

REGIONAL ADVOCACY TOOL

Sexual and Reproductive Health
and Rights Advocacy in Latin America

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DRAFT for discussion

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DRAFT for discussion

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I. Executive Summary

The Latin American region has some of the most progressive human rights and social protection policies and programs in the world. Despite this, many are still excluded, and perhaps the most pressing agenda in the region is the need to pay attention to equity, and to reaching the poorest and most marginalized within each country. For this to happen, countries must analyze population data by geographic location (urban/rural), sex, age, socio-economic status, ethnicity, race, gender, health status, etc in order to effectively tailor their policies and programs to diverse needs. Investing in the health, education, and human rights protections of children, adolescents, and young people in the region will contribute to greater economic growth and social justice. Very few have access to safe and legal abortions in the region, making legal reform and provision of safe services where legal urgent priorities for public health, human rights, and justice. Attending to poor pregnant women with little access to maternity care with the necessary interventions is also an urgent priority, as is reaching women with the contraceptive method of their choice free from violence, coercion and discrimination.

A significant number of Latin American countries have institutionalized the Programme of Action of the UN International Conference on Population and Development (1994) by changing their population policies from focusing on narrow family planning programs, to incorporating family planning into wider reproductive health services within a human rights framework. After 1994, Argentina, Bolivia, Brazil, Colombia, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru and Venezuela either created or strengthened reproductive health programs to provide women with the fertility regulation method of their choice, maternity care, prevention of sexually transmitted infections, and adequate gynecological care within primary health care (Morlachetti, 2007).¹ The right to access information and to decide on the number and spacing of children by any necessary means are both implied in the national Constitutions of Brazil, Colombia, Ecuador, Guatemala, Mexico, Paraguay, Bolivia, Peru and Venezuela. In addition, the new Constitutions of Ecuador and Bolivia explicitly stipulate the right of all people to make informed and responsible decisions, free from violence and coercion, about their sexual lives and the number of children they wish to procreate, adopt, support and educate (Morlachetti, 2007).²

Capital cities in the region have moved forward in guaranteeing lesbian, gay, bisexual and transgender people social protection and human rights in Mexico City, Montevideo and Buenos Aires. Chile has issued protocols for the distribution of emergency contraception and makes it obligatory to freely distribute and provide it to all patients who request it, without limitations to age or conscientious objection. Mexico City and Uruguay have legalized abortion in the first trimester, and Colombia has expanded the circumstances under which safe abortion services are to be provided and guaranteed as a right. Undoubtedly, there are progressive forces moving sexual and reproductive rights in the region ahead.

Despite normative progress, however, implementation is slow. Conservative and fundamentalist religious forces in nearly all countries of Latin America have worked to prevent the translation of normative change into practical reality by opposing implementation of any laws or country-wide programs related to women's control over sexuality and reproduction and by supporting the maintenance of restrictive policies in relation

¹ Morlachetti, Alejandro: Notas de Población No. 85, CEPAL, 2007.

² Ibid.

to sexual and reproductive rights, particularly access to safe abortion services, assisted reproduction technologies, and comprehensive sexuality education.

In addition, the increase in economic inequality has stifled progress, making Latin America the most unequal region in the world with at least one third of people living in poverty and being denied their human rights: to health, education, decent work, equality and non-discrimination, among others. It would appear that the Latin American region fares relatively well in terms of health, education, and employment compared to the rest of the developing world. However, there are grave inequalities within and among countries: between urban and rural zones, between poor and wealthy populations, and between indigenous and afro-descendent people, particularly women. Rural poverty is almost three times greater than urban poverty with the majority of the poor being from ethnic and racial minorities and indigenous peoples (ECLAC, 2010).³ Moreover, since 1990, there are more women than men living in extreme poverty.

While the region has benefited from a demographic transition both in terms of women having less children and populations becoming more urban, it still has deeply rooted social and cultural taboos that have an impact on the achievement of human rights related to sexuality and reproduction, gender equality, and family life. Finally, the region is known for a weak rule of law system, although there are strong and vibrant social justice movements and civil society.

This paper provides an overview of the advances made in the region since countries signed on to the International Conference on Population and Development's Program of Action in 1994; and to identify barriers to implementation and regressions if any since 1994 in three areas: sexual and reproductive health services; sexual and reproductive rights; and the specific sexual and reproductive health needs and rights of young people.. The focus is on the most marginalized in the region in terms of rights, protections and access to health services: indigenous women, particularly those who are adolescents and young. Through a case study of adolescent indigenous girls in a rural community in Puebla, Mexico, this work aims to illustrate the progress and setbacks in Latin America's promises to fulfill sexual and reproductive health and rights in the twenty-first century.

³ Los Objetivos de Desarrollo del Milenio: Desafíos para lograrlos. CEPAL, p.10 <http://www.eclac.org/publicaciones/xml/1/39991/portada-indice-intro.pdf>

II. Comprehensive Sexual and Reproductive Health Services

A. Background information on SRH services

Most countries of the region have sexual and reproductive health policies and programs in place (ECLAC, 2013).⁴ However, progress on women's sexual and reproductive health and rights since 1990 has been uneven, and the fulfillment of women's reproductive rights seems to be retrogressing in numerous cases due to conservative religious forces permeating many aspects of society. It would appear that the maternal mortality ratio for the region is relatively low (72 per 100,000 live births) (WHO, 2012)⁵. However, when looking within countries and by the lowest quintile of income, the levels of maternal deaths are shocking, as maternal mortality often affects poorer women who are often of indigenous or Afro-descendant origin.⁶ In Brazil, for example, a country with a large Afro-descendant population, maternal mortality rates vary- with 90.4 among Afro-descendant women and 58.8 among white women (WHO, 2010)⁷.

These preventable deaths are primarily due to hemorrhage and sepsis during childbirth and unsafe abortions, which can all be remedied with affordable, accessible, available and adequate access to contraceptives, skilled birth attendants, obstetric care and essential medicines. Moreover, between 1970 and 2005, the region's fertility rates dropped dramatically - from 5 children per woman in 1970 to 2.8 in 2005. This significant change is predominantly explained by higher levels of access to contraceptives enjoyed by relatively urban, educated and wealthier women (ECLAC, 2012).⁸ The challenge remains in enabling access for poor, rural, indigenous and afro-descendant women who lack the information, access to the contraceptive of their choice and quality of care.

Table 1. Sexual And Reproductive Health Indicators for Latin America

2011 figures	MMR	TFR	CPR	Adolescent Fertility Rate
Argentina	77	2.2	78%	55
Bolivia	190	3.3	61%	73
Brazil	56	1.8	81%	72

⁴ ECLAC: Cumplimiento del PA-CIPD en América Latina y el Caribe (2013) <http://www.cepal.org/publicaciones/xml/3/50503/CRPDSintesis.pdf> p.27

⁵ WHO, UNICEF, UNFPA, and The World Bank. Trends in Maternal Mortality: 1990 to 2010 p.63 http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

⁶ ECLAC

⁷ WHO (2010). Access and Health Expenditure for Ethnic/Racial Groups in the Region of the Americas. p.4 <http://www.who.int/healthsystems/topics/financing/healthreport/IndigenousPAHOBPN046.pdf>

⁸ ECLAC: Aging, Solidarity and Social Protection. Costa Rica 2012. <http://www.cepal.org/celade/noticias/paginas/7/46027/2012-114-CRE-Ingles.pdf> p.23

Chile	25	1.8	58%	56
Colombia	92	2.3	79%	70
Costa Rica	40	1.8	82%	62
Ecuador	110	2.6	73%	78
El Salvador	81	2.2	73%	77
Guatemala	120	3.9	54%	99
Honduras	100	3.1	65%	86
Mexico	50	2.2	73%	65
Nicaragua	95	2.6	72%	103
Panama	92	2.5	52%	80
Paraguay	99	2.9	79%	68
Peru	67	2.5	75%	52
Uruguay	29	2.1	78%	59
Venezuela	92	2.4	70%	85

Source: World Bank Health Database

The Latin American region has benefitted from extraordinary economic growth throughout the last decade and most countries in the region are now considered “middle income”. However, programs targeting the poorest and most vulnerable have not been prioritized. For example, the lack of access to health services of indigenous and afro-descendent women is noticeable. Rural areas, indigenous territories, or urban slums are often places where multiple inequalities interact. There are limited health services, poor sanitation, little access to transport and lack of formal employment opportunities. The limited health services that do exist are not appealing or adequate to indigenous people’s cultural needs, are highly bureaucratic and are

designed from the capital cities without input from the communities, which further perpetuates discrimination (ECLAC, 2013).⁹

It is important to note that Latin America is the most unequal region of the world. Indigenous and afro-descendant populations register the worst human development indicators: life expectancy, access to education, morbidity and mortality, among others. Indigenous and afro-descendant women and girls suffer from ethnic and gender discrimination, often live in poverty and face great barriers to accessing culturally appropriate health services, as well as to controlling their sexuality, fertility and reproduction (ECLAC, 2013)¹⁰.

In Mexico, for example, indigenous peoples represent at least 10 per cent of the total population (UNDP, 2013)¹¹. The rates of maternal mortality and adolescent pregnancies are much higher than among white and mestizo women (Torres Parodi WHO, 2010)¹². Sexual violence is rampant as well as other harmful practices such as early and forced marriage and early pregnancy (KINAL, 1997)¹³. All of this points to a constant violation of indigenous women's sexual and reproductive rights, as well as insufficient and inadequate resources and programs available to them (ECLAC, 2013).¹⁴

The following snapshot of sexual and reproductive health services the Latin American region indicates that even though there is progress in terms of policies and programs, there still remains much more to be done to reverse the inequities in access, stigma and discrimination, and gender power relations that continue to deny many women their sexual and reproductive rights and health.

Contraception

Statistics from the region indicate that 70% of women have necessary information and access to a modern method of contraception. However, when analyzing disparities within countries, it is evident that the poorest women, often those who have very low levels of education, live in rural areas, and are of indigenous or afro-descendant origin, have the lowest rates and that these vary greatly with the rates of the highest quintile (ECLAC, 2013)¹⁵. In Bolivia, for example, the poorest quintile has a 23% contraceptive prevalence rate while the wealthiest reaches 47%. In Honduras, the rate is 41% versus 65%; Nicaragua 50% versus 71%, Peru 34% versus 54%. (See Table 2). These disparities at least partially reflect differential access to

⁹ ECLAC (2013) Implementación del Programa de Acción de la CIPD sobre Población y Desarrollo en América Latina y el Caribe p.26
<http://www.cepal.org/publicaciones/xml/3/50503/CRPDSintesis.pdf>

¹⁰ Ibid

¹¹ UNDP (2013) Ciudadanía Intercultural
<http://www.undp.org/content/dam/undp/library/Democratic%20Governance/Spanish/LIBRO%20CIUDADANIA%20INTERCULTURAL%20PNUD%20democracia.pdf>

¹² WHO (2010). Access and Health Expenditure for Ethnic/Racial Groups in the Region of the Americas.

¹³ Kinal Antzetik, A.C. 1997: *Balance del movimiento de mujeres indígenas: desde Quito hasta México* in “Memoria II Encuentro Continental de Mujeres Indígenas, Primeras Naciones de Abya Ayala, Mexico D.F. 1997”

¹⁴ ECLAC (2013) Implementación del Programa de Acción de la CIPD sobre Población y Desarrollo en América Latina y el Caribe p.26
<http://www.cepal.org/publicaciones/xml/3/50503/CRPDSintesis.pdf>

¹⁵ ECLAC (2013) Implementación del Programa de Acción de la CIPD sobre Población y Desarrollo en América Latina y el Caribe
<http://www.cepal.org/publicaciones/xml/3/50503/CRPDSintesis.pdf> P.28

birth control such that millions of poor women who may want to control their fertility are unable to do so.

In addition, the available choices in contraceptive methods are often limited, and poor women living in rural areas often do not have access to modern temporary methods, like hormonal pills or male and female condoms, and research suggests that female sterilization is the often the most common (Guttmacher, 2007).¹⁶ Indigenous, rural, and afro-descendant women and adolescent girls particularly need urgent access to contraceptive information, education and services of their choice and that best suit their needs. In Guatemala and Nicaragua, 7 of every 10 indigenous women do not use a modern method of contraception; in Ecuador, Bolivia, Mexico and Peru, it is 5 out of 10 (ECLAC 2010).¹⁷ This can be attributed perhaps not only to lack of access to a method of their choice, but possibly also to the power relations that exist within their own homes, the difficulty women have in negotiating birth control with their male partners, and that pregnancy is often a desired state and motherhood may be women's only source of pride, worth and societal acceptance.

Table 2. Contraceptive Prevalence Rate in Select Countries by Geographic and Wealth differentials

Country	Place of Residence		Wealth Quintile	
	Rural	Urban	Lowest	Highest
Bolivia	26	40	23	47
Colombia	72	73	68	75
Honduras	51	62	41	65
Nicaragua	60	71	50	71
Peru	40	53	34	54

Source: World Health Organization (2012) *World Health Statistics 2012*

¹⁶ Guttmacher Institute (2007). Changes in Contraceptive Method Mix in Developing Countries at: <http://www.guttmacher.org/pubs/journals/3311707.pdf>

¹⁷ ECLAC (2010) Salud materno-infantil de indígenas y afrodescendientes <http://www.eclac.cl/publicaciones/xml/8/41668/LCW346.pdf> p.45

Maternity Care

Indigenous women, women living in rural areas and those with very low levels of education in all countries of the region have less than 40% of coverage in accessing health services.¹⁸ A very high percentage of indigenous women deliver at home (Bolivia 52%; Ecuador 69%; Guatemala 80%, Mexico 54%, Nicaragua 64%, Paraguay 38% and Peru 84%) and have little access to basic antenatal care services (Torres Parodi WHO, 2010).¹⁹ Basic maternity care is often too costly for them, and the discrimination they face from health personnel pose grave risks to their lives and that of their newborns.

In Guatemala, for example, 70% of maternal deaths occur among indigenous women, three times higher than for non-indigenous women (311 vs. 70 per 100,000) (ENMM, 2003).²⁰ In the State of Potosí, Bolivia, which is mainly indigenous, there are 376 maternal deaths per 100,000 live births (ENDSA 2003).²¹ In Mexico, the risk of a woman dying from complications of pregnancy and childbirth is 6 times higher in indigenous communities than in the rest of the country (Palomo, 2003).²² In Brazil, the state of Paraná reports that afro-descendent women are three times more likely to die in childbirth than white women (Tanaka, 2001).²³

Obstetric violence, is prevalent throughout the region and for indigenous women in particular. It is a specific form of human rights and reproductive rights violation that combines both gender-based violence as well as violence perpetrated by public providers within health institutions. Through a myriad of coercive, violent and discriminatory behaviors, public health providers commit violations that include the right to equality, non-discrimination, information, health, and reproductive autonomy within the context of seeking maternity care within health services (GIRE 2013).²⁴ In small villages and rural areas of Latin America, midwives continue to be the primary health care providers for pregnant women, and they have the trust of the communities. But while strengthening midwifery skills and supporting midwives is critical, this must be accompanied by adequate referral services in cases of emergencies. The death of women during pregnancy and childbirth is preventable, and therefore one of the most flagrant human rights violations.

¹⁸ Ibid p.74

¹⁹ WHO (2010). Access and Health Expenditure for Ethnic/Racial Groups in the Region of the Americas.

²⁰ Encuesta nacional de mortalidad materna de Guatemala (ENMM), 2007 and Every Woman Counts Guatemala Fact Sheet http://everymothercounts.org/sites/default/files/education/files/guatemala_fact_sheet_final.pdf

²¹ Encuesta Nacional de Demografía y Salud de Bolivia (ENDSA), 2003

²² Palomo, Nellys (2003), “La muerte materna en zonas indígenas. La otra mirada a la salud”, Mujeres negras e indígenas alzan su voz, Cuaderno Mujer SaludN° 8, RSMLAC, Adriana Gómez. Ed.

²³ Tanaka, AC. (2001), “Mortalidade materna” en Rocha MIB, Araújo MJO, Ávila MB. (orgs.), Saúde da mulher e direitos reprodutivos: dossiê, São Paulo (SP): Rede Nacional Feminista de Saúde e Direitos Reprodutivos;. p. 23-39

²⁴ GIRE (2013) Omisión e Indiferencia p. 120

Budgetary Accountability for eliminating Maternal Mortality in Mexico²⁵

The Mexican government included designated budgets within its Federal Budget towards the elimination of maternal deaths by 34.8% in 6 years. FUNDAR, a leading Mexican transparency and human rights think-tank, documented the programs mandated with the implementation of these resources by year of operation. In this analysis, the organization concluded that even though there had been resources designated to combat maternal mortality in the most prevalent areas of the countries (mostly rural and indigenous communities in the Southern part of Mexico), 1,115 more women died in 2008 than in 2007. This increase of nearly two percent was primarily due to the lack of the public system's health personnel available nearby to provide women with emergency obstetric care from complications during childbirth. FUNDAR was unable to discover how the resources assigned to the National Center for Reproductive Health and Gender Equality, the Seguro Popular, and Arranque Parejo en la Vida were used instead of for this purpose. The distribution of resources is difficult to make sense of since there were four government programs concurrently operating for improving maternal health in the country; all operated under different budgets. This lack of harmonization and transparency of public monies for reproductive health programs points to a real lack of operational capacity, product of the Popular Health Insurance (Seguro Popular) and of how budgets and programs are decentralized. These affect programs that do not have assigned budgetary allocations, including for maternity care. The disconnect between programs and expenditures is one of the structural barriers towards implementing quality health services, including maternity care, to those dependent on the public health system. It also raises questions of budgetary accountability from the States to the Federal Government on health spending and decision-making.

Abortion

Unsafe abortion rates in Latin America are the highest in the world (WHO, 2008).²⁶ In the region, 93% of the 4.2 million abortions performed each year are unsafe and pose serious threats to women's lives. This is a public health priority as well as a human rights and social justice one. While illegal abortions are usually also unsafe, even when legal abortions can be unsafe as a consequence of social stigma and of economic inequalities. The voluntary interruption of a pregnancy is legal within the first trimester only in Mexico City, Uruguay, and Cuba. In Colombia and Brazil, abortion has also been decriminalized further in the last few years, expanding the scope for providing safe and legal services to women whose lives are at risk as well as to preserve their physical and mental health in the case of Colombia, and in cases of anencephaly of the fetus in the case of Brazil. The de-criminalization of abortion and provision of safe abortion services through clear protocols for implementation are critical in order to guarantee women's reproductive rights and their health. However, Latin America is the region with the most restrictive abortion laws in the world: Nicaragua, Chile, Honduras, Dominican Republic and El Salvador completely ban abortion services and criminalize women who decide to have one with no exception.

Women's access to having a safe and legal abortion is an issue of gender equality, justice and human rights. Draconian abortion laws that criminalize women, but not men who also share equal responsibility for an unintended pregnancy, are profoundly discriminatory. Often it is poor women who cannot afford to

²⁵ Díaz, Daniela, Fundar 2012: http://www.fundar.org.mx/np2009/onepagers_2009/Mortalidad%20Materna.pdf

²⁶ WHO Unsafe Abortion Incidence and Mortality 2008 http://apps.who.int/iris/bitstream/10665/75173/1/WHO_RHR_12.01_eng.pdf

interrupt their pregnancies safely and thus resort to clandestine and unsafe situations where they may face serious, even life-threatening, health consequences. A basic principle of justice and equality is violated by not allowing women to control their bodies and their lives.

In 2013, Beatriz, a 22 year old Salvadorian woman who was pregnant, had lupus and kidney failure and whose fetus had anencephaly, risked dying in childbirth. The fetus had no chances of survival. Nonetheless, the country's Supreme Court rejected her claim to terminate her pregnancy and thereby denied her right to life. Due to international pressure, including a first-time statement issued by the Inter-American Commission on Human Rights, and pressure from national women's organizations, the country's Surgeon General ordered that an emergency cesarean section be performed as otherwise, she would die. The country has so far jailed 628 women for terminating their pregnancies since abortion was completely banned and criminalized in 1998.

In nearly all of Latin America, conservative forces have permeated not only the political sphere but also the public health field. Throughout the region, doctors think that they have a right to conscientious objection in matters related to women's reproductive autonomy regardless of their legal obligations. So even though the ICPD five-year review and human rights mechanisms have stated that all medical professionals shall be adequately trained to provide safe abortions where permissible by law, practitioners often use the "conscience clause" to deny women this right and do not refer her to another practitioner who might provide the service. Denying women their reproductive rights constitutes a violation of the human rights of women and is contrary to Latin American governments' human rights obligations, including under the International Covenant on Social, Economic and Cultural Rights, the Convention on all forms of Discrimination against Women, and the Convention against Torture, Cruel, Inhuman or Degrading Treatment. Despite the pronouncement of several International Human Rights Treaty Bodies, the Inter-American Commission on Human Rights, and Human Rights Experts on this matter, the region's governments continue to deny women their fundamental human rights in the realm of sexuality and reproduction and do not face any consequences for doing so (ADC, GIRE, 2012).²⁷

Prevention and Treatment of Sexually Transmitted Infections, including HIV

A major gap in Latin American health services has been the lack of integration of sexual and reproductive health services, particularly for women. HIV services, including treatment to prevent vertical transmission or access to contraceptives for women living with HIV and AIDS is not included in reproductive health plans throughout the region. Although half of all countries in Latin America have norms that include the provision of contraception for women living with HIV, only Nicaragua includes contraceptive use by positive women within its national HIV/AIDS program. In addition, assisted reproduction technologies and comprehensive family planning counseling as part of HIV care are completely absent (Balance, 2011).²⁸ To make matters worse, within reproductive health programs, women living with HIV are often highly stigmatized and discriminated against and are not properly attended. The diagnosis and treatment of other sexually transmitted infections is overlooked.

²⁷ ADC y GIRE: "Informe sobre la situación de la accesibilidad al aborto no punible en América Latina y el Caribe" Junio 2012: <http://www.adc.org.ar/download.php?fileId=686>

²⁸ Balance, Promoción para el Desarrollo y la Juventud (2011). Factsheet.

Although the Latin America region is considered to have a concentrated epidemic among men who have sex with men, the total proportion of women with HIV in the region has increased significantly in recent years, with nearly 30% (550,000) of the 1.6 million people living with the virus being women in 2010 (UNAIDS, 2010).²⁹ An analysis undertaken by Balance, a feminist organization based in Mexico working on women and HIV throughout 9 countries of Latin America, determined that while most national HIV and AIDS plans mention the necessity of a gender perspective, the region lacks women-centered HIV prevention policies with the exception of those targeting female sex workers and pregnant women. For those programs that do consider women as a target population, namely El Salvador, Honduras and Nicaragua, these programs narrowly define “women at risk” to be those who are pregnant, with the intention of preventing vertical transmission to the fetus. Further, national HIV Plans do not consider women in stable relationships and in the general population, including those who experience violence, as being “at risk” of HIV infection (Balance, 2011).³⁰

B. Achievements, Challenges and Recommendations for comprehensive sexual and reproductive health services

Perhaps the greatest achievement towards securing comprehensive sexual and reproductive health services in Latin America has been the expansion of health programs based on the blueprint provided by the ICPD Program of Action. As discussed above, however, there has been slow progress in the implementation of comprehensive, rights-based sexual and reproductive health programs, because of a wave of religious fundamentalism permeating all spheres that affect women’s bodily autonomy and human rights, and inadequate political will and financial investments to secure the needed services.

Advances have been made throughout the region to create health programs that aim to provide women with universal access to comprehensive reproductive health services through health coverage expansion programs in Mexico, Argentina, Colombia, Chile, Costa Rica, Guatemala and Peru (World Bank, 2013).³¹ However, there are serious critiques from women’s health movements that the region’s so-called progressive policies and programs have serious weaknesses and often lack means of implementation, evaluation, and transparency in the use of public resources.

In addition to the problem of significant inequality discussed in the previous sub-section, the application of social policies and particularly of health policies in several Latin American countries has been characterized by lack of continuity, poor program evaluation, and little attention to reaching those most in need. De-centralization of the health system in Mexico, Peru, Brazil, Argentina, Bolivia, Chile, Colombia and Guatemala, among others, has been characterized by little accountability in the use of public monies and program implementation (Pérez Lugo, 2006).³² This has made evident by the insufficient attention paid to providing quality services and ensuring financial coverage for those communities most in need, such as indigenous and afro-descendant women. Partly, the crisis of the health sector can be attributed to

²⁹ UNAIDS. (2010). Report on the Global AIDS Epidemic, Annex 1: HIV and AIDS estimates and data 2009 and 2001. http://www.unaids.org/documents/20101123_GlobalReport_Annexes1_em.pdf

³⁰ Balance 2011. <http://www.redbalance.org/doctos/factsheetregionalingles.pdf>

³¹ World Bank 2013. <http://www.worldbank.org/en/news/feature/2013/02/14/universal-healthcare-latin-america>

³² Pérez Lugo, J et al. “Descentralización y sistemas de salud en América Latina. Revista de Ciencias Sociales v.XII n.1 Maracaibo, Venezuela 2006.

the way in which subsidized assistance programs have been conceptualized and programmed from countries' capitals, ignoring critical population data to inform planning, such as urban/rural distribution, age, sex, socio-economic status disaggregation among others.

Donor dependence of many Latin American governments for sexual and reproductive health services is also manifesting in the erosion of these programs as donor funding has fallen in volume and priorities have shifted to other regions. According to a report by the UN Population Fund in 2010, total donor support for Latin America and the Caribbean was only 7%, compared with Sub-Saharan Africa (63%) and Asia (25%) (UNFPA 2010).³³ Sexual and reproductive health organizations working in the region have been staunchly advocating for contraceptive security because the availability of hormonal contraceptives and of condoms throughout the region has significantly declined in the last twenty years. This is due to donors "graduating" these countries and a reluctance of national governments to purchase and distribute contraceptive methods to their people (IPPF/WHR 2010).³⁴ Women's human rights and reproductive health organizations throughout the region continue to demand the provision of contraceptives through the public health system from their governments. However, it is often in rural areas where local government officials, because of lack of resources, political will, or – perhaps most alarmingly - due to their own personal beliefs, do not distribute contraceptives.

Another challenge to fulfilling the Cairo goal of universal access to reproductive health in Latin America is in the realm of removing barriers to access services, particularly for adolescents and young people who require parental consent, but also for indigenous and afro-descendant women who are most marginalized and discriminated against, disrespected, and not treated with the dignity and respect that is their right.

Fulfilling comprehensive and integrated sexual and reproductive health services in Latin America requires:

- Ensuring equity in access to an essential package of sexual and reproductive health services (that includes maternity care, safe abortion, contraceptive mix, STI/HIV prevention and treatment and prevention and treatment of reproductive cancers) by reaching women close to where they live, with the care and quality that they need, free of charge, and with full respect for their diversity, confidentiality and human rights. Providing timely and culturally appropriate maternity care for women, particularly indigenous women, is hugely important - as is training and deploying health care providers (including midwives) accordingly.
- Decriminalizing abortion and ensuring women's access to all forms of fertility regulation of their choosing is vital to secure women's reproductive rights. This includes ensuring health providers' compliance with human rights obligations regardless of personal beliefs or conscientious objection.

³³ UNFPA (2010) Donor Support for Contraceptives and Condoms for Family Planning and STI/HIV Prevention. p.iv
<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/FINAL%20Donor%20Support%202010-2.pdf>

³⁴ See UNFPA and IPPF/WHR, IWHC, PPFA and others' fact finding mission to Peru, 2010.
http://www.ippfwhr.org/sites/default/files/DRAFT_EXECUTIVE_SUMMARY_PERU_.pdf

- The designation of increased financial resources devoted to integrated sexual and reproductive health programs and services within national health budgets and holding health policy makers accountable for making these budgets transparent and accountable to citizens.

DRAFT for discussion

III. Sexual and Reproductive Health and Rights of Young People

In Latin America, beliefs about sexuality and gender range significantly, from very conservative to permissively liberal depending on geographical location, ethnic background, race, socio-economic status and gender. In urban areas or in highly developed countries within the region such as Uruguay and Argentina, adolescents date freely, have sexual relations, and have ample access to comprehensive sexuality education and to sexual health services, including emergency contraception and condoms. In other countries and primarily in rural areas and indigenous communities, young people's sexuality is for the most part still considered taboo, although there are significant changes. Still, indigenous young people often marry or cohabit early, face premature and unwanted pregnancies, and have very little negotiating power over their sexuality and reproductive lives.

Adolescents 10-19 account for 30% of the population of the region (PAHO-ECLAC 2011)³⁵ and urgently need attention to prevent early pregnancies, maternal deaths, forced sex, violence, and unsafe abortions. Gender bias in access to resources and to power contributes to poor health among female teens and young adults. Gender inequality exacerbates discriminatory nutrition patterns, foments violence against girls and women, diminishes their power to make decisions about their bodies and their lives, creates unjust divisions of labor, and hampers their possibilities of leading healthy lives. The Pan American Health Organization estimates that one fourth of adolescent girls aged 15-19 already have children in the biggest countries of the region (Brazil, Mexico and Colombia), and in some this is even higher (PAHO 2012)³⁶ Adolescent fertility in the region is the second highest in the world (UNFPA 2013).³⁷

Often, young women do not know their bodies or their rights and are unable to negotiate safe sex, say no to unwanted sex, or to access the information and health services they need. Tackling unsafe abortions among adolescents in the region could avoid one fourth of maternal deaths, as an estimated 670,000 unsafe abortions occur among adolescent girls ages 15-19 (Shah, 2012).³⁸ HIV infections have grown among young women particularly, where those between 15 and 19 years old are three to six times more likely to be infected with HIV than their male counterparts (Shah, 2012).³⁹ Bringing sexual and reproductive health services that are sensitive to their age and cultural needs to adolescent girls, particularly in rural areas, is essential.

Adolescent Health Policies

At the mark of the five year review of the ICPD in 1999, Argentina, Brazil, Costa Rica, Cuba, Chile, Colombia, Ecuador, Guatemala, Mexico and Peru all had adolescent health programs in place. These programs have largely focused on preventing adolescent pregnancies, sexually transmitted infections, and alcohol and drug abuse. However, except for Peru, Colombia and Ecuador, Latin American countries lack comprehensive sexuality education policies or programs. Existing health and education policies are often

³⁵ OPS-CEPAL (2011) Salud de la población joven indígena, p.17

³⁶ PAHO (2012) Oportunidades, Enfoques y Opciones p.24

³⁷ UNFPA: <http://www.unfpa.org/worldwide/lac.html> website

³⁸ I Shah, E Ahman. Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women. *Reproductive Health Matters*, 2012; 20 (39): 169-173)

³⁹ Op Cit 1, p.34

not integrated, thus failing to attend to adolescents and young people in a holistic manner. According to a study conducted by the Pan American Health Organization, there is also limited use of available scientific evidence in the design and implementation of adolescent health programs, neglecting important factors such as age, stage of development, ethnicity, socio-economic status, educational attainment, gender power relations, cultural barriers, among others. Exacerbating this is the negligible attempt at making health services within the public system appealing, affordable, and accessible to adolescents and young people (PAHO, 1999).⁴⁰ Finally, it is important to note that there is a dearth of data on younger adolescents ages 10-14, as is the lack of specific programs and policies targeting this cohort.

Comprehensive Sexuality Education

Latin American feminists and sexual rights organizations have been advocating for as well as designing and implementing comprehensive sexuality education programs for decades. It has only been rather recently, in the last fifteen years or so and thanks in part to the HIV and AIDS epidemic, that Health and Education ministries have become more interested in providing this vital information and skills building curricula to children and young people. In principle, the concept of sexuality education in the region is thus being constructed as one that enables the individual to find his or her sexuality freely and responsibly, to negotiate sexual behavior in relationships with all the information and critical thinking skills at hand, and to respond to the cultural and socio-economic pressures that might arise. It also takes into consideration sexual diversity free from judgment and discrimination and enables individuals to understand and apply the principles of gender equality, non-discrimination, non-violence and respect for human rights.

However, despite important commitments by governments throughout the region to provide comprehensive sexuality education programs to adolescents and young people, there has been inadequate progress, with only a handful of countries expanding access to CSE within the health and/or education sectors (IPPF/WHR, 2013).⁴¹ As Latin American and Caribbean governments recommit their efforts to achieving the ICPD twenty years later, they must ensure that every adolescent girl and boy has access to comprehensive information and education on human sexuality, on sexual and reproductive health, and on human rights and gender equality as an urgent priority. In 2009, Ministers of Health and Education of Latin America and the Caribbean signed a Ministerial Declaration: “Educate to Prevent”, which committed them to expanding comprehensive sexuality education in schools significantly and reducing by 50% the number of adolescents and young people not covered by health services to attend to their sexual and reproductive health (UNAIDS, 2010).⁴² Further, an Expert Group Meeting held in Cuba in November 2012 urged governments to implement this Ministerial Declaration and further called on governments to conduct assessments of comprehensive sexuality education in the region “as a cost-benefit investment for economic and social development and for sustainable human development” (CENESEX, 2012).⁴³ The

⁴⁰ PAHO (1999) The legislative and Policy environment for Adolescent Health in Latin America and the Caribbean: <http://www2.paho.org/hq/dmdocuments/2011/Adolescent%20and%20Youth%20Regional%20Strategy%20and%20Plan%20of%20Action.pdf> p.58-67

⁴¹ Coalición Mesoamericana: <http://coalicionmesoamericana.org/sites/default/files/MesoRegion.pdf>

⁴² Ministerial Declaration (2009) UNAIDS: http://data.unaids.org/pub/BaseDocument/2008/20080801_ministerdeclaration_es.pdf

⁴³ Centro Nacional de Educacion Sexual CENESEX: Declaration of the Meeting of Experts on Comprehensive Sexuality Education. Cuba, November 2012. <http://www.cenesexualidad.sld.cu/declaration-meeting-experts-comprehensive-sexuality-education-programs-and-strategies-latin-america>

implementation of such recommendations are urgent in order to make good on government promises set out nearly 20 years ago in Cairo.

The Health and Rights of Rural Indigenous Adolescents and Young People

At a meeting held in May 2013 by the Instituto de Liderazgo Simone de Beauvoir⁴⁴, indigenous women leaders from Mexico, Nicaragua, Argentina, Peru and Guatemala emphasized that secondary schooling as well as music, cinema and television have significantly changed the way in which youth identities are constructed, including in relation to sexuality. Traditional “courting” where adolescent girls and boys would enter into union (or get married) and start having children at younger ages is changing. In an indigenous community in Puebla, Mexico, for example, early adolescents in rural areas start engaging in relationships at the age of 11 or 12 in order to “pass time”. This concept of “spending time” with each other for “fun” connotes a possibility of leisure time, a phenomenon that is relatively new among young people in indigenous communities. It is different from the experiences of their parents or grandparents, for whom, by the age of 13 or 14, unions were already formalized, long hours were spent working in the fields, and there was little time for “fun” or for developing more intimate relationships with others.

Nonetheless, in all countries where key indigenous organizations were consulted (Mexico, Guatemala, Nicaragua, Peru, Argentina), their data and experiences seemed to confirm across the board that the regulation of girls’ and women’s bodies and of their sexuality continued through the reinforcement of traditional gender roles including safeguarding the virginity of single women and girls. The sexual division of labor is still very much entrenched in indigenous cultures throughout the region, where access to collective land rights and to salaried work are predominantly male. Young men are employed predominately in agriculture, whereas young women continue to do the domestic and care work.

Girls’ access to formal education (primary and secondary) has increased in all countries of the region, including within indigenous communities. This has also changed courting and sexuality patterns among adolescents and young people because it has allowed girls and boys to spend more time together, construct different youth identities, and form new types of relationships (Rodríguez and Keijzer, 2002).⁴⁵ The increase in school enrollment in the last 20 years has also given rise to the social recognition of sexual desire and courtship among young people. Undoubtedly, girls and boys in the countryside are appropriating urban language and popular symbols which contrast with those employed by adults or by their societies and customs, especially on issues of sexuality, gender and autonomy. This includes the changes in location for dating purposes, the physical distance between couples, the function of leisure time, and the emotional-affective expressions within relationships, as well as individualized notions of the body and bodily autonomy (Rodríguez and Keijzer, 2002).⁴⁶

Although these changes in rural areas and within predominately indigenous communities have brought about greater permissiveness in young people’s sexuality, this change has predominately been for males. There are still widely entrenched power relations that give males cultural and social control over females’

⁴⁴ Mesa Redonda Instituto de Liderazgo Simone de Beauvoir, Mayo 23, 2013. Mexico D.F.

⁴⁵ Rodríguez, Gabriela and de Keijzer, Benno: “La noche se hizo para los hombres. Sexualidad en los procesos de cortejo entre jóvenes campesinos y campesinas”, Libros para todos y Population Council, México D.F., 2002 p.220

⁴⁶ *ibid* 222.

bodies and sexuality. In all thirteen interviews conducted for this paper, unequal power relations were cited as predominant. These were manifested through: feelings of ownership by men over women, male imposition on the decision to establish a union or a marriage, male violence against women, male control over when to have sex, how, and whether or not protection could be used, and control over the mobility of girls and women out of their homes without male permission.⁴⁷

Ensuring that adolescent girls and boys have their sexual and reproductive rights fulfilled requires:

- That they have access to accurate information about sexuality and reproduction (including through comprehensive sexuality education that teaches gender, sexuality and human rights) so that they can claim their rights and access services;
- That they can access comprehensive sexual and reproductive health services, including the contraceptive of their choice, male and female condoms, safe abortion services, and prevention and treatment of sexually transmitted infections and HIV and AIDS, free of stigma, discrimination, violence and coercion and with full attention to their privacy and confidentiality;
- That there is an enabling environment created so that health care providers, parents, teachers and communities can best support adolescents and provide them with the information, skills and supplies that they need to exercise their sexual and reproductive rights and protect their health in the rapidly changing contexts and realities of their lives;
- That adolescents, in all their diversity, participate in the design and evaluation of national, regional and local programs and policies that affect them.

Adolescent Pregnancy in Indigenous Communities in the Northern Mountains of Puebla, Mexico: A Case Study⁴⁸

Demographics

The Northern Mountains of Puebla include 65 indigenous municipalities, made up of 1.2 million people, out of which approximately 300,000 are adolescent girls between the ages of 10 and 19. 87% of adolescent girls ages 15 to 19 are not enrolled in school, and nearly a third of them speak their native language but not Spanish, thus increasing their barriers in accessing social services. The little knowledge these girls acquire in primary schools is insufficient for claiming their human rights and taking care of their health.

Early Marriage

Early marriages between the ages of 15 and 19 account for 1 out of every 5 marriages in the region, and adolescent girls abandon school soon after they turn 14. In the state of Puebla, around 38.7% of women 15 and over reported having suffered violence within their communities, and out of these, 35% reported having suffered from sexual violence (Espacio Espiral, 2011).⁴⁹. The notion of rape within marriage or in union

⁴⁷ Mesa Redonda Instituto de Liderazgo Simone de Beauvoir, Mayo 2013

⁴⁸ This case study was developed by the author on a field trip to the region and through interviews with key informants and organizations in April of 2013.

⁴⁹ Observatorio de Violencia de Género en la Sierra Norte de Puebla (2011). Violencia Social y de Género en la Sierra Norte de Puebla: Investigación Cuantitativa. Espacio Espiral.

is non-existent and thus not accounted for in regional and national statistics. However, women's organizations working in these communities attest to thousands of testimonies of girls and young women who cannot exercise autonomy in their sexual lives and suffer from sexual, physical and emotional violence by their intimate partners.

Adolescent pregnancy

Adolescent pregnancy has its origins in the social discrimination and violence against women that is deeply rooted in the region, limiting the realization of women's human rights as well as the capacity of these communities to access development. In order to understand the issue of adolescent pregnancy, Espacio Espiral, a feminist organization working in this region, identifies with the following factors as central to combat this social problem:

Equality and equity across age, gender and sexuality; poverty differentials; lack of supplies, opportunities, and control; Information that is appropriate, accessible, and complete; Health services that are culturally sensitive, integrated, free, and of quality; Access to safe abortion services and Access to justice. They also attribute the following factors as impediments to combating adolescent pregnancy in the Northern Mountains of Puebla: The supremacy of men over women in indigenous customs and traditions; the total lack of attention on the part of the State to these communities; the racism and sexism embedded in local laws and Gender based violence

Persistent discrimination against women

The women in the communities of the Northern Mountainous region of Puebla continue to be assigned lower social status than their male counterparts. Municipal and local offices are given almost exclusively to men and a woman has never taken public office. Young women throughout their lives are placed in a situation of submission vis-à-vis adults, especially men. Young women have little to no say in their homes or communities. Although research indicates that indigenous adolescents begin sexual activity earlier than their non-indigenous counterparts, female chastity and virginity continue to be the norms against which women are measured.

Regardless of the multiple barriers that young women and their families face when they get pregnant, once the children are born, the stigma surrounding their early pregnancy outside of marriage is transformed into respect for their roles as mothers. Through this newfound identity and social assignation of status, the power structure within families and the community shifts in order to permit women to achieve social and community recognition and to have a voice in public life (e.g.as beneficiaries of government programs for their sons/daughters and in their children's schools). In the region, planned and intended pregnancies are thus very common due to the social status and value that the community assigns to women in the maternal role.

Early marriage/union and pregnancies in this region can be attributed in part to the lack of opportunities in education and employment that young women have. Girls and young women's search for a boyfriend at an early age is often due to considerable influence and pressure from their parents in the belief that this union will provide financial security for her and her family. In a municipal health post in the municipality of Cuetzalan, Puebla, health personnel report of adolescent girls under the age of 17 who are married and are often worried that they cannot get pregnant, facing abandonment by their husbands and violence and discrimination from their families. Not being able to "consummate a union" goes against their traditions

and customs, which dictate that if a woman does not become pregnant within a year of living with her partner, the man has the right to send her back to her family of origin. However, if girls had greater education and employment opportunities they could leave the family home and break the cycle of poverty, violence, dependency and submission in which they live. Without the necessary economic resources, access to services and opportunities and capacity to control their own lives, young indigenous women have little ability to exercise their bodily autonomy and therefore prevent unwanted pregnancies.

DRAFT for discussion

Access to Information and Education about Sexuality and Reproductive Health

The Observatory on Sexual Violence from the region conducted a study among adolescent girls and young indigenous women in Cuetzalan Puebla during 2011⁵⁰. The results were the following:

- 3 out of 10 indigenous youth who had a secondary education also had accurate and sufficient knowledge about human sexuality and reproductive health.
- 70% believed that they could not get pregnant during their first sexual encounter
- 65% believed that interrupted coitus was an effective method of contraception
- 30% did not know how to prevent a pregnancy
- 70% were not aware of emergency contraception
- 20% believed that contraceptives were harmful to their health
- 60% did not have sufficient information about contraceptives and STI/HIV prevention methods

Due to the lack of comprehensive sexuality education programs in the Northern Mountainous Communities of Puebla, adolescents and young people get most of their information from the internet. However, there is little information on the type of information they are accessing and whether it is accurate or not. Organizations working with indigenous youth in the region believe, however, that the internet does not provide accurate information on how to effectively prevent sexually transmitted infections, unintended pregnancies, unsafe abortions, homophobia, or sexual violence.

The only other place where indigenous youth have access to information is in local health posts, with health personnel who provide talks to beneficiaries of social protection programs. The young people report that the most successful of these are those provided by health promoters who are from the community, speak their language, and are able to transmit the information in honest but culturally sensitive ways. Despite a few civil society initiatives and programs, there are few spaces for discussions held in native languages and on issues that adolescent girls in particular consider important, such as the symbolic importance placed within their communities on gender roles involving maternity, reproduction and sexuality. The only public program that provides “information on reproductive health to adolescents” is focused on early motherhood and is called *Borrowing a Baby*. This program consists of giving married adolescent/young couples an information session about family planning and a doll for a week that cries every 20 minutes in order to signal the need for food, a diaper change, etc. The intention of this program is to show young people how demanding child-care is and to promote the importance of delaying first pregnancies. However, these programs have been limited in their success. It has been observed that the information sessions are perfunctory, uninteresting, that men do not accompany women to these sessions, and that the women go just to get a doll for a week since they have never seen something like this and want to play. Girls and women in these communities have been taking care of babies since they are 6 or 7, so they understand the demands and responsibility that maternity entails. They do not, however, gain information on how to protect themselves from STIs, avoid unwanted sex and unintended pregnancies, or how to negotiate condom use.

⁵⁰ Observatorio de Violencia de Género en la Sierra Norte de Puebla (2011). Violencia Social y de Género en la Sierra Norte de Puebla: Investigación Cuantitativa. Espacio Espiral.

Access to Sexual and Reproductive Health Services

Generally, health services in the region are insufficient, of bad quality, and difficult to access. Public health centers are equipped to provide immediate attention to what they consider the most prevailing medical needs, meaning infections of the stomach, influenza and tuberculosis. Sexual and reproductive health services, particularly for adolescents, is especially negligible. The only contraceptive that is widely available are male condoms, which are not widely used or demanded by adolescents due to the stigma and discrimination surrounding their request, which implies their signing their names and addresses for them to obtain them free of cost. Adolescent privacy and confidentiality is therefore compromised.

Pregnant adolescent indigenous girls are frequently denied services that are often conditional on spousal/parental consent. Midwives and traditional birth attendants are the health providers that most frequently attend to indigenous pregnant women within their same communities. They are often not trained to provide friendly services to adolescents, but are the ones who are most likely to reach them and often provide the only care available.

The Observatory on Sexual Violence from the region estimated that over 30% of registered abortion and post-abortion care services were among adolescent girls ages 13 to 19. Abortion is almost completely illegal in the State of Puebla, with the exception of rape and to save the life of the woman, so the health services for the most part do not provide safe abortion services. Indigenous women who want to interrupt their pregnancies reach out to midwives who prepare traditional medicinal remedies, which traditionally has been used for “menstrual regulation” within the first eight to ten weeks or so and that is tacitly accepted within the community. However, women who discover they are pregnant after the 10th week have difficulties in accessing safe services. Increasingly, adolescent girls and young women are accessing medical abortion (misoprostol), which costs between 9 and 20 dollars per pill- not inexpensive considering the minimum wage in this area is around 4 dollars a day. There are numerous documented cases where medical abortion has failed due to its improper use. Deaths by unsafe abortion within these communities are stigmatized and thus attributed to other causes. There is still limited official data on unsafe abortion as a cause of maternal deaths in this region, particularly of adolescent girls.

In the state of Puebla it is legal to access a safe abortion service if the pregnancy is result of rape or incest. However, in 2011 there were no cases registered of this service being provided, despite the high incidence of sexual violence towards adolescent girls in these communities. According to testimonies of midwives, 6 out of every 10 pregnancies that they attended in 2011 were of girls younger than 16 years old who had had forced/coerced sex with older men. However, none of these adolescents claimed their right to a safe and legal abortion, having the babies instead.

The inadequate sexual and reproductive health care devoted to adolescents in this region is clearly due to a) the lack of political will, financial resources, and necessary sexual and reproductive health supplies by public health authorities, and b) the lack of information that adolescents have about sexuality and reproduction, where and how to claim their sexual and reproductive rights, including access to adequate health care services.

Human Rights of adolescents

Even though the State of Puebla and the Mexican Constitution have numerous laws that recognize the human rights of indigenous peoples and specifically stipulate non-discrimination, these are not applied. The mestizo population (mixed race) promotes racial segregation, and public institutions deny indigenous peoples vital services such as health, justice and education, as well as decent work. Their human rights are therefore completely ignored. In terms of guaranteeing the sexual and reproductive rights of adolescent girls and young women, the Mexican State has issued official norms, protocols, and regulatory frameworks for the provision of health services that respect their cultural diversity and provide them with adequate sexual and reproductive health services with quality of care. But once more, due to the lack of active voice and participation by adolescent girls and young women claiming these rights, local authorities pay no attention and ignore their needs.

Guaranteeing indigenous adolescents' access to justice is paramount to break this cycle of violence, poverty, stigma, discrimination, and sexism. Although it is evident that cultural specificity in relation to indigenous peoples' access to justice must be respected, it is also fundamental that women's human rights be respected, protected and fulfilled. State and municipal authorities are often afraid to question or counter customary law from a human rights and gender equality perspective. Often, it is adolescent girls' and women's sexuality that is most contested in this regard, with sexual violence not considered a crime within the community if the man decides to marry the woman, for example, or with the acceptability of physical violence towards women for the sake of "disciplining" women and maintaining them in their roles of acceptable wives and mothers.

Conclusions

Adolescent pregnancies among indigenous girls in the northern mountains of the State of Puebla can be attributed to the grave inequalities in access to information, opportunities, health and education services, as well as the structural and root causes that maintain girls and women in subordinate positions to boys and men. The response, according to Espacio Espiral, must be multi-sectoral and integrated among both governments and communities. It is not enough to provide health and education services, enact laws and policies, and increase economic growth in the region. Socio-cultural changes are necessary in order for there to be real transformation among communities. These must be brought about through involving the members of the communities themselves- in this case, adolescent girls and young women- to participate in the design and implementation of policies and programs that affect them.

IV. Sexual and Reproductive Rights

Progress

Most countries of Latin America have, at least in discourse, written in constitutions, laws and policies, the rights of women to determine the number, spacing and timing of their children, as well as to control their sexuality free from violence, coercion and discrimination. This has been due, in large part, to the strong involvement, determination and persistence on the part of women's health and human rights advocates in each country who have attempted to hold governments accountable. The region has made important strides in the formal and legal recognition of sexual and reproductive rights, including in the form of their recent enshrinement in the constitutional reforms of Ecuador and Bolivia. There has also been progress in legalizing the voluntary interruption of pregnancy in the first twelve weeks in Mexico City and Uruguay; several reforms to criminal codes in Colombia and Brazil which expand access to safe abortion where legal; and the enactment of protocols to provide safe abortion services in Argentina. The expansion of access to emergency contraception as part of the basic healthcare package has been established in various countries of the region, including Mexico, Peru and Chile.

Numerous countries have also enacted legislation destined to expand access to sexual and reproductive health care of adolescents, including access to voluntary and confidential access to contraceptives and HIV prevention methods such as male and female condoms.⁵¹ Several human rights principles relevant to adolescent health, such as those of privacy and confidentiality in accessing sexual and reproductive health services, have been written into law in Chile, Ecuador and Peru. These countries have recently enacted adolescent health programs to implement this legislation that seem to be properly financed and which were developed with the input of feminist and young people's organizations.

Finally, the struggle for recognition of lesbian, gay, bisexual and transgender people's human rights, as well as those of sex workers and people living with HIV has been at the forefront of progressive social movements in the region during the last two decades. Ecuador approved the second constitution in the world in 2008 banning discrimination on the basis of HIV status, sexual orientation, and gender identity. The 2010 law in Argentina legalizing gay marriage and adoption, followed by Mexico City and now Uruguay, point to a growing trend in the region of social acceptance and the full guarantee of civil and economic rights to same sex couples. Recent indications in Colombia and Brazil suggest there may be positive changes in those countries in the near future. In the case of Colombia, same sex couples have received equal benefits within the public service as of 2007. In 2010, El Salvador issued a decree banning discrimination in the public service based on sexual orientation and gender identity, and Brazil, Costa Rica and Colombia's Supreme Courts have issued similar rulings favoring non-discrimination towards same sex partnerships among public servants.

It is important to recognize that the Latin American region has been a leader globally in its support for and recognition of sexual diversity and sexual rights. Latin American countries have repeatedly recognized the human rights of women, men and adolescents to have control over and decide freely and responsibly on all

⁵¹ Some examples are the National Adolescent Pregnancy Prevention Program in Bolivia; the Colombian Program on Prevention of Adolescent Pregnancy, the National Law on Family Planning and Adolescent Pregnancy Prevention in Ecuador, and the National Adolescent Health Program in Mexico.

matters related to their sexuality, free from violence, coercion and discrimination⁵² in United Nations development and human rights negotiations. The regional reviews of the ICPD and Beijing in 1999, 2005, 2010 and 2013 have also reaffirmed this basic right. In addition, Argentina, Brazil and Uruguay have played instrumental roles in strengthening international norms and standards relating to sexual orientation and gender identity within the United Nations Human Rights Council and within the United Nations Economic and Social Council resolutions on gender equality and population and development⁵³.

Backlash

Despite all this progress, however, the region is still marred by strong conservative religious forces which impede the realization of sexual rights and reproductive rights. Reports of hatred, violence and discrimination on the basis of sexual orientation and gender identity are on the rise. Lesbian, gay, bisexual and transgender people, as well as those involved in sex-work are imprisoned, tortured, raped and even murdered. Thousands of so-called hate crimes have been documented in Mexico, Brazil, Honduras and Colombia, all countries where prominent sexual rights activists have been brutally murdered in recent years (GIRE, 2013).⁵⁴

Politicians and religious leaders throughout the region are known to make homophobic and hateful comments about women, LGBT people, gay marriage, and abortion. The hierarchies of Catholic and Evangelical churches are also contributing to this conservative and hateful environment. In addition, public servants such as the police, teachers and health care providers are often those who discriminate against people of diverse sexualities and gender identities the most, sometimes employing violence and abusive tactics without being held accountable. Thus, although legal rights are becoming more and more of a reality for LGBT people, the systematic violence and discrimination they face propagates an unfriendly environment within which to realize these rights.

Access to safe, legal abortion as a right is still far from being guaranteed. The criminalization of women who decide to interrupt their pregnancies is increasing in Central America. In Mexico, where voluntary interruption of pregnancy is only legal in Mexico City but criminalized in 17 of the other states, there have been 679 women charged with the crime of abortion since 2007, and 127 of these have resulted in incarceration (GIRE, 2013).⁵⁵ In El Salvador, Nicaragua, Dominican Republic and Honduras, abortion has been completely criminalized, including in cases to save the life of the woman and of rape. Between 2000 and 2011, at least 129 women in El Salvador have been incarcerated for abortion, which is equated with homicide. During the same period, forty nine of these women were sentenced to serve up to eight years in prison (Sahaquillo, 2013).⁵⁶ The total ban on abortion generates a climate of fear, increases stigma and

⁵² This is the basic definition for “sexual rights” which was first adopted by consensus during the World’s Fourth Women’s Conference held in Beijing in 1995 and then expanded to include men and adolescents in 2009 and 2012 respectively at the UN Commission on Population and Development.

⁵³ International Conference on Population and Development Key Further Actions (1999) UN Doc: A/RES/S-21/2; ICPD at 10 Outcome Economic Commission for Latin America and the Caribbean; Beijing Platform for Action; Beijing +5 A/RES/S-23/3; Beijing +10 E/CN.6/2005/2; United Nations (2012) Adolescents and Youth: Resolution of the Commission on Population and Development; ECLAC (2013) Montevideo Consensus

⁵⁴ Human Rights Watch World Report 2013

⁵⁵ Omisión e Indiferencia: Derechos Reproductivos en México GIRE, 2013 p.4

⁵⁶ María Sahaquillo: “Entre rejas por abortar” El País, Junio 9, 2013.

discrimination towards women, and violates their basic human rights to control their bodies, their sexuality and their reproduction. More importantly, these draconian abortion laws lead women to seek clandestine abortions which are often unsafe and can threaten their long-term health and even their lives.

Regional leadership: A note of caution

In August 2013, Latin American and Caribbean Governments adopted the most progressive regional political document to date: The Montevideo Consensus, which marked the twentieth anniversary of regional achievements in the implementation of the Program of Action of the International Conference on Population and Development. This landmark document defined sexual rights; pledged to review laws that criminalize women's sexuality and reproductive choices; committed to implementing comprehensive sexuality education as well as sexual and reproductive health services; and recognized the need for addressing inequalities and prioritizing indigenous and afro-descendant populations.

Hopefully, this regional commitment will translate into greater political will and financial commitments within countries towards these programs.

Globally, however, Latin America's leadership role in advancing norms and standards on sexual and reproductive rights and health for the last twenty years may be dwindling. Brazil's progressive stance on sexuality and reproductive rights at the Human Rights Council and within UN-NY negotiations for years had provided important international leadership that worked hand in hand with sexual and reproductive rights advocates to move the agenda forward. However, the 20th Anniversary of the Rio Conference on Sustainable Development in 2012 marked a sharp ending to this era, when the Brazilian government did not promote the inclusion of reproductive rights in the Outcome Document. In the year since, the Brazilians have begun to take much more conservative positions in their multi-lateral actions, evidenced by the 2013 Commission on the Status of Women and the Commission on Population and Development. Countries, including Argentina, Mexico and Uruguay, which are other multi-lateral supporters of sexual and reproductive rights, will often not take singular leadership unless a group position can be taken, and Brazil is often the lead. This shift in Brazil's position might be due to the rise in influence of conservative evangelical churches. More and more legislators, judges and public servants are applying their personal religious beliefs in their public life, countering the claims of feminist and sexuality movements in the region for decades to secure the secular nature of the State. Thus, it is imperative that social movements in Brazil continue to exert pressure and hold the State accountable for meeting its international human rights commitments, including towards fulfilling women's human rights and sexual and reproductive health.

Despite Brazil's changes and their coming elections, Uruguay is keen to lead the region to take more progressive stances on sexual and reproductive health and rights internationally given the success of the Montevideo Consensus.

V. Conclusion

Latin American feminists and sexual and reproductive health and rights activists should continue to mobilize constituencies in order to galvanize political will and financial commitments to:

1. Create an enabling environment in order for girls and boys to be able to know their bodily rights and to have the skills and knowledge to claim them, including through the provision of comprehensive sexuality education programs in and out of schools.
2. Ensure that girls, boys, women, men and transgender individuals in all their diversities have access to comprehensive and integrated sexual and reproductive health services free from violence, coercion and discrimination. This includes the availability and affordability of the full range of contraceptives, including emergency contraception, as well as maternity care services, safe abortion services, and STI and HIV prevention and treatment services.
3. Amend existing legislation that discriminates against women and minors (including the decriminalization of abortion, spousal and parental consent requirements) and liberalize legislation that guarantees women and people of diverse sexualities social entitlements (including safe abortion, inheritance and property rights, marriage and equal employment opportunities)
4. Increase the allocation of resources devoted to sexual and reproductive health and rights in national health and education budgets and ensure accountability mechanisms
5. Strengthen policies and programs that aim to end violence against women and girls, including by enacting social mobilization campaigns, ensuring access of survivors of violence to critical health and refuge services.
6. Ensure the sustainable development of indigenous communities by listening, attending, and responding to the needs and human rights of indigenous girls and women. This includes fulfilling their collective and individual rights so that they can control their bodies, have access to quality sexual and reproductive health information and services, protect their lands and resources, and live lives free from violence and discrimination.

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