Review

Pan American Journal of Public Health

Sexual and reproductive rights for contraception in Bolivia, Colombia and Uruguay in the framework of human rights*

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Suggested citation (original article): Cordova-Pozo KL,Cordova-Pozo G,Monza A, Píriz G,Moreno-LopezD, Cardenas I. Derechos sexuales y reproductivos para la anticoncepción en Bolivia, Colombia y Uruguay en el marco de los derechos humanos. Rev Panam Salud Publica. 2017;41: e140. doi: 10.26633/RPSP.2017.140

ABSTRACT

Objective. *Compare World Health Organization (WHO) guidelines for contraception in a human rights framework with the existing regulatory frameworks of Bolivia, Colombia, and Uruguay and evaluate which aspects of those regulations need to be developed.*

Methods. *A systematic analysis was based on the WHO analytical framework "Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations" to determine whether the legislation of Bolivia, Colombia, and Uruguay contain general references to the population, specific references to adolescents, or do not refer to the topic. To this end, 36 documents related to contraception were analyzed: 9 from Bolivia, 15 from Colombia, and 12 from Uruguay.*

Results. *It was confirmed that each country's legislation complies with several WHO recommendations. The three countries have strengths in nondiscrimination and in opportunity for informed decision-making, and have weaknesses in accessibility, quality, and accountability. Acceptability is a strength in Colombia and Bolivia, and confidentiality is a strength in Bolivia and Uruguay. Colombia has weaknesses in availability, confidentiality, and participation.*

Conclusions. *Comparison of national legislation with WHO guidance helps to see the strengths and weaknesses of national regulatory frameworks and to see opportunities to improve regulations.*

Keywords Contraception; legislation; health legislation; Bolivia; Colombia; Uruguay; adolescent; human rights.

Sexual and reproductive health (SRH) is a critical issue for adolescents (defined as 11-19 year olds). Actions during this stage can have consequences for the rest of their lives, such as adolescent motherhood, and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV). The adolescent population is 22% in Bolivia, 18.4% in Colombia and 15.3% in Uruguay. In Bolivia and Colombia, 13% of adolescent girls are married, and 20% girls under the age of 18 have already carried a pregnancy to term (1). In Uruguay, the number of births in adolescent mothers is 16.4%; only 3.6% of mothers are in a favorable economic environment and 22.4% are mothers are in unfavorable economic environments (2).

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* Non-official English translation revised by the authors. In case of discrepancy between the two versions, the Spanish original shall prevail.

With regards to HIV, 31.5% of the study population in Bolivia and 26% in Colombia know about HIV, 8.9% in the urban area and 17.6% in rural areas. The prevalence of HIV in the population aged 15-24 years is 0.3% in Bolivia and 0.5% in both Colombia and Uruguay (1).

The prevalence of modern methods of contraception is 33.7% in Bolivia, 72.7% in Colombia and 74.8% in Uruguay; condoms being the least popular method: 4% in Bolivia, 7% in Colombia, and 30.8% in Uruguay (1). These statistics are similar throughout South American countries, with differences between regions, rural-urban areas, and socio-economic contexts, since South America has high levels of inequality that hinder social inclusion and sustainable growth (3).

The Montevideo Consensus urges Governments to change their legislation in order promote of sexual and reproductive health and rights (SRHR) (4). This Consensus is a strategic framework for advancing the Program of Action of the International Conference on Population and Development in Cairo in 1994 and the Latin American and Caribbean Consensus on Population and Development adopted in Mexico in 1993.

The aim of this manuscript is to compare the recommendations of the World Health Organization (WHO) (5) to provide contraceptive information and services with the normative framework of Bolivia, Colombia and Uruguay, evaluating contraceptive legislation and highlighting the aspects necessary to develop and achieve respect for human rights.

METHODS

A systematic analysis and evaluation was carried out based on the analytical framework, circumscribed in the WHO document ¨Respect of human rights when providing contraceptive information and services: guidance and recommendations¨ (2014) (Table 1). The legislation of Bolivia, Colombia and Uruguay were reviewed to see if they contain general references to the population, specific references for adolescents, or no reference to these recommendations. Similar studies have already been carried out under this methodology (6,7). The analysis only presents the existing legislation and not its degree of implementation.

Thirty-six documents including laws, decrees, resolutions, policies, guidelines and manuals related to contraception were collected and reviewed; nine from Bolivia, 15 from Colombia and 12 from Uruguay (Annex 1). The analysis was multidisciplinary and per country; conducted, by a Bolivian political economist and a medical doctor; by a Colombian adolescent technical leader and a specialized professional of the Ministry of Health and Social Protection; and by a Uruguayan psychologist and a gynecologist from the SRH area of the public system.

RESULTS

The results are presented in numerical order under the WHO's analytical framework, entitled "Human Rights Respect when providing contraceptive information and services: guidance and recommendations" (WHO, 2014) (Table 1)[a] .

1) Discrimination in the provision of contraceptive information and services [1.1-1.2]

The three countries have regulations to ensure access to contraceptive information and services without discrimination [1.1]. In Bolivia all healthy adolescents are eligible for any contraceptive method after guidance and counseling, and the guidelines recommend designing of friendly establishments that take care of regional and cultural particularities to favor the access and use of contraceptives by multiple users, including adolescents (8,9). Colombia guarantees SRHR, freedom of violence, equality, autonomy and without discrimination due to sex, age, ethnicity, sexual orientation, gender identity, disability, religion or victims of armed conflict (10,11). Colombia detects and addresses risk factors, promotes protective factors for adolescents (12). Uruguay recommends the universalization of primary care in sexual and reproductive health (SRH) with integrality, quality, opportunity, and commitment of human resources and adequate information systems, guaranteeing universal access to contraception (13,14).

All three countries support laws and policies with established programs [1.2]. Bolivia focuses on discrimination-free services (15) and is based on basic principles of the right to life such as physical integrity, gender and generational equity, participation, solidarity, social justice and reciprocity with respect to cultural diversity (16). Raising awareness of adolescent health and training in differentiated services are also promoted (17). Colombia's sexuality policy is articulated within national and international norms on sexuality and SRHR (11), which helps to achieve common objectives in other laws (Primary Health Care, the Ten-year Public Health Plan 2012-2021, the General System of Social Security in Health (GSSS, Law 100/93). This regulates the Plan of Basic[1] Attention and STI/HIV and unwanted pregnancy prevention programs through information, education, communication and use of the male condom, guaranteeing the free access of adolescents to contraceptive services (18-21). Uruguay focuses on creating contraceptive and fertility treatment protocols for the population (13).

2) Availability of contraceptive information and services [2.1]

Bolivia provides yearly a planning for provision and storage based on a programmatic goal for each health facility and is added at the municipal, local, departmental, and national levels (8) to strengthen the National Single Supply System and the Medicines Logistics Administration Subsystem and Inputs, which ensure the provision of materials, medicines and contraception (16). No specific regulations were found for Colombia. Uruguay has regulations for purchases that revise, consolidate and estimate needs annually, based on the previous consumption coordinated by the SRH departments, ensuring access and quality of care (22, 23).

3) Accessibility of contraceptives information and services [3.1-3.10]

The three countries meet 4/10 sub-recommendations but there is a lack of improved access for displaced populations and those living in crisis [3.4]. There is also a lack of mobile services for those facing geographical barriers [3.8].

The three countries have regulations for comprehensive sexuality education (CSE), indicating that educational institutions and health centers are required for education, SRH guidance, and responsible and SRHR-free exercise [3.1]. For Bolivia, HIA must be consistent with

a In this manuscript the numbers in brackets refer to the item listed in table 1.

1 This program frames both the Collective Intervention Plan (PIC) and the Obligatory Health Plan (POS)

TABLE 1. Comparative analysis of legislation under the WHO analytical framework "Ensuring human rights in the provision of contraceptive information and services" (WHO, 2014)

Summary of the WHO Recommendations		Bolivia	Colombia	Uruguay
1.	**Non-discrimination**			
1.1	Guarantee access to information and services			
1.2	Legal and political support to the established programs			
2.	**Availability**			
2.1	Available supply of medicine and contraception			
3.	**Accessibility**			
3.1	Provision of comprehensive sexual education			
3.2	Eliminating financial barriers			
3.3	Interventions to improve access to users with difficulties			
3.4	Interventions to improve access to displaced populations			
3.5	Information and services as part of HIV test and treatment			
3.6	Provision of contraception as part of antenatal and postpartum care			
3.7	Integrate the provision of contraception with abortion/post-abortion care	a		
3.8	Mobile outreach services to populations that face geographical barriers			
3.9	Eliminating third-party or spousal authorization requirements		b	b
3.10	Eliminating parental authorization for adolescents			
4.	**Acceptability**			
4.1	Include gender-sensitive counselling, skill building tailored to needs			
4.2	Priority to follow-up services and side-effects			c
5.	**Quality**			
5.1	Quality assurance processes			
5.2	Insertion and removal services, counselling on side-effects			
5.3	Competency-based training and supervision of health-care personnel	d	d	d
6.	**Informed decision-making**			
6.1	Scientific evidence for informed choice			
6.2	Informed choice without discrimination			
7.	**Privacy and confidentiality**			
7.1	Confidentiality and privacy of individuals			
8.	**Participation**			
8.1	Participation in the programme and policy design, implementation and monitoring.			
9.	**Accountability**			
9.1	Effective accountability mechanisms, remedies and redress: individual/ systems			
9.2	Evaluating and monitoring to guarantee the highest quality and respect to human rights			

Legend: *orange* specific normative guidance pertaining to general population and to adolescents; *yellow* specific normative pertaining to general population only; *green* specific normative guidance pertaining to adolescents only; *gray* normative guidance for that recommendation is not present in the country legislation.

a Abortion is illegal in Bolivia

b Colombia and Uruguay have legal provisions but the normative tells that consent has to be requested.

c Uruguay has no legislation on side-effects management

d Bolivia, Colombia and Uruguay have no legislation to monitoring personnel

Source: Comparative analysis based in the WHO document, 2014

physical and psychological development (17), the families must also be educated (16). Colombia promotes self-knowledge, self-esteem, and expression sexual identity while being treated with fairness, respect, and allowance of a harmonious family life and according to psychological, physical needs as appropriate for age (24,25). Where the family and school are obliged to the formation, orientation and stimulation of the exercise of rights, responsibilities and autonomy for responsible exercise of SRHR and life as a couple, and the social security system offers specialized services for adolescents (25). Uruguay focuses on training teachers in schools and SRH services for counseling and prevention of STIs in all age groups (13,14). Uruguay promotes reduction of unwanted pregnancies through teaching about proper condom use (26,27).

All three countries guarantee free, secure and reliable access to contraceptive information and services for the general population and adolescents [3.2]. These services include intrauterine devices (IUD), oral contraception (including emergency contraception, which in Bolivia is only available at pilot centers) and condoms. Implants are not universally available (8,13). In Bolivia, contraception is free, part of the family planning and HIV/AIDS/STI programs (16), preventing the cost of service and contraception from limiting the options

available to adolescents (28). Colombia aims for the prevention of STIs/HIV and unwanted pregnancies with free distribution of reversible methods of contraception to the population in health facilities, in the social security system and where sexual acts are performed (brothels) (18-20,29).

Uruguay has universal access to safe and reliable reversible contraception. Permanent contraceptives are reserved for persons over 18 or married, divorced or widowed women. (13-14); in private clinics condoms are given for twelve months for a small fee (26). Adolescent access the method and a promotion and prevention consultation in SRH, is distributed by vending machines (26). Female condoms can also be distributed from vending machines (27,30).

None of the countries have regulations to improve access to the rural and urban poor [3.3]. Colombia and Uruguay provide information and access to adolescents on contraception and condom use as part of the vulnerable population (20,26). Colombia focuses on improving the health of vulnerable groups, adolescents and those who have scarce resources (31).

None of the countries studied have regulations to improve access for the displaced or those in crisis scenarios [3.4]. The three countries have regulations for universal access to prevention and comprehensive treatment of STIs and HIV/AIDS, providing information, counseling and delivery of condoms, with testing and treatment of the general population and adolescents [3.5] (8,18,19, 26,27). Bolivia promotes the use of condoms to avoid STI transmission (8). Colombia focuses on STI counseling and treatment for pregnant women (21). Uruguay contextualizes adolescents, gender and their sexual practices (27).

All three countries have regulations for contraception to prevent unwanted and postnatal pregnancy [3.6] (8,20,26,32,33). Uruguay focuses on counseling of adolescents, instructions on the correct use of condoms and other recommendations to prevent recurrence of unwanted pregnancies (26).

All three countries have regulations for the provision of post-abortion contraception [3.7] (8, 20,34). In Bolivia, abortion is illegal, except in the cases of rape, incest, or to protect the woman's health. Abortion is legal in Colombia in the case of rape, incest, or to protect the woman's health, including for girls (35). In Uruguay, voluntary abortion is decriminalized and post-event contraception counseling is provided (34).

None of the countries have regulations on mobile services to reduce geographical barriers [3.8].

Elimination of authorization of the spouse or third parties [3.9]: In Bolivia, any woman or man can undergo long-term or permanent sterilization in a safe manner, prior to counseling and informed consent, without consent of their partner (8); co-responsibility is encouraged for adolescents, but if they attend alone, they must give the necessary information and can choose the desired method, even if their partner has not consented (28). Colombia and Uruguay emphasize free decision and autonomy, although they refer to the fact that it is common practice to ask the authorization of the partner for consent in the case of female sterilization, but not for male sterilization (11,34).

The three countries have regulations for not requiring parental consent for the adolescent; age is not a medical reason for denying SRH counseling or access to contraception [3.10] (21,26,28,36). All three offer reversible methods on request. Bolivia pays special attention to the provision of non-reversible methods (28). Colombia also guarantees access to information and education (20,37). Uruguay offers some services respecting the progressive autonomy of the adolescent (13,38).

4) Acceptability of contraceptive information and services [4.1-4.2]

All three countries have regulations to provide acceptable information and services based on needs, gender-sensitive counselling, particularly for adolescents [4.1] (12,13,28). Bolivia indicates orientation and listening based on the adolescent's concerns to use a contraception, fosters co-responsibility, generates negotiation skills, reports on effectiveness and side effects, follows-up consultations, and provides services for both married and single individuals (8,28). In Colombia, adolescents are a cross-cutting part of their policy and the social determinants to eradicate discrimination based on gender, STI and HIV/AIDS, and discrimination based on sexual orientation or gender identity (12). Uruguay focuses on the training of health personnel for informed choice (13).

Regarding follow-up services and side effects [4.2]: Bolivia has the following priority tracking services for contraceptive side effects: a) eight week follow-up post initial consultation and further follow-up every three months for consultation on consistency of method use, and side effects; b) twelve months later for a pelvic examination, cervical cancer or STI screening, , and assessing for side effects of each method (8.28). Colombia, on the other hand, focuses a follow-up of adolescents vulnerable to method adherence (20). Uruguay promotes follow-up with a gynecologist three months after starting a contraceptive method (39) but has no regulations for the management of side effects.

5) Quality of contraceptive information and services [5.1-5.3]

Bolivia and Colombia do not have norms in quality assurance processes [5.1]. In Uruguay, the Ministry of Health defines contents, plans awareness activities and training references for professionals to improve the quality of care (13).

In the case of Bolivia and Uruguay, they do not show norms for IUD insertion and removal services or implants [5.2] nor for advice on side effects. Colombia offers the application and removal of the IUD and insert of the implant and advises on side effects (29).

All three countries have staff training based on competencies [5.3]. Bolivia focuses on providing guidance and care with qualified personnel for the understanding, and management of current contraceptive policies and standards, its application in the promotion of SRHR and access to counseling and services (8) for adolescents. Staff should have training in communicating with adolescents, families, and the general to ensure acceptable comprehensive care, and to ensure impartiality without making value judgments (28). Colombia indicates that medical or nursing professionals should be trained in IUD insertion and removal, counseling and obtaining informed consent (29). Uruguay focuses on the adequate training of technical aspects, information provision, skills for communication and treatment provision; psychologist, and sexual assault services (13), orientation training, and condom delivery (26). Bolivia, Colombia and Uruguay do not have regulations for personnel supervision.

6) Informed decision-making [6.1-6.2]

The three countries have regulations that promote information and advice on contraception in order to allow users to make their own informed choice, giving adolescents the freedom to choose after receiving information on available contraception, advantages, disadvantages, consequences of so that an individual can choose based on their needs [6.1] (8,11,30). Bolivia focuses on unwanted pregnancy prevention, the spacing of children (16) and comprehensive adolescent care (9). Colombia values personal decision as the maximum expression of individual and citizen freedom in lay contexts with knowledge, reason, discernment, will, assumption of limits and consequences of decisions (11). For adolescents, focus is on systematic use of a chosen contraceptive method (20). Uruguay focuses on age, lifestyle, values, pattern of sexual activity and acceptability of the method while highlighting safety, efficacy, comfort and accessibility (30). This is based on gender, rights and diversity for the exercise of a pleasurable, free and responsible sexuality (26).

The three countries have regulations for free decision making on the correct use of contraception, tolerance and improvement in their quality of life for adolescents and the general population [6.2]. Bolivia focuses on intercultural adaptation and respect for women's self-determination, where the WHO intervenes to facilitate the exercise of rights over the use of contraception, recognizing and respecting their ability to make decisions (8,16). Any adolescent can have a contraceptive consultation; the health services must respect that right and help evaluate the decision of the professional, individual, or couple (28). For Colombia, informed consent means that people can say they were told and know about reversible and contraceptive long-term effects, and can freely choose or change their decision before the procedure without consequence (20). Uruguay leaves the choice of the method to the adolescent and the professional advises and accompanies this process explaining the reasons that support or discourage the use of the method based on evidence (26).

7) Privacy and confidentiality [7.1]

Bolivia and Uruguay have regulations to regulate and respect privacy and confidentiality (13,16,31,40). Bolivia focuses on adolescents (28) while Uruguay focuses on guaranteeing the quality and privacy of individuals (13). Colombia focuses on confidentiality and privacy in general, not explicitly pertaining to contraception for adolescents (31).

8) Participation [8.1]

In Bolivia, there are norms for participation in health and SRH with local youth councils and social control groups to guarantee the quality of services (31). The standard provides training for young people to exercise their rights, decision making, and self-management of their health and life projects.

The contraceptive standard promotes community participation in the promotion of SR&R and intersectoral activities, indicating that participation and co-responsibility are shared between the State, society and youth for the creation, execution and control of social transformation political, economic and cultural policies, (31). Colombia has a regulation to organize an intersectoral National Commission to promote and guarantee research and development comprised of government units, not including adolescents or the general population (41). Uruguay promotes inter-institutional coordination with the participation of social networks and users to exchange information, health education and solidarity support and active participation in the implementation and monitoring of actions in SRH (13,42).

9) Accountability [9.1-9.2]

No country has accountability mechanisms with respect to contraceptive information and services provided, including means of compensation to the individual.

All three countries have evaluation and supervision systems to guarantee quality, but only Colombia has an evaluation and supervision system to guarantee human rights. In Bolivia, Colombia, and Uruguay, regulations were found to strengthen management, monitoring, evaluation, implementation control, and policy objectives through data collection through Information Analysis Committees in Bolivia (16), Social Protection Information System in Colombia, and the incidence and mechanisms of HIV/STI/AIDS transmission in Uruguay (13).

Bolivia focuses on knowledge for reassigning budgets and achieving goals (17). Colombia focuses on ensuring respect for freedom of thought, free expression in sexuality and reproduction, and minimizing judgments in health care processes through political, religious or cultural positions (11). Uruguay has supervision of institutions providing SRH with Coordinating Teams of Reference to guarantee benefits established in Law 18,426 with monitoring and evaluation, with identification of barriers, facilitators, coordination and users to monitor benefits and elaborate evaluation mechanisms (43).

DISCUSSION

This study verified that the legislation of the three countries complies with a number of WHO recommendations for contraceptive information and services in the framework of human rights (5). All three countries have strengths in non-discrimination [1] and spaces for informed decision-making [6]. Its weaknesses are in accessibility [3], quality [5] and accountability [9]. Acceptability [4] is a strength for Colombia and Bolivia; confidentiality [7] is for Bolivia and Uruguay. Colombia has weaknesses in availability [2], confidentiality [7] and participation [8] (Table 1).

The challenges of these countries lie in reforming the laws to optimize contraceptive provision in a human rights framework and to make contraception inclusive of the general population and adolescents (Table 2). Improving legislation must address an articulated environment based on weaknesses and strengths of the national context and of the health, education, economy and community system so that it can be effectively and equitably implemented (3).

This review is built on similar analyses in Paraguay and South Africa (6,7). Together with Paraguay, Bolivia, Colombia and Uruguay, they recognize that adolescents have special needs and require specific legislation on contraception from the perspective of human rights from which the population also benefits. The four share

similar challenges in accessibility [3], quality [5], participation [8] and accountability [9] and being signatories of the Montevideo Consensus could work in multinational consensuses to improve these areas.

One limitation of this study is that it analyzes the normative framework and not its implementation. Actions taken to improve contraceptive services and information, as well as the challenges that each country faces due to its health system, socioeconomic situation, taboos, degree of implementation of laws and non-recognition of the rights can make a country comply with the WHO recommendations. Future studies could carry out the analysis of the implementation and the limitations for comprehensive contraceptive provision.

It is concluded that the comparison of the national legislation of Colombia, Bolivia and Uruguay with the WHO guide to contraception shows strengths and weaknesses in the national and regional normative framework to find opportunities to strengthen legislation. A normative framework that guarantees respect for human rights endorses the political commitment on development promotes good practices towards a quality service.

TABLE 2. Opportunities to strengthen the legislation in Bolivia, Colombia and Uruguay

Availability [2], accessibility [3] of contraceptive information and services:
- Col: Integrate contraception within the essential medicine supply chain to increase availability [2.1]
- Bol: Create interventions for the rural residents, urban poor [3.3]
- Bol / Col / Uru: Include interventions to displaced populations and in crisis settings [3.4]
- Bol / Col / Uru: Include mobile services to reduce geographical barriers [3.8]
- Col / Uru: Explicitly state that no spousal authorization is needed [3.9]
Acceptability [4], quality [5], confidentiality [7] of contraceptive information and services:
- Uru: Include normative for side-effects management [4.2]
- Bol / Col: Include quality assurance processes [5.1]
- Bol / Uru: Include the provision of long-acting reversible contraception, insertion and removal [5.2]
- Bol / Col / Uru: Explicitly include normative for supervision [5.3]
- Col: Include normative to respect confidentiality and privacy of individuals [7]
Participation [8] and accountability [9] of contraceptive information and services:
- Col: Include participation in the programme and policy design, implementation and monitoring. [8]
- Bol / Col / Uru: Include accountability mechanisms, remedies and redress [9.1]
- Bol: Include evaluation and monitoring to respect human rights [9.2]

Bol., Bolivia; Col., Colombia; Uru., Uruguay
Each number in square bracket can be compared with table 1
Source: Based on the WHO (2014) document and the review of legislation

Conflicts of interest. None stated by the authors

Declaration. The opinions expressed in this manuscript are the responsibility of the author and do not necessarily reflect the criteria or the policy of the RPSP / PAJPH and / or PAHO

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Original (Spanish) manuscript received on 28 March 2017. Revised version accepted for publication on 5 June 2017.

RESUMEN

Derechos sexuales y reproductivos para la anticoncepción en Bolivia, Colombia y Uruguay en el marco de los derechos humanos

Objetivo. Realizar una comparación entre las Directrices de la Organización Mundial de la Salud (OMS) para la anticoncepción en el marco de los derechos humanos (DDHH) con el marco normativo existente en Bolivia, Colombia y Uruguay y evaluar los aspectos que son necesarios desarrollar en la normativa.
Métodos. Se realizó un análisis sistemático con base al marco analítico de la OMS ¨Respeto de los DDHH cuando se proporciona información y servicios de anticoncepción: orientación y recomendaciones¨ para determinar si la legislación de Bolivia, Colombia y Uruguay contienen referencias generales a la población, referencias específicas para los adolescentes o no hacen referencia. Para este fin, se analizó un total de 36 documentos relacionados con la anticoncepción: 9 de Bolivia, 15 de Colombia y 12 de Uruguay.
Resultados. Se verificó que la legislación de cada país cumple con varias recomendaciones de la OMS. Los tres países tienen fortalezas en la no discriminación y el espacio para las decisiones informadas; sus debilidades están en la accesibilidad, la calidad y la rendición de cuentas. La aceptabilidad es una fortaleza para Colombia y Bolivia; la confidencialidad es para Bolivia y Uruguay. Colombia tiene como debilidad la disponibilidad, la confidencialidad y la participación.
Conclusiones. La comparación de la legislación nacional con la guía de la OMS ayuda a ver las fortalezas y las debilidades en el marco normativo nacional y ver oportunidades para mejorar la normativa.

Palabras clave Anticoncepción; legislación; legislación sanitaria; Bolivia; Colombia; Uruguay; adolescente; derechos humanos.

RESUMO

Direitos sexuais e reprodutivos de contracepção na Bolívia, Colômbia e Uruguai como parte dos princípios dos direitos humanos

Objetivo. Comparar as diretrizes da Organização Mundial da Saúde (OMS) para contracepção como parte dos princípios dos direitos humanos com os enquadramentos regulamentares existentes na Bolívia, Colômbia e Uruguai e avaliar os elementos destes enquadramentos que precisam ser melhorados.
Métodos. Realizou-se uma análise sistemática segundo a metodologia analítica descrita no documento da OMS ¨Respeito aos direitos humanos ao prestar informações e serviços sobre contracepção: orientação e recomendações com o propósito de verificar se as legislações da Bolívia, Colômbia e Uruguai fazem referências gerais à população, referências específicas aos adolescentes ou não fazem referências. Ao todo, 36 documentos sobre contracepção foram analisados: 9 provenientes da Bolívia, 15 da Colômbia e 12 do Uruguai.
Resultados. Verificou-se que as legislações dos três países cumprem com diversas recomendações da OMS. Não discriminação e oportunidade para decidir de forma esclarecida são os pontos fortes e acessibilidade, qualidade e prestação de contas são os pontos fracos. A aceitabilidade é um ponto forte na Colômbia e Bolívia e a confidencialidade, na Bolívia e Uruguai. Disponibilidade, confidencialidade e participação são os pontos fracos na Colômbia.
Conclusão. A comparação das legislações nacionais com o guia da OMS possibilita identificar os pontos fortes e fracos no enquadramento regulamentar nacional e encontrar oportunidades para melhorar.

Palavras-chave Anticoncepção; legislação sanitaria; Bolívia; Colômbia; Uruguai; adolescente; direitos humanos.