

· THE ·

CONTINUUM *Complete*
International
ENCYCLOPEDIA
OF SEXUALITY

· ON THE WEB AT THE KINSEY INSTITUTE ·

<http://www.kinseyinstitute.org/ccies/>

RAYMOND J. NOONAN, PH.D., CCIES WEBSITE EDITOR

Encyclopedia Content Copyright © 2004-2006 Continuum International Publishing Group.
Reprinted under license to The Kinsey Institute. This Encyclopedia has been made
available online by a joint effort between the Editors, The Kinsey Institute, and
Continuum International Publishing Group.

This document was downloaded from *CCIES at The Kinsey Institute*, hosted by
The Kinsey Institute for Research in Sex, Gender, and Reproduction, Inc.
Bloomington, Indiana 47405.

**Users of this website may use downloaded content for
non-commercial education or research use only.**

All other rights reserved, including the mirroring of this website or the placing of
any of its content in frames on outside websites. Except as previously noted,
no part of this book may be reproduced, stored in a retrieval system,
or transmitted, in any form or by any means, electronic, mechanical,
photocopying, recording, or otherwise, without the
written permission of the publishers.

Edited by:

ROBERT T. FRANCOEUR, Ph.D., A.C.S.

and

RAYMOND J. NOONAN, Ph.D.



Associate Editors:

Africa: Beldina Opiyo-Omolo, B.Sc.

Europe: Jakob Pastoetter, Ph.D.

South America: Luciane Raibin, M.S.

Information Resources: Timothy Perper, Ph.D. &
Martha Cornog, M.A., M.S.



Foreword by:

ROBERT T. FRANCOEUR, Ph.D., A.C.S.



Preface by:

TIMOTHY PERPER, Ph.D.



Introduction by:

IRA L. REISS, Ph.D.

· THE ·

CONTINUUM *Complete*
International
ENCYCLOPEDIA
OF SEXUALITY

Updated, with More Countries

2004

The Continuum International Publishing Group Inc
15 East 26 Street, New York, NY 10010

The Continuum International Publishing Group Ltd
The Tower Building, 11 York Road, London SE1 7NX

Copyright © 2004 by The Continuum International Publishing Group Inc

All rights reserved. No part of this book may be reproduced,
stored in a retrieval system, or transmitted, in any form or by any means,
electronic, mechanical, photocopying, recording, or otherwise, without
the written permission of the publishers.

Typography, Graphic Design, and Computer Graphics by
Ray Noonan, ParaGraphic Artists, NYC <http://www.paragraphics.com/>

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

The Continuum complete international encyclopedia of sexuality / edited
by Robert T. Francoeur ; Raymond J. Noonan ; associate editors, Martha
Cornog . . . [et al.].

p. cm.

A completely updated one-volume edition of the 4-volume International
encyclopedia of sexuality (published 1997-2001), covering more than 60
countries and places, 15 not previously included.

Includes bibliographical references.

ISBN 0-8264-1488-5 (hardcover : alk. paper)

1. Sex—Encyclopedias. 2. Sex customs—Encyclopedias. I. Title:
Complete international encyclopedia of sexuality. II. Francoeur, Robert
T. III. Noonan, Raymond J. IV. Cornog, Martha. V. International
encyclopedia of sexuality.

HQ21.I68 2003

306.7'03—dc21

2003006391

Contents

HOW TO USE THIS ENCYCLOPEDIA	viii
FOREWORD	ix
<i>Robert T. Francoeur, Ph.D., A.C.S.</i>	
PREFACE	xi
<i>Timothy Perper, Ph.D.</i>	
AN INTRODUCTION TO THE MANY MEANINGS OF SEXOLOGICAL KNOWLEDGE	xiii
<i>Ira L. Reiss, Ph.D.</i>	
ARGENTINA	1
<i>Sophia Kamenetzky, M.D.; Updates by S. Kamenetzky</i>	
AUSTRALIA	27
<i>Rosemary Coates, Ph.D.; Updates by R. Coates and Anthony Willmetts, Ph.D.</i>	
AUSTRIA	42
<i>Dr. Rotraud A. Perner, L.L.D.; Translated and Redacted by Linda Kneucker; Updates by Linda Kneucker, Raoul Kneucker, and Martin Voracek, Ph.D., M.Sc.</i>	
BAHRAIN	59
<i>Julanne McCarthy, M.A., M.S.N.; Updates by the Editors</i>	
BOTSWANA	89
<i>Godisang Mookodi, Oleosi Ntshhebe, and Ian Taylor, Ph.D.</i>	
BRAZIL	98
<i>Sérgio Luiz Gonçalves de Freitas, M.D., with Eli Fernandes de Oliveira and Lourenço Stélio Rega, M.Th.; Updates and comments by Raymond J. Noonan, Ph.D., and Dra. Sandra Almeida, and Luciane Raibin, M.S.</i>	
BULGARIA	114
<i>Michail Alexandrov Okoliyski, Ph.D., and Petko Velichkov, M.D.</i>	
CANADA	126
<i>Michael Barrett, Ph.D., Alan King, Ed.D., Joseph Lévy, Ph.D., Eleanor Maticka-Tyndale, Ph.D., Alexander McKay, Ph.D., and Julie Fraser, Ph.D.; Rewritten and updated by the Authors</i>	
CHINA	182
<i>Fang-fu Ruan, M.D., Ph.D., and M. P. Lau, M.D.; Updates by F. Ruan and Robert T. Francoeur, Ph.D.; Comments by M. P. Lau</i>	
COLOMBIA	210
<i>José Manuel Gonzáles, M.A., Rubén Ardila, Ph.D., Pedro Guerrero, M.D., Gloria Penagos, M.D., and Bernardo Useche, Ph.D.; Translated by Claudia Rockmaker, M.S.W., and Luciane Raibin, M.S.; Updates by the Editors; Comment by Luciane Raibin, M.S.</i>	
COSTA RICA	227
<i>Anna Arroba, M.A.</i>	
CROATIA	241
<i>Aleksandar Štulhofer, Ph.D., Vlasta Hiršl-Hečej, M.D., M.A., Željko Mrkšić, Aleksandra Korać, Ph.D., Petra Hobljaj, Ivanka Ivkanec, Maja Mamula, M.A., Hrvoje Tiljak, M.D., Ph.D., Gordana Buljan-Flander, Ph.D., Sanja Sagasta, Gordana Bosanac, Ana Karlović, and Jadranka Mimica; Updates by the Authors</i>	
CUBA	259
<i>Mariela Castro Espín, B.Ed., M.Sc., and María Dolores Córdova Llorca, Ph.D., main authors and coordinators, with Alicia González Hernández, Ph.D., Beatriz Castellanos Simons, Ph.D., Natividad Guerrero Borrego, Ph.D., Gloria Ma. A. Torres Cueto, Ph.D., Eddy Abreu Guerra, Ph.D., Beatriz Torres Rodríguez, Ph.D., Caridad T. García Álvarez, M.Sc., Ada Alfonso Rodríguez, M.D., M.Sc., Maricel Rebollar Sánchez, M.Sc., Oscar Díaz Noriega, M.D., M.Sc., Jorge Renato Ibarra Guitart, Ph.D., Sonia Jiménez Berrios, Daimelis Monzón Wat, Jorge Peláez Mendoza, M.D., Mayra Rodríguez Lauzerique, M.Sc., Ofelia Bravo Fernández, M.Sc., Lauren Bardisa Ecurra, M.D., Miguel Sosa Marín, M.D., Rosaida Ochoa Soto, M.D., and Leonardo Chacón Asusta</i>	
CYPRUS	279
<i>Part 1: Greek Cyprus: George J. Georgiou, Ph.D., with Alecos Modinos, B.Arch., A.R.I.B.A., Nathaniel Papageorgiou, Laura Papantoniou, M.Sc., M.D., and Nicos Peristianis, Ph.D. (Hons.); Updates by G. J. Georgiou and L. Papantoniou; Part 2: Turkish Cyprus: Kemal Bolayır, M.D., and Serin Kelâmi, B.Sc. (Hons.)</i>	
CZECH REPUBLIC	320
<i>Jaroslav Zvěřina, M.D.; Rewritten and updated by the Author</i>	
DENMARK	329
<i>Christian Graugaard, M.D., Ph.D., with Lene Falgaard Eplov, M.D., Ph.D., Annamaria Giraldi, M.D., Ph.D., Ellids Kristensen, M.D., Else Munck, M.D., Bo Møhl, clinical psychologist, Annette Fuglsang Owens, M.D., Ph.D., Hanne Risør, M.D., and Gerd Winther, clinical sexologist</i>	
EGYPT	345
<i>Bahira Sherif, Ph.D.; Updates by B. Sherif and Hussein Ghanem, M.D.</i>	
ESTONIA	359
<i>Elina Haavio-Mannila, Ph.D., Kai Haldre, M.D., and Osmo Kontula, Ph.D.</i>	
FINLAND	381
<i>Osmo Kontula, D.Soc.Sci., Ph.D., and Elina Haavio-Mannila, Ph.D.; Updates by O. Kontula and E. Haavio-Mannila</i>	
FRANCE	412
<i>Michel Meignant, Ph.D., chapter coordinator, with Pierre Dalens, M.D., Charles Gellman, M.D., Robert Gellman, M.D., Claire Gellman-Barroux, Ph.D., Serge Ginger, Laurent Malterre, and France Paramelle; Translated by Genevieve Parent, M.A.; Redacted by Robert T. Francoeur, Ph.D.; Comment by Timothy Perper, Ph.D.; Updates by the Editors</i>	
FRENCH POLYNESIA	431
<i>Anne Bolin, Ph.D.; Updates by A. Bolin and the Editors</i>	

GERMANY	450	NEPAL	714
<i>Rudiger Lautmann, Ph.D., and Kurt Starke, Ph.D.; Updates by Jakob Pastoetter, Ph.D., and Hartmut A. G. Bosinski, Dr.med.habil., and the Editor</i>		<i>Elizabeth Schroeder, M.S.W.</i>	
GHANA	467	NETHERLANDS	725
<i>Augustine Ankomah, Ph.D.; Updates by Beldina Opiyo-Omolo, B.Sc.</i>		<i>Jelto J. Drenth, Ph.D., and A. Koos Slob, Ph.D.; Updates by the Editors</i>	
GREECE	479	NIGERIA	752
<i>Dimosthenis Agraftiotis, Ph.D., Elli Ioannidi, Ph.D., and Panagiota Mandi, M.Sc.; Rewritten and updated in December 2002 by the Authors</i>		<i>Uwem Edimo Esiet, M.B., B.S., M.P.H., M.I.L.D., chapter coordinator; with Christine Olunfinke Adebajo, Ph.D., R.N., H.D.H.A., Mairo Victoria Bello, Rakiya Booth, M.B.B.S., F.W.A.C.P., Imo I. Esiet, B.Sc, LL.B., B.L., Nike Esiet, B.Sc., M.P.H. (Harvard), Foyin Oyebola, B.Sc., M.A., and Bilkisu Yusuf, B.Sc., M.A., M.N.I.; Updates by Beldina Opiyo-Omolo, B.Sc.</i>	
HONG KONG	489	NORWAY	781
<i>Emil Man-lun Ng, M.D., and Joyce L. C. Ma, Ph.D.; Updates by M. P. Lau, M.D., and Robert T. Francoeur, Ph.D.</i>		<i>Elsa Almås, Cand. Psychol., and Esben Esther Pirelli Benestad, M.D.; Updates by E. Almås and E. E. Pirelli Benestad</i>	
ICELAND	503	OUTER SPACE and ANTARCTICA	795
<i>Sóley S. Bender, R.N., B.S.N., M.S., Coordinator, with Sigrún Júlíusdóttir, Ph.D., Thorvaldur Kristinsson, Haraldur Briem, M.D., and Guðrún Jónsdóttir, Ph.D.; Updates by the Editors</i>		<i>Raymond J. Noonan, Ph.D.; Updates and new material by R. J. Noonan</i>	
INDIA	516	PAPUA NEW GUINEA	813
<i>Jayaji Krishna Nath, M.D., and Vishwarath R. Nayar; Updates by Karen Pechilis-Prentiss, Ph.D., Aparna Kadari, B.A., M.B.A., and Robert T. Francoeur, Ph.D.</i>		<i>Shirley Oliver-Miller; Comments by Edgar Gregerson, Ph.D.</i>	
INDONESIA	533	PHILIPPINES	824
<i>Wimpie I. Pangkahila, M.D., Ph.D. (Part 1); Ramsey Elkholy, Ph.D. (cand.) (Part 2); Updates by Robert T. Francoeur, Ph.D.</i>		<i>Jose Florante J. Leyson, M.D.; Updates by J. F. J. Leyson</i>	
IRAN	554	POLAND	846
<i>Paula E. Drew, Ph.D.; Updates and comments by Robert T. Francoeur, Ph.D.; Comments by F. A. Sadeghpour</i>		<i>Anna Sierzpowska-Ketner, M.D., Ph.D.; Updates by the Editors</i>	
IRELAND	569	PORTUGAL	856
<i>Thomas Phelim Kelly, M.B.; Updates by Harry A. Walsh, Ed.D., and the Editors</i>		<i>Nuno Nodin, M.A., with Sara Moreira, and Ana Margarida Ouró, M.A.; Updates by N. Nodin</i>	
ISRAEL	581	PUERTO RICO	877
<i>Ronny A. Shtarkshall, Ph.D., and Minah Zemach, Ph.D.; Updates by R. A. Shtarkshall and M. Zemach</i>		<i>Luis Montesinos, Ph.D., and Juan Preciado, Ph.D.; Redacted and updated by Felix M. Velázquez-Soto, M.A., and Glorivee Rosario-Pérez, Ph.D., and Carmen Rios</i>	
ITALY	620	RUSSIA	888
<i>Bruno P. F. Wanrooij, Ph.D.; Updates by B. P. F. Wanrooij</i>		<i>Igor S. Kon, Ph.D.; Updates by I. S. Kon</i>	
JAPAN	636	SOUTH AFRICA	909
<i>Yoshiro Hatano, Ph.D., and Tsuguo Shimazaki; Updates and comments by Yoshimi Kaji, M.A., Timothy Perper, Ph.D., and Martha Cornog, M.S., M.A., and Robert T. Francoeur, Ph.D.</i>		<i>Lionel John Nicholas, Ph.D., and Priscilla Sandra Daniels, M.S. (Part 1); Mervyn Bernard Hurwitz, M.D. (Part 2); Updates by L. J. Nicholas, Ph.D.</i>	
KENYA	679	SOUTH KOREA	933
<i>Norbert Brockman, Ph.D.; Updates by Paul Mwangi Kariuki and Beldina Opiyo-Omolo, B.Sc.</i>		<i>Hyung-Ki Choi, M.D., Ph.D., and Huso Yi, Ph.D. (cand.), with Ji-Kan Ryu, M.D., Koon Ho Rha, M.D., and Woong Hee Lee, M.D.; Redacted with additional information and updated as of March 2003 by Huso Yi, Ph.D. (cand.), with additional information by Yung-Chung Kim, Ki-Nam Chin, Pilwha Chang, Whasoon Byun, and Jungim Hwang</i>	
MEXICO	692	SPAIN	960
<i>Eusebio Rubio, Ph.D.; Updates by the Editors</i>		<i>Jose Antonio Nieto, Ph.D. (coordinator), with Jose Antonio Carroble, Ph.D., Manuel Delgado Ruiz, Ph.D., Felix Lopez Sanchez, Ph.D., Virginia Maquieira D'Angelo, Ph.L.D., Josep-Vicent Marques, Ph.D., Bernardo Moreno Jimenez, Ph.D., Raquel Osborne Verdugo, Ph.D., Carmela Sanz Rueda, Ph.D., and Carmelo Vazquez Valverde, Ph.D.; Translated by Laura Berman, Ph.D., and Jose Nanin,</i>	
MOROCCO	703		
<i>Nadia Kadiri, M.D., and Abderrazak Moussaïd, M.D., with Abdelkrim Tirraf, M.D., and Abdallah Jadid, M.D.; Translated by Raymond J. Noonan, Ph.D., and Dra. Sandra Almeida; Comments by Elaine Hatfield, Ph.D., and Richard Rapson, Ph.D.; Updates by the Editors</i>			

M.A.; Updates by Laura Berman, Ph.D., Jose Nanin, M.A., and the Editors

SRI LANKA972
Victor C. de Munck, Ph.D.; Comments by Patricia Weerakoon, Ph.D.

SWEDEN984
Jan E. Trost, Ph.D., with Mai-Briht Bergstrom-Walan, Ph.D.; Updates by the Editors

SWITZERLAND995
Prof. Johannes Bitzer, M.D., Ph.D., Judith Adler, Ph.D., Prof. Dr. Udo Rauschfleisch Ph.D., Sibyl Tschudin, M.D., Elizabeth Zemp, M.D., and Ulrike Kosta

TANZANIA1009
Philip Setel, Eleuther Mwageni, Namsifu Mndeme, and Yusuf Hemed; Additional comments by Beldina Opiyo-Omolo, B.Sc.

THAILAND1021
Kittiwut Jod Taywaditep, Ph.D., Eli Coleman, Ph.D., and Pacharin Dumronggittigule, M.Sc.; Updates by K. J. Taywaditep, Ryan Bishop, Ph.D., and Lillian S. Robinson, Ph.D.

TURKEY1054
Hamdullah Aydın, M.D., and Zeynep Gülcat, Ph.D.; Rewritten and updated in 2003 by H. Aydın and Z. Gülcat

UKRAINE1072
Tamara V. Hovorun, Ph.D., and Borys M. Vornyk, Ph.D. (Medicine); Rewritten and updated in 2003 by T. V. Hovorun and B. M. Vornyk

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND1093
Kevan R. Wylie, M.B., Ch.B., M.Med.Sc., M.R.C.Psych., D.S.M., chapter coordinator and contributor; with Anthony Bains, B.A., Tina Ball, Ph.D., Patricia Barnes, M.A., CQSW, BASMT (Accred.), Rohan Collier, Ph.D., Jane Craig, M.B., MRCP (UK), Linda Delaney, L.L.B., M.Jur., Julia Field, B.A., Danya Glaser, MBBS, D.Ch., FRCPsych., Peter Greenhouse, M.A., MRCOG, MFFP, Mary Griffin, M.B., M.Sc., MFFP, Margot Huish, B.A., BASMT (Accred.), Anne M. Johnson, M.A., M.Sc., M.D., MRCGP, FFPAM, George Kinghorn, M.D., FRCP, Helen Mott, B.A. (Hons.), Paula Nicolson, Ph.D., Jane Read, B.A. (Hons.), UKCP, Fran Reader, FRCOG, MFFP, BASMT (Accred.), Gwyneth Sampson, DPM, MRCPsych., Peter Selman, DPSA, Ph.D., José von Bühler, R.M.N., Dip.H.S., Jane Wadsworth, B.Sc., M.Sc., Kaye Wellings, M.A., M.Sc., and Stephen Whittle, Ph.D.; Extensive updates and some sections rewritten by the original authors as noted in the text

UNITED STATES OF AMERICA1127
David L. Weis, Ph.D., and Patricia Barthalow Koch, Ph.D., editors and contributors, with other contributions by Diane Baker, M.A.; Ph.D.; Sandy Bargainnier, Ed.D.; Sarah C. Conklin, Ph.D.; Martha Cornog, M.A., M.S.; Richard Cross, M.D.; Marilyn Fithian, Ph.D.; Jeannie Forrest, M.A.; Andrew D. Forsythe, M.S.; Robert T. Francoeur, Ph.D., A.C.S.; Barbara Garriss, M.A.; Patricia Goodson, Ph.D.; William E. Hartmann, Ph.D.; Robert O. Hawkins, Jr., Ph.D.; Linda L. Hendrixson, Ph.D.; Barrie J. Highby, Ph.D.; Ariadne (Ari) Kane, Ed.D.; Sharon E. King, M.S.Ed.; Robert Morgan Lawrence, D.C.; Brenda Love; Charlene L. Muehlenhard, Ph.D.; Raymond J. Noonan, Ph.D.; Miguel A. Pérez, Ph.D.; Timothy Perper, Ph.D.; Helda L. Pinzón-Pérez, Ph.D.; Carol Queen, Ph.D.; Herbert P. Samuels, Ph.D.; Julian Slowinski, Psy.D.; William Stackhouse, Ph.D.; William R. Stayton, Th.D.; and Mitchell S. Tepper, M.P.H. Updates coordinated by Raymond J. Noonan, Ph.D., and Robert T. Francoeur, Ph.D., with comments and updates by Mark O. Bigler, Ph.D., Walter Bocking, Ph.D., Peggy Clarke, M.P.H., Sarah C. Conklin, Ph.D., Al Cooper, Ph.D., Martha Cornog, M.A., M.S., Susan Dudley, Ph.D., Warren Farrell, Ph.D., James R. Fleckenstein, Robert T. Francoeur, Ph.D., Patricia Goodson, Ph.D., Erica Goodstone, Ph.D., Karen Allyn Gordon, M.P.H., Ph.D. (cand.), Eric Griffin-Shelley, Ph.D., Robert W. Hatfield, Ph.D., Loraine Hutchins, Ph.D., Michael Hyde, M.F.A., Ph.D. (cand.), Ariadne (Ari) Kane, Ed.D., Patricia Barthalow Koch, Ph.D., John Money, Ph.D., Charlene L. Muehlenhard, Ph.D., Raymond J. Noonan, Ph.D., Miguel A. Pérez, Ph.D., Helda L. Pinzón-Pérez, Ph.D., William Prendergast, Ph.D., Ruth Rubenstein, Ph.D., Herbert P. Samuels, Ph.D., William Taverner, M.A., David L. Weis, Ph.D., C. Christine Wheeler, Ph.D., and Walter Williams, Ph.D.

VIETNAM1337
Jakob Pastoetter, Ph.D.; Updates by J. Pastoetter

LAST-MINUTE DEVELOPMENTS1363
Added by the Editors after the manuscript had been typeset

GLOBAL TRENDS: SOME FINAL IMPRESSIONS1373
Robert T. Francoeur, Ph.D., and Raymond J. Noonan, Ph.D.

CONTRIBUTORS and ACKNOWLEDGMENTS1377

AN INTERNATIONAL DIRECTORY OF SEXOLOGICAL ORGANIZATIONS, ASSOCIATIONS, AND INSTITUTES1394
Compiled by Robert T. Francoeur, Ph.D.

INDEX1405

For updates, corrections, and links to many of the sites referenced in these chapters, visit *The Continuum Complete International Encyclopedia of Sexuality on the Web* at <http://www.SexQuest.com/ccies/>.

Readers of *CCIES* are invited to submit important news items or reports of findings of new sex research being done in any of the countries covered here, or any other country in the world. We will try to keep the SexQuest *CCIES* website updated with your help. Send items in English if possible, with appropriate citations, to Raymond J. Noonan, Ph.D., *CCIES* Editor, Health and Physical Education Department, Fashion Institute of Technology, 27th Street and 7th Avenue, New York, NY 10001 USA, or by email to rjnoonan@SexQuest.com.

Special Pricing Just for Users of CCIES at The Kinsey Institute Website!

The Continuum Complete International Encyclopedia of Sexuality (Noonan & Francoeur, 2004)

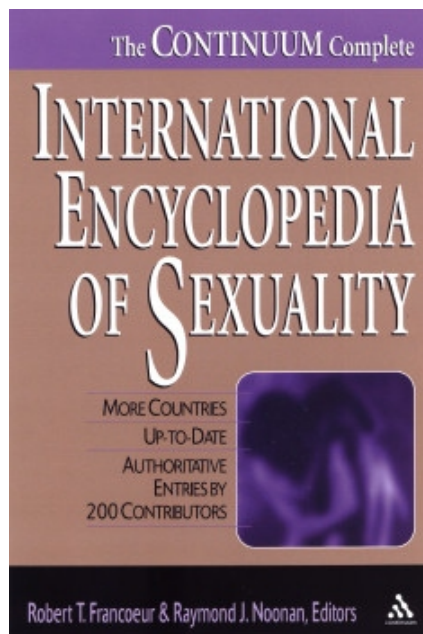
\$195/£100 plus \$4.50/£9.50 S&H (save \$55 US/£30 UK!)

The 1,436-page, 1.5 million-word, single-volume *Continuum Complete International Encyclopedia of Sexuality*, edited by Robert T. Francoeur, Ph.D., and Raymond J. Noonan, Ph.D., with contributions from 280 scholars on seven continents, contains 60 countries and 2 extreme environments:

- The 31 countries published in volumes 1–3 (1997), updated & revised: Argentina, Australia, Bahrain, Brazil, Canada, China, Finland, French Polynesia, Germany, Ghana, Greece, India, Indonesia, Iran, Ireland, Israel, Japan, Kenya, Mexico, Netherlands, Poland, Puerto Rico, Russia, South Africa, Spain, Sweden, Thailand, Ukraine, United Kingdom, and United States
- Plus the 17 countries and places published in volume 4 (2001), updated & revised: Austria, Colombia, Croatia, Cyprus, Egypt, Iceland, Indonesia, Italy, Morocco, Nigeria, Outer Space, Papua New Guinea, Philippines, Portugal, South Korea, Turkey, and Vietnam
- Plus 14 new countries and places: Botswana, Bulgaria, Costa Rica, Cuba, Denmark, Estonia, France, Hong Kong, Nepal, Norway, Outer Space/Antarctica, Sri Lanka, Switzerland, and Tanzania

Come see our other titles at: <http://www.continuumbooks.com>.

Special pricing available only with this page. Print it out and take it to your school or local library and encourage them to add CCIES to their collection.



ORDER FORM

SHIP TO:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

BILLING INFORMATION:

☐ Enclosed is my check/money order, payable to **Continuum**; or

☐ Please charge my: ☐ Visa ☐ Mastercard ☐ AmEx

Card Number:

Exp. Date:

Signature: _____ Telephone: _____

ORDER DETAILS:

Author/Title	ISBN	Special Price	Quantity	Subtotal
Francoeur/Noonan: Continuum Complete International Encyclopedia of Sexuality	0826414885	\$195/£100		
(Add \$4.50 first book; \$1.00 each additional book/£9.50 in U.K.)			Shipping	
(NY residents please add 8.375% sales tax; PA residents please add 6% sales tax)			Sales Tax	
			TOTAL	



In North, Central, or South America, mail or fax this page to: Emma Cook, Marketing Manager, Continuum, 80 Maiden Lane, Suite 704, New York, NY 10038; Fax: 212-953-5944; Email: emma@continuum-books.com

In the rest of the world, mail or fax this page to: Academic Marketing Department, Continuum, The Tower Building, 11 York Road, London SE1 7NX, United Kingdom; Fax: +44 (0)20 7928 7894

Critical Acclaim for *The Continuum Complete International Encyclopedia of Sexuality*

1. The International Encyclopedia of Sexuality, Vols. 1-3 (Francoeur, 1997)

The World Association of Sexology, an international society of leading scholars and eighty professional organizations devoted to the study of human sexual behavior, has endorsed *The International Encyclopedia of Sexuality* as an important and unique contribution to our understanding and appreciation of the rich variety of human sexual attitudes, values, and behavior in cultures around the world.

Recipient of the "1997 Citation of Excellence for an outstanding reference in the field of sexology," awarded by the American Foundation for Gender and Genital Medicine and Science at the Thirteenth World Congress of Sexology, Valencia, Spain.

Recommended by *Library Journal* (October 1, 1997) to public and academic librarians looking to update their collections in the area of sexuality: "An extraordinary, highly valuable synthesis of information not available elsewhere. Here are in-depth reports on sex-related practices and culture in 32 countries on six continents, contributed by 135 sexologists worldwide. . . . For all academic and larger public collections."

Picked by *Choice* (Association of College & Research Libraries/American Library Association) as Best Reference Work and Outstanding Academic Book for 1997: "Although this encyclopedia is meant as a means of understanding human sexuality, it can also be used as a lens with which to view human culture in many of its other manifestations. . . . Considering coverage, organization, and authority, the comparatively low price is also notable. Recommended for reference collections in universities, special collections, and public libraries."

"Most impressive, providing a wealth of good, solid information that may be used by a wide variety of professionals and students seeking information on cross-cultural patterns of sexual behavior . . . an invaluable, unique scholarly work that no library should be without."—*Contemporary Psychology*

"... enables us to make transcultural comparisons of sexual attitudes and behaviours in a way no other modern book does. . . . Clinics and training organizations would do well to acquire copies for their libraries. . . . Individual therapists and researchers who like to have their own collection of key publications should certainly consider it."—*Sexual and Marital Therapy* (U.K.)

"... scholarly, straightforward, and tightly-organized format information about sexual beliefs and behaviors as they are currently practiced in 32 countries around the world. . . . The list of contributors . . . is a virtual who's who of scholars in sexual science."—*Choice*

"... one of the most ambitious cross-cultural sex surveys ever undertaken. Some 135 sexologists worldwide describe sex-related practices and cultures in 32 different countries. . . . Best Reference Sources of 1997."—*Library Journal*

"What separates this encyclopedia from past international sexuality books is its distinct dissimilarity to a 'guidebook to the sexual hotspots of the world.' . . . An impressive and important contribution to our understanding of sexuality in a global society. . . . fills a big gap in people's knowledge about sexual attitudes and behaviors."—Sexuality Information and Education Council of the United States (SIECUS)

"Truly important books on human sexuality can be counted on, perhaps, just one hand. *The International Encyclopedia of Sexuality* deserves special attention as an impressive accomplishment."—*Journal of Marriage and the Family*

"... a landmark effort to cross-reference vast amounts of information about human sexual behaviors, customs, and cultural attitudes existing in the world. Never before has such a comprehensive undertaking been even remotely available to researchers, scholars, educators, and clinicians active in the field of human sexuality."—Sandra Cole, Professor of Physical Medicine and Rehabilitation, University of Michigan Medical Center

2. The International Encyclopedia of Sexuality, Vol. 4 (Francoeur & Noonan, 2001)

"... a masterpiece of organization. The feat of successfully compiling so much information about so many countries into such a coherent and readable format defies significant negative criticism."—*Sexuality and Culture*, Paul Fedoroff, M.D., Co-Director, Sexual Behaviors Clinic Forensic Program, The Royal Ottawa Hospital, Ottawa, Canada

3. The Continuum Complete International Encyclopedia of Sexuality (Francoeur & Noonan, 2004)

"... [a] treasure trove. . . . This unique compilation of specialized knowledge is recommended for research collections in the social sciences . . . as well as a secondary source for cross-cultural research."—*Library Journal*, March 15, 2004, p. 64

"... a book that is truly historic, and in many ways comparable to the great sexological surveys of Havelock Ellis and Alfred Kinsey. . . . Many works of undeniable importance are intended to speak about human sexuality. But in this encyclopedia we hear the voices of a multitude of nations and cultures. With coverage of more than a quarter of the countries in the world, . . . not only will the *Continuum Complete International Encyclopedia of Sexuality* remain a standard reference work for years to come, but it has raised the bar of sexological scholarship to a rigorous new level."—John Heidenry, editor, *The Week*, and author of *What Wild Ecstasy: The Rise and Fall of the Sexual Revolution*

For more review excerpts, go to www.SexQuest.com/ccies/.

Colombia

José Manuel Gonzáles, M.A.,* Rubén Ardila, Ph.D.,
Pedro Guerrero, M.D., Gloria Penagos, M.D., and
Bernardo Useche, Ph.D.

Translated by

Claudia Rockmaker, M.S.W., and Luciane Raibin, M.S.
Updates by the Editors; Comment by Luciane Raibin, M.S.

Contents

- Demographics and a Brief Historical Perspective 210
- 1. Basic Sexological Premises 211
- 2. Religious, Ethnic, and Gender Factors
Affecting Sexuality 212
- 3. Knowledge and Education about Sexuality 213
- 4. Autoerotic Behaviors and Patterns 214
- 5. Interpersonal Heterosexual Behaviors 214
- 6. Homoerotic, Homosexual, and Bisexual Behaviors 216
- 7. Gender Diversity and Transgender Issues 217
- 8. Significant Unconventional Sexual Behaviors 218
- 9. Contraception, Abortion, and Population Planning 219
- 10. Sexually Transmitted Diseases and HIV/AIDS 220
- 11. Sexual Dysfunctions, Counseling, and Therapies 222
- 12. Sex Research and Advanced Professional Education 223
- References and Suggested Readings 224

Demographics and a Brief Historical Perspective

ROBERT T. FRANCOEUR

A. Demographics

Located in the northwest corner of South America, Colombia is bordered by the Caribbean Sea on the north, Panama on the northwest, the Pacific Ocean on the west, Ecuador and Peru on the south, and Brazil and Venezuela on the east. With a landmass of 439,735 square miles (1,138,910 km²), Colombia is larger than Texas and smaller than Alaska. Three mountain ranges, the Andes, the Western, and the Central and Eastern Cordilleras, run through the country from north to south. The eastern range is mostly high tablelands and is densely populated. The Magdalena River rises in the Andes and flows north to the Caribbean Sea through a rich alluvial plain. The sparsely settled eastern plains are drained by the Orinoco and Amazon Rivers. Colombia is the only South American country with coastlines on both the North Pacific Ocean and the Caribbean Sea. The climate is tropical along the coast and in the eastern plains, and cooler in the highlands.

In July 2002, Colombia had an estimated population of 41 million. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: 0-14 years: 31.6% with 1.02 male(s) per female (sex ratio); 15-64 years: 63.6% with 0.95 male(s) per female; 65 years and over: 4.8% with 0.81 male(s) per female; *Total population sex ratio:* 0.97 male(s) to 1 female

Life Expectancy at Birth: *Total Population:* 70.85 years; *male:* 67 years; *female:* 74.83 years

Urban/Rural Distribution: 73% to 27%

Ethnic Distribution: *mestizo:* 58%; *Caucasian:* 20%; *mulatto:* 14%; *black:* 4%; *mixed black-Amerindian:* 3%; and *Amerindian:* 1%

*Communications: Mtro. José Manuel González, M.A., Apartao Aereo 1190, Barranquilla, Colombia; jmgonzalez@playnet.net.co. Rubén Ardila: psycolo@latino.net.co. Bernardo Useche: busechea@aol.com.



(CIA 2002)

Religious Distribution: Roman Catholic: 90%

Birth Rate: 21.99 births per 1,000 population

Death Rate: 5.66 per 1,000 population

Infant Mortality Rate: 23.21 deaths per 1,000 live births

Net Migration Rate: -0.32 migrant(s) per 1,000 population

Total Fertility Rate: 2.64 children born per woman

Population Growth Rate: 1.6%

HIV/AIDS (1999 est.): *Adult prevalence:* 0.31%; *Persons living with HIV/AIDS:* 71,000; *Deaths:* 1,700. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (defined as those age 15 and over who can read and write): 91.3%

Per Capita Gross Domestic Product (purchasing power parity): \$6,300 (2001 est.); *Inflation:* 7.6%; *Unemployment:* 17%; *Living below the poverty line:* 55%

B. A Brief Historical Perspective

Prior to the arrival of Europeans, the area that is now Colombia was home to various sedentary and semi-sedentary cultures, including the kingdoms of Funza and Tunja and the semi-sedentary Chibcha, who might have numbered about a million. Some of the area was part of the Inca Empire. By the 1530s, Spain had conquered the area and in 1538 established the colony of New Granada, with its capital in Bogotá, within the jurisdiction of the Viceroyalty of Peru. In 1740, a new Viceroyalty was established that included modern-day Colombia, Ecuador, Panama, and Venezuela. In 1819, forces under Simon Bolívar defeated the Spanish at the Battle of Boyacá, and the area gained its independence in 1821.

Colombia then became part of the Federation of New Granada. Venezuela and Ecuador broke away from this federation in 1829. By the 1850s, Colombia and Panama had adopted a federal system, but the system quickly deteriorated with the semi-sovereign states locked in a constant struggle with the central government for autonomy. In 1903, when the Colombian government rejected an offer by the United States for construction of a canal in Panama, the United States supported a revolt by Panama, which then declared its independence from Colombia.

Since the 1850s, Colombian politics have been characterized by a struggle between two groups that early on coalesced into the Liberal and Conservative parties. The ongoing Liberal-Conservative struggle has led to at least six civil wars, usually ending in interparty compromise. For most of the last century, the Roman Catholic Church played a major role in Colombia's social life and political struggles. The 1987-1988 Concordat gave the Church "official protection," while the state assumed authority over public education. The Church's central position in Colombian society was not substantially affected by the Concordat of 1942.

The worldwide depression of the 1930s seriously disrupted both the economy and the politics of Colombia. The overall economic collapse, coupled with the Conservative Party's brutal repression of the labor movement, led to a Liberal victory in 1930, followed by a new civil war between peasants loyal to the two parties. By 1934, Liberal president Alfonso López had inaugurated his "Revolution on the March" program of socioeconomic reform.

During the 1946 elections, Conservatives won the presidency with a minority of the overall vote, defeating a split Liberal Party. Armed conflict instigated by leaders of the two parties erupted to start *La Violencia*, from 1948 to 1957, during which more than 200,000 people died. In the summer of 1957, the two parties reached an agreement on constitutional reform that was designed to last 16 years and allow for regular alternation of the presidency between the two parties. This agreement lasted 11 years, until 1968, when constitutional revisions allowed official recognition of other political parties.

The 1960s and 1970s were marked by the emergence of terrorist and paramilitary groups on both the right and left, some with ties to the drug trade. This violence greatly reduced the power-sharing monopoly of the two parties. Since 1989, political violence has claimed over 35,000 lives. In March 1990, one of the most notorious left-wing groups, M-19, laid down its arms, entered the political mainstream, and won 19 of the 70 seats in a constitutional convention called to rewrite the Constitution. Other left-wing groups soon followed suit.

Colombia has also had to cope with a thriving and growing narcotics trade. Throughout the 1980s, narco-terrorists murdered and kidnapped government officials, journalists, and innocent bystanders with impunity. Despite the assassination of four presidential candidates prior to the 1990 election, the Liberal Party won with a vigorous campaign against the narcotics trade. In 1994, another Liberal president was elected on the promise to invest billions of dollars to improve Colombia's infrastructure using money from newly discovered oil fields. Between the summer of 1995 and September 1996, the government arrested the seven top members of the Cali drug cartel.

[*Comment 2003*: Like most third-world countries, Colombia's economy is unstable. The instability is exacerbated by the battle between the government, the "Drug Cartel," and paramilitary groups inside the country. In the past few years, this conflict has escalated, and human life has lost much of its value. Today, someone is kidnapped every three hours in Colombia. In 2002 alone, there were 2,986 kidnappings. Since 1996, this number has grown to 18,795. In this same period, over 800 people have died in captivity. Nine out of ten kidnapping cases last for about three months. Among the victims are politicians, businessmen, professionals, and common people, whose only reason for being kidnapped is to finance the "guerrilla" and other paramilitary groups.

[In the hopes of trying to appease the "guerrilla" and paramilitary groups, the Colombian government has even given these groups control over specific territories in the

country. In these regions, cocaine plantations are common and the Revolutionary Armed Forces of Colombia (FARC) charge the growers taxes on the crops to help finance their activities. The government knows of these activities but cannot do anything to prevent it.

[The United States has partnered with the Colombian government to fight organized crime. There are close to 100,000 men involved in this effort. In 2002, the homicide rate in the country was 60 deaths per 100,000 inhabitants. In Bogotá, the capital city, the rate is a lower (31 deaths per 100,000 inhabitants).

[The victims are meticulously chosen, and it is this fact that is the most disturbing. In the past few years, four presidential candidates, two ex-ministers of justice, 10 supreme-court justices, a dozen journalists, hundreds of magistrates, and thousands of police officers have been murdered. In 2002, over 70 police officers were killed. The minister of defense, Martha Lucia Ramirez, has alerted the religious community, because the violence towards the clergy has also been escalating. In 2002, 13 clergymen were killed.

[This daily environment of unpredictable violence has, of course, widespread effects on the intimate lives, emotions, and psychology of Colombians of all classes and stations in life and society (*Estado de Sao Paulo*, March 23, 2003). (*End of comment by L. Raibin*)]

1. Basic Sexological Premises

BERNARDO USECHE

A. The Cultural Legacy

Observing pieces of Pre-Colombian art and the descriptions of the historians of the Indies (when the colonists arrived), one finds strong evidence that the majority of the aboriginal tribes inhabiting the Colombian territory freely practiced the pleasurable side of sexuality. Among the art pieces of the time, one encounters representations of all possible sexual attitudes: masturbation, heterosexual activity, oral sex, homosexual activity, and bestiality. With the arrival of the Spaniards in the 16th century, the sexual interests of the conquistadors towards the Indian women made interracial marriages very popular. The evidence of interracial marriage is evident in the fact that 58% of Colombians today are *mestizo* Spanish/Amerindian and 14% *mulatto* black/Caucasian. At the same time, the Spaniards brought the Catholic religion and the repression of eroticism. The arrival of the African slaves during the 17th and 18th centuries signified a new miscegenation and the integration of new cultural elements favorable to pleasure rather than procreative sexuality. At the time of independence from Spain and the birth of the republic in the 19th century, a nation had been forged that, with respect to sexuality, was somewhere between the exalted libido of the macho population and the erotophobic restrictions of their profoundly religious culture. Toward the end of the 20th century, especially in recent decades, the progressive influences of North American culture have been added to Colombian culture. Profound transformations to the family structure and the traditional ideology have been generated by the changes in the Colombian economy at the end of the 20th century. This has opened a new sexual panorama that is much more complex than in colonial times.

Even though there are important urban, rural, and regional differences, today's sexual attitudes in Colombia are characterized by a double standard, where men are permitted all types of sexual activities while "decent" women are limited to sexual activities within the confines of marriage for reproduction purposes. There is, however, the beginning of a more permissive attitude towards a woman's sexual pleasures if she is in a serious relationship, because the im-

poverished situation of the majority of Colombians makes it very hard for couples to maintain stable ties.

Colombia continues to be a country where the majority of the population is Catholic, with traditions deeply rooted in the cultural values of Spain. But the few studies that have been done on this issue indicate that the sexual conduct of the people frequently does not conform with the Church's religious norms. This implies that *machismo* has played an important role in Colombian society. It has perpetuated discrimination towards women in family life, the work environment, and throughout society as a whole. *Machismo* places great value on female virginity, emphasizes the importance of the extended family, and supports the underlying concept of sin and guilt as it pertains to sexuality.

The modernization of Colombia, beginning in the 1930s and continuing well into the 1980s, changed many of these societal values. Colombia was transformed from a rural country to an urban country. No longer was religion the focal point of education. In spite of opposition from the Catholic Church, couples were having fewer children and birth control was more widely used. The status of women improved considerably. Employment of women outside the home has led to changes in the family structure. It allowed women to make choices, including how many children they bear, as well as changed their societal status. These societal changes, brought about by the modernization, industrialization, and urbanization of Colombia, continue into the start of the 21st century.

B. Sexual Roles

Machismo, with its horrible discrimination against woman, is still present in Colombian family life, the work environment, and society. There are few men, even those in the lower socioeconomic bracket, who help with the housework or the raising of the children. With the impoverishment of the country, the number of single mothers who are head of the household increases constantly, but they are still not given the basics: same work, same salary, or even a job. This situation has driven many women and their daughters to prostitution. Politically, women were given equal rights under the law in the 1950s, but they are still the minority in positions of power or in government jobs. Only in the last decade has it been possible for Catholic couples to get a divorce. Abortion is still illegal in Colombia, even though there are estimates that over 300,000 illegal abortions are performed each year. A growing sexual liberation of women has been observed in the past 30 years, but the differences in the sexual conduct of young people of both sexes are still very significant, as seen in Table 1.

In the movement toward gender/sexual equality in Colombia, we find sexologists like Heli Alzate, who was one of the first to vehemently refute the assumed physical, intellec-

tual, and emotional inferiority of women. Also, intellectuals like Maria Lay Londoño and Florence Thomas, pioneers of the feminist movement since the 1970s, have dedicated enormous efforts to the study of couples and the promotion of sexual equality. The ground won by women in respect to their sexuality has not yet had an impact on the *machismo* attitudes of men. When it does, as it likely will in the near future, one can expect a crisis in the current model of masculinity.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

JOSÉ MANUEL GONZÁLES

Recent studies (Bodnar et al. 1999; González 1999a) show the presence of important religious beliefs related to sexuality. The concept of sin related to pleasure in sex, birth control, and some religious concepts that emphasize feminine resignation, are important in the sexual life and relationship of couples in Colombia. According to Paulo Romeo, Apostolic Nuncio in Colombia, the Catholic Church is losing 200 practitioners daily (*El Tiempo* 1997). According to the calculation presented at the Assembly of Bishops, only 60 of every 100 people baptized will take their first communion. According to Carlos Alzate of the Episcopal Conference of Colombia, only 15 out of 100 people who consider themselves Catholics on surveys go to Mass (*El Tiempo* 1997).

To better understand our sexuality, it is necessary to understand the influences of the three biggest ethnic groups in our heritage: the Spanish culture, the African culture, and the Indian culture (González 2000).

- The Spanish cultural influence, which is a mix between the Arab-Andaluzian influences, mixes the glorification of sensuality and eroticism in its most beautiful form with the Spanish Catholic Inquisition's very strong repressive ideas. This is a major influence in much of what is known about sexuality in Latin America.
- The African culture looked at sexuality, eroticism, and sexual vigor as natural phenomena. Much is known about this influence on contemporary Colombian culture.
- The sexuality of the local aborigines was quite varied, but there is not much information about their common features and differences. When the conquistadors arrived in Colombia, they encountered a wide variety of indigenous cultural attitudes regarding sex, a sample of which follows:
 - The Panches, a Caribbean culture, practiced female infanticide and clitorectomies eight days after birth. If the child survived the sexual mutilation, its marriage was immediately arranged. If the firstborn was a female, she was immediately killed.
 - Among the Lanches in the Boyacá region, if a woman had five consecutive boys, the youngest would get special attention and was expected to take on the female role. They were brought up as females and were married off to a male.
 - The Pantagoros of Caldas were very puritanical and disapproved of any nudity. Their women were covered up to their ankles and were very careful, when sitting, not to show their legs. On the other hand, the Pijaos from Tolima would proudly show off their genitals.
 - Both male and female Quimbayas from the western side of the central Andes were very sexually active. Among the Muisca, from Cundinamarca and Boyacá, there was total freedom with respect to premarital sex, whereas among the Pijaos, it was common for the husband to kill his bride if she was not a virgin. The Pantagoros accepted infidelity, whereas the Pijaos pun-

Table 1

General Differences of Sexual Conduct

Sexual Activity	Men Percent	Number Responding	Women Percent	Number Responding
Masturbation	92.3%	379	43.2%	604
Vaginal coitus	62.2	379	30.8	604
Oral sex	44.8	353	23.1	566
Anal sex	20.6	355	7.7	560
Group sex	21.6	310	1.6	492
Same sex	17.1	346	9.3	572
Victim of rape or sexual abuse	6.4	345	13.9	583

(Useche 1999)

ished infidelity very severely. An unfaithful Pijaos woman would be given to the single men of the village for their pleasure, after which she would be buried up to her waist in a public place where she would be whipped to death. The Muisca had similar punishments for female infidelity.

- Both the Muisca and the Quimbayas celebrated fertility festivals where they would get drunk and have sexual relations without restrictions. The Liles from the Valle would marry their sisters and nieces. The female Guane, from Santander del Sur, were very involved with the conquistadors. They were described as being the prettiest, the whitest, the cleanest, and the ones with the greatest ability to learn Spanish.
- Among the Noanamas and the Taso, from Choco, anal sex between men was very common. Sexual relations with women were only for reproductive purposes. Most female infants were drowned at birth.

3. Knowledge and Education about Sexuality

PEDRO GUERRERO

A. Government Policies and Programs

We can affirm with full accuracy that from the Spanish Conquest to the passing of Resolution 03353 by the Ministry of Education in July 1993, sexuality education in Colombia has functioned according to the guidelines set forth by the Catholic Church. Accordingly, sermons originating from the scriptures and dictated from the pulpit were obligingly echoed in all educational institutions.

Our medical students receive their sexological training via lectures in gynecology, urology, and psychology. However, this coursework does not include the erotic aspects of sexuality. It only deals with biological reproduction and the pathologies found in the genital organs. Sexually transmitted diseases are generally discussed with apprehension. At the same time, therapy for sexual dysfunctions remains unknown, and the concept of the woman and the family is rooted in the old patriarchal ideology.

National Program on Sexual Education

The National Program on Sexual Education is best described as a set of principals and guidelines that collectively form the knowledge base, attitudes, behaviors, and values of sexuality. Its purpose is to meet the needs of Colombians in living a healthy, responsible, and gratifying sexual lifestyle, while promoting gender equality. Furthermore, it encourages the people to redefine the traditional roles of men and women, as well as the patriarchal family structure, thus attaining greater equality between marital couples and parents and their children. In addition, the National Program on Sexual Education encourages men and women, without coercion or pressure, to choose the appropriate time at which to bear children. As a result, they need to learn to adequately utilize effective birth control methods. The guidelines proposed by the National Program on Sexual Education should be viewed as a framework for the formation and pedagogical organization of sexual education programs in Colombian schools. Therefore, this proposal is optional and not mandatory.

The following items should be taken into consideration while reviewing these guidelines:

1. We must acknowledge the importance that culture plays in sexual education. Culture holds ethical values, morals, and spiritual and religious convictions. These not only determine the significance of the multiple dimensions of human existence, but also determine the people's level of acceptance of the academic proposals.
2. We must understand that sexuality is a fundamental dimension of humanity, which is ever-present in the lives of all men and women.
3. It is suggested that sexual education be integrated into the curriculum from a science and humanities context. This would then serve as an introduction to self-esteem, independence, interpersonal relationships, and health.
4. Sexual education is thought to be the responsibility of the educational community, including all educational institutes in both the public and private sectors, teachers and administrative staff, and parents and students.
5. The family is considered to be the primary source of education for children, as stated in Article 68 of the National Constitution of Colombia. In accordance with Article 68, the family reserves the right to choose the quality of education for their children. It is noted that the family unit serves as a model for the child's future perspectives on sexuality. It is in the family where children of both sexes learn their first lessons on solidarity, sensitivity, and gratitude. It is where a child learns to love and be loved, to tolerate and be tolerated, to hold a dialogue, to share, and to respect and value life. By the same token, it can also be the place where a child can experience and later repeat child abuse, sexual abuse, gender discrimination, and other types of domestic violence.
6. The importance of *etiquette* in sexual education is evident. The National Constitution of Colombia addresses the issue of the rights and responsibilities as they pertain to the concept of sexuality. Among other rights, the Constitution stipulates the rights of all to personal development, the equality of rights and responsibility of a couple, and the right to choose the number of children they are to bear, among other rights.
7. It is suggested that sexual education should be a pedagogical program that forms the basis of all fundamental studies. That being said, all educational institutions are left with the task of creating their own sexual education programs.
8. The proposed curriculum consists of developing programs that focus on basic sexual education themes, as they relate to the individual student, the couple, the family, and society as a whole. Each fundamental objective is to be modified to the age and grade level, the developmental level, and the specific needs of the target audience. The proposed programs target primary through secondary grade levels. Suggested topics include: identity, tolerance, reciprocity, life in general, affection, communication, love-sexuality, responsibility, imagination, and critical-thinking skills.
9. Workshops for educators are a suggested method of sharing information, as opposed to traditional methods like didactic lectures. In workshops, individuals can share information with the group in an open forum.

In order to test the effectiveness of the National Sexual Education Programs, two studies were initiated. The first case study, conducted by the Ministry of National Education, investigated 332 schools in 155 school districts in Colombia. Using quantitative methods, it was found that 92% of the schools utilized the sex education programs. These schools reported a marked improvement in school morale, as related to sexuality themes.

The second case study, also conducted by the Ministry of National Education, complemented the previous study in that it investigated the pedagogical process of the National Sex Education Programs in academic institutions. Utilizing qualitative methods to examine 16 subjects at different developmental stages in four different regions of Colombia, this

study indicates that the sex education programs are at a critical phase of development. They have been introduced to the school system, and opened up avenues of employment and a new view on sexuality, but they have also identified four areas where further effort and development are needed:

1. Restructuring the aspects of human sexuality taught;
2. Promoting policies and other movements geared towards sexual well-being and reproduction with youth, both within and outside the educational system;
3. Increased utilization of sex education programs in academic institutions and successful replication of studies indicating their effectiveness; and
4. Participation and support from the congressional body, the judicial system, and educational institutions at both the national and international levels, for human sexuality, sex education, sexual health, and reproduction.

B. Informal Sources of Sexual Knowledge

JOSÉ MANUEL GONZÁLES

Investigations conducted by a variety of groups that strongly support sex education have found that parents are reclaiming their roles as the primary informants of sex education. Mantilla (1993) reported that men's primary sources of information on sexuality were: friends, mother, father, and school. Women reported that their primary sources of information on sexuality were: friends, mother, school, and father. Gutierrez and Franco (1989) found that women reported that their primary sources of information on sexuality were: school, mother, friends, and the general media. Men reported that their primary sources of information were: friends, school, the general media, and father. The Institute of Social Securities (Instituto de Seguros Sociales 1994) found that adolescents posed questions regarding sexuality primarily to their mothers, 47% of females and 20% of males, whereas only 16% questioned their friends and 11% questioned their fathers.

Every day, the Colombian mass media discusses sexuality more freely. Several related programs have surfaced. Maria Ladi Londoño-Cali, was one of the first pioneers in this area. Lucia Nader and Marta Lucia Palacio joined in on two major networks, Caracol and RCN (Palacio 1999), and presented a compilation of the most frequently asked questions by her viewers. In print, the pioneering column on sexuality was "Window to Sexuality" (González 1998, 1999b). This column was originated by José Manuel Gonzáles and is presently written by Fernando Bohorquez, Ph.D. The *Herald* (Barranquilla) has published an entire page dedicated to human sexuality since 1999, titled "Love and Intimacy" (González 2000). The pioneering television program was *Sexology on Television*, hosted by Elkin Mesa (August 1979). Lucia Nader, Marta Lucia Palacio, Alonso Acuña, and Pedro Guerrero initiated another program, titled *It's Time to Live*. This program touched on all aspects of human sexuality. It was a popular program that also served as a basis for a book by the same name. Lucia Nader developed a magazine titled *In Private* (1996). Its theme was fundamentally sexuality. *Accent* was a magazine geared towards the gay community, published in 1997. Both publications have since gone off the market because of financial difficulties.

4. Autoerotic Behaviors and Patterns

A. Children and Adolescents

Erotic autostimulation is rather common among children. Ardila (1986a) interviewed 700 mothers, pertaining to different Colombian subcultures, and found that three out of four mothers reported masturbatory behavior among children of 4 years of age. Acuña and associates (1986) ex-

plored the existence of this behavior and the anxiety that it causes for parents. In general, this type of autoexploratory and sexual gratification behavior is repressed by the adults.

Autoerotic behaviors are also common among adolescents. Masturbation generally starts between the ages of 13 and 15 (Alzate 1989; Domínguez et al. 1988; González 1995; Giraldo 1981; Gutiérrez & Franco 1989; Useche 1999). Among the adolescents, between 60% and 95% of men and 14% and 68% of women have masturbated at least once in their lives (Alzate 1989; Domínguez et al. 1988; González 1995; Giraldo 1981; Gutiérrez & Franco 1989; Useche 1999). In general, feelings of guilt and anxiety are reported with respect to masturbation (Domínguez et al. 1988; González 2000; Gutiérrez & Franco 1989).

B. Adults

Sexual autostimulation is also very common among adults. About 90% of men and 70% of women report having masturbated at least once in their lives (Alzate 1989; Elijaiké et al. 1987; González 1979, 1985, 1995, 2000). The majority of those studies report a greater incidence of masturbatory behavior in those who are less religious.

A relationship between the personality, as measured by Eysenck's MPI test, and masturbation has been detected by González (1979). Men with high scores in introversion have confirmed a higher frequency of masturbatory behavior. Women with high scores for neuroticism have demonstrated a lower frequency of masturbatory behavior as compared to woman with normal scores. With relation to age, it has been reported that in people over 60 years of age, single women masturbate more than men (Bardugo & Segura 1988, González & González in press).

Sexual autostimulation generates many negative feelings. There are many myths and misinformed beliefs on the subject (Giraldo 1981; González 2000). In a recent survey done in the four biggest cities of Colombia, it was found that only 32% of women and 53% of men find masturbation to be a healthy sexual behavior. The rest believe that it is a crazy conduct that should be avoided, because it is a sexual deviance and a sin (*Semana* 1999).

5. Interpersonal Heterosexual Behaviors

JOSÉ MANUEL GONZÁLES

A. Children

Childhood sexual rehearsal play and sexual exploration are quite common. One out of every two mothers reported observing sexual rehearsal play in their 4-year-old children (Ardila 1986). Still, childhood sexuality is a theme that produces great anxiety in adults (Acuña et al. 1986; González 2000).

B. Adolescents

There are no widespread rituals of initiation to puberty. In some rural areas on the Caribbean coast of Colombia, it is common for adolescents to engage in sexual acts with animals, namely mules (González 2000).

Sexual activity among adolescents occurs frequently and functions according to the traditional male-dominant cultural pattern. Forty-four percent of Colombians initiate sexual interactions between the ages of 11 and 18. By 18 years of age, 72% of males and 40% of females have had sexual intercourse, according to Ministry of Health of Colombia (Ministerio de Salud 1994). Generally, female adolescents' first sexual encounter occurs with their boyfriends. Often, sexual relations between Colombian adolescents stem from an intimate relationship and not from an encounter with a prostitute (Bonder et al. 1999; González 1995; González et al. 2000; Useche 1999).

C. Adults

Premarital Relations, Courtship, and Dating

Premarital sex is quite common in Colombia. In recent studies, it was found that 90.4% of males and 62.8% of females have engaged in premarital sex prior to starting college life (González et al. 2000). Love is usually on the forefront. It is a fundamental part of Colombian culture: music, magazine articles, soap operas, and movies (Bodnar et al. 1999; González 1998; Guerrero 1996a, 1996b). In recent years, initiating friendships and intimate relationships has become easier. Formal introductions are no longer required. People have become more direct in their approach.

In recent studies, González (2000) found that men experience difficulties in expressing love and affection. It is common that people have unrealistic expectations regarding love, and, as a consequence, great frustrations and clashes between fantasy and reality in relationships. Frequently, the expectation is that the lover will satisfy all of their needs, provide unconditional love, and be who they want them to be and not who they actually are. They believe that pain, suffering, and jealousy are essential parts of a relationship. Generally, the woman is expected to be responsible for the affective part of the relationship. She is often expected to prove her love by engaging in sex with her partner. It is also believed that a sure way of keeping a man, or winning him back, is through sex. All the conditions aforementioned make choosing an appropriate mate difficult. Frequently, a partner is not chosen on reality-based merits. Instead, he or she is chosen on unrealistic expectations, which inevitably will lead to a failed relationship.

Sexual Behavior and Relationships of Single Adults

Among adults, there exists a misconception of what sexual pleasure is. Generally, they do not understand the physiological and/or psychological concepts of eroticism. As a result, there exist irrational and unhealthy beliefs (González et al. 2000). Sex is commonly seen as bad, dirty, ugly, and degrading. This sex-phobic mindset distorts and impedes a healthy sexual lifestyle (González 1981). Often egotism is perceived as a process leading towards reproduction. Anything else is seemingly considered illegal, promiscuous, and guilt-ridden (González 1999a).

According to the *machismo* ideology, males tend to initiate sexual activity earlier than females. It tends to be more intense and promiscuous (Alzate 1989; Bodnar et al. 1999; González et al. 2000; Institute of Social Securities 1993; Useche 1999). Adult males will have more sexual partners than their female counterparts: One out of every three males reported having two or more sexual partners in the last 12 months, whereas only three out of every 100 females reported multiple partners (Institute of Social Securities 1993). Generally, the male initiates sexual interactions within the relationship. Couples engage in sex frequently: 2% reported daily sexual activity, 19% reported sexual activity several times a week, 41% reported weekly sexual activity, and 16% reported monthly sexual activity (Ministerio de Salud 1994). The sexual positions most frequently practiced were the missionary man-on-top/woman-on-bottom position, the straddle where the woman sits on top of the man, and the rear-entry position with the man behind the woman (González 1994).

Eljaiek et al. (1987) found that almost 50% of the couples surveyed did not engage in sexual relations during menses, and almost 10% discontinued sexual activity during pregnancy. There also exists a great irresponsibility, for both men and women, in practicing safe sex and using some form of contraception. There is a high rate of sexual dissatisfaction for both genders (González 1998).

Marriage and Family

Colombians place a great importance on feeling as though one is "in love." Love is the primary motivating factor for matrimony, as reported by 87% of women and 69% of men (Eljaiek et al. 1987).

The marriage rate has decreased while the rate of cohabitation has increased, especially in the younger population. Mature couples in their mid-80s reported that 84% were married through the Catholic Church, while 15% cohabitated. Married couples in their mid-30s reported that 44% were married through the Catholic Church, while 54% cohabitated (Rojas 1997). The average age for matrimony or cohabitation has decreased for males and has increased for women (Presidential Council for Youth, Women, and Their Families 1994).

Rojas (1998) found that couples feel unfulfilled in their relationships. They feel that their counterparts do not demonstrate affection both physically and verbally, that they do not support their efforts, and that they do not make them feel valued. Additionally, they feel that there is a lack of communication with regards to problems, misunderstandings, and resolutions. Rojas also noted that of the couples surveyed, 50% did not have a set time in which to communicate.

The marital union in Colombia tends to be non-democratic and lacks equality between the partners. Often women seek gender equity, only to be met with violence from their counterparts. There also exist religious beliefs that support submissiveness and perpetuate this unjust marital relationship (González 2000). Misinformation pertaining to masculinity, femininity, and their interrelatedness permeates societal expectations. Men are perceived in terms of money, power, bravery, and freedom. Women, on the other hand, are perceived as tender, submissive, tolerant, able to bear suffering, and having a need to sexually satisfy their partner at the expense of her own sexual needs. These *machismo*-based values are believed to be biological in nature, disregarding educational, physiological, and/or psychological cultural factors (González 1998, 2000).

There has been an increase in separations and multiple sequential marriages in Colombia: 35% of all couples surveyed have been separated at least once (Presidential Council for Youth, Women, and Their Families 1994). Zamudio and Rubiano (1991b) found that the primary causes for separations among Colombian couples were: infidelity, jealousy, or falling in love with another person, falling out of love or falling into a rut, and financial difficulties, in that order.

According to Gutierrez de Pineda (1975), there are four types of family structures: Andino, Santandereano, Negroide, and Antioqueno. These are characterized by the following factors:

- *Andino Family Structure* in the Cundinamarca and Boyaca regions. The dominant feature in this region is the patriarchal structure in which the father is the head of the household. The mother and children are viewed as subordinates. The male children imitate the father while the girls imitate the mother. Initially, the mother is the disciplinarian. However, as the boys grow older, the father tends to intervene more frequently.
- *Santandereano Family Structure* in the Santanderes. Here, the power of the male over the female is evident. His aggressiveness and physical dominance characterize the male. He takes great pride in his sons; however, he withholds any type of affection. Great emphasis is placed on the rift between social classes.
- *Negroide Family Structure* on the Atlantic Coast, in the regions of Chocó and Magdalena, Cauca, and the lower

region of Antioquia. The basic characteristic of this family structure is the incidence of cohabitation. For men, it is considered prestigious to have multiple partners. Much attention is focused on the male genitals. The man is determined to father a vast number of children without regard for the childrearing responsibilities. Usually, the mother raises the children with the almost complete absence of the father.

- *Antioqueno Family Structure* in the regions of Antioquia, Caldas, Risaralda, Quindio, El Valle, Tolima, and parts of El Chocó. Here, religion has a great impact on the family structure. Catholic matrimonies are a dominant feature. The traditional gender roles are practiced. The man is the head of the household, but the woman rules in the home. The mother is strict with her daughters, especially as it pertains to sexuality. She is compliant with her sons, especially the youngest one.

Although these discrepancies are no longer as rigid as they once were, the general tendency continues to follow these traditional patterns (Gutierrez de Pineda 1975).

Extramarital Sex

Infidelity is an important element in a Colombian marriage (González 1998). Murillo (1993) found that there were three males for every one female who engaged in extramarital sexual relationships. Nadar and Palacio (1989) found the same results. Nadar and Palacio also found that 30% of separations were a result of infidelity. Findings indicate that there is a greater incidence of infidelity for men as the socioeconomic levels rise higher. For women, infidelity is more common at the upper-middle-class levels (Rojas 1997). A common misconception is that a man's infidelity is less serious because he is biologically driven, whereas women's infidelity is not.

Sexuality and Physically Disabled and Elderly Persons

Colombian sexology has little literature regarding disabled and elderly persons. The prevailing attitude is that this population is nonsexual and has no need for sexual intimacy. In a recent study of adults over the age of 60, González and González (in press) found that 94% of the men and 24% of the women maintain sexual interactions with their mates; males engaged in sex every two weeks, whereas women engaged in sex on a monthly basis. Seventy-six percent of men and 36% of women reported that there was a decrease in gratifying sexual intercourse after the age of 60. It was reported that 88% of these older men and 30% of the women are satisfied with their sex life. Eighty-two percent of the men and 18% of the women reported that they continue to seek out their partners for sexual activity. Forty percent of the men surveyed reported having sexual relations with someone other than their regular partner. Eighty percent of men and 52% of women reported that relations with their partners are at least cordial. Forty percent of all women surveyed reported that they do not have a good relationship with their partners. Seventy-two percent of men and 50% of women reported that they continue to be affectionate with their partners. The authors believe that the predominant *machismo* values distort a couple's lifestyle, resulting in resentful women.

Incidence of Anal and Oral Sex

Although there are no laws prohibiting anal sex and oral sex, they continue to be highly criticized in public and frequently practiced in private. Almost 80% of men and 70% of women have engaged in oral sex, now a regular part of foreplay (Eljaiek et al. 1987; González 1994, 1998).

6. *Homoerotic, Homosexual, and Bisexual Behaviors*

RUBEN ARDILA

There has long been an interest in homosexuality in Colombia. Behaviors that can be categorized as homosexual have been noted within the cultures that existed in Colombia during the arrival of the Europeans. However, the study of homosexuality is filled with methodological ambiguities. There are certain behaviors that may or may not be considered *homosexual* by today's societal standards. Even so, these behaviors existed long before the arrival of the Spaniards. As in other cultures, homosexual behaviors were found more frequently among men than women.

From the onset of studies on sexuality amongst Colombians, homosexuality was always an interest (Alzate 1978, 1982; Botero 1980; González 1985). It was found that there were differences in homosexual activity between men and women. In Bogotá, 28% of the men and 13% of the women reported having had same-sex relationships. Interestingly, there was a marked difference between the various cities in Colombia. These ratios are not limited to homosexual activities exclusively. It reflects the number of individuals who engaged in some type of sexual activity with someone of the same sex. It could have been an isolated incident and/or the regular practice of homosexual or bisexual behaviors.

Anthropological and Social Aspects

José Fernando Serrano (1997, 1998), an anthropologist, has pointed out that the formation of the homosexual identity, as described by societal constructs, has been a long process. He reviewed sociological studies originating in Colombia and indicated which ones supported the argument of sexual orientation. He also argued the problem of collective identities at the international level.

The modernization of Colombia, which took place in the latter half of the 20th century, enabled people to look outside their immediate society and expand their provincial traditions. It enabled them to study ideas from other countries, primarily from France and other regions of Europe, and the United States. The gay and lesbian liberation movements of Germany, several other European nations, and later from the United States slowly made their way to Colombia. Nevertheless, they had a great impact on the organization of the gay and lesbian movements. Modernization gradually brought about internationalization, globalization, and societal changes that influenced people's private lives.

Homosexual Identity

The beginnings of organized homosexual groups in Colombia began in 1970. Manuel Antonio Velandia, a sociologist and philosopher, initiated them. He associated with people who were interested in human rights, social change, and the general counterculture of the 1960s and 1970s on an international level. These gay and lesbian movements were difficult to organize, and were at times very short lived. Finally, in the late 1980s and 1990s, gay and lesbian groups succeeded in uniting and achieving their goals (Velandia 1999).

Velandia founded the Gay Liberation Group and the Homosexual Liberation Movement of Colombia in 1976. He also organized the first Gay Pride March in 1983 in Bogotá. These movements gained importance in 1998 and 1999 and included weeklong lectures on sexual diversity, collective identity, human rights, legislation, and other related topics. However, gay and lesbian communities are slow in coming. Although gay meeting places have been established since the 1970s, homosexual literature remains unseen. The first writings pertaining to the gay lifestyle—poetry, novels, theater,

and soap operas—surfaced in the 1980s. This is not to discount earlier works by P. Barba Jacob. Today, soap operas and movies frequently touch on homosexuality.

The Constitution of Colombia, passed in 1991, prohibits discrimination in any form or manner. It recognizes that all people have the right to free personal development. The Constitution stipulates that homosexuals may not be discriminated against based on their sexual orientation. Sexual orientation that is not shared by the majority does not justify unequal treatment.

The rights given by the Colombian Constitution pertaining to sexual orientation during the 1990s have been favorable for homosexuals and bisexuals. For example, in April 1991, a law was passed that protects an individual's rights to free sexual identity. It affirms that homosexuality should be considered valid and legitimate. The Colombian Constitution also addressed the debate regarding homosexual educators. They determined that homosexuality has no bearing on an individual's ability to teach (in September 1998). Additionally, in July 1999, the Colombian legislature passed a law protecting homosexuals in the military. It states that individuals may reveal their status as homosexuals and continue to be held to the same norms and expectations as heterosexuals.

The Colombian legislature has defined the family as a union of a man and a woman (March 7, 1996). However, it went on to acknowledge the rights of partners, including same-sex couples, in terms of inheritance, transfer of assets, and financial support, among other things. There have been several attempts to legalize homosexual marriages, as has been done in several other areas, e.g., Denmark since 1989, Norway since 1993, Sweden since 1995, Iceland since 1996, Hungary since 1996, and Holland since 1997. In some cases, there exist legal sanctions against same-sex marriages because of the possibility of adoption. There are, however, gay activist groups who support the legalization of the *gay family* in all aspects, including adoption. The Family Pride coalition is one of the most important advocates of this movement.

One of the most recent proposals, in September 1999, sought to equalize the rights of homosexual couples with those of heterosexual couples. For instance, after two years of cohabitation, the couple may apply for Social Security benefits. Additionally, should the relationship end because of death, one partner may inherit the assets of the other. There already are companies in the private and public sectors that will allow an employee's partner of the same sex to register for benefits.

Psychological Investigations

Psychological studies regarding homosexuality, bisexuality, and homoeroticism have been conducted by Octavio Giraldo and his team (1979, 1981, 1982) at the University of "El Valle." Similar studies have been led by Ruben Ardila (1985, 1986, 1995, 1998) at the National University of Colombia.

Ruben Ardila has focused on sexual orientation in the studies he has conducted for the past 15 years. Some of the issues he has researched have been: adaptation of homosexual males, lesbianism, sexual orientation, heterosexual attitudes towards homosexuals, stability of the homosexual couple, the lifecycle of homosexuals and lesbians, the biological aspects of homosexuality, politics as they pertain to homosexuality, and other related topics.

One such study looked at the adaptation of male homosexuals (Ardila 1998). There were 100 subjects, between the ages of 18 and 52 years of age. They all scored a five or six on the Kinsey Scale (indicating predominantly or exclusively homosexual). The following factors were studied: depression, solitude, timidity, social alienation, interrela-

tions with heterosexuals, interrelations with homosexuals, sexual practices, traditional values, religion, morals, conformity, acceptance of homosexuality, emotional stability, guilt, concept of homosexuality as a mental illness, effeminacy, responsibility, interrelations with the opposite sex, secretiveness of homosexuality, personal adjustment, and psychosomatic symptoms.

The results indicate that Colombian homosexuals are well adapted and do not present any pathological qualities. However, 10% manifested signs of severe depression, while 44% were highly stable. Only 4% reported feeling guilty about their homosexuality. Fifty-nine percent stated that they had positive interpersonal relations, and 48% accepted their homosexuality. For further material on diverse aspects of sexual orientation for both women and men, see the References and Suggested Readings section.

Sexual Orientation in Colombian Society

Our society, based on the Judeo-Christian faith, has a very negative attitude towards homosexuality. Homosexuality is viewed as a violation, an illness, or a deviation from the norm that threatens normal behaviors and society. This homophobic view has permeated Colombian society throughout its history, although there have been different levels of acceptance, depending on the individual's level of education, rural-versus-urban setting, age, and their affiliation with the Catholic Church. There is a deeply rooted belief that homosexuals are a threat to society, good upbringing, and family values. Similarly, homosexuality is thought to be related to child sexual abuse, AIDS, substance abuse, delinquency, and other serious social problems.

Homosexuals are discriminated against in education, in the workplace, in housing, in the mass media, and generally in daily living. This homophobia has its origins in the Latin American cultures, which practice *machismo*, emphasize the importance of the family unit, and are highly influenced by the Catholic Church. In spite of this, the situation has considerably improved in recent years, from the homosexual liberation movements in the 1970s to the legislative, medical, and psychological advances that occurred later. In the larger cities of Colombia, especially those with higher levels of education, homosexuals are accepted. They are respected and are considered equal to heterosexuals. In these areas, discrimination is hardly noticeable. It is no longer believed that male homosexuals are less masculine than heterosexual males or that lesbians are any less feminine than female heterosexuals are. Additionally, there are certain groups within the Church who have worked towards improving the quality of life for gays and lesbians. Social support has shown improvement, which will then lead to a more pluralistic, diversified, and egalitarian society.

7. Gender Diversity and Transgender Issues

BERNARDO USECHE

As in most of the Latin American countries, Colombia also does not have serious studies or reliable statistics on the frequency or psychological evolution of those people whose sexual identity is not well-defined or is confused. But, based on clinical exams and interviews with those people, it is possible to differentiate two large groups.

In the first group, one encounters heterosexual and homosexual transvestites and a few male-to-female transsexuals who were born and raised in lower-class environments and have socially isolated themselves in areas dedicated mostly to prostitution. Because of the almost nonexistent control over the sale of hormones in the country, it is quite easy for such people to seek physical changes through

automedication with estrogen. This type of hormonal auto-medication normally starts during adolescence and has the effect of changing the body type to the feminine phenotype, even though the vast majority of this group will not seek surgical sex reassignment.

Given the context of the social problems encountered by people living in poverty, members of this first group become sexually active at a very early age and soon transition to promiscuity and prostitution. A few work as strippers in the clubs that are very common in the prostitution areas of the big cities. A few others, under the auspices of "trans-formists," work as singers or actresses in nightclub shows. Very seldom, and only if sex-reassignment surgery is involved, will someone from this group obtain some type of professional therapy through the almost nonexistent public health system. Members of this group also have received some help and orientation from nongovernmental agencies involved in the prevention of HIV infection.

The following quote perfectly demonstrates what happens to members of this group:

I began to dress permanently as a woman and take hormones when I was 18, and that provoked adverse emotional reaction from my parents who kicked me out of the house. They accepted me as a homosexual but not as a transsexual. The only place that accepts me as I am is the brothel where I go to work when I need money. (Author's clinical notes)

The second group is composed of those who belong to the upper classes, many of whom have college degrees and work as professionals. This group is currently composed of transvestites, fetishist transvestites, and some transsexuals who have access to information regarding their sexual identity, especially through the Internet. Some have their own Web pages and communicate among themselves, taking advantage on the initial anonymity of cyberspace to better understand themselves. Even though this group has the means to obtain professional help and counseling through private practice, they seldom do so. This is because of the fact that many therapists have no knowledge on the subject, and some even have a negative attitude to those who approach them with these problems. In the words of one client in this group:

In the anguish of my situation I went to a psychiatrist who referred me to the best sex therapist in this city. In our first meeting, the sexologist was very frustrating and I felt offended and attacked. I never returned. (Author's clinical notes)

In recent years, sex-reassignment surgery has been performed in large cities like Bogotá, Cali, and Medellín.

8. Significant Unconventional Sexual Behaviors

JOSÉ MANUEL GONZÁLES

A. Coercive Sex

Child Sexual Abuse and Incest

Colombian law considers child sexual abuse a crime under Articles 303, 304, and 305 of the Penal Code. It is calculated that one Colombian child is sexually molested every six hours (Afecto Foundation 1999). In the great majority of cases, the aggressor is a person the victim knows (Florez & Consuegra 1998). These authors studied the cases of 80 girls under the age of 15 in the urban area of Barranquilla. In 53% of the cases, the aggressor was someone the victim knew but was not a family member, 41% of the perpetrators were family members, and only 6% were complete strangers. In 1.25% of the cases, pregnancy was a consequence.

Incest is also considered a crime under Article 259 of the Penal Code. Even though there are no reliable statistics, it is widely calculated that incest is a common phenomenon. In a recent survey conducted in the four largest cities, *Semana* (1999) found that 3% of males and 1% of females had had sexual relations with their father, mother, or a sibling.

In Colombia, 2 million children are victims of abuse, 850 of whom were in critical condition at the time of the Afecto Foundation survey (1999). In Colombia, an estimated 148 of every 1,000 Colombian children are abused in some way. Of these 148, 100 are verbally abused, 40 are physically abused, and 8 are sexually abused (*El Tiempo* 1999).

Sexual Harassment

Sexual harassment is not considered a crime in Colombia. Even though there are no reliable statistics, it is a very common phenomenon in academic and work environments. The *machismo* cultural pattern makes many men think it is their God-given right to sexually harass their female employees and coworkers.

Rape

Rape is considered a crime under Article 298 of the Penal Code and does happen with some frequency. Profamilia (Planned Parenthood of Colombia 1995) found that 5.3% of women in the fertile age group have been forced to have sexual relations. Before 1996, forced sexual relations within married couples were not considered a crime. With the creation of Law 294 under Article 25, forced sexual relations within married couples are now a crime.

Spousal abuse is a very common phenomenon. In 1996, of the 42,963 cases seen by the Legal Medicine group, 71% involved spousal abuse. Of those cases, 95% of the victims were women, with a ratio of 18 women for every man. The group at most risk of abuse are women between the ages of 25 and 34. In a 1998 study in several Colombian cities, 14.3% of the persons interviewed said that they had been attacked by their spouses (*El Tiempo* 1998). Further interviews showed that 60% of the women had been verbally, physically, psychologically, or sexually attacked by their husbands or partners. Twenty percent were physically attacked and 10% were forced to have sexual relations with their husbands (Profamilia 1995). Most of these women tried to solve their problems without the intervention of the police or other governmental agencies. Most of these women were completely passive regarding the attacks of their partner. Most battered women say that the main causes of the aggression are drunkenness and jealousy on the part of their partners. The most common physical abuses are punches 88%, kicks 27%, and shoves and pushes 24%. In 35% of the cases, the episode is observed by a child (Profamilia 1995).

B. Prostitution

Prostitution is considered a crime under Articles 308, 309, 311, and 312 of the Penal Code. In 1998, the Renacer Foundation estimated 30,000 Colombian boys and girls were engaged in prostitution. At the same time, the Foundation estimated that there were 90,000 sex workers in the country. The sex trade seems to be increasing in the past five years, particularly in the tourist areas and with minors. In the most recent government administrations, there has been a greater emphasis on efforts to combat situations, such as the sex trade, that are problematic to the community.

C. Pornography and Erotica

Pornography possession and its use among adults are not crimes. Article 312 of the Penal Code does limit and penalize the circulation of pornographic material for minors under age 18 years. Pornographic movies can be seen or

rented with great ease in the cities. Pornographic magazines circulate all over the country. A 1999 survey by *Semana* shows that 48% of men and 35% of women think that pornographic movies and magazines make their sexual life more interesting. Regarding pornographic magazines, 13% of men and 3% of women reported having read one in the previous 30 days. It is also interesting to note that 16% of men and 44% of women had never read a pornographic magazine in their lives. As for pornographic movies, 21% of men and 6% of women confirmed having had seen a pornographic movie in the previous 30 days. Also, 14% of men and 39% of women stated that they had never seen a pornographic movie in their lives. In the large cities, live sexual shows are performed, but 65% of men and 85% of women claimed they had never seen one (*Semana* 1999).

The new digital media, Internet, and World Wide Web have also been affecting sexual relationships: 17% of men and 4% of women affirmed having visited a pornographic site on the Internet. Also, 14% of men and 4% of women admitted to having engaged in phone sex.

9. Contraception, Abortion, and Population Planning

GLORIA PENAGOS

A. Contraception

Birth control, more commonly known as family planning, was introduced in Colombia in 1964. It was managed under the sponsorship of population and medical specialists. The objective was to improve the health of women and their children, to facilitate the growth of women in areas related to motherhood, and population control.

Although the majority of Colombians practice Catholicism, which prohibits the use of any type of artificial birth control, economic and social needs, marital instability, and constant changes in the family structure have led to the acknowledgment of the civil rights of all couples and their children. Thus, the contradiction between what is forbidden by the Catholic Church and what is practiced by the general public has led to an appreciation of the right to the enjoyment of sexuality without the burden of pregnancy. The majority of people continue to practice Catholicism without feeling the guilt put upon them by the Church regarding birth control. Close to three quarters of all women in a relationship, 72.2%, utilize some method of birth control. However, for every six women using birth control, only one man uses a contraceptive (Profamilia 1995). Table 2 shows a comparison of the use of birth control worldwide and the usage in Colombia in 1995.

The most commonly used methods of birth control are tubal ligation and vasectomy. Recently, Colombia's Social

Security System and medical service providers, the equivalent of Medicaid in the United States, now fund these procedures. In the past, they may not have been funded by the government out of deference to religious authorities rather than for economic reasons. Nonetheless, the cost of unwanted pregnancies and abortions reinforces the current position.

Oral contraceptives are the second most frequently used contraceptive method. According to Article 100 of the Social Security act, provision of oral contraception is mandatory. However, 70% of Colombians who use oral contraceptives obtained them through the private sector, whereas 30% obtained them through the public sector. This evident lack of active participation by the state would suggest that most families prefer to incorporate the cost of oral contraceptives into the family budget rather than rely on the government.

Colombia has several laws that protect the rights of women and children; however, implementation is often lacking. Family planning is viewed as an individual's right and an obligation of the state. The Constitution of 1991, Articles 17 through 30, denounces all forms of discrimination against women: "Women have civil rights as they pertain to reproduction and the judicial system equal to men in education, nationality, employment, health, matrimony and family." Two other articles deal with pregnancy and children:

- Article 42 stipulates that a couple has the right to freely and responsibly choose the number of children they will bear. They will provide and educate them while they are minors unable to provide for themselves.
- Article 43 states that men and women have equal rights and opportunities. A woman cannot be discriminated against. The law also protects a woman while pregnant and postpartum, and the state will provide financial assistance and food supplements should she be unemployed and/or homeless. The state will assist women who are heads of households.

The aforementioned legal structure allows us to reflect on how little the state is actually doing to defend the rights of individuals, and, in failing to acknowledge the discrimination, women suffer within Colombia's poorly organized health system.

B. Teenage (Unmarried) Pregnancies

One out of every ten adolescents has had sexual relations between the ages of 13 and 14 years. Four out of every ten adolescents have had sexual relations between the ages of 15 and 17 years. Seven out of ten have had sexual relations by the time they reach the age of 18.

One out of every three adolescents believes that abortion is unacceptable; however, 70% feel that it may be necessary in certain situations. Sixty-two percent have had some discussion on sexually transmitted diseases and 95% understand that anyone can contract AIDS. The contraceptive methods most commonly used by adolescents are: the condom (94%), oral contraceptives (77%), and contraceptive suppositories (60%). The rhythm method is the least-used method (42%), which coincides with women's lack of awareness of their menstrual cycle (Profamilia 1995).

There has been an increase in birthrates among adolescents. This may be because of several factors: earlier onset of puberty, earlier onset of sexual activities, low socioeconomic levels, low levels of education, increased age for marriage, changes in value system because of urbanization, and the increased ability of communication.

According to a study conducted by the University of Colombia (Universidad Externado de Colombia 1992), one third of all women between the ages of 15 and 19 years, of

Table 2

A Comparison of Birth Control Methods Used Worldwide and in Colombia (1995)

Contraceptive Method	Worldwide Usage	Colombian Usage
Tubal ligation	13.0%	16.9%
Vasectomy	5.9	0.7
Vaginal suppository	1.0	1.0
Oral contraceptives	8.0	8.5
Intrauterine device (IUD)	9.0	7.4
Injectable contraceptives	1.0	1.8
Coitus interruptus	4.0	6.0
Rhythm	4.0	5.3
Condom	5.0	4.3

low educational level, and who had at least one child, were single, lived in an urban area, and were more fertile than their counterparts living in rural areas.

Profamilia (1995) reported that 17% of women between the ages of 15 and 19 years were mothers or were pregnant at the time of the study. At the age of 19, four out of every ten women surveyed were mothers and 9% already had at least one child. It was also reported that 33.6% did not utilize birth control because they believed that they were infertile. Ten percent of these women and 2.8% of their contemporaries are opposed to the use of birth control. Three percent were unfamiliar with birth control methods and 7.9% were afraid of the side effects. These results reflect the lack of adequate information, existing myths, unawareness, and a lack of responsibility in spite of knowing the consequences.

Pregnancy in adolescents brings with it many consequences, including compromised physical and mental health and both economic and social challenges, which affect the mother, father, and child, as well as the family and society as a whole. The education dropout rate in this population is very high, leading to limited employment opportunities. Children born of adolescents show a higher incidence of prematurity, lower birthweight, more congenital diseases, and a higher incidence of abandonment and abuse. It is estimated that about 10% of children of teenage mothers are given up for adoption (Pardo & Uriza 1991).

C. Abortion

The actual incidence of abortion in Colombia is unknown. It is estimated that 24% of all pregnancies end in abortion and 26% result in unwanted pregnancies (Profamilia 1995). In a 1992 study, *The Incidence of Abortion in Colombia*, researchers at the Universidad Externado de Colombia found that 30% of urban women between the ages of 15 and 49 years had had at least one abortion, with the highest incidence among women between ages 20 and 29 years. In at least 78% of those cases, no birth control was utilized; the remaining 22% had used a birth control method that failed and resulted in pregnancy. There is a 22% incidence of abortion among women ages 45 to 49 years of age, and a 19.4% incidence of abortion among women ages 50 to 55. A third of the women surveyed reported that they had been pressured by their partners to abort.

Abortion is illegal in Colombia, and women go to health clinics much too late in the pregnancy when they show complications that cannot be resolved on their own. Complications are the most common reason for aborting, and abortion is the leading cause of death for Colombian women. There is an estimated 300,000 illegal abortions yearly. In other words, for every 10 births, there are four illegal abortions, and one out of every 100 women between the ages of 15 and 49 years old has had at least one abortion. The women most likely to abort are those who failed to use contraceptives.

The majority of families in Colombia are rooted in the traditional patriarchal family structure, based on economic, political, and religious power, which conditions women to utilize family planning methods. However, contraception should not be limited only to birth control. The meaning and implications of contraception should also include the significance, attitudes, and values people place on relationships, affection, and sexuality. These factors should take us beyond the stereotypes created by patriarchal gender roles, thus facilitating a better understanding of the individual, their health, and their relationships (Londoño 1996). In this extended meaning of contraception, it is necessary for women to acquire higher educational levels to attain better employment opportunities. They should be able to access better social security and health systems. The medical assis-

tance model should not be solely based on doctors and technology, but also on the premise of caring for one's self and gaining the knowledge women need to balance, preserve, and improve their health.

D. Population Programs

Since the introduction of contraceptives in the mid-1960s, Colombia's population growth rate has decreased steadily. Between 1980 and 1995, Profamilia estimates the population growth rate decreased by 23%. On average, there were 7 children born per family in the 1960s. In early 2001, the average Colombian family has 2.8 children per family. However, the averages vary from region to region. In the mountainous regions, the average family size is 4.3 children. Education level also plays an important role in determining the number of children per family. On average, there are 5 children per family for women with no formal education versus 1.8 children per family for women with higher levels of education (Profamilia 1995).

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

JOSÉ MANUEL GONZÁLEZ and GLORIA PEGANOS
Incidence

A true evaluation of the incidence of sexually transmitted diseases (STDs) is very difficult in any country, because the percentage of actual cases is considerably higher than the number of cases reported to health officials. In 1994, the Institute of Social Security found that 2% of Colombian males and 1.1% of females had some type of STD. The most common infections were gonorrhea, condylomas (warts), genital herpes, and syphilis. The majority of cases occurred in people between the ages of 15 and 44. Useche (1999) found that 4% of male students in high school reported some type of STD. Zuluaga and contributors (1991) found that 16.4% of male and 2.4% of female Mendellin University students had had some type of STD, the most common being gonorrhea and condylomas. Among university students from Baranquilla, González (1985) found that 13% of males and 1% of females had had some type of STD. In a follow-up study ten years later, González (1995) found that 12% of males and 2% of females had had some type of STD, with gonorrhea being the most prevalent. In the last few years, the incidence of STD cases has grown considerably. This is in part because of teenagers having sexual relations earlier than in previous times, teenagers having sex without protection, and cultural stereotypes that only sex workers can get STDs and not promiscuous men. When the increase in STDs is compared to the increase in the population, however, one can actually see a slight decrease in the overall percentage of STDs in the population.

Papilloma and Condyloma Infections. Although the actual incidence of STD infections is not known, there has been a large increase in the number of new diagnosed cases, in conjunction with other infections like gonorrhea, syphilis, nongonococcal urinary tract infections, trichomonas, and HIV. Ninety percent of the precancerous lesions in the uterine matrix test positive for the papilloma virus. Between 75% and 80% of the atypical cell cultures in women between the ages of 15 to 25 show infections of the human papilloma virus. Based on this, when tested, 40% of their partners are also infected by the disease.

Gonococcal Infections. Only 33% of acute cases of inflammatory pelvic disease (IPD or PID) test positive on the Tayer

Martin test, but this result is in direct relationship to the beginning of the infection and when the sample was taken. Half of the gonococcus-infected patients are asymptomatic and therefore can present the following complications: Asymptomatic tuboperitoneal factors result in infertility in 20 to 30% of patients, chronic pelvic inflammatory disease in 20 to 25%, chronic pelvic pain in 5 to 15%, ectopic pregnancies in 7%, and irregular menstrual cycles in 5%.

Syphilis. The number of congenital syphilis cases has decreased in Colombia. In 1998, the following number of cases were reported in Colombia by region. Costa Atlántica, 64; Amazonia, 25; Orinoquia, 21; Oriente, 193, including Boyacá, Cundinamarca, Santanderes, Tomolina, and Bogotá; and Occidente, 347, including Caldas, Antioquia, Chocó, Quindío, and Valle. Two cities in the Occidente must be highlighted: Antioquia with 99 cases and Valle with 149 cases. The incidence of reported cases of congenital syphilis is 36.6 cases per 100,000 live newborns (Ministerio de Salud 1998, 1999).

Treatment

There are some formal programs available for the treatment of STDs. However, they are poorly organized and not fully developed as of early 2001.

B. HIV/AIDS

JOSÉ MANUEL GONZÁLES and GLORIA PENAGOS

On January 5, 1983, a 23-year-old woman, a known prostitute, was hospitalized at the University Hospital of Cartagena. She died four months later. She was the first person to be officially diagnosed with AIDS in Colombia (González 2000). According to the Colombian Coalition Against AIDS, there are 200,000 people living with HIV (González et al. 2000). Every hour someone new is infected.

In 1997 and 1998, 81% of all reported cases were between the ages of 15 and 44 years (Ministerio de Salud 1998). Even though the group most at risk for contracting AIDS are adolescents, the general public continues to remain unaware of the dangers involved. Of households with children under the age of 18 years, 63.3% believe that they were not at risk of contracting HIV/AIDS. There was no discussion on AIDS prevention in 39% of households where there were minors under the age of 18 years.

According to the Colombian Ministry of Health, in 1986, there was one woman for every 47 men infected with HIV. In 1997, the ratio was one woman to four males. It was estimated that in 2001, the ratio will be 1:1. The risk among women is quite high and is believed to be related to the social inequity between men and woman. Women are kept at the subordinate level socially, by marital status, and economically, which contributes to their inability to adequately protect themselves. Consequently, religious beliefs that reject the use of condoms, anal sex at the insistence of the male, failing to acknowledge adultery for fear of being accused of infidelity, all these factors and other similar ones lead to an increase in HIV/AIDS-positive women (Penagos 1997).

Sexual contact constitutes the primary mode of transmitting HIV/AIDS (Ministerio de Salud 1998). For females, heterosexual contact accounted for 91.5% of cases of HIV infection, blood transfusions for 1.7%, and 6.8% became infected during delivery or perinatally. (No percentage was given for other modes of transmission, notably intravenous drug usage.) In men, 56.1% contracted HIV through heterosexual relations, 41.8% through homosexual/bisexual contact, perinatal transmission was 0.7%, and by transfusions were 1.4%.

One of the most important factors contributing towards the transmission of AIDS is the lack of adequate information. González (2000) conducted a study with university students, in which the following information was found:

- 95% of the students were unaware that anal penetration is the most high-risk sexual activity that may lead to the transmission of AIDS;
- 78.9% were unaware that it may take three months or more for an AIDS test to come up positive once a person is infected;
- 66.4% were unaware that it may take five to ten years to develop any AIDS-related symptoms;
- 48.1% were unaware that individuals may transmit HIV as quickly as they have acquired it; and
- 41.2% were unaware that semen is the body fluid that carries the highest concentration of HIV.

The study also found that 80.2% of men and 88.5% of women believe that there is a high risk of contracting AIDS while having unprotected sex with someone you do not know. Fifty-six percent of men and 66.9% of women believe that there is a high risk of contracting AIDS while having unprotected sex with an occasional partner; 14.8% of men and 16.1% of women believe that there is a high risk of contracting AIDS while having unprotected sex with a regular partner. As is evident, there is a popular misconception that AIDS can only be transmitted through unprotected sex with a one-time partner or an occasional partner. Consequently, people who are in new (exclusive) sexual relationships fail to practice safe sex. They do not take into account previous sexual partners nor have they taken an AIDS test (González et al. 2000).

Generally, there is minimal use of condoms. González and colleagues (2000) found that 33% of males and 53% of females have never used condoms during vaginal penetration. It was also reported that 48.4% of men and 63.2% of women never used condoms during anal sex.

The Colombian Constitution of 1991 enacted laws that protects the rights of all citizens. These laws stipulate that anyone living with HIV/AIDS, with or without financial means, can receive social security benefits. Although there exists budgeting and administrative problems that may delay the process, everyone has the fundamental right to medical care, psychological care, and pharmacological care. Generally, those individuals living with HIV/AIDS have access to antiviral medication.

On June 12, 1997, the Colombian Ministry of Health passed Decree #1543. It provides a standardized protocol for people with AIDS that indicates their rights and obligations. The protocol is as follows:

- Written consent from an individual is required in order to obtain an AIDS test.
- A healthcare provider or institution cannot deny care to someone diagnosed with HIV/AIDS.
- Comprehensive care must be provided: psychological, biological, and social.
- All records pertaining to patient care must remain confidential.
- Requesting an AIDS test to secure or maintain access in an educational facility, religious center, political group, cultural center, rehabilitation center, workplace, or health-related services, or to gain entry to a country is strictly prohibited.
- AIDS-test results may only be exchanged between patient and a qualified caregiver.
- Guaranteed job relocation when needed.

The decree also created CONASIDA (National Council on AIDS). It is comprised of the Ministry of Health, Ministry of Education, Ministry of Communication, Ministry of Employment, Colombian Institute of Family Wellness, National Institute of Health, Public Defendants, the Institute of Drug Administration and Regulations, ONUSIDA (AIDS Organization of the United Nations), representatives from nongovernmental organizations (ONGs), and advocates for AIDS victims. Generally, people who are living with AIDS are involved in political development and decision-making processes, as recommended by ONUSIDA. Presently, the ONGs are changing the image of AIDS from a "terminal disease" to a "treatable chronic disease."

AIDS-prevention programs and assistance to victims of AIDS are faced with serious financial problems. There have been government budget cuts since 1998. Additionally, discrimination and rejection of AIDS victims are two problems that must be addressed in health and sexuality.

[Update 2001: According to the CIA *World Factbook*, the estimated adult prevalence rate for HIV/AIDS in 1999 was 0.31%, with 71,000 Colombians living with HIV/AIDS and 1,700 deaths because of the infection. (End of update by R. T. Francoeur)]

[Update 2002: UNAIDS Epidemiological Assessment: The first AIDS case in Colombia was recorded in 1983. As of December 2001, the reported cumulative number of persons living with HIV/AIDS was 19,603. Of this total, 6,437 are AIDS cases and 13,166 are HIV cases; 84.6% are males and 15.4% are females. According to the National Statistics Administrative Department (DANE), there are 12,410 registered AIDS deaths, although only 3,645 AIDS deaths have been registered at the MOH; 807 of the DANE-registered deaths are among children younger than 15 years. National estimates of the total number of people living with HIV/AIDS vary from 139,000 to 148,000.

[Sexual transmission accounts for 78.0% of reported cases, mother-to-child transmission for 1.6%, and blood transmission for 0.6%. In 19% of registries, mode of transmission has not been recorded. Among those with known sexual transmission, 47.7% were heterosexual, 34.0% homosexual, and 28.2% bisexual. The annual male-to-female ratio has changed from 18:1 in 1986 to 4:1 in 2000. Of the total number of HIV infections reported, 44% were in persons aged 15 to 35 years.

[The first case of vertical transmission in Colombia was reported in 1987. Since then, 615 cases have been registered, with a sustained increase since 1995. Analysis of the regional data collected between 1990 and 1995, in conjunction with the results of five sentinel anonymous unlinked studies conducted between 1992 and 1999, indicates that there are important geographical differences in the predominant mode of HIV transmission through sexual contact. Injection drug users who have sex with men (IVISM contact) remains predominant in Bogotá and in the central western region; in these areas, men who have sex with men accounted for more than 50% of infections registered between 1990 and 1995, with a male-to-female ratio of 28:1 and 9:1, respectively. In the Caribbean and in the northeastern regions, HIV infection has spread mostly through heterosexual contact, with a male-to-female ratio of 2:7.1. The estimated prevalence among the adult general population is 0.37%. Sentinel studies have been conducted in a varied number of cities. The largest study, conducted in 1999 in 11 cities, among pregnant women, female sex workers, and STD patients, found HIV-prevalence rates of 0.2%, 0.6%, and 0.8%, respectively. In 1999, a study conducted in Bogotá among men who have sex with men showed an 18% HIV-prevalence rate.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	140,000 (rate: 0.4%)
Women ages 15-49:	20,000
Children ages 0-15:	4,000

[No estimate is available for the number of adults and children who died of AIDS during 2001.

[At the end of 2001, an estimated 21,000 Colombian children under age 15 were living without one or both parents who had died of AIDS. (End of update by the Editors)]

11. Sexual Dysfunctions, Counseling, and Therapies

JOSÉ MANUEL GONZÁLES

Until the 1980s, sexual dysfunction was unknown as a health-related problem. Traditionally, treatments for sexual problems were seen as something unnecessary and even excessive. Generally, people who suffered from sexual dysfunctions failed to seek professional help because of embarrassment or guilt, even though, for more than 50 years, there have been private institutions in Colombia that provided sex therapy (González 1999c).

In the last five years, there has been an important change in the outlook on sexual dysfunction. The National Program on Sexual Education has generated a change in attitude towards sexuality and sexual health. There are now a few professionals who specialize in clinical sexology. An association of professional sex therapists has yet to be organized. In the next few years, there will be an increase in the quantity and quality of sex therapists because of the high demand for their services.

Dr. Rodríguez A. [sic] was the pioneer in sexual therapy in Colombia (González 1999c). He studied abroad in France, where he specialized in reflexology. In the late 1940s, he returned to Santafé de Bogotá, where he founded a clinic for sexual dysfunctions. He trained prostitutes in collaboratively assisting in his patients' treatments. This is what is now called sexual surrogates, or bodywork therapists. However, an animosity developed between Dr. Rodríguez A. and his colleagues that resulted in lawsuits and other legal problems. Consequently, Dr. Rodríguez A. closed his institute in Santafé de Bogotá (Guerrero 1997) and shortly thereafter opened a sexual therapy clinic in Fusagasuga. He died in the late 1970s.

In the late 1960s, a group of doctors and psychologists, including Heli Alzate, Cecilia Cardinal de Martin, Octavio Giraldo, and German Ortiz Umana, developed an interest in sexology and sexual therapy. In 1968, Heli Alzate offered the first formal courses in sexology to medical students attending the University of Caldas in Manizales. Octavio Giraldo offered courses in sexology to medical students at the University of El Valle. In 1971, Celcilia Cardinal de Martin and German Ortiz Umana offered coursework in sexology at the University of Rosario de Bogotá. José Manuel Gonzáles initiated the coursework in sexology in the Metropolitan University of Barranquilla in 1976. Luis Dragunsky offered coursework on sexology at the University of Santo Tomas in Bogotá in 1977. During this time, the first texts on sexology were published: *Medical Sexology in Summation* (Alzate 1978), *Lectures in Sexology* (Dragunsky & González 1979), and *Exploration of Human Sexuality* (Giraldo 1981).

In May 1978, the Colombian Institute on the Development of Advanced Studies (ICFES) brought together a group of specialists to discuss and evaluate the state of sexology as a science: Heli Alzate, Cecilia Cardinal de Martin, Octavio Giraldo, José Manuel Gonzáles, and German Ortiz Umana. They generated an important document,

which stated specific recommendations (ICFES 1978). As a result of this meeting, the participants felt a need to develop a committee that would coordinate the efforts and publicize the findings of studies that would support the development of sexology in Colombia.

One year later, the Colombian Association of Sexology was founded in June 1979. The original founders were: Heli Alzate, Maria Clara Arango, Mario Bedoya, Cecilia Cardinal de Martin, Luis Dragunsky, Mario Gartner, Octavio Giraldo, José Manuel Gonzáles, Maria Ladi Londoño, Saulo Munoz, German Ortiz Umana, Francisco Sanchez, and Jorge Villarreal Mejia. The elected president was Heli Alzate. As a consequence, sex therapy has developed its own niche in the larger cities. The group in Manizales has generated the most investigations and published internationally. The Cali group, with Octavio Giraldo, Mari Ladi Londoño, Javier Murillo, Diego Arbelaez, Nelssy Bonilla, Monica Lozada, and other colleagues, has been most active in advocating for the rights of minorities and the oppressed: women and homosexuals. Two other active groups, in Bogotá, Medellín, have pioneered in the treatment of premature ejaculation, erectile problems, patients suffering from various psychosexual dysfunctions, prolonging the pleasure phase, transsexuals, and interesting ways of dealing with infertile couples (Acuña et al. 1997).

Sex therapy in Colombia is marked by several characteristics (González 1999c):

- It is interdisciplinary, although most of the professionals in the field are also trained in the medical or psychological fields.
- It originates mostly from behavioral psychology, cognitive psychology, and human development, with little basis in psychotherapy.
- It provides advocacy for the rights of minority groups and oppressed groups, specifically homosexuals and lesbians.
- Private practice and college coursework solely dedicated to sex therapy is nonexistent. Most sex therapists have maintained their origins in psychology and/or medicine.
- There is an absence of formal training for sex therapists. In 1983, Luis Dragunsky and José Manuel Gonzáles founded the first accrediting committee, the Colombian Association of Sexology (CAS). Only five sex therapists have been accredited by CAS and very few Colombian sex therapists are accredited by the Latin American Federation of Sexological Societies and Sexual Education (FLASSES).
- There is extensive coverage by the mass media.

There has been active participation by most sex therapists in the events sponsored by the Colombian Association of Sexology.

12. Sex Research and Advanced Professional Education

BERNARDO USECHE

Generally, scientific studies in Colombia are very scarce and poorly funded. In 1999, the total budget earmarked by Colciencias, a government body responsible for all studies conducted in Colombia, was approximately US\$6,000,000. Only recently have there been doctoral programs in the basic sciences. However, there are no doctoral programs offered in disciplines that could directly contribute towards the study of sexology, such as physiology, anthropology, psychology, or sociology. It is in this context that we must understand the limited development of the study of human sexuality in Colombia.

In recent years, Abel Martinez of the University of Pedagogy and Technology of Tunja has specialized in the study of *Colombian Sexual Archeology* (unpublished). He presents a poetic description of sexuality during the Spanish Conquest, colonization, independence, and the beginning of the Republic. The study of the mythology of the aborigines and the key role the erotic played in the blending of the races is evident throughout his work. In *Daughters, Wives and Lovers*, anthropologist Suzy Bermudez discusses the same timeframe covered by Abel Martinez, the Spanish Conquest to the Republic. However, she took a feminist perspective, dealing with native women, European women, African slave women, married women, widows, and single women. Although it was not her main objective, Bermudez attempted to clarify how social class, ethnicity, and age play an important role in understanding the history of women's sexuality in Colombia.

In the second half of the 20th century, Virginia Gutierrez de Pineda (1975) led an important anthropological investigation that set the foundation for the comprehension of human sexuality for Colombians. In her analysis and classification of the various cultural elements that correspond to the different regions of Colombia, Gutierrez explained the logic behind the different types of marriages and polygamy, and the significance of prostitution and homosexuality thought to be tolerated but tacitly encouraged by religious subcultures in hopes of preserving young women's virginity and protecting the institution of matrimony. Her description of families in the second half of the 20th century is considered to be a key reference for anyone wanting to study the changes in the sexuality of Colombians at the end of the century.

Heli Alzate, another pioneer of sexology in Latin America, developed an extensive and rigorous curriculum for the School of Medicine at the University of Caldas. He also published four books and numerous scientific articles in North American and European publications. A member of the editorial committee of the *Archives of Sexual Behavior* for a quarter century, Alzate has theorized a conceptual model of the function of erotica and completed three studies pertaining to sexuality:

1. Evaluation of a curriculum pertaining to sexuality (Alzate 1990);
2. Sexual behavior of secondary-level students and university-level students (Alzate 1989; Useche, Alzate, & Villegas 1990; Alzate & Villegas 1994); and
3. Studies pertaining to vaginal erogeneity (Alzate 1985; Alzate & Hoch 1986; Alzate, Useche, & Villegas 1989).

Alzate also evaluated the knowledge and sexual attitudes of his medical students with an adapted version of the Sexual Knowledge and Attitude Test, or SKAT, originally formulated by Harold Lief. Later results from his modified SKAT, or ACSEX, indicated that it is possible to impart scientific knowledge and achieve a positive attitude towards sexuality utilizing coursework in sexology, audiovisual media, and active class participation from medical students.

The studies of the sexual behavior of the younger generation with secondary- or university-level education in one of the most traditional and conservative areas of Colombian culture give a fair picture of the evolution of Colombian sexuality in the past quarter-century, the incidence of first sexual encounters, the motives behind sexual activity, the types of couples, and, above all, the differences in sexual behaviors between genders.

Of particular interest, in view of the significant growth of the women's liberation movement in recent years in Colombia, are several studies on the erogenous zones of the vagina. According to these studies, the majority of women,

if not all, have vaginal erogenous zones, frequently located in the anterior vaginal wall, which, if stimulated appropriately, will culminate in orgasm. Colombian researchers consider this a vital factor in the context of normal sexuality of the woman and also as important in the treatment of coital dysfunctions of women. Alzate believes that the theories, that have thus far been conceptualized to explain these sexual dysfunctions, should be revised. He also believes that sex therapists who are confronted with these issues should recognize the necessity of referring clients for gynecological exams so as to locate their erogenous zones (Alzate 1997b). Alzate also introduced modifications of the human sexuality functioning model originally proposed by William Masters and Virginia Johnson and later enriched by Helen Singer Kaplan. Alzate's premise was to "seek out and responsibly enjoy pleasure." Presently, there are no other systemic studies by Colombians in the field of sexology other than those provided by Alzate.

At the international level, publications by Colombians in the area of human sexuality are very scarce, almost nonexistent. However, there have been other unpublished works that originated in Colombia. Florence Thomas's 1994 *Dissertation on Love and Communication* analyzed communications from a gender perspective, and Guillermo Carvajal (1993) completed a psychoanalytic vision of the adolescent. Pedro Guerrero (1985) led a study on the use of erotica in literature by some of the most prominent writers in Colombia, and Maria Ladi Londoño has published numerous articles dealing with sexuality and reproductive rights. In a recent study, also of note, is Ruben Ardila's 1998 study of 100 male homosexuals, which found that, generally, these individuals did not have serious adaptation problems, nor did they seem to suffer from adjustment issues.

The *Latin American Journal on Sexology of Colombia* (ISSN 0120-7458), with a base in Colombia, serves as the medium for the Latin American Federation of Sexological Societies and Sexual Education (FLASSES).

The Colombian Society of Sexology, founded in 1979, has organized ten congress meetings, several seminars, and other academic events. These have involved world-renowned researchers, among others, Eli Coleman, John Money, Ira Reiss, Eusebio Rubio, Luis Dragunsky, Joseph LoPiccolo, Andres Flores Colombino, and Ruben Hernandez.

Other sexological studies in Colombia have been conducted by students in their postgraduate studies. These are generally non-funded and usually remain unpublished. Some of these studies have originated from the University of Bogotá (Bodner et al. 1999), University Simon Bolivar of Barranquilla (González 1999b; González et al. 2000), and the University of Caldas in Manizales (Useche 1999). Since the Ministry of Education established the National Project on Sexual Education in 1993, there has been a significant increase in the need for these studies. Private universities have thus developed them.

In terms of the future, we hope that the small group of dedicated and diverse Colombian professionals interested in sexological issues will be able to continue their work with sexological organizations and individuals around the world, and thereby contribute to a more solid and in-depth understanding of human sexuality, if the economic crisis in Colombia allows.

References and Suggested Readings

- Acuña, A. 1987. *Tercera edad y sexualidad*. IV Congreso Colombiano de Sexología, Medellín, 9-12 de octubre.
- Acuña, A., L. Nader, M. Palacio, & P. Guerrero. 1993. *Sexo al día: Es tiempo de vivir*. Bogotá: Unidad de Psicoterapia y Sexualidad Humana.
- Acuña, A., M. Palacio, & P. Guerrero. 1986. *Sexo: En los niños*. Santafé de Bogotá: Editora Cinco.
- Alzate, H. 1977. Comportamiento sexual de los estudiantes de medicina. *Acta Médica Colombiana*, 22:111-118.
- Alzate, H. 1978. *Compendio de sexología medica*. Santafé de Bogotá: Temis.
- Alzate, H. 1985. Vaginal eroticism. *Archives of Sexual Behavior*, 14:529-537.
- Alzate, H. 1987. *Sexualidad humana* (2 edición). Bogotá: Editorial Temis.
- Alzate, H. 1989. Sexual behavior of unmarried Colombian university students: A follow-up. *Archives of Sexual Behavior*, 18:239-250.
- Alzate, H. 1990. Effectiveness of an independent sexology course for Colombian medical students. *Medical Teacher*, 12:69-75.
- Alzate, H. 1997a. *Sexualidad humana* (Reimpresión de la 2ª edición). Bogotá: Temis.
- Alzate, H. 1997b. *La sexologie a l'université de Caldas, Manizales, Colombie. Panoramiques*. Paris: Arléa-Corlet.
- Alzate, H., & Z. Hoch. 1986. The 'G spot' and 'female ejaculation': A current appraisal. *Journal of Sexual & Marital Therapy*, 12:211-220.
- Alzate, H., B. Useche, & M. Villegas. 1989. Heart rate change as evidence for vaginally elicited orgasm intensity. *Annual of Sex Research*, 2:345-357.
- Alzate, H., & M. Villegas. 1994. Sexual behavior of unmarried Colombian university students in 1990. *Journal of Sex Education and Therapy*, 20:287-298.
- Ardila, R. 1985. La homosexualidad en Colombia. *Acta Psiquiátrica y Psicológica de América Latina* [Buenos Aires], 31:191-210.
- Ardila, R. 1986a. *Psicología del hombre colombiano*. Santafé de Bogotá: Planeta.
- Ardila, R. 1986b. Homosexualidad y aprendizaje. *Revista Latinoamericana de Sexología*, 1:45-54.
- Ardila, R. 1995 (26 de Noviembre). Nuevos hallazgos sobre homosexualidad. ¿Fatalidad biológica o deformidad cultural? *El Tiempo Lecturas Dominicales*, pp. 2-4.
- Ardila, R. 1998. *Homosexualidad y psicología*. México: El Manual Moderno.
- Berdugo, E., & A. Segura. 1988. *Estudio descriptivo del comportamiento sexual de las personas mayores de 60 años en Barranquilla* (Tesis de grado). Barranquilla: Facultad de Psicología, Universidad del Norte.
- Bodnar, Y., E. Tovar, R. Arias, N. Bogoya, P. Bricño, J. Murillo, & E. Rodriguez. 1999. *Cultura y sexualidad en Colombia*. Bogotá: Universidad Distrital Francisco José de Caldas.
- Botero, E. 1980. *Homofobia y homofilia. Estudios sobre la homosexualidad, la bisexualidad y la represión de la conducta homosexual*. Medellín, Colombia: Editorial Laelon.
- Caballero, M. C. 1996. Conocimiento y comportamiento de riesgo de infección por VIH en estudiantes universitarios. Un caso: Universidad Industrial de Santander. *Revista Latinoamericana de Sexología*, 11(1):41-56.
- CIA. 2002 (January). *The world factbook 2002*. Washington, DC: Central Intelligence Agency. Available: <http://www.cia.gov/cia/publications/factbook/index.html>.
- Colombia. Consejería Presidencial para la juventud, la mujer y la familia. 1994. *Año Internacional de la Familia*. 1994, 1(2).
- Colombia. Instituto Nacional de Medicina Legal y Ciencias Forenses. *Regional Norte*. 1996. Primer semestre (Boletín informativo).
- Domínguez, E., A. Mendoza, L. Merlano, M. & Navas. 1988. *Estudio descriptivo del comportamiento sexual del estudiante de Bachillerato de Barranquilla* (Tesis de grado). Barranquilla: Facultad de Psicología, Universidad del Norte.
- Dragunsky, L. 1977. *El mito del sexo*. Bogotá: Editorial Pluma.
- Dragunsky, L., & J. Gonzales. 1979. *Lecciones de sexología*. Santafé de Bogotá: Editorial Pluma.

- El Tiempo. El Catolicismo pierde clientela.* 1997 (13 de Julio). p. 17A.
- Eljaiek, L., M. Saade, & P. Vargas. 1987. *Estudio descriptivo del comportamiento sexual de hombres y mujeres que mantienen relación de pareja* (Tesis de grado). Barranquilla: Facultad de Psicología, Universidad del Norte.
- Florez, P., & E. Consuegra. 1998 (16 de Octubre). *Abuso sexual en adolescentes. IX Jornada Científica de Ginecoobstetricia.* Barranquilla: Universidad Libre.
- Fuscaldo, M., R. Mercado, & M. Rolong. 1987. *Estudio descriptivo del comportamiento sexual del estudiante universitario en Barranquilla* (Tesis de grado). Barranquilla: Facultad de Psicología, Universidad del Norte.
- Giraldo, O. 1979. La homosexualidad masculina: Una revisión. *Revista Latinoamericana de Psicología*, 9:81-100.
- Giraldo, O. 1981. *Explorando las sexualidades humanas.* México: Trillas.
- Giraldo, O. 1982. Más allá de la heterosexualidad. *Avances en Psicología Clínica Latinoamericana*, 1:79-94.
- González, J. M. 1979. Masturbación: Un proyecto de investigación. *Revista Sexualidad Humana y Educación Sexual*, 2(1):11-17.
- González, J. M. 1985. *El comportamiento sexual del universitario.* Santafé de Bogotá: Fundación para el Avance de la Psicología.
- González, J. M. 1993. SIDA: Síndrome de inmunodeficiencia adquirida. *Serenidad. Revista del Programa de Alcoholismo y Drogadicción*, 1(3):8-10.
- González, J. M. 1994. *Educación de la sexualidad.* Barranquilla: Club del Libro.
- González, J. M. 1995. Diferencias genéricas en el comportamiento sexual de estudiantes universitarios solteros de Barranquilla. *Revista Latinoamericana de Sexología*, (2):161-76.
- González, J. M. 1996. El aporte de la Sociedad Colombiana de Sexología. *Revista Latinoamericana de Sexología*, Separata 1, 166-192.
- González, J. M. 1997. *Eyaculación precoz: Evaluación y tratamiento.* X Seminario Colombiano de Sexología, Barranquilla, 1-3 de Noviembre.
- González, J. M. 1998. *Sexología y periodismo: Una columna de preguntas sobre temas sexuales en un periódico colombiano.* 8 Congreso Colombiano de Psicología, Santafé de Bogotá, Abril 30-Mayo 3.
- González, J. M. 1999. Abuso sexual infantil en mujeres alcohólicas y drogadictas de Barranquilla. *Revista Terapia Sexual [Brasil]*, 2(1):37-43.
- González, J. M. 1999a. Pobreza, valores humanos y sexualidad. *Revista Encuentro Bolivariano, Barranquilla*, 2(2):121-126.
- González, J. M. 1999b. Sexualidad y sesarrollo. *Revista Investigación Bolivariana, Barranquilla*, 2(2):195-199.
- González, J. M. 1999c. La terapia sexual en Colombia: 1948-1998. *Revista Terapia Sexual*, 2(1):33-36.
- González, J. M. 1999d. Pobreza, salud sexual y desarrollo. *Revista Salud Sexual*, 2(1):25-30.
- González, J. M. 2000. *Amor & intimidación en el caribe colombiano.* Barranquilla: Editorial Antillas.
- González, J. M., M. Alonso, & I. Pinto. 1991. Sexualidad y farmacodependencia en pacientes de dos clínicas de Barranquilla, Colombia. *Revista Latinoamericana de Sexología*, 6(3):235-246.
- González, J. M., J. Cepeda, L. Fonseca, N. Burgos, I. Pinto, & L. Sanchez. 1996. Estudio descriptivo de la sexualidad en 30 mujeres farmacodependientes de Barranquilla, Colombia. *Archivos Hispanoamericanos de Sexología*, 3(1): 79-91.
- González, J. M., I. Gomez, & T. de Cortes. 1977. Comportamiento sexual: Un estudio exploratorio. *Revista Latinoamericana de Psicología*, 9(1):13-20.
- González, J. M., & J. Gonzales. en prensa. *Sexualidad en el adulto mayor.*
- González, J. M., J. C. Marin, D. Chala, R. Schmalbach Fruto, & N. de Albade Alba. 2000. *Juventud y VIH/SIDA: Una experiencia universitaria en el caribe colombiano.* Barranquilla: Editorial Antillas.
- González, J. M., M. C. Rosado, M. Bernal, & J. C. Marin. 2000. *Pobreza, salud sexual y desarrollo.* Bogotá: Plaza & Jane.
- Guerrero, P. 1985. *El miedo al sexo.* Bogotá: Antares.
- Guerrero, P. 1996a. Amor, sexualidad y matrimonio en los medios de comunicación. *Revista Latinoamericana de Sexología*, Separata 1, 129-135.
- Guerrero, P. 1996b. Amor, sexualidad y matrimonio en los graffiti. *Revista Latinoamericana de Sexología*, Separata 1, 136-139.
- Guerrero, P. 1997. Comunicación personal.
- Gutierrez de Pineda, V. 1975. *Familia y cultura en Colombia.* Santafé de Bogotá: Instituto Colombiano de Cultura.
- Gutierrez, M. de, & G. Franco. 1989. Encuesta sobre sexualidad en adolescentes. *CAFAM. II Curso de atención integral al adolescente.* Santafé de Bogotá: CAFAM.
- Instituto de Seguros Sociales (ISS) [Institute of Social Securities]. 1994. *Encuesta nacional sobre conocimientos, actitudes y practicas relacionadas con las enfermedades de transmisión sexual, SIDA, enfermedades cardiovasculares, cáncer y accidentes.* Santafé de Bogotá: ISS.
- Londoño, M. L. 1991. *Prácticas de libertad.* Cali: Impresor Feriva.
- Londoño, M. L. 1996. *Memorias Congreso Sexualidad y Género... Un proceso cultural.* VII Congreso Colombiano de Sexología, Medellín, Mayo 23 al 25, 1996.
- Mantilla, A. 1993. El modelo Gamma de educación sexual. En: *Asociación salud con prevención. Sexualidad en la adolescencia.* Santafé de Bogotá: Editorial Presencia.
- Ministerio de Salud. 1994. *Estudio nacional de salud mental y consumo de sustancias psicoactivas.* Santafé de Bogotá: Ministerio de Salud de Colombia.
- Ministerio de Salud. 1995. *Boletín epidemiológico nacional, Enero-Marzo.*
- Ministerio de Salud. 1997 (15 de Marzo). *Boletín epidemiológico nacional*, 2(5).
- Ministerio de Salud. 1997. *Medicina legal en cifras. Enero-diciembre 1996-1997.* Bogotá: Instituto Nacional de Medicina Legal y Ciencias Forenses.
- Ministerio de Salud. 1998 (30 de Noviembre). *Boletín Epidemiológico Nacional*, 3(22).
- Ministerio de Salud 1998. *Lineamientos para la política de salud sexual y reproductiva.* Santafé de Bogotá: Dirección General de Promoción y Prevención.
- Ministerio de Salud, Oficina de Epidemiología. Informe Quincenal Epidemiológico Nacional. (Enero 15) *Dirección general de promoción y prevención*, 4(1).
- Murillo, J. 1993. Relaciones extramatrimoniales, celos y familia. *Revista Latinoamericana de Sexología*, 8(1):56-65.
- Murillo, J. 1996. *Trabajadoras sexuales.* Palmira: CORPICH.
- Nader, L., & M. L. Palacio. 1989. Relaciones extramaritales. En: *Es tiempo de vivir. Unidad de psicoterapia y dexualidad humana.* Santafé de Bogotá.
- Nader, L., M. L. Palacio, & A. Acuña. 1997. *Modelo terapéutico en disfunciones sexuales.* X Seminario Colombiano de Sexología, Barranquilla, 1-3 de Noviembre.
- OPS/OMS, Programa Regional de SIDA/ETS. *Vigilancia del SIDA en las Américas. Informe trimestral 10 de junio de 1997.* OPS/HCA/97.006.
- Organización Panamericana de la Salud 1985. *La salud del adolescente y el joven en las Américas* (Publicación científica N. 489). Washington, DC.
- Ortiz, G. 1993. El sexo de asignación, el de crianza y los papeles sexuales en la familia. *Revista Latinoamericana de Sexología*, 8(1):38-45.
- Palacio, M. L. 1999. *Hablemos de sexo con Marta Lucía Palacio.* Bogotá: Intermedio.
- Pardo, F., & G. Uriza. 1991 (Abril-Junio). Estudio de embarazo en adolescente en 11 instituciones Colombianas. *Revista Colombiana de Obstetricia y Ginecología [Bogotá]*, 42(2): 109-121.

- Penagos, G. S. 1997. Mujer, género y SIDA. *Memorias Congreso Internacional de ETS, SIDA*. Medellín.
- PNUD—Programa de las Naciones Unidas para el Desarrollo. 1995. *Informe sobre desarrollo humano 1995*. New York: Naciones Unidas.
- Profamilia. 1995. *Encuesta nacional de demografía y salud 1995*. Santafé de Bogotá: Profamilia (Planned Parenthood of Colombia).
- Riso, W. 1996. *Deshojando margaritas. Acerca del amor tradicional y otras malas costumbres*. Santafé de Bogotá: Norma.
- Rojas, N. 1997. *La pareja* (7ª edición). Santafé de Bogotá: Planeta.
- Rojas, N. 1998. *Qué nos une. Qué nos separa*. Santafé de Bogotá: Planeta.
- Ruiz, M. 1996. Conocimientos, actitudes y comportamiento sexual de los adolescentes. *Memorias XX Congreso Colombiano de Obstetricia y Ginecología*. Medellín.
- Semana. 1996 (9 de Enero). La gran encuesta del 96 (Edición 714).
- Semana. 1997 (28 de Julio). Sexo: Informe especial (Edición 795).
- Semana. 1999 (30 de Agosto). Sexo 99 (Edición 904).
- Serrano, J. F. 1997. Entre negación y reconocimiento. Estudios sobre "homosexualidad" en Colombia. *Nómadas Universidad Central* [Bogotá], 6:67-79.
- Serrano, J. F. 1998. Igualdad, diferencia y equidad en la diversidad de la experiencia sexual. Una mirada a las discusiones sobre los derechos sexuales de lesbianas y gays. *Memorias del Tercer Seminario Nacional sobre Ética, Sexualidad y Derechos Reproductivos* (pp. 25-54), CERFAMI, Medellín, Colombia, agosto 13 y 14 de 1998.
- Servicio Seccional de Salud de Risaralda. 1997. *Plan de información y educación sexual a la mujer y a la familia*.
- UNAIDS. 2002. *Epidemiological fact sheets by country*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS/WHO). Available: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm.
- Universidad Externado de Colombia. 1992. *La incidencia del aborto en Colombia* [The incidence of abortion in Colombia] Bogotá: Universidad Externado de Colombia.
- Useche, B. 1999. *5 Estudios de sexología*. Manizales: ARS Ediciones.
- Useche, B., M. Villegas, & H. Alzate. 1990. Sexual behavior of Colombian high school students. *Adolescence*, 25(98):291-304.
- Velandia, M. A. 1999. *Y si el cuerpo grita . . .* Bogotá: Equiláteros. Proyecto de Diversidad y Minorías Sexuales de Colombia.
- Zamudio, L., & N. Rubiano. 1991a. *La nupcialidad en Colombia*. Santafé de Bogotá: Universidad Externado de Colombia.
- Zamudio, L., & N. Rubiano. 1991b. *Las separaciones conyugales en Colombia*. Santafé de Bogotá: Universidad Externado de Colombia.
- Zuluaga, L., C. Soto, & D. Jaramillo. 1991. *Problemas de salud asociados al comportamiento sexual en estudiantes de último año*. Medellín: Universidad de Antioquia.