Abstract

This article examines adolescent sexual and reproductive health in Peru as compared to other developing and industrialized countries worldwide. The article examines relevant international commitments and program-related provisions in light of the sexual and reproductive health of adolescents and argues that a human rights framework can be useful in the promotion and protection of adolescent sexual and reproductive health-related rights. Application of a human rights framework can be especially useful in contexts where there is strong opposition to adolescent sexuality and adolescent participation.

Cet article examine la santé sexuelle et génesique des adolescents au Pérou en comparaison avec d'autres pays en développement ou développés dans le monde. L'article met en contraste l'examen des engagements internationaux applicables existants et les clauses liées à des programmes sur la santé sexuelle et reproductrice des adolescents, et montre comment une structure de droits de l'homme peut s'avérer utile dans la promotion et la défense des droits se rapportant à la santé sexuelle et génesique des adolescents. Une structure de droits de l'homme peut être particulièrement utile dans les contextes où il existe une forte opposition à la sexualité et à la citoyenneté des adolescents.

Este artículo examina la salud sexual y reproductiva de los y las adolescentes en Perú en comparación con otros países desarrollados y en vías de desarrollo en todo el mundo. La autora examina los actuales compromisos internacionales y las estipulaciones programáticas pertinentes a la salud sexual y reproductiva de los adolescentes, y argumenta que un marco de derechos humanos puede ser útil en la promoción y protección de los derechos sexuales y reproductivos de ellos y ellas. La utilización de un marco de derechos humanos puede ser particularmente útil en contextos en los cuales hay una fuerte oposición al ejercicio de la sexualidad de parte de los adolescentes y a la participacion de los adolescentes en el diseño y implementación de programas de salud sexual y reproductiva.

Adolescent Sexual and Reproductive Rights in Latin America

Maria Raguz

Adolescent sexual and reproductive health indicators in Latin American countries illuminate the ways in which the current situation violates international agreements such as the Universal Declaration of Human Rights and the Convention on the Rights of the Child (CRC), as well as nonbinding but nonetheless important frameworks for action such as those agreed upon at the International Conference on Population and Development (ICPD), the Fourth World Conference on Women (FWCW), and their follow-ups. Adolescent maternal mortality, early and unwanted pregnancy, gender-based and sexual violence, sexually transmitted infections, HIV/AIDS, and gender-based discrimination in its various forms can all be clearly linked to violations of the rights to health, freedom from violence, survival, life, and development. Adolescent sexual and reproductive health is not only a population issue that governments should address in order to ensure development, but also entails rights as understood within international human rights agreements.

It was not until 1984, at the International Conference on Population in Mexico City, that governments acknowledged adolescent early pregnancy to be a public health issue.

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It took two more decades, and the efforts of women's organizations and human rights groups for reproductive health—including sexual health—to be recognized, and the link between their realization and the promotion and protection of human rights to be acknowledged in the ICPD. Adopting WHO's definition of health as a state of complete physical, mental, and social well-being to which all persons are entitled without distinction because of age, gender, race, culture, education, economic status, or any other social condition, reproductive and sexual health were each recognized as essential to well-being and as key elements for individual and societal development. Reproductive health implies a safe, satisfying sexual life and the freedom to reproduce, if so desired. This requires universal access to information and to quality reproductive health services, including family planning. Human rights encompass reproductive rights as they relate to sexual and reproductive health.

The 1995 FWCW in Beijing reinforced these concepts and emphasized eradicating violence and discrimination against women and girls, as well as empowering women and girls in relation to development and citizenship, with clear responsibilities delineated for states and civil society. Sexual and reproductive health rights imply both a personal responsibility inherent to their exercise and a social and governmental responsibility for the protection and promotion of this integral aspect of health. The dual nature of these responsibilities, which was acknowledged at the ICPD and FWCW, points to shortcomings in their application, particularly [as rights] in relation to adolescent sexual and reproductive health. Societies still viewed adolescent sexuality as a problem in and of itself instead of connected to the rights of adolescents, so education, information, and counselling initiatives intended to limit adolescent sexuality and encourage abstinence and the postponement of sexual initiation and sexual activity were stated as goals.

The evaluations of the ICPD and FWCW that took place five years after the conferences made it clear that many countries—mainly developing countries—are still debating whether adolescents have rights to exert their sexuality and to access reproductive health information, education, and

services. Ongoing discussion continues concerning whether services should be limited to information and counselling or if they should also include access to modern contraception which would provide protection from unwanted pregnancy and sexually transmitted diseases and infections. Proponents of what are termed parental rights are opposed to confidentiality and self-determination for adolescents because of stated difficulties in defining the best interests of the child and adolescent, their level of maturity, and their citizenship status. As Kelleher and Padian note, in many developing countries cultural norms for adolescents can shift, and after the ICPD youth have increasingly enjoyed greater independence and greater respect for their rights.[1] Unfortunately, educational and social service systems have not evolved as quickly and are often unable to effectively respond to the needs of adolescents. This problem is compounded for adolescents living in poverty, and can also be an issue for young members of minority populations in industrialized countries. Reproductive health programs for youth the world over face resistance because of cultural beliefs about sexuality, gender roles, and the role of the family and community. Restrictive laws and policies also limit access to reproductive health care and informal barriers exist for health workers and educators who want to provide these services. This is true even in areas where policies and programs are more positive, as is the case in much of Latin America, as studies from PAHO, POPTECH, and Focus On Young Adults show.[2]

Today, we are still confronted with governments that disregard the language and concepts of rights when dealing with children and adolescents, even though these rights have been recognized for more than 50 years. This has tremendous repercussions for adolescent sexual and reproductive health in developing countries in Latin America, such as Peru. The present article will try to depict the reality of adolescent sexual and reproductive health in Peru as compared to other developing and industrialized countries worldwide; confront this picture with the existing relevant international commitments and program-related provisions on adolescent sexual and reproductive health; and show

how a human rights framework can be useful in the promotion and protection of adolescent sexual and reproductive rights and how to ensure maximum policy impact.

Adolescent Sexual and Reproductive Health in Latin America

When depicting the status of adolescent sexual and reproductive health within a country, it has been found most useful—especially for purposes of advocacy—not only to portray the situation and to highlight disparities based on age, gender, civil status, poverty, and urban/rural status within the country, but also to compare the realities faced by people living within the country to people living in other industrialized and developing countries both within and between regions. Highlighting such differences allows one to visualize possible change and to better assess the dimensions of a problem. Thus, the depiction of the adolescent sexual and reproductive rights in Latin America in this article includes comparative statistical data from countries and regions throughout the world.

Everywhere in the world a tendency toward earlier average age of first menstruation can be observed, in part as a result of better nutrition.[3,4] At the same time, the mean age of marriage or union has declined in the last 20 years, mostly in the industrialized world and in urban populations.[5] These facts, taken together, imply a potentially longer time span for adolescent unprotected sexual activity and unwanted pregnancies. In Peru, 1980 data showed that the mean age of first menstruation was 14.8 years and the mean age of union for females was 22 years of age. By 1988, the mean age of first menstruation had fallen to 12.5 years and the mean age of union had risen to 24.3 years of age—the window of opportunity for fertility before marriage had grown by 4.6 years.[6] A study showed 43.9% of the adolescent girls menstruated between ages 11 and 12 and another 45.7% had begun menstruation by 14 years of age.[7]

Early marriage—before age 20—is more common in the developing world than in industrialized countries; while 26% of adolescent girls are married in the less developed world, this is the case for only 6% in the more industrialized

world.[8] In some countries, such as Nigeria, the percentage of married female adolescents is as high as 60%. In Latin America, the mean percentage of early marriage is 15%, and in Peru 12% of adolescent girls are in union.[9] On the other hand, only 4% of German women and 1% of French women marry early. In Latin America between 20% and 40% of women marry early, with these rates varying between countries.[10] Early marriages are often forced and tend to be the marriage of a young bride and an older husband that leaves the girl with little economic or social power. All around the world, early marriage is more frequent in young women with less than seven years of schooling, as shown in Table 1. In addition, early marriage is strongly associated with pregnancy mainly in developing countries.[11]

In Peru, the probability for pregnancy is higher when sexual initiation takes place in women younger than 19 years of age—this in a context in which the mean age of first sexual activity is 16.8 years and in which unprotected sex prevails. About 4.6% of Peruvian girls aged 15 to 19 have their first sexual activity before age 15.[12, 13] Early marriage and adolescent pregnancy in Latin America lead to more children and more frequent pregnancies. This, in turn, leads to the discontinuation of education and training, more unstable unions,and a lower future income than exists for women in the same peer group with no adolescent pregnancy.

Education	Dominican Republic	Guatemala	El Salvador	México	Peru	Bolivia	Brazil	Ecuador	Colombia
Less than 7 years of education	64	48	48	46	43	34	34	42	42
More than 7 years of education	18	10	16	13	9	18	14	15	15

Table 1. *Percentage of Early Marriage And Education Level in Select Countries in Latin America.*[106]

In Peru, early mothers tend to be single or in a consensual union—only 7.5% are or will be married. Later in life, these same women tend to head single-parent households in extreme poverty.[14]

Early sexual initiation—before age 15—has an inverse relationship with the level of education, with seven years of schooling being a critical breakpoint for many countries. In Peru, as in all of Latin America, people who have had less than seven years of education are four to five times more likely to engage in early sex.[15] There seem to be no great differences among industrialized and developing countries in the mean age of sex initiation; an unpublished study shows the mean age of sexual initiation among Latin American youth to be 16.7 for males and 18 for females.[16] On the other hand, early sexual initiation is much more frequent in developing countries (26%; 15% in Latin America) than in industrialized ones (6%). A study shows that both young males and male adolescents in seven American countries report significantly higher rates of sexual initiation than female adolescents and youth.[17] Higher rates of sexual initiation are found in Jamaican and Brazilian male adolescents (more than 60%) and in North American male adolescents (55%) than in their female counterparts. These percentages decrease to 45% in Peru and 42% in Costa Rica. Among female adolescents, higher rates of sexual initiation are found in North American (45%), Jamaican (37%), and Brazilian adolescents (22%). These rates decrease to 15% in Costa Rica and 10% in Peru. Young Latin American females tend to experience their sexual initiations with male partners who are approximately two years older. Percentages of sexual initiation rapidly rise from adolescence to young adulthood. By age 24, about 90% of the Brazilian, North American and Jamaican males have had sex, while 78% of Costa Rican males have had sex. Among females in the same age group, 75% of the North American, 65% of the Jamaican, and 51% of the Brazilian youth have had sex, a rate that decreases to about 35% in Peru and Costa Rica.[18]

Here a note of caution must be sounded. Peruvian official statistics suggest that urban/rural gaps are important to understanding rates of reported adolescent sexual initiation.

Sexual initiation in rural adolescents in the jungle and coastal regions is double than that reported in the highland region—sexually-initiated urban adolescents in Lima represent only 6% of the total number of sexually initiated Peruvian adolescents.[19] These differences are not reflected in national aggregate-level statistics. The study discussed above found differences in reported sexual initiation of more than 10 percentage points between urban and rural male youth in Peru and Haiti and differences of more than 25 percentage points between urban and rural female Brazilian youth.[20]

"Sexually initiated" does not necessarily mean "sexually active." Measures of reported sexual activity in a one-month period in these Latin American countries show gender and age gaps, as well as differences between countries. Youth—defined as people aged 20–24 years—report higher rates of sexual activity than adolescents, and males report much higher rates of sexual activity than do females.[21] Brazil evidences much more sexual activity in adolescents and youth, both male and female, than other countries. This is illustrated in Table 2.

In brief, important differences exist between and within countries, and gender and urban/rural differences must also be taken into consideration. Additionally, sexual activity in Latin American adolescents does not seem to be very

	Brazil	Peru	Haiti	Costa Rica	Dominican Republic	Jamaica
Adolescent Males	31	25	25	20	20	25
Adolescent Females	12	3	6	6	6	17
Young Adult Males	61	56	39	38	47	47
Young Adult Females	29	11	11	11	16	20

Table 2. *Percentages of Reported "Sexual Activity" in Select Countries in Latin America.*[107]

frequent, whether male or female. For example, among single adolescents, less than 5% in Mexico and Guatemala; 5 to 10% in Ecuador, Peru, and Trinidad and Tobago; and between 10 and 15% in Bolivia, Costa Rica, Dominican Republic, El Salvador, Honduras, and Nicaragua report sexual activity in the previous month. In Brazil the rate is higher than 15%.[22]

Adolescent sexual activity does not necessarily imply unprotected sex and unwanted pregnancies. Comparative data shows that, while adolescent sexual activity is very frequent in industrialized countries (67%), it is lower in developing countries, especially in sub-Saharan Africa (38%).[23] An estimated 28% of adolescents in Latin America are "sexually active." Inversely, rates of teen pregnancies in developing countries are much higher than in industrialized countries. For example, rates of adolescent pregnancies in sub-Saharan Africa are more than three times higher (55%) than in industrialized countries; in Latin America, more than two times higher (34%). Of 612,000 births in Peru in 1996, 66,000 were to adolescent mothers. Important regional differences can be observed: Lima has only 8% of adolescent mothers, while in the jungle percentages rise to 28% (Madre de Dios, Amazonas), 29% (Loreto), or higher (33% in Ucayali and 34% in San Martin).[24]

It should also be noted that, while adolescent sexual activity in industrialized countries does not imply marriage or stable union, adolescent sexual activity in developing countries does imply an adolescent union and reproduction (not necessarily in this order). Data shows that out of the 15% of Latin American and Caribbean adolescent girls 15-19 years old who are married, the highest numbers are found in the Caribbean and Central America (including Mexico) as compared to 5% in the United States.[25] On the other hand, 35% of young women 20–24 years old in Latin America gave birth before age 20, as compared to 19% in the United States. Teen pregnancy is closely related to lower levels of education, not only in Latin America but throughout the world. In Latin America, girls who have only a primary education or less have a higher probability of adolescent pregnancy than those with secondary or higher education,

although in Nicaragua only higher education relates to lower pregnancy rates (Table 3).[26] In Peru, for example, only 7% of all women who had an adolescent pregnancy achieved university studies or higher education (Figure 1).[27] Additionally, out of all adolescent mothers in 2000, less than 3% had higher education and less than 9% had completed high school, while 55% had never attended school and 31% had only completed elementary school.[28] Having attended less than seven years of school raises the risk of teen pregnancy both in industrialized and developing countries (See Table 4). Since lower levels of education are more frequently found in developing countries, it is not surprising that the proportion of adolescent mothers in these countries

Education	Dominican Republic	Peru	Brazil	Nicaragua
No Schooling	59	55	55	44
Primary School Completed	42	31	27	26
Secondary/High School Completed	23	9	17	26
Higher Education	10	3	7	17

Table 3. *Percentage of Reported Early Pregnancy and Education Level in Select Countries in Latin America.*[108]

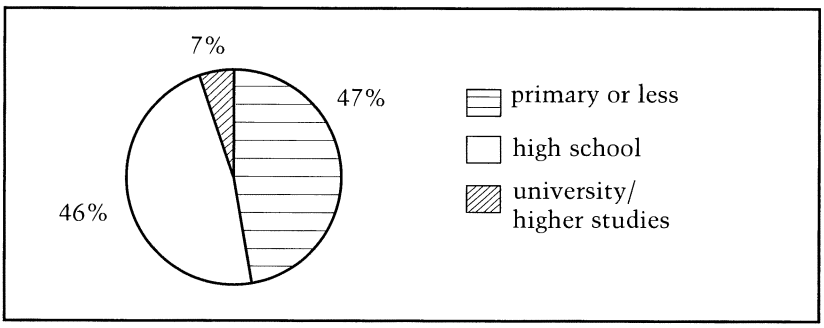

Figure 1. *Reported Levels of Education of Peruvian Women with Early Pregnancy.*[109]

is high (42%; 35% in Latin America).[29] In some developing countries outside of Latin America, the reported rate of adolescent motherhood is even higher: in Mauritania it is as high as 84%; in Bangladesh, 63%.[30] Education, *per se*, is not the primary factor, but education levels are likely to be an accurate indicator of development. Access to education also relates to access to information and services. The fact that unwanted pregnancy prevails in poor women clearly proves this to be the case. For example, 20.3% of Peruvian women in poverty have had an adolescent pregnancy, while this is true for only 14.6% of women who are not poor.[31] Cultural factors also interact with poverty to impact sexual behavior and reproductive health. Early pregnancy may affect a women's entire life. For example, many adolescent girls in Peru leave school primarily because of economic factors (20%) and adolescent pregnancy (19%). Adolescent mothers in Peru tend to discontinue education. 42% do not study or work, 22% study and work at the same time, and only 6% dedicate themselves primarily to study.[32] Additionally, a tendency toward termination of consensual unions or marriages in early unions has been shown in Colombia, Panama, and Peru, with a pattern of subsequent multiple unstable unions. Also, adolescent mothers tend to have more children.[33] Adolescents, especially those in poverty, are more likely than adult women to experience unwanted pregnancies, even when they are using contraception,

Education	Bangladesh	Zimbabwe	India	México	Columbia	USA	Egypt	Indonesia
Less than 7 years of education	54	49	38	34	33	33	28	26
More than 7 years of education	19	18	9	8	8	5	2	3

Table 4. *Percentage of Reported Early Pregnancy and Education in Select Countries.*[110]

because they have less knowledge, fewer skills, a limited ability to negotiate safer sex, limited access to health services and fewer economic resources.

One contributing factor to unwanted or unplanned pregnancy is the ineffective use or lack of use of contraceptive methods. Modern contraceptive use is low among adolescents. Only 22% of adolescent girls use contraception—modern or traditional—in developing countries. Rates of contraceptive use are as low as 11% in Haiti. In other regions of the developing world contraceptive use is also low; for example, 13% and 7% in countries of sub-Saharan Africa and India, respectively.[34] In some countries there is a difference between reported adolescent in-union and outside-union contraceptive use. In Latin America there is no general pattern. In Peru, use of modern contraceptives is higher among adolescents living in union (31%) than in single sexually active adolescents (20%). Caution must be applied here, since reported use does not imply continuous, consistent contraceptive use across partners, nor does it imply effective use. If one considers only modern contraceptive methods, these numbers fall even further. Only about 31% of adolescents in developing countries report using modern contraceptive methods, with striking differences among countries among and within regions. For example, while Brazil evidences relatively high contraceptive use (61%), use is dramatically lower in Kenya (about 19%), Paraguay, Zambia, and Tanzania (around 11%).[35] These low rates cannot be attributed to a desire to have children, since most adolescents who do not use contraception do not want a child. In Peru, for example, between 30 and 40% of adolescent pregnancies are undesired.[36] This results in one-third of adolescent pregnancies ending in induced abortions, mostly high-risk abortions. It is clear that low rates of contraceptive use in adolescents and early pregnancies are largely attributable to legal, cultural, and social barriers impacting on rights to information, education, and services. It is also clear that a gender perspective is necessary to better understand the power inequities, traditional values, and practices which impact on adolescent girls' vulnerabilities to unwanted or unplanned pregnancy.

About 13% of the total births in the world are to adolescents (14% in Latin America). While women in industrialized countries tend to have between one and two children during their lives, women in developing countries have between three and four children. Europe has a fertility rate of 1.4 and Africa has a fertility rate of 5.3. In Latin America, Paraguayan and Bolivian women have an average of between four and five children. While only 31 out of 1,000 births occur in adolescent girls in the industrialized world, in developing countries, 71 out of 1,000 births occur in adolescent girls. In Latin America this rate is even higher: 80 out of 1,000 births.[37] Important differences among countries can be observed in the Americas. In the Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, and Nicaragua, more than 100 out of 1,000 births are to adolescents between 15 and 19 years of age. This is related to the association between high rates of early sexual initiation and early union. The rate drops to between 75 and 100 out of 1,000 births to adolescents in Belize, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Haiti, Mexico, Peru, and Venezuela, and falls to less than 75 out of 1,000 total births in Argentina, Barbados, Chile, Cuba (where abortion has no legal restrictions), Guyana, Suriname, Trinidad and Tobago, and Uruguay. Moreover, differences exist within countries, depending on the girl's educational level.[38]

Statistics from the late 1990s show that in Bolivia only 56% of children born to adolescents were conceived in wedlock or union, 26% were born out of union and another 18% were conceived out of union but born after marriage. A similar, though less marked, pattern can be observed in Peru (63% conceived in wedlock) and Colombia (61%). Of these, 17% are conceived out of union, but born after marriage. Even so, 21% of conceptions and births are out of union. In Brazil and Haiti, most conceptions occur in union (69% and 73%, respectively) and another 22% are reported to lead to a union. On the other hand, in the Dominican Republic and Nicaragua, more than 87% of conceptions in adolescents occur within unions.[39] A note of caution must be sounded here, because when a single mother is of a higher socioeconomic status, one may assume she has more of an option to

choose not to marry or couple than a low-income, low-education adolescent mother, since economic factors would not be as pressing.

Every year, an estimated 14 million children are born to adolescent mothers.[40] Adolescent pregnancy represents not only a reproductive risk in terms of prenatal, perinatal and postnatal care, but it also impacts the mother's life aspirations, the quality of her life, and her potential for development. These effects are exacerbated if she lives in poverty. In a national survey of adolescents in Peru, where 23% of pregnant women are adolescents, 60% said that the main reason for children and adolescents not being enrolled in school was adolescent pregnancy.[41, 42] More than half a million women die each year from pregnancy-related causes, and 99% of these women are in developing countries. These deaths occur mainly because of the unavailability of services, including life-saving interventions, as well as delays in recognizing complications, in deciding to seek medical services, in arranging transport, and in reaching services.[43] Complications during pregnancy are the most common cause of death among female adolescents.[44]

Women born in developing countries have a much higher risk of dying from causes related to maternity (1:48) than women born in industrialized countries (1:1,800).[45] One in 130 mothers dies in Latin America (in Africa, the rate is one in 16). Only one in 1,400 mothers dies in Europe, and one in 3,700 in North America.[46] Peru has one of the highest rates of maternal mortality and, specifically, adolescent maternal mortality (362 deaths for every 100,000 live births), in Latin America; much higher than global maternal mortality rates (265:100,000).[47] This high mortality rate has been attributed to insufficient prenatal care, nutritional deficiencies, inadequate risk evaluation of pregnancy, and birth complications, hemorrhages, and postnatal infections (many surely result from illicit abortions). Additionally, more than a third of pregnant adolescents are believed to give birth with no trained help whatsoever.[48] Most maternal deaths in the world occur during or after giving birth, despite this, coverage of maternity services is very limited in the developing countries. While 99% of women in the industrialized coun-

tries have access to these services, this is the case for only 53% of women in the developing world. The gap is also significant for postnatal care (90% as compared to 30%) and prenatal care (97% vs. 65%).[49] Access to prenatal and postnatal care is even more restricted for pregnant adolescents and adolescent mothers.[50]

Abortion

Of the 40–50 million abortions that are performed each year worldwide, 20 million are estimated to be unsafe, and 95% of these take place in the developing world. These unsafe abortions are believed to result in the deaths of over 70,000 women and the suffering of millions of others.[51] Every year, four million abortions take place in Latin America. Estimates of the annual number of abortions are even higher for Africa (five million) and Asia (nine million). In comparison, the estimated number of abortions is 800,000 in Eastern Europe and 30,000 in Northern Europe.[52] More importantly, high-risk abortions prevail in countries where abortion is more restricted by law, which is common in developing countries, where access to quality reproductive health services is often also limited. The post-abortion risk of death is 0.05% in Europe, 0.11% in Latin America, 0.40% in Asia, and 0.67% in Africa.[53] Worldwide, an estimated one in four unwanted adolescent pregnancies ends in unsafe abortions, which amounts to five million unsafe abortions each year.[54] Forty percent of these are considered to be high-risk abortions and 33% are hospital abortions that lead to complications. It is estimated an even higher percentage of unsafe abortions are induced outside of hospitals.[55] Unsafe abortions greatly increase adolescent maternal mortality rates and, in some countries, complications from unsafe abortions constitute the main cause of adolescent maternal death.[56] Unsafe abortion is estimated to be a contributing factor in 21% of maternal deaths in Latin America and the Caribbean, a rate which is higher than in Africa, Asia, or Eastern Europe, where unsafe abortion contributes to about 12 to 13% of maternal deaths.[57] Adolescents tend to delay abortion longer than adult

women, resort more to unskilled persons and dangerous techniques, and wait longer before seeking help for complications.[58] Complications are also more common in adolescents.[59] Worldwide, between 40 and 60% of abortions that lead to infection are believed to occur in adolescents.[60]

Peru has one of the highest aggregate rates of adolescent abortion in the Americas (24 abortions per 1,000 live births; 23 girls out of 1,000 have an abortion each year, as compared to 13 in Mexico).[61] As with rates of sexual activity, important differences are found in rates of adolescent abortion among cities in the coastal, highlands, and jungle regions. Out of 16 regions, Lima is reported to have the highest rate of adolescent abortion (206:1,000 live births), as compared, for example, with Loreto (82:1,000) or Marañon (68:1,000), according to the 1996 official statistics.[62] Peru also has one of the highest rates of adolescent maternal death in the Americas, of which abortion is considered to be one of the three main causes; the others being severe bleeding and infections—in many cases themselves the result of an unsafe abortion.[63]

It is important to note that a high percentage of adolescents declare their pregnancies to have been desired, but it is believed that this may have much to do with cultural values associated with motherhood. More sensitive measures show that 30–40% of adolescent mothers report that they would have preferred to delay motherhood to a later stage in life if given the chance. In Guatemala, Honduras and Nicaragua, where most early pregnancies are associated with early union, early pregnancies are more likely to be reported as desired. In Brazil, Haiti, and Jamaica, early pregnancy is far more likely to be negatively perceived, whether for social, moral, or cultural reasons.[64] Pregnancies explain 15-20% of school desertion by adolescent girls in Brazil, Colombia, the Dominican Republic, Nicaragua and Peru, rising to 30% if early unions are added to the equation.[65]

HIV/AIDS

Sexual health also implies freedom from sickness and the availability of adequate prevention and treatment.

HIV/AIDS has called world attention to some of the problems associated with adolescent sexual health. Some 10 million young people are living with HIV/AIDS and six young people become infected every minute.[66] An unknown number of street children contract HIV through commercial sex, rape, tainted blood, or infected needles.[67] In at least two Latin American countries—Brazil and Honduras—around 30% of people infected with HIV are believed to have become infected as adolescents.[68] An estimated 60% of HIV infections in developing countries take place in people 15–24 years of age. The 1997 statistics in African countries are even more frightening: about 25% of adolescents in Zimbabwe and Botswana, 19% in Namibia and Zambia, and 18% in Swaziland are believed to be infected with HIV/AIDS.[69] In Latin America, where infection rates are still low when calculated across the general population (0.5%), the highest rates of infection are found in the Caribbean, with 5.2% HIV-infected adolescents, and in Central America, in Guyana (2.1%).[70] When countries in the Americas are compared with respect to the prevalence of HIV/AIDS in people 15–24 years old, the countries of the Caribbean are most clearly affected. While gender gaps are evident in all countries, with more young men suffering infection than young women, these gaps are closing because women's rates are rapidly increasing, as can be seen in Argentina, where, in 12 years, the 20:1 gap has narrowed to 3:1.[71] Women and girls are four times more likely to get HIV from men than vice versa. This is not only due to higher biological risks—experts in the field note a higher risk in women due also to cultural factors and gender inequities.[72] As Focus On Young Adults notes, youth who are poor are more vulnerable to the risk of contracting HIV/AIDS; girls are particularly vulnerable to the economic factors that contribute to the spread of HIV/AIDS because they tend to have fewer economic and educational opportunities and are therefore more likely to be forced to engage in involuntary or risky sexual behavior. These factors help explain why, globally, two of every three young persons living with HIV is a girl or young woman.[73]

In Peru, only in recent years has the state made

HIV/AIDS a priority. As a result, an AIDS National Network was developed. The Ministry of Health reported in 2000 that less than five years ago only 25% of public health services offered STD detection and treatment and condoms. To date, prevention measures for adolescents and the general population have received insufficient attention, but revisions are currently underway. The new proposals emphasize sexually transmitted diseases and infections other than HIV/AIDS, which has received most of the focus of health programs in recent years, with new programs and campaigns being implemented at a national level. Still, information and education have reached only part of the adolescent population, with 56% of adolescents with no schooling never having heard of AIDS, as compared to 98% of those with higher education. The same pattern is observed in Guatemala, where the gap is 25% to 95%. Furthermore, while 80% of Peruvian urban adolescent girls know that a condom offers protection against HIV, this information has reached only 15% of adolescent girls with no schooling. Educational gaps are also found in Bolivia (70% to 3%) and Guatemala (53% to 1%), but not in all countries in the Americas.[74]

Violence and Abuse Against Adolescents in Latin America

Violence and abuse pose another set of dangers to sexual and reproductive health for adolescents. Some issues include gender-based violence and sexual abuse, sexual exploitation, forced prostitution, early forced marriages, and genital mutilation. At least one in five women suffers rape or attempted rape in her lifetime.[75] In a study of 35 countries, between 25 and 50% of all women reported having been physically abused by their partners; between 40 and 60% of sexual abuse victims are adolescents, many 15 years of age or younger. The assaults on adolescents are most often carried out by a person they know, usually from the family.[76] Between one-third and two-thirds of rape victims are 15 years of age or younger.[77]

The low status of women and girls due to cultural norms and discrimination makes them more vulnerable particularly—but not exclusively—in the least developed coun-

tries. Thus, it is not surprising that one-third of the women in the world have been beaten, coerced into sex, or abused.[78] Each year, an estimated four million women and girls are bought and sold worldwide, either into forced prostitution, slavery, or forced marriage. In Western Europe alone, a reported half million women and girls from developing countries and economies in transition are trapped in the slave trade.[79] Two and a half million children and adolescents in Latin America are involved in sexual commerce, mostly in Brazil.[80] HIV/AIDS, unwanted early pregnancies, and unsafe abortion constitute a triple menace that increases health risks for adolescents.[81] Female adolescents also face increased risks of sexual exploitation and violence. An estimated 95% of early pregnancies in Costa Rica are reported to be the result of incest.[82] In Peru, much progress toward eliminating family violence is being made by NGOs and the government, but more progress is needed concerning structural violence against women and, particularly, violence against female adolescents and children. Hope for the future exists with Peru's recent ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Legal frameworks are undergoing revision and a new National Gender Equity Plan has been proposed.

All of these sexual and reproductive health indicators attest to the complexity of the problem and the fact that these indicators are interrelated and that gender inequity and other social inequities are integral to them all. Much is still to be done concerning adolescent sexual and reproductive rights, especially in developing countries. There is a need for new policies, programs, and intersectorial actions (partnerships). Although the objective is the well-being of adolescents, new initiatives should work at all levels of society and include all relevant actors. These actions would benefit from an approach based in human rights, and by addressing the underlying structural causes of sexual and reproductive health inequalities.

A Human Rights-Based Approach to Adolescent Sexual and Reproductive Health

The adolescent sexual and reproductive health landscape described above can be better understood when a human rights-based approach is adopted. Social inequities, gender inequities, and age inequities underlie this reality. Access to information, education, and health services—especially sexual and reproductive health—is still restricted, especially for adolescent women in poverty. Relevant human rights instruments, such as the International Bill of Human Rights, the 1981 CEDAW, and the 1990 CRC are key legally binding commitments. Other international instruments, although nonbinding, are specifically relevant to adolescent reproductive and sexual health, such as the ICPD and ICPD+5 Programs for Action and the FWCW and FWCW+5 Platforms for Action. These provide a legal basis for the more specific and program-related aspects of adolescent reproductive and sexual health. Nevertheless, it has become clear in the last few years that sexual and reproductive rights cannot be realized without broader attention to social, economic, and political rights. The political rights of children and adolescents, especially girls, have been particularly ignored.[83] Clearly the need for international action is great. While much attention has been given to the protections offered by the legally binding instruments, the following section will summarize the main points concerning adolescent sexual and reproductive health contained in other international instruments.

ICPD and ICPD+5

The Cairo ICPD was the first international agreement to focus on universal access to reproductive health and family planning services without discrimination on the basis of age, civil status, or any other condition.[84] The specific needs of adolescents were addressed within a human rights framework, and governments recognized that their policies and programs had been limited in this regard.[85] The adoption of

a human rights framework was possible due to the active participation of civil society—that is, NGOs and human rights and women's advocacy organizations with gender and rights perspectives—in the negotiation process, lending a different quality to the action-oriented strategies, policies, and programs governing adolescent sexual and reproductive health that were developed.

Fifty years ago, the WHO defined health as "a state of complete mental, physical, and social well-being and not merely the absence of disease or infirmity."[86] This definition was endorsed at the ICPD, an action which supported recognition of the highest attainable standard of health as one of the fundamental rights of all human beings. When applied to sexual and reproductive health, this meant defining reproductive health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[87] The fact that sexual and reproductive health was considered within a human rights framework set a precedent relevant to adolescent reproductive rights.

Most international agreements prior to the ICPD dealt with reproductive health primarily as it related to sickness and loss of life caused by pregnancy and delivery, population size, and sexually transmitted diseases and infections. At the ICPD conference, health—particularly reproductive health—was acknowledged as a key element for development. This shift led to setting goals concerning empowering women and the girl child, fostering equality and equity between the sexes, and promoting and defending a definition of reproductive health that included relevant language: "Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."[88] Thus, reproductive rights and, implicitly, sexual rights were recognized for all persons. Additionally, countries were urged to "protect and promote the rights of adolescents to reproductive health education, information, and care and greatly reduce the number of ado-

lescent pregnancies."[89] Although qualified with references to parental rights and cultural and religious values to assuage conservative delegations' misgivings, the ICPD specifically called for states to "safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent..." in health services.[90] Further, governments and NGOs were urged to meet the special needs of adolescents, including programs that include education and counselling in gender relations and equality, responsible sexual behavior and family planning, reproductive health, STDs and HIV/AIDS, prevention and treatment of sexual abuse and incest and other reproductive health services. The ICPD called for adolescents to be fully involved in the planning, implementation, and evaluation of such information and services and stressed the value of training for parents, families and others who provide guidance to adolescents concerning responsible sexual and reproductive behavior and health.

Five years later, at the 1999 ICPD+5, an evaluation of the implementation of the ICPD's Program for Action highlighted progress made and obstacles encountered. The ICPD+5 concluded that there is still discrimination against women and the girl child; maternal mortality is still very high; HIV/AIDS and other sexually transmitted diseases have not been sufficiently attacked; millions still lack access to sexual and reproductive health information and services; and adolescents are still vulnerable to unwanted pregnancy, unsafe abortion, and sexual and reproductive risks. Key measures adopted at the ICPD+5 echoed those of the ICPD and continued to emphasize the health-related rights and needs of children and adolescents. The ICPD+5 evaluation shows that much work remains to be done and more pressure needs to be exerted on states to fulfill their commitments to ensure the reproductive and sexual rights of adolescents.

FWCW and FWCW+5

The importance of reproductive rights was reaffirmed at the 1995 Fourth World Conference on Women held in

Beijing, at which governments explicitly recognized the reproductive rights of women, adolescents, and girls. The human rights framework of the conference called attention to the fact that, for sexual and reproductive rights to be exercised, governments, civil society, and cooperating organizations must work together using a broad and gender-sensitive framework and strategies to promote gender equity and development. In the conference document, women's development was related to poverty, education, and training; women's health (using the definition adopted at the ICPD); violence against women; armed conflict; economy, power, and decision-making; women's human rights; mass media; the girl child and adolescent; and institutional mechanisms for the advancement of women.

The following objectives were identified at the FWCW in relation to the female adolescent and the girl child: promoting and protecting their rights; fostering their potential; eradicating discrimination, violence, and exploitation; raising their status in the family and society; and promoting their political, social, and economic participation.[91] Recommendations for action were similar to those of the ICPD, including education and services that take into account the urgent need to avoid unwanted pregnancy, the spread of STDs—especially HIV/AIDS—and such phenomena as sexual violence and abuse. The rights of the child are again highlighted, and specific sexual and reproductive health needs of adolescents are acknowledged.

Five years later, the FWCW+5 evaluation of the implementation of the Platform for Action underlined the continued need to adopt gender mainstreaming in policies and programs and highlighted the fact that many variables interact to make it more difficult to achieve gender equity and women's advancement.[92] Sexual and reproductive rights were again stressed, and the economic autonomy of women and their access to education, health resources, and political participation in a context of equity and development throughout the life cycle of women were, once more, demanded.

With regard to adolescents, the FWCW+5 notes that access to sexual and reproductive health information, edu-

cation, and services is still limited and that adolescents' rights are generally not respected.[93] This situation contributes to high rates of adolescent maternal mortality and unsafe abortion, particularly in developing countries. Additionally, the FWCW+5 notes that violence against women, including sexual abuse and sexual and economic exploitation, in the context of weak legal measures and fragmented and reactive prevention strategies, all continue to affect women, female adolescents, and the girl child.[94] Even countries adhering to CEDAW are often still unwilling to recognize many forms of violence against women, adolescents, and the girl child.

A series of measures are laid out in the FWCW+5 resolution for governments, civil society, and cooperating organizations. Some specific steps regarding adolescents are: the provision of full and equal access for women throughout their life cycles to health care, information, education, and services, and recognition of the new demands for service and care by women and girls resulting from the HIV/AIDS pandemic; design and implementation of programs, with full involvement of adolescents, as appropriate, to provide education, information, and services to address effectively their reproductive and sexual health needs, taking into account both adolescents' and parents' rights and responsibilities, and adolescents' evolving capabilities in the framework of ensuring the best interests of the child.[95, 96] The FWCW+5 also stresses building adolescent girls' self-esteem and helping them take responsibility for their own lives; the promotion of gender equity and responsible sexual behavior; the prevention of STIs, including HIV/AIDS, of sexual violence and abuse, and of unwanted and early pregnancies.[97]

As members of the Peruvian technical delegation to FWCW+5 and ICPD+5, we encountered many representatives of developing countries who resisted the recognition of women's citizenship. Recognition of the rights of female adolescents and the girl child was even more strongly opposed. In many countries, traditional cultural beliefs prevail which block the development of women and female adolescents and impair their sexual and reproductive health

and rights as defined in the ICPD and FWCW. This makes it even more difficult for adolescent girls to access education and services that respond to their demands and ensure a positive and responsible sexuality, and to achieve an integral well-being that includes sexual health for a better life and personal relationships. Many early pregnancies and STIs in adolescents are recognized to be associated with poverty, lack of parental guidance, lack of information and education, gender violence and sexual violence, and lack of services. As stated in these documents, future actions taken by states and NGOs must address these deficiencies, so as to promote gender equity and women's empowerment, as well as universal access to education, health, and services. Families must respect the rights, capacities, and responsibilities of all their members. Parental care, motherhood, and fatherhood must be equally valued, and the social and economic contributions of men and women equally recognized.[98]

Other Regional Agreements and NGO Recommendations

Some other important agreements on adolescent sexual and reproductive rights have been developed specifically within and for Latin America. For instance, the 1997 San José de Costa Rica Regional Meeting on Latin American Adolescents' Sexual and Reproductive Health: Commitment for the Future produced a situation diagnosis and recommendations.[99] It highlighted unmet needs and a number of causes of poor sexual and reproductive health of adolescents in the region, including: a scarcity of youth policies, poorly coordinated programs, scarce human resources training, limited learning aids, ineffective educational programs, poor services, a lack of focus on early pregnancy and STDs/STIs, limited cooperation between the public and private sectors, and extremely little youth participation in the programs that do exist. These findings coincide with the analysis made by the Iberoamerican Youth Organization's (OIJ) Regional Program for Action for the Development of the Youth in Latin America (PRADJAL), 1995-2000 and the Iberoamerican Letter for the Rights of the Youth (under

development), which addresses the sexual and reproductive health of adolescents and young adults as a priority in the public agenda.[100] The X Conference of Spouses of Chiefs of State of the Americas and the Caribbean that was scheduled to take place in Peru in 2000 chose adolescence as its topic. It was unfortunately cancelled due to a political crisis, but adolescent sexual and reproductive health will be one of the main issues it will address when it is rescheduled. Some NGOs, including REDESS Jóvenes, were part of the Technical Advisory Committee planning this conference. Among the projects to have been presented was the creation of a regional network for adolescent policies and programs, which included a health component and, within it, a sexual and reproductive health sub-component. The creation of this network is to be taken up at the XI Conference in Ecuador in November 2001; we can only hope they will reach consensus on the creation of such a network. In addition to these regional agreements, it is useful to take into consideration the Center for Reproductive Law and Policy's legal and political recommendations for adolescent reproductive health care and other recommendations on the subject in Shepard, PRB, and In Focus, which can provide guidance on improving sexual and reproductive health care for adolescents in the region.[101, 102, 103, 104] In Peru, the Guidelines for Policies on Youth were approved on July 29, 2001, and the PRADJAL and other international youth treaties, as well as ICPD, ICPD+5, FWCW, and FWCF+5 were taken as a framework for action. The sexual and reproductive rights of youth 15 to 24 years old are explicitly recognized and the promotion of youth sexual and reproductive health is legally ensured through access to information, education, and health services.[105]

UN Special Session on Children

After more than a decade to evaluate the strengths and limitations of the implementation of the World Summit for Children, the preparatory sessions to the United Nations Special Session on Children, which was originally scheduled for September 2001, have taken place. The first draft outcome document, "A World Fit for Children," was sub-

mitted in January of 2001, but sexuality, sexual education and sexual and reproductive health and rights were nowhere mentioned, apart from brief references to sexual abuse and to HIV/AIDS. Some delegations, particularly the United States, which has not ratified the CRC, were opposed to using human rights language in relation to children. As part of the Peruvian delegation, we argued for the inclusion of human rights language and stressed the best interests of the child, as defined in the CRC. We also argued for differentiating children from adolescents, girls from boys, and for adopting a gender perspective. This encountered resistance from some delegations and, although some new paragraphs now deal with sexual and reproductive health (limited only to language already used in the ICPD and FWCW), there has been difficulty in convincing many delegations to accept the term "services" when related to sexual and reproductive health, and many delegations were unwilling to talk of sexual and reproductive rights at all. There was some advancement of the human rights approach at the subsequent preparatory sessions. The June 16 draft included language addressing the best interests of the child and acknowledged children and adolescents to be participating citizens. States agreed to call for the elimination of discrimination against children on any basis, including sex, and to promote gender equality. Similarly, consensus has been reached concerning reduction of HIV/AIDS and sexually transmitted diseases. However, further negotiation still needs to take place to produce a document to be approved by Heads of State at the Special Session that does not represent a step backwards for adolescent sexual and reproductive health and rights policies and programs. As the conference has now been postponed until early 2002, it is hoped that the final outcome document will provide useful language in improving the sexual and reproductive health of adolescents, and that a human rights perspective will more fully find its way into the final process.

These international and regional agreements provide useful guidance to address the problems of adolescent sexual and reproductive health in Latin America, but, as is evi-

denced by the opening sections of this article, much still needs to be done. The final section of this paper will examine some potential advantages to using a human rights framework in addressing these problems.

Conclusion

There is still a long and difficult way to go to ensure that the sexual and reproductive rights of adolescents, particularly those in developing countries, are promoted and protected by the governments and societies where they live. The cruel reality of statistics such as those cited above should force politicians, decision-makers, and societies to be more sensitive to the need to create the enabling conditions for these rights to be exercised. In our experience advocating for adolescents' rights, it has proven most useful to use comparative information as well as qualitative information—e.g., testimonies—to humanize cold statistics. International frameworks have also proven to be key elements in creating pressure on governments and supporting argumentation.

Human rights instruments, including the CRC, the ICPD, the FWCW, their follow-up conferences, and the UN Special Session on Children, should be used as frameworks in developing coherent policies and programs. In Peru, where 47% of the population is 19 years old or younger, 63% of children are poor, and two million children live in extreme poverty, civil society representatives have advocated for the past decade to try to ensure adolescents' sexual and reproductive rights. Reproductive rights and sexual and reproductive health language has been adopted in the Peruvian National Policy on Population, the National Program of Sexual Education, and the National Program of Reproductive Health. In the face of a new presidential election, and a strong push by conservative forces to reverse progress in the rights of adolescents, the international instruments cited above, along with comparative data on our adolescents' sexual and reproductive health, have again proven useful to the advocacy activities of Peruvian NGOs. REDESS Jóvenes, CEDRO, and Transparencia are three NGOs that have used these international frameworks and

health statistics to advocate for youth's rights and citizenship. They have now managed to obtain a signed agreement from the recently elected president and his political party, as well as the second runner-up, to adopt sexual and reproductive rights language within their policies and program proposals concerning adolescents and to ensure this issue remains within the government's political agenda. The recent approval of the Presidential Decree that fosters adolescent and young adult sexual and reproductive health and rights helps ensure that the issue will, indeed, remain on the agenda. Currently, REDESS Jóvenes and the Metropolitan Committee on Youth Policies have been involved in advocacy with mayors from Lima and other cities, and again using statistical data and international agreements to put the sexual and reproductive health and rights of adolescents and young adults on their agendas, these authorities have also signed an agreement to work on these issues. Aside from this, REDESS Jóvenes and other NGOs have fostered the formation of a Working Table on Youth under the leadership of the National Congress Commission on Youth and Sports, and youth sexual and reproductive health is included in its agenda. International frameworks will remain useful reminders and help to strengthen the work of civil society actors to ensure the effective implementation of these political commitments.

This is complex work, for the sexual and reproductive health of adolescents involves the interaction of many political, economic, cultural, and social factors that demand the use of different strategies. Civil society must be mobilized to exert pressure on those in power, so that the human rights of all people are not only promoted, but also protected. In addition, the roots of problems regarding sexual and reproductive health and rights must be effectively addressed. The structural changes required will no doubt engender opposition from those whose ideas about what it means to be a person, a woman, a child, a man, a family, or a society conflict with the human rights approach. We must revise our values, beliefs, principles, ethics, and knowledge to build "a new world, fit for all," as the Special Session on Children proposes. It will not be easy, but it will be fruitful and it is urgently needed. Our work toward eliminating pre-

ventable death, sickness, unhappiness, and injustice should lead our way to a different world, in which the best interests of all, including children and adolescents, are fully taken into consideration. This is necessary if we are to be truly human.

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