved in seeking medical attention is closely related to the obstacles that emerged as themes in this research – particularly the issue of lost time, as bureaucratic processes combined with insufficient resources result in extensive time lost throughout the process of seeking medical attention. Considering the lack of support faced by this population due to factors such as familial
separation and social exclusion, time lost becomes an even more significant challenge. Without family or friends to assist in the process, they must find the time to do it themselves, likely losing time at work and creating a financial burden. This issue is compounded in the case of those with children, as they must seek medical attention for both themselves and their child. Of course, even then, there is an assumption that they understand the health care system well enough to navigate it, despite the lack of any formal education on the subject within the youth reintegration program. As illustrated by Fabian and Gabriel, they must aim to learn the information themselves.

Finally, to return to the topic of obstacles relating to affiliation – one of the most significant issues is related to the seemingly constant EPS closures. Relating to this research, the most notable closures are perhaps that of Salud Cóndor in 2013 and Caprecom in 2016 (after the completion of this research). In addition to requiring that users ensure the completion of their transfer to the new EPS system, EPS closures cause sudden and drastic increases in enrollment to other EPSs resulting in overburdened providers and scarcity of resources for existing and new enrollees alike. The closure of Caprecom alone is likely to have affected at least three participants in this research, as well as the youth currently in the Hogar Tutor program (a key informant reported that it was their health care provider).

HEALTH-SEEKING BEHAVIOR AND PERCEPTIONS OF HEALTH CARE

A key informant in this research described the resistance and fear that many youth have towards receiving medical treatment upon their arrival to the Hogar Tutor program, explaining that it eventually leads to them choosing to not go to the doctor as adults. In contrast to this, a majority of research participants stated that they never had a problem with going to the doctor or receiving medical attention. There was however, some variety in the responses, as with Fabian who stated that he had not been to the doctor before his arrival to the Hogar Tutor program and that it was initially uncomfortable. One can speculate that some participants may now be ashamed to admit that they were frightened - or even simply made uncomfortable - by something so seemingly benign as seeing a doctor. Yet based on the rural
origins of the vast majority of child soldiers and the lack of access to basic services in these areas, it is likely that Fabian was not the only one introduced to Western medicine at that critical moment.

Unlike the aforementioned key informant, who worked with Hogar Tutor when it was operated by CEDAT— a key informant who was working in the current program in Manizales explained that youth do not want to go to the doctor because they lack a “culture of self-care” rather than because of fear. However, they added that some youth must be accompanied because they are resistant to speaking with the doctor and are uneager to describe the pain or other problems they may be experiencing. Regardless of the origin of their aversion (fear or culture), it stands to reason that based on the experiences of these key informants, significant resistance to receiving medical attention does exist among many youth in the program.

While the described resistance was not absent among participants and some clearly dislike going to the doctor, participants overwhelmingly gave the impression that it is not their aversion to seeing a doctor, but rather the barriers to access they are facing, that keep them from accessing health services with more regularity. Gabriel’s statement encompasses the general feeling towards the health care system and the pointlessness of seeking care in most instances:

“You go to the doctor because you feel like you have one foot in the cemetery and the other outside, but for the rest you do not go to the doctor.”

While some participants continually utilize health services to the best of their ability, despite their frustrations, others seem resigned to going without medical attention, providing self-care, or paying for care outside of the EPS. The systemic challenges are so vast and impossible to ignore that it is difficult to truly investigate conceptions of health, feelings towards health care, and when individuals choose to seek or not seek medical attention in a way that is independent from the systemic issues. It is difficult to truly explore the role of fear or discomfort as described by key informants, as well as variations in perceptions of health care, without downplaying the larger issues and thus placing blame on the individual rather than the larger processes at fault.
As described in Chapter 4, some participants feel that is their “responsibility” to go to the doctor, despite not wanting to and this perceived responsibility seems linked to the lack of a support system. Gabriel and Fabian emphasize the importance of taking responsibility for themselves, crediting their own efforts for ensuring their successes, with what gives the impression of a “bootstrapping” mentality, despite their recognition of systemic flaws. Overall, a lack of social inclusion seems to create a burden of responsibility, in which the individual is responsible for accessing health care, even when their right to health is largely inaccessible due to systemic flaws and other obstacles. In order to be “responsible”, the individual must shoulder the cost of seeking care outside of the public health system or continue to invest time and effort into accessing care within the public health system. This is consistent with ideas present in the anthropological literature suggesting, “In advanced liberal societies, the notion of individual responsibility for health has become enmeshed with the idea of responsible citizenship…” (Horton, Abadía, Mulligan, & Thompson, 2014, p. 3).

Children, and specifically child soldiers, are often discussed as being resilient, presenting a contrast to the idea of a traumatized and helpless “lost generation” (O'Driscoll, Loots, & Derluyn, 2013; Wessells, 2006). While this is done in an effort to mitigate the persistence of the idea that child soldiers are apolitical and voiceless victims, it is worth questioning how, for the individual, the promotion of resilience may evolve into feelings of responsibility and the need to provide for oneself (as with Fabian paying for health care to compensate for lack of access) and if this in turn may result in victims’ not seeking or demanding access to their rights.

SUMMARY

In this chapter, I compared characteristics of participants in this research to the larger population of former child soldiers as seen in the literature, and provided an overview of some of the significant challenges and concerns that emerged as themes in this research. Individual and structural factors interact to create substantial barriers to accessing health care in Colombia. While this is true for all Colombians who rely on the public health system, this research shows that these challenges are often multiplied
among former child soldiers. In the next chapter I will present final thoughts and conclusions of this research, as well as recommendations for future research and improvements to health education in reintegration.
CHAPTER 6: RECOMMENDATIONS AND CONCLUSION

INTRODUCTION

The results of this research, as presented and discussed in the previous two chapters, suggest that former child soldiers in Colombia face significant challenges and barriers in accessing health care. Results suggest that obstacles to health care access are the result of structural barriers combined with challenges specific to this population such as high mobility, a lack of social support, security concerns, and fear of discrimination. Overall perceptions of- and experience with the health care system among participants tend to be negative. This combined with a lack of awareness regarding their rights and understanding of how to effectively navigate the health care system may be resulting in a lack of attempted access or, at best, low-quality or delayed care, which in turn hinders the ability to effectively reintegrate to civil society.

The following sections of this chapter will provide recommendations for future research, as well for health education initiatives within ICBF and the ACR. I will then briefly discuss the anthropological and public health implications of this research and conclude this thesis with some final remarks on the key findings and implications of this study.

RECOMMENDATIONS

Future Research

Future research should seek to better understand the health implications of child soldiering and reintegration in Colombia. In order to achieve this, a long-term cohort study should be conducted on the health of child soldiers, to include comparison of the health outcomes of youth in institutional care versus
those in home-based reintegration programs. To provide a comprehensive look at health issues among this population, the study should begin at the time of demobilization and continue through their tenure in the program.

Future research should also seek to explore perceptions of former combatants (both adult combatants and child soldiers) among medical professionals in order to understand the extent to which discrimination affects treatment, as well as if they have an understanding of the needs and experiences of former combatants. In addition, research should seek to understand how the concept of resilience (specifically strong and resilient bodies) and its promotion among child soldiers affects health and if it discourages the seeking of medical assistance at the expense of health.

**Health Education**

Health education should be a requirement within ICBF programs. Topics covered should include basic health concepts and the promotion of health as a form of autonomy and a way to regain ownership of one’s own body. ICBF programs should also utilize health education programs to teach youth about their right to health and how the health system operates (affiliation, how to make appointments, etc.). Education should also be provided for all madre tutoras on the right to health and access to health services for youth in their care.

The ACR should also provide more frequent opportunities for health education, though it is important that the health-related information is adapted to better suit the audience. Information presented should focus on being accessible and centered on topics that are of the greatest interest and need to former combatants. In addition, more time should be dedicated to addressing individual challenges and concerns pertaining to health.

Finally, a list of health resources for victims should be compiled in cooperation with the Secretary of Health in order to ensure that services are being utilized. A line of communication should be established between the Secretary of Health and those working directly with victims such as the ICBF and
the ACR so that important health information can be transferred and disseminated (i.e. changes in policy, availability of new resources, EPS closures, etc.).

ANTHROPOLOGICAL AND PUBLIC HEALTH IMPLICATIONS

Anthropology

This research contributes to the existing body of anthropological literature through the use of a qualitative approach that allows for an understanding of the lived realities and experiences of Colombia’s former child soldiers. Through the use of a critical medical anthropology approach, this research contributes to the understanding of health policy, reintegration, and transitional justice. By taking into account the arbitrary nature of age as a factor in the reintegration process, as well as the treatment of child soldiers as voiceless victims, this research provides theoretical contributions to the anthropology of childhood and child soldiering. Through the use of a ‘vector of rights’ approach, this research also contributes to the understanding of how child soldiers experience intersectional vulnerabilities, which are often unacknowledged.

Applied Anthropology

In addition to theoretical contributions to the anthropology of childhood and child soldiering, the applied nature of this research allows for insight into how health can be improved through micro- and macro-level changes. This research contributes to applied anthropology by highlighting some of the gaps in current reintegration and health policy and by providing recommendations for future research, as well as ways to improve health within the current system. Knowledge acquired during the research process and the results of this research are available to CEDAT and may be utilized in their efforts to assist former child soldiers in accessing health services.

This research also contributes to applied anthropology by illustrating the benefits of interdisciplinary collaboration between applied anthropology and fields such as social work or
psychology. By working with CEDAT, I was granted both the access needed to complete this research and a group of collaborators. As most researchers from CEDAT are psychologists and social workers that have worked in reintegration extensively, this allowed me to gain a better understanding of mental health among this population, as well as a clearer picture of their lives prior to and during reintegration. Their insight guided my research and allowed me to bring to the table a different perspective, grounded in anthropological theory and methods, with which I was able to further explore the issue of health and access to health care.

Public Health

This research contributes to the understanding of the public health effects of conflict, the reintegration process, and the realities of the Colombian public health care system. It also contributes to the sparse body of literature on the physical health of child soldiers and – to an extent – the understanding of the long-term health effects of child soldiering. More broadly, this research contributes to the public health literature on the health effects of disasters and the understanding of humanitarian crisis, as well as the need for a multifaceted response in addressing related challenges. In particular, this research highlights the importance of addressing individual, micro- and macro-level factors when working in areas as complex as reintegration, in order to ensure that response takes into account the lived realities of individuals and how these are shaped by larger social, cultural, and historical contexts.

By highlighting the physical and mental health challenges that participants are facing, this research adds to the understanding of child soldiering as a serious human rights violation, with considerable long-term health consequences at both the individual and societal level. This thesis suggests that international organizations working in the area of public health, such as the United Nations and the World Health Organization (WHO), should take a tougher stance on the issue of child soldiering and dedicate future resources to the development of a more thorough understanding of the topic and how the reintegration process can be improved.
Finally, through the use of body mapping, this research also contributes to the understanding of how visual methods can be used in health research. This research shows that in addition to providing a way to better understand how individuals perceive and categorize their own health problems, visual methods can be used as a way to encourage discussion among research participants.

CONCLUSION

While this thesis was being written, peace talks between the FARC and the Colombian government were in the final stages, suggesting that mass demobilization of the FARC would begin in the near future. While demobilization is an important step in the peace process, it is just one part of the larger DDR process, whose success largely hinges upon the degree to which ex-combatants can be effectively reintegrated to civil society. Global examples, such as the recent remobilization of the Renamo in Mozambique, 20 years after the signing of a peace agreement, illustrate the importance of not just effective demobilization, but also reintegration (Wiegin, 2015). While Colombia’s reintegration process for child soldiers is perhaps one of the most comprehensive, this thesis, in combination with existing research, suggests that there continue to be vast shortcomings in the process, due in large part to the incompatibility of the current reintegration process and transitional justice with social, political, and economic realities.

While Colombia is unique in its years of during-conflict reintegration experience, there are vast shortcomings and gaps in the assistance provided. For reparations and attempts at reintegration to have their intended effect, former child combatants must first have access to their basic rights. The small scope of this research allowed for only a brief glimpse into the challenges this population faces during reintegration and specifically in regards to health and access to health care, yet it shows that former child soldiers face often-insurmountable obstacles in access to quality health care and this in turn likely affects their ability to fully reintegrate and thrive in civil society. This is illustrative of the incompatibility of transitional justice and the right to health within a neoliberal system that treats health as a commodity. The challenges faced by all who are reliant on the state health system are magnified among victims’
populations. The obstacles to access faced by the country’s displaced are well-established in the literature and this research suggests that former child soldiers face similar challenges to the displaced, in addition to unique challenges.

This research illuminates the challenges of implementing transitional justice within the context of broad structural shortcomings, with combined anthropological and public health perspectives enabling an understanding of how individual and local realities interact with, and are determined by, larger structures and processes. This serves to highlight the ways in which insufficient access to basic services hinders the implementation of transitional justice. While this thesis focuses on the very specific issue of health care among former child soldiers, many of the findings can likely be applied to other areas, such as education and in other victims’ populations. Transitional justice efforts seeking to reestablish rights can only be truly effective if built on a solid foundation. In this case, access to health care cannot be guaranteed to victims if the health care system is unable to function smoothly, while fulfilling the needs of all its patients.

As explained by Correa (2015), shortcomings in the provision of health as well as education, combined with socio-economic challenges, can limit the ability of victims of illegal recruitment to use the ‘administrative compensation’ they receive in ways that would benefit their long-term quality of life, so that they can pay for access to basic services such as health care. Simultaneously, the call for improved access to health care specifically for victims of the armed conflict brings to mind the concept of biological citizenship: “a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it” (Petryna, 2013, p. 6). O’Driscoll, Loots, and Derulyn (2013) touch upon the potential implications of privileging demobilized youth, with a quote from a former child soldier explaining that as a child he received no governmental assistance and how this implied that to receive support he must join an armed group. Consequently, it is difficult to find a middle ground between demanding rights for victims of illegal recruitment so that they may more effectively reintegrate, and avoiding notions of biological citizenship, in which access to rights is dependent on biological injury due through victimization.
Thus, the conclusion of this research is not to suggest that former child soldiers in Colombia should receive preferential treatment in access to health care, as this is a right of all Colombians. It is important that access to rights is not contingent on victimization or biological injury. The overwhelming systemic flaws and obstacles to health care access must be addressed on a larger scale so that health may truly be treated as a right for all, rather than as a commodity. What this research illuminates are the challenges specific to this population and the shortcomings in reintegration, specifically in efforts to prepare the individual to operate as effectively as possible within the existing system. In addition, this research suggests that former child soldiers must be aware of their rights as both citizens and as victims, so as to reduce the burden of responsibility for the individual and allow space for social and political participation.

Due to Colombia’s unique experience in reintegration during ongoing conflict, further research and discussion on the subject of reintegration and how it can be improved, based on past experience, has the potential to improve the reintegration process and its effectiveness in anticipation of the mass demobilization of the FARC. Furthermore, as child soldiering continues to take place worldwide, Colombia provides a valuable case study from which other countries may seek guidance. In addition to the human rights benefits related to improving reintegration, improving the process may serve to prevent future conflict by reducing risk of remobilization, such as in Mozambique. Thus, reintegration can be seen not only as a necessity from a human rights perspective or an important step in ending conflict, but also as a method of preventing future conflict and its public health consequences.
REFERENCES


APPENDIX A: INTERVIEW GUIDE

1. How old are you?
2. What is your marital status?
3. Do you have any children?
4. Are you employed?
5. Describe your current living situation.
   5a. Who do you live with?
6. How long were you in Hogar Tutor?
   6a. Were you in other government programs?
7. Describe the transition from government protection programs for demobilized youth to independence.
   7a. Who helped you with the transition?
   7b. What was the biggest challenge?
8. Are you currently affiliated with an EPS?
9. Do you have SISBEN?
   9a. [If not] Why?
10. Are you currently experiencing any health problems? Pain? Injuries?
   10a. Do you have any chronic health conditions?
11. Have you had problems accessing health services?
12. With what frequency do you go to the doctor?
   12a. The dentist?
13. Have you recently accessed any health services?
   13a. In the last year? In the last six months?
   13b. [Women only] Have you accessed any reproductive health services?
14. Have you had any problems accessing those services?
   14a. Do you have to wait a long time to get an appointment?
   14b. If you need or want to see a specialist, have you had problems getting a referral?
15. If it were easier to get an appointment, would you go to the doctor more often?
16. How often did you go to the doctor when you were in Hogar Tutor?
   16a. [If more than #12] Why do you go more now?
17. I am going to give you a list of scenarios. Please tell me how you would respond to each one (for example: go to the doctor, treat it at home, alternative medicine):
   a. You fell and hurt your wrist but you are not sure if it is broken.
   b. You have had flu-like symptoms for two days.
   c. You have been experiencing severe and reoccurring headaches.
   d. You have had mild to moderate, but chronic, back pain for three months.
   e. You have been feeling unusually tired or down.
   f. You have chronic digestive pain or discomfort.

18. When you go to the doctor, is it usually a good experience or does it make you feel nervous or uncomfortable?
   18a. Have your feelings towards going to the doctor changed since you were in Hogar Tutor?

19. When possible, do you prefer to treat yourself at home or seek another form of assistance, rather than go to the doctor?

Added to final 4 interviews (asked after question 17):

- How did you learn to use the health system?
- Do you remember when the first time you made an appointment for yourself was?
- Do you feel that you have a clear understanding of how the health system works?
- Has anyone ever explained to you which preventative health services you can have every year/2 years/3 years?
APPENDIX B: IRB APPROVAL

June 24, 2015

Adriana Dail
Anthropology
Tampa, FL 33613

RE: Expedited Approval for Initial Review
IRB#: Pro00022299
Title: Perceptions of Health and Access to Health Services Among Former Child Soldiers in Manizales, Colombia


Dear Ms. Dail:

On 6/23/2015, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Dail-IRB Protocol 06_17_15.docx

Consent/Assent Document(s)*:
Verbal Consent Form  **granted a waiver

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s). **Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:
(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board