



**SOCIO-CULTURAL FACTORS THAT AFFECT REPRODUCTIVE HEALTH
IN LATIN AMERICA: EMERGING OPPORTUNITIES, CHALLENGES AND
LEARNING ON CONTEXT, CONCEPT AND PRACTICE**

FINAL REPORT

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ABBREVIATIONS

CFFC	Catholics for a Free Choice
CEIMM	Centro de Estudios de Información de la Mujer Multiétnica
CELADE	Centro Latinoamericano y Caribeño de Demografía
ECLAC	Economic Commission for Latin America and the Caribbean
FBO	Faith-based Organization
FCI	Family Care International
FEIM	Fundación para el Estudio e Investigación de la Mujer
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICT	Information and Communication Technologies
IFFI	Instituto de Formación Femenina Integral
IPPF	International Planned Parenthood Federation
IT	Information Technology
LGBT	Lesbians, Gays, Bisexuals and Transgenders
MDGs	Millennium Development Goals
MSM	Men who have sex with men
NGO	Non-governmental organization
NICTs	New Information and Communication Technologies
PAHO	Pan American Health Organization
PEX	Post-exposure prophylaxis
PLWHA	People Living with HIV/AIDS
RH	Reproductive health
SRH	Sexual and reproductive health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
VAWG	Violence against Women and Girls

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I. INTRODUCTION: BUILDING DEMAND FOR SERVICES, INFORMATION AND OTHER RESOURCES¹

In health service planning, most attention usually goes to planning on the supply side of services. The question as to whether the services will be used is often neglected, even when it is clear there are factors that could limit demand and uptake of health services like denial, fear, stigma, discrimination, socio-cultural issues and high costs.

Undoubtedly quality health services are needed to achieve universal access to reproductive health, but we have also learned from extensive program experience that simply providing or strengthening health services may not necessarily lead to their use, particularly by poor women and the ones most at risk. Given the scope and complexities of social, cultural, economic, and geographic factors that infringe upon ones health-seeking behavior, it is evident that not all these factors can be addressed through health system strengthening initiatives and therefore require a more expansive set of strategies and leadership at the community level to influence social norms and catalyze action.

Increasingly, public health, including reproductive health care provision, is being seen as a system — a changing dynamic of entitlement and obligations between people, communities, providers and governments. Within this new lens, community participation, health promotion, social support and empowerment of individuals (especially of women) are seen as critical to achieving sustainable improvements in sexual and reproductive health care.

“Public policies and their services respond, among others, to prevailing cultural and gender social systems. To prevent that services turn ineffective because of differences between what they offer and what the population expects, means for active participation of the beneficiaries that guarantee the incorporation of their cultural and gender demands need to be searched for.”

(Bant s/f:7)

In other words, good reproductive health requires partnership. While governments are obliged to make quality reproductive services and information widely accessible, users should be encouraged to articulate what they need and expect in terms of services, information and other resources. Users can also provide valuable input into monitoring and

¹ Mainly extracted from UNFPA (2009): “*Sexual and Reproductive Health: Building Demand for Services, Information and other Resources*”. New York: UNFPA.

evaluation efforts that can improve quality of care. In this way, users can provide a feedback mechanism to support services and information appropriate to their needs.

The health care system implies an interaction between care provision/supply (trained personnel, equipment, commodities, services, information and other resources) and needs/demand (active participation of individuals, families and communities) for quality services. Interaction between these two parts of the system can improve effectiveness and efficiency of responses to the reproductive health needs of users.

“For the individual it is important to have a sense of identity and belonging to a group that shares values and other cultural linkages. But each individual can identify himself/herself with various distinct groups...Identity also has an optional dimension: within these groups, individuals can decide which priority to give to one with respect to the other, depending on changes in the circumstances.”

(PNUD 2004:3)

The intersection of human rights, culture and gender relations underpin this whole model. The rights of individuals to exert control over their own lives and their reproductive health needs have been acknowledged by the international community. To be able to exert these rights, people need information, as well as affirmation and support in articulating and exercising their rights and in expressing demand for the services they need.

Furthermore, building demand for health services brings about a unique opportunity to broaden the scope of work to include sectors whose main mandate lies outside the health sector. That is why UNFPA works on many levels. In addition to supporting reproductive health services, the Fund also promotes behavior change, communications, advocacy, community involvement, male participation, education and empowerment, particularly of women. These kinds of interventions can encourage individuals and communities to increase demand and support for quality reproductive health services.

Therefore, raising demand for reproductive health services, information and systems requires understanding the users' perspectives, raising public awareness and overcoming cultural, social and financial obstacles. Within this framework, this study is part of an inter-branch activity to analyze social and cultural factors that influence reproductive health and service demand, as well as to identify, develop and disseminate strategies on comprehensive approaches to generate or increase demand for reproductive health and services.

Latin American countries have faced critical political changes that have undoubtedly impacted on the particular national history of reproductive health and rights. Political events have most frequently represented hazards for the advancement of reproductive health and rights but have also created opportunities for the advancement of sexual and reproductive issues, oftentimes within a context of ambivalence, contradictions and controversies. The capacity to take advantage of these “openings” has varied substantially between countries and periods. Also, the heterogeneity and dynamicity of the events has many times resulted in uneven and fragmented progress in relation to the RH.

“More generally, although social and political crises create the potential for positive social transformation, whether or not that potential is realized is highly dependent on the larger local, national, and even global context at the moment when those crises occur.”

(Nathanson, Sember and Parker n/d:394)

In any case, considerable and diverse experience, inspiring good practices, lessons learned and evidence-based knowledge has been generated in the region that must be capitalized to nourish innovation, effective and efficient practice in addressing reproductive needs and bridging the gap between health services’ supply and demand. This study aims to contribute in this direction.

II. THE STUDY

II.1 RATIONALE AND GENERAL APPROACH

"Culture is a matrix of infinite possibilities and choices. From within the same culture matrix we can extract arguments and strategies for the degradation and ennoblement of our species, for its enslavement or liberation, for the suppression of its productive potential or its enhancement."

—Wole Soyinka, Nigerian Nobel Laureate

Traditionally, cultures -and particularly indigenous cultures- have been approached in terms of "cultural barriers" that inhibit access to health services:

"Cultural barriers present the most complicated challenge because there is little understanding of the social and cultural factors deriving from the knowledge, attitudes, and practices in health of the indigenous peoples."

(Qtd. in Cunningham 2009:173-174)

This barrier-centred approach has gone beyond indigenous populations and has tainted a great number of studies on RH and health services; while important in alerting about the gap between reproductive needs and health service provision and identifying within this framework key influential factors, today this approach has become insufficient and limitative to capture experience, generate knowledge and contribute to innovative, effective and efficient solutions.

From a more general perspective, research on sexual and reproductive health issues frequently confronts the following problems and limitations: a) academic isolation/limited accessibility; b) limited dissemination; c) type of knowledge produced (usefulness); d) ethnocentric approaches; e) gap between researchers and policy-makers (findings not translated to policy recommendations); and f) decision-making at different levels not knowledge and evidence-based.

Without abandoning a critical view and ignoring persisting and even severe RH and service provision problems in the region, this study proposes a "positive" approximation

"Whether and how the transformative potential of mere "happenings" is realized depends on how these happenings are interpreted by interested actors and on the extent to which those actors possess the material and symbolic resources necessary to grasp the political opportunities such happenings present."

(Sewell qtd. in Nathanson *et al.* n/d:390)

towards social and cultural dimensions, focusing on strengths, enabling

factors and opportunities. At the same time, it aims to capture experience, inspiring practices and evidence-based knowledge. Increasingly so, social and economic disciplines, approaches and methodologies are focusing on capitalizing strengths and identifying opportunities, as the best means for empowering people, finding efficient solutions and building sustainability.

In general terms, the study aims to reflect the following approaches:

Strategic: aims to guide decision-making processes and policy design.
Useful: practice-oriented.
Evidence-based.
Learning-oriented: focuses on what can be learned from – good and bad- past experiences to improve future practice.
Prospective: searches to identify trends and anticipate events.
Systemic: looks for relational analysis and integrated proposals.
Reflexive: “nothing is obvious, nothing is unquestionable.”
Relevant: takes into account specific contexts, as well as actual dynamics and issues.
Renovated: Provides new approaches/understandings of old/traditional topics.
From the specific to the general: looks for the underlying factors and logic of particular experience to elaborate general analysis and recommendations.

II.2. OBJECTIVES

Purpose

To qualify the design, implementation and evaluation of rights-based pertinent, effective, efficient, gender and culturally-sensitive policies and strategies to improve reproductive health of most disadvantaged and vulnerable populations in Latin America.

Main Objective

To provide key strategic knowledge -research findings, evidence-based information, context analysis, best practices and lessons learned- on social and cultural factors that influence reproductive health in Latin America.

Specific Objectives

- Provide a brief situational, quantitative and qualitative analysis for each of the five selected topics.
- Analyze sexual and reproductive attitudes and behaviours from cultural and social perspectives.
- Identify and analyze key social and cultural factors that influence reproductive health and stimulate (or inhibit) demand for SRH services.
- Gather evidence and good practices that favoured reproductive health and increased demand for sexual and reproductive health services, based on identifying and taking advantage of social and cultural “opportunities”.
- Identify lessons learned from initiatives to address reproductive health problems and access to SRH services.
- Develop key recommendations to strengthen RH interventions and increase demand for health services.

II.3. THEMATIC CHOICES

Five themes were selected for the study, in a combination of “traditional” issues and problems, with new, arising topics; issues where a lot has been produced and others with less available information and knowledge:

- ✓ **Religion, culture and reproductive health**
- ✓ **Maternal health**
- ✓ **Adolescent and youth health**
- ✓ **HIV prevention**
- ✓ **Gender-based violence**

It should be noted that all five topics are closely interrelated and some specific issues “belong” to more than one topic (e.g. adolescent pregnancy), so that thematic delimitation is oftentimes for analytical purposes.

The broad thematic and regional spectrum implies, to a certain extent that for Latin America a general, exploratory panorama has been privileged over a very in-depth analysis of fewer topics.

II.4. METHODOLOGY

The research is primarily a desktop review based on secondary sources: reports, studies, evaluations, analytical articles and others. Web search played a very important role, as well as the valuable contributions received from contacted key informants. A high proportion of documents found where in Spanish². Consequently it must be noted that when directly quoted, translations are all by the author of this paper.

The extensive bibliography shows the vast number of documents reviewed. As a matter of fact, one of the challenges of this endeavour was to manage or keep control over the enormous volume of information. This also reveals that the main issue to be targeted to promote evidence-based decisions is not the existence of information but its dissemination, availability and use.

Though focused on qualitative data and analysis, quantitative information was also compiled to provide a situational state of the art, balance and basic comparative analysis, allowing the visibility of sub-regional and/or national differences and inequalities, as well as the identification of shared patterns and common trends for the different topics addressed.

Participation in the Seminar on “Interculturality and rights’ exercise in the Andean Sub-region, with emphasis on Sexual and Reproductive Health” during November 2009 allowed knowledge of the most recent approaches and debates in relation to indigenous cultures and diversity, mainly though not exclusively in the Andean countries. It also enabled access to just published materials and contact with prominent researchers and relevant people at international level.

In 2005, a compilation and analysis of 49 research studies on sexual and reproductive health of indigenous populations of Chile, reported the predominance of quantitative over qualitative methodologies, approximately two thirds vs. one third (Pérez Moscoso 2005:56). Socio-cultural studies are less dominant and predominantly concentrated in rural areas, even in countries like Chile where the indigenous population is predominantly urban (Pérez Moscoso 2005:93). In general, research topics have not always accompanied and reflected changes in the situation and dynamics of indigenous peoples. However, trends towards an increased importance of socio-cultural research - also linked to the emergence of the indigenous populations in the region and the need to understand their realities- as well as combined qualitative-quantitative approaches, can be observed in the last years.

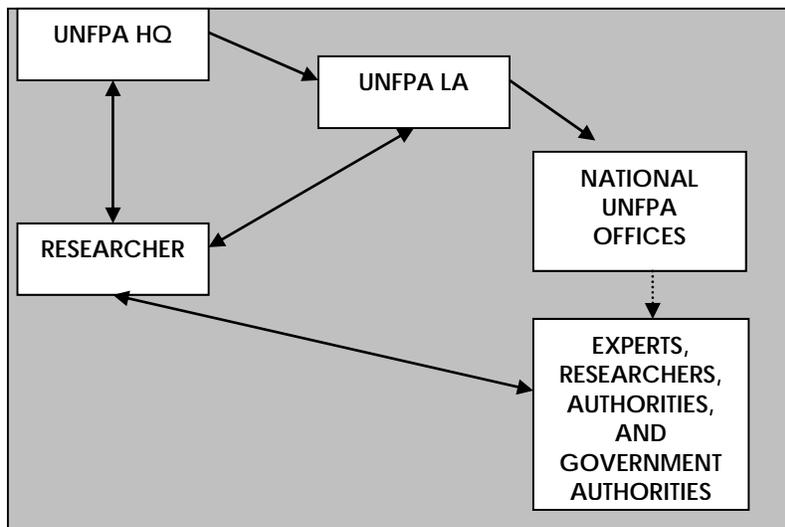
The regional UNFPA office supported the process by informing the national offices about this project and requesting their contributions. Considering that the paper is meant to nourish prevailing approaches, enhance

² Literal and not literal translations are all by the author of this paper.

performance and improve impact, this was an important step to increase potential appropriation and use of the research findings.

The positive answer and support of the Argentina, Uruguay and Colombia offices need to be highlighted. Documents were shared and key people -

researchers, consultants and national reproductive health authorities- were referred, who also gave an amazing positive response to the request for information and inputs³. Thus, the methodology could be strategically defined as “using and building networks.”



Beyond this, other key people and institutions were contacted by the researcher through interviews and informal interviews to gather information, experiences and materials.

In general, people contacted were most open and willing to share information and knowledge, and thus definitively contributed significantly to the quality of the paper and, mainly, to access to recent studies and documents (see list in attachment).

³ A special thanks to Dr. Cristina Grela, Dr. Carlos Cáceres, Carlos Güida, Dr. Silvana Weller, Dr. Enrique Ezcurra, Gerardo Fernández, Ineke Dibbits, Diana Urioste and Maria Dolores Castro for their positive response, valuable inputs and suggestions.

II.5. CONCEPTUAL CONSIDERATIONS (ISSUES, DISCUSSIONS AND CLARIFICATION OF USED TERMINOLOGY)

Culture matters

In the last decades new theories and approaches have emerged, that link development or underdevelopment and poverty reduction to the concrete and diverse experience of the involved

“The various parts of the country have different perspectives on homosexuality, which reflect diverse levels of exposure to global cultures as well as the experience of indigenous cultures with varying degrees of integration with Spanish culture.”

(Cáceres, Cueto and Palomino n/d:153)

population. As Bant points out, one of the main contributions of such theories is a “differentiated approach” that “emphasizes the impact of age, ethnicity, social class and gender conditions on the experience of poverty, social and cultural changes, health, environmental crisis, marginality, participation and personal development”⁴ (n/d:3). Additionally, globalization, migration, information and communication technologies, among other key dynamics have added complexity to the regional and national diversity, cultural constructions and permanent changes.

“Cultures are the context in which all development work takes place and where all international human rights agreements are implemented.”

(UNFPA 2008b:10)

Globally, the extensive bibliography produces mainly in the last 15 years reflects the increased concern and interest on the relation between culture and development; it includes different definitions, approaches and pays particular

attention to good practices and lessons learned in concrete experiences.

For UNFPA and according to the *State of the World Population 2008*, culture is made up essentially of inherited patterns of meaning that allow common understandings and influence how people live their daily lives (UNFPA 2008a:12) .

⁴ All translations of direct quotations correspond to the author of this paper.



Other institutions, like UNDP, have also developed a definition and own approach to culture and development under the concept of “cultural freedom”: Cultural freedom aims to expand the individual options “and not to preserve values and practices as a goal”; thus, it is not “unconditionally loyal” to traditions and does not foster cultural diversity based on conservatism. Cultural freedom can even diminish cultural diversity if this results from peoples’ free choices (PNUD 2004:4).

Due to political, social and cultural changes in many countries of the region, and the emergence and progressive empowerment of historically marginalized indigenous populations, the definition of “culture” is generally biased by and limited to an ethnic meaning. But culture “is everywhere”: in every human relation and interaction; in every organization and institution made up by people; in the thoughts and words of every person.

Box 3: The Culture Lens

The Culture Lens Encourages Finding Locally Grown Solutions to Ensure Ownership and Sustainability of Development Results

The “culture lens” is a programming tool that helps policymakers and development practitioners analyze, understand and employ cultural values, assets and structures in their planning and programming processes. This allows a deeper understanding of the ICPD Programme of Action, strengthens programming effectiveness, and creates conditions for ownership and sustainability of UNFPA programmes in the areas of women’s empowerment and promotion of reproductive health and rights. The culture lens is an approach promoted by UNFPA that can advance the goals of programming effectively and efficiently, with strong community acceptance and ownership. It allows the community to determine how to go about identifying what needs to change in order to achieve the basic rights of people to a better life.



The culture lens clarifies:

- Realities and socio-cultural assets of societies in which programmes are delivered. These assets could be religious congregations or prayer groups.
- Influential local power structures and pressure groups that can be potential allies or adversaries to development programming. In fact, some powerful partnerships have been forged by groups of religious leaders.
- The internal cultural tensions and aspirations of the various subcultures. Some of these tensions are between human rights and gender vis-à-vis religious communities and religious interpretations.

These perspectives can help policymakers and development practitioners achieve the goals of development programming more effectively and efficiently, with stronger community acceptance and ownership, by:

- Developing skills for interacting with and engaging individuals, communities and interest groups living in a specific cultural context—for example, by setting up acceptable meeting times that do not collide with religious services or decency requirements.
- Using culturally acceptable and persuasive language in communication with partners and stakeholders.
- Building bridges between local cultural values and universally recognized human rights and gender equity and equality.
- Creating a favourable environment for programme ownership by engaging stakeholders in consultations, design, implementation, monitoring and evaluation of programmes, thus ensuring sustainability of these programmes.

Source: UNFPA 2008b:18)

Diversity and change within cultures

Shared meanings and common understandings neither imply cultural homogeneity nor uniqueness of thought and behavior: “People are products of their cultures, but they are also active participants in

“Such over-simplification can lead to the assumption that every member of a culture thinks the same way. This is not only a mistaken perception but ignores one of the drivers of cultural change, which is multiple expressions of internal resistance, out of which transitions emerge. The movement towards gender equality is a good example of this process at work.”

(UNFPA 2009a:1)

shaping these cultures”—that is, they are agents in and of cultures (Qtd. in UNFPA 2008b:17). Thus every individual has the implicit right to accept, reject or re-elaborate cultural contents. Cultures also change in their encounter with external circumstances:

“Cultures have never been static, constrained and homogeneous, even though this belief is still common throughout the world. Cultures do not have rigid borders. On the contrary, they are open to multiple influences, and changes are happening at an accelerated speed, with cultural information and people flowing more freely across borders than ever before.”

“The interaction between cultures is a complex process of negotiation. New ideas are confronted, contested, integrated or rejected within historical and cultural contexts.”

(Kipuri 2009:70).

Static, preservationist approaches towards cultures tend to be based on cultural and ethnic fundamentalisms (based on absolute ideas) that endanger the exercise of individual and even collective human rights. - On the other hand it is also important not to overestimate cultural change: the forces of cultural preservation are strong, changes are slow and not always sustainable.

Cultural sensitivity and “interculturality”

For UNFPA, cultural sensitivity is with human rights and gender equity one of the three principles and methodological pillars that guide its practice. Culturally sensitive approaches recognize that “different

“Appeals for cultural sensitivity and engagement are sometimes wrongly interpreted as acceptance of harmful traditional practices, or a way of making excuses for noncompliance with universal human rights. This is far from the case – such relativism provides no basis for action and produces only stalemate and frustration.”

(UNFPA 2009a:2)

social and cultural realities create both challenges and opportunities for achieving internationally agreed upon goals” (<http://www.unfpa.org/culture/overview.htm#more>).

Culturally insensitive and ethnocentric approaches have resulted in: ineffective and inefficient interventions; rights violations; gaps/disparities broadened; limited capacity development; and unsustainable processes and results.

Cultural sensitivity does not imply limitless, uncritical acceptance of cultural diversity (cultural relativism); it does imply an understanding of differences between cultures and within cultures, the possibility to capitalize cultural opportunities and to effectively promote cultural change.

“Embracing cultural realities can reveal the most effective ways to challenge harmful cultural practices and strengthen positive ones.”

Culturally sensitive approaches:

- go beyond “what” to “how” and “why” things are the way they are;
- seek the local knowledge and relationships that can provide the basis for dialogue and positive change;
- avoid generalizations and acknowledge differences in values and objectives, even within the same culture;
- encourage humility among those who work with communities; and
- ensure that deep understanding of human realities, including culture, rather than theories or assumptions, become the basis for policy.

(UNFPA 2009a:2)

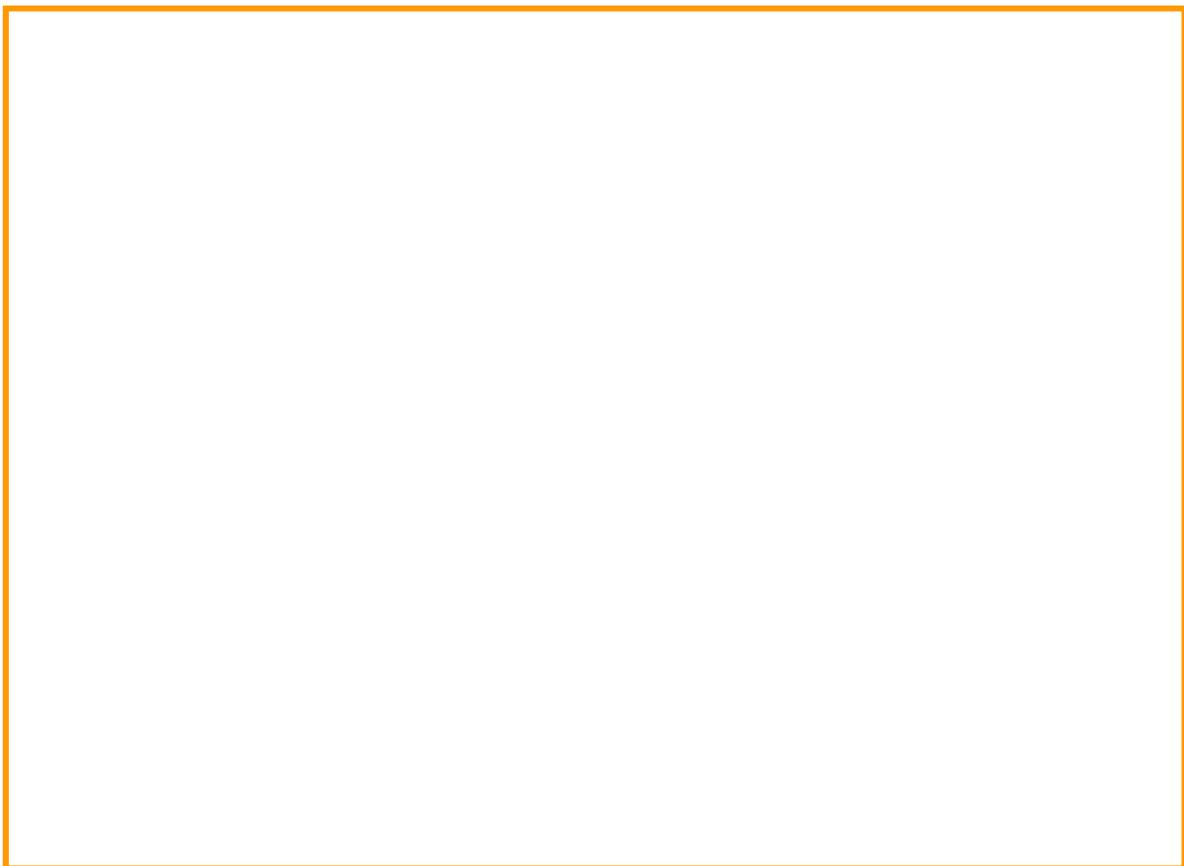
In Latin America, the irruption of indigenous peoples in different national scenarios, the recognition of their rights and participation as social, cultural and economic actors, has confronted societies and states with the need to visualize an ideal or pattern of pacific coexistence and interactions between different (and historically unequal) population groups.

Oftentimes, interculturality has been approached as a communication issue, focusing on idiomatic barriers that inhibit basic exchange. The idea is not erroneous but limited because it does not emphasize the role of power and meaning for effective intercultural communication: fundamental communication gaps are not idiomatic.

Furthermore, this challenge is based on “new” indigenous rights and demands in terms of cultural relations, aims to inhibit new cultural hegemonies and recognizes the “inevitability” of human and thus cultural interactions and influence. Within this context, the concept of “interculturality” has emerged in the region to characterize the “encounter and open, respectful, reflexive and self-critical dialogue between cultures that recognize themselves as legitimate and take the possibility of change

and learning, without this implying their loss of identity" (Salinas 2008, personal notes). So, "interculturality" goes beyond the mere multicultural coexistence to address inter-cultural relations. It also implies the self-critical capacity of cultures to recognize intrinsic power relations, exclusion and discrimination patterns within cultures. The idea of "interculturality" accepts the possibility of conflict as an opportunity for change, recreation and shared construction. Given the context, Interculturality has been mostly used in relation to ethnic diversity but the concept is applicable to all inter-cultural relations.

The idea of Interculturality is implicit in the culture-sensitive approach, especially in terms of the relation between the external agent (in this case UNFPA) and so-called "local agents of change": "Cultural sensitivity also necessitates taking into account the many other local efforts for change by organizations such as women's, youth and workers' groups and the ways they work with and reinforce" (UNPFA 2008a:4). Internal and external actors are expected to engage in dialogue, listen, share knowledge and insights, and jointly plan:



Culture, gender and human rights

For UNFPA, an effective strategy has to include gender-mainstreaming and women’s empowerment, cultural sensitivity and a human-rights’ approach. Within this framework, it proposes an integrated programming approach that recognizes the close interrelation and potential positive synergies between gender, culture and human rights:



Source: UNFPA 2010:5

This approach is based on the identification of the mutually influencing relations between these three factors, at the same that it emphasizes the need to address the particularities and specificities of each dimension:



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The integrated approach provides a “reality check” through an analysis of the human rights situation. It allows for an understanding of the specific cultural contexts and the human-rights situation beyond formal or legal frameworks, enabling also the identification and analysis of various kinds of potentially coexisting forms of subordination and exploitation (UNFPA 2010:2).

“Culturally sensitive approaches go beyond standard explanations of male behaviour to investigate the relationship among social, political and legal contexts and resulting cultural norms, and the conditions under which men and women resist them. Building on this knowledge with local initiatives enables targeted and measured development support” (UNFPA 2008a:5).

The integrated approach contributes to strengthen explicative frameworks, develop and implement effective and efficient actions and increase potential sustainability.

Intercultural Health

For the past years organizations like WHO and PAHO have acknowledged that the conventional definition of “health” linked to a notion of individual biological, physical and mental wellbeing, “is insufficient to capture the full meaning of health in societies that are diverse in their cultures, religions and forms of social organization” (Cunningham 2009:157).

Within this more general concept, and due to already mentioned contextual characteristics, main concern and attention has been paid to the Western vs. indigenous health issue, recognizing that the indigenous concept of health differs from Western health paradigms because it is integral and holistic; it “articulates physical, mental, spiritual and emotional elements, from both individual and communal points of view, and involves political, economic, social and cultural aspects” (Cunningham 2009:157).

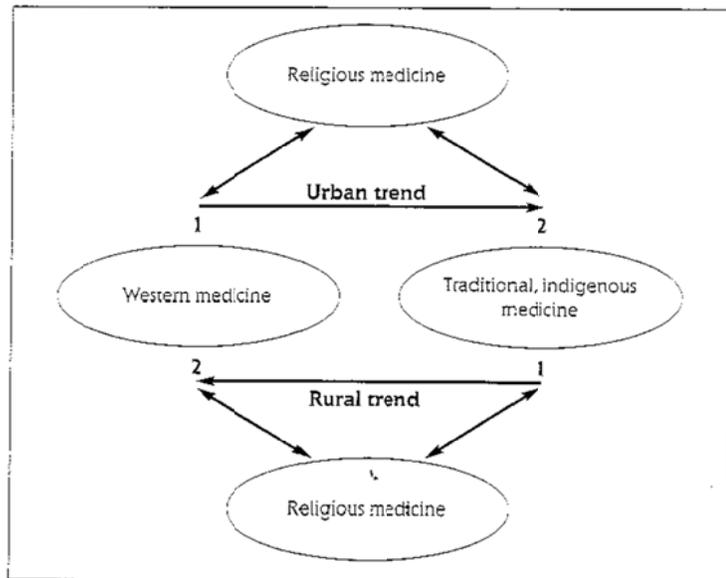
So, in apparent contradiction with the degree of development, rationality and institutionalization of biomedicine, today culture -and with it subjectivity- is reconsidered as key health factor and strategic approach. According to Comelles, “denying the ‘cultural’ – and the ‘social’- in medicine has definitively only been one form to build a specific professional culture” (2004:18).

Traditionally Western medicine has been drastically opposed to such concept and integration, but today worldwide an important trend in medicine is towards more integrated and holistic approaches that systemically address the individual and his/her environment. Although the hegemony of Western medicine is still far from being defeated, the situation today is not as polarized as usually presented, and allows for a wider range of recognized or "legitimate" options that integrate the indigenous views to address health issues.

The previous does not imply, however, that other partial approaches - like the heterosexual and biological bias in policies, programs and services- have been necessarily overcome, but it does imply that the situation is not hegemonic anymore.

It is important to emphasize that the concept of "intercultural health" has to be addressed within the framework of rights-based multicultural policies that aim to fight exclusion and discrimination. Within this framework, assumptions like the idea that indigenous women necessarily or always prefer indigenous medicine need to be questioned. In a study performed

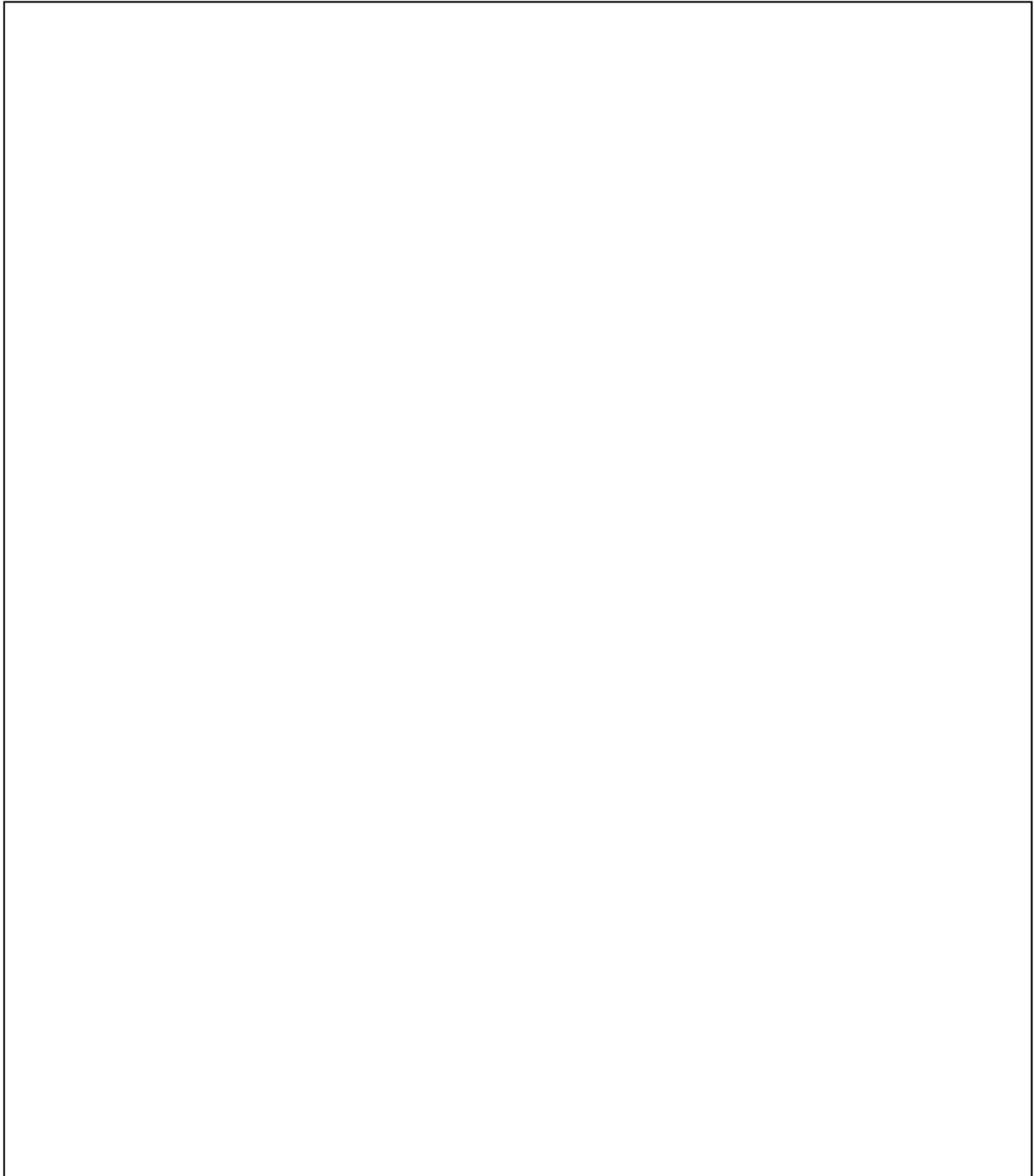
during 1998 in Bolivia, Salinas identified that "considering the existence of the various service alternatives, people decide where to go depending on the particular characteristics of their health problem. It is not an excluding system, but rather one of complementary specialisation" (Salinas 1998:339).



The basic concept is that women and men have increased options to make their choices and that their preferences can vary over time and depending on each specific situation.

However, the concept of interculturality goes beyond and is essentially based on the idea that cultural encounters can provide a unique opportunity for the advancement towards universal health based on the strengths of every culture, the compromise and synergies of diverse actors

based on shared goals and common grounds. Intercultural health recognizes the legitimacy and potential of cultural diversity to create new opportunities for the development and implementation of innovative proposals and effective and solutions to tackle key health problems.



II. 6. OVERVIEW OF THIS DOCUMENT

The document is organized in eleven chapters. Chapter I introduces the topic of the study from the perspective of building demand for RH services, information and other resources. Chapter II presents the characteristics of the study including the rationale and approach, the objectives, methodology, thematic choices, conceptual considerations and this document overview. The next chapter (III) presents a broad overview of expressions of cultures, diversity and inequality in the region, including age composition, rural and urban residence, indigenous peoples and afro-descendants. Chapter IV addresses key social and cultural dynamics that influence reproductive health in the region, focusing on opportunities and challenges that derive of globalization, localization, decentralization, and migration, educational and family changes. The next five chapters (V-IV) develop the analysis around the five selected topics, following the same structure: a brief overview of the regional situation, followed by the identification of opportunities and challenges and a section focused on capitalizing experience dedicated to promising practices, inspiring examples and lessons learned. Chapter X deals with strategic learning on how to address social and cultural factors that influence reproductive health. Finally, chapter XI presents a set of recommendations.

III. EXPRESSIONS OF DIVERSITY, INEQUALITY AND CULTURES WITHIN THE LATIN AMERICAN PEOPLES

Several documents address the issue and consequences of the lack of disaggregated data and culturally relevant indicators:

“The lack of vital statistics or breakdown by ethnic groups, gender, and age makes the generation of policies and managerial processes based on evidence more difficult, which, in turn, jeopardizes the formulation of priorities and appropriate monitoring and evaluation systems for indigenous populations.”

(PAHO, qtd. in Cunningham 2009:166)

Furthermore, many initiatives meant to tackle this issue have not been continuous, coherent and sustainable, thus inhibiting comparative analysis over time.

But despite these widely acknowledged regional limitations in the data availability, quality and comparability, some improvements have been made that allow the following panorama of diversity, inequality and cultures among Latin American peoples.

Age composition

The last decade has represented important changes in the age composition structure of the region. In 2000 the typical pyramidal structure starts to change: the proportion of people under 15 years reduces in all countries, reaching an average of 31% at regional level due to fecundity decent. Only in the least developed countries this percentage increases to 40%, while in the more developed the percentage is 27% (Huenchuan 2009:52). As an average, people older than 60 represent 8.3%, with country differences that range between a 14% and a 6.1%. The population between 15 and 59 years increased to 60% in the year 2000 (Huenchuan 53).

Rural and urban residence

Urban transition can be synthesized as follows: 80% of the population is urban; two of each three people live in cities with a population of at least 20.000 habitants and one of each three live in cities with a population over a million; rural emigration has never stopped (CEPAL/UNFPA 2010a:36).

Indigenous peoples

According to Del Popolo *et al.*, based on data from the 2000 round, “the indigenous population of Latin America stands at least 30 million, of whom no less than 12 millions (about 40%) live in urban areas. However, this regional average masks differences between countries...In half of the 10 countries studied, at least 80% of the indigenous population lives in rural areas (Costa Rica, Ecuador, Honduras, Panama and Paraguay). In Guatemala and Mexico about one in three indigenous individuals lives in urban areas, while in the remaining three countries (Bolivia, Brazil and Chile) over half of the indigenous population live in cities (particularly in Chile, where the proportion rises to 64.8%)” (2007: 15).

Considering that 671 state-recognized indigenous peoples are identified, another key issue relates to the different indigenous people in each country; for example, Brazil has over 200 indigenous peoples speaking over 180 languages; Bolivia has over 30 groups but the Quechuas and Aymaras are the great majority and account for 56% of the total population; in Chile the indigenous composition is dominated by the Mapuches that account of over 87% of the indigenous population in one country: “In summary, the areas with the largest indigenous population are determined by the presence of the largest indigenous group (Chile, Honduras and Panama); of groups belonging to the same linguistic family (Ecuador and Guatemala); of various indigenous peoples (Brazil, Costa Rica, Mexico and Paraguay); and, in the case of Bolivia, of the two largest indigenous groups living in the two main administrative divisions, with a third major area characterized by a diversity of indigenous peoples” (Del Popolo *et al.* 2007:19-20).

Migration – internal and external- and urbanization dynamics confirm that indigenous peoples “are not immune to increasing sociocultural heterogeneity, which in today’s globalized world manifests itself as hybridization, cultural diaspora and a “detritorialization” of identities” (Bastos, qtd. in Del Popolo *et al.* 2007:35).

“A World Bank study on indigenous peoples and poverty in Latin America concluded that “poverty among Latin America’s indigenous population is pervasive and severe”. This study, which documented the socioeconomic situation of around 34 million indigenous people in the region, representing 8 per cent of the region’s total population, showed that the poverty map in almost all the countries coincides with indigenous peoples’ territories. A similar study in the region by the Inter-American Development Bank observed that being poor and being indigenous were synonymous.”

Qtd. In Carino, J. (2009). “Poverty and Well-Being”. In: *State of World’s Indigenous Peoples*. New York:

Gender and age breakdowns among rural and urban indigenous populations vary considerably from country to country (Del Popolo et al. 2007:20). On the other hand, while in general the indigenous condition is associated to poverty, the basic indicators show that “the living conditions of urban indigenous populations are more favourable than those of indigenous people in rural areas. Nevertheless, ethnic inequities persist in the cities and in some cases are intensified, reflecting the discrimination and social exclusion that affect indigenous persons who live in cities” (Del Popolo et al. 2007:75).

Afro descendants

Several studies have stated the difficulties of precise data on the number of afro descendants in the region; given numbers range between 80 and 150 millions of afro descendants in Latin America and the Caribbean, this is between 15.6% and 30%. Despite the limitations in estimating the percentage, it can be affirmed that afro descendants are disperse in all counties in the region and represent important volumes in some of them, like Brazil and Cuba where the percentage is between 45% and 35%. In Colombia the percentage is 11% and in Ecuador 5%. In the rest of the countries the percentage is less than 2% (Antón *et al.* 2009:32).

IV. KEY SOCIAL AND CULTURAL DYNAMICS THAT INFLUENCE REPRODUCTIVE HEALTH IN THE REGION: A GENERAL OVERVIEW OF PRESENT CHALLENGES AND OPPORTUNITIES

"There is no question, in our view, that the global transformations of recent decades have opened up important new spaces in almost all societies and institutions ... for advocacy and activism in defense of gender equity and sexual freedom."
(Nathanson, Sember and Parker n/d:408)

This chapter presents an overview of some general social and economic dynamics that impact on reproductive health in the region, generating new opportunities and challenges that need to be considered for effective integrated solutions.

Globalization

Globalization is a quite controversial though inevitable issue that influences peoples' lives even in very distant rural communities in the region. It is linked to migration, market dynamics and the new information and communication technologies that create transnational, interregional cultural bridges.

"For indigenous peoples, globalization is a mixed blessing. It both constitutes an unprecedented opportunity for empowerment and an unprecedented threat to the autonomy of their cultures. Globalization has made it easier for indigenous peoples to organize, raise funds and network with other groups around the world. It has also made it possible to alert and mobilize the international community in times of crisis, raise awareness about human rights abuses and have greater political reach and impact than before."

(Kipuri 2009:70)

The impact of globalization

"Cultures do not have rigid borders. On the contrary, they are open to multiple influences, and changes are happening at an accelerated speed, with cultural information and people flowing more freely across borders than ever before."

The interaction between cultures is a complex process of negotiation. New ideas are confronted, contested, integrated or rejected within historical and cultural contexts. The telephone, internet and global media bring realities of life across the globe into people's living rooms, making them aware of the many products available for consumption."

Kipuri, N. (2009). "Culture". In: *State of World's Indigenous Peoples*. New York: United Nations.

According to Gianotten and the Wit (n/d), many studies (including those in the RH area) focus on the particularities of local societies and groups but do not reflect adequately the different ways that local societies and cultures are linked to the national and international contexts. "The fact that peoples in developing countries also manage global perspectives that are incorporated in their balance of priorities and possibilities" is frequently ignored. Among others, this includes access to information, new life perspectives, cultures, products, services and networking opportunities.

In relation to RH, issues linked to globalization are increasingly being considered but mostly in relation to their impact on adolescent and youth health. This generation bias is justified to a certain extent by facts like

"While stereotypical and commercially oriented, the profusion of positive LGBT characters and themes in films and TV shows is contributing to a normalization of sexual diversity, particularly among those with access to cable TV. At a more official level, new international instruments recognizing sexual rights, as well as positive legal changes in other countries, are sending a clear message to local lawmakers and judges."

(Cáceres, Cueto and Palomino n/d:163-164)

access and use of new information and communication technologies, but might be ignoring other important impacts and reproducing "age-based cultural exclusion".

In the framework of these prevailing traditional approaches towards (inevitable) cultural encounters and transformations, the debate around globalization and loss of cultural identity has unfortunately been limited to the defence of national sovereignty, conservation of the ancestral indigenous patrimony and the protection of "national culture". Issues like the local/national Southern influence on global cultures, or the reinterpretation of global cultural messages at local/global level, have received little attention.

According to the 2004 UNDP Human Development Report, multicultural policies within the context of globalization need to be based on four principles or considerations (2004:88):

- That defending traditions can inhibit human development.
- That respect for the differences and diversity is essential.
- That diversity prospers in a global and interdependent world when people have multiple and complementary identities and are part not only of a local community and a country but also of humanity as a whole.
- That to address the lack of equilibrium in the political and economic power helps to stop the hazards towards the cultures of the poorest and most defenceless communities.

In the health sector, globalization has come with a change in the global health policy actors towards more diversity and emphasis of the private sector and the establishment of global health priorities. On the other hand, "health policy-making has become increasingly fragmented and verticalized, with the increasing emphases on selected interventions, the increasing number of partnerships and especially because of the founding of new entities for various health issues." Furthermore, "an emphasis on innovations and innovative approaches encourages the use of new technologies and the building of new structures" (Ollila 2005: n/p).

Globalization has also generated new opportunities to develop innovative concepts and initiatives to advance towards universal health based on new information and communication technologies. Such is the case of so-called "telemedicine": "There is no generally accepted definition of telemedicine. The literal meaning is 'health [care] at a distance'. Thus, telemedicine may represent health care practised in real time, using a video link for example, or asynchronously, perhaps by email. The type of health care interaction is perfectly general, and may encompass diagnosis and management, education – of staff, patients and the general population – and administrative meetings" (Wootton, R. *et al.* 2009:n/p).

Despite some important remaining questions about the potential value of such developments to people in resource-constrained settings, based on already existing experiences worldwide it is increasingly considered that the use of ICT may:

- ✓ Improve access to health care, particularly in countries with major problems of inequity and broad geographical areas to be covered;
- ✓ Enhance the quality of service delivery;
- ✓ Improve the effectiveness of public health and primary care interventions; and
- ✓ Improve the global shortage of health professionals through collaboration and training.

Table 2.1 Examples of the use of ICT in health systems and services

Broad area	Examples
Access to information and knowledge	<ol style="list-style-type: none"> 1. Improved access to health information, research, literature and training materials, such as access to biomedical and social sciences research. This supports the health research enterprise and enables comprehensive, evidence-based management of acute and chronic conditions 2. Improved access to resources on prevention, awareness and education, for the general public as well as for health professionals, researchers and policy makers
Networking and collaboration	<ol style="list-style-type: none"> 1. Collaboration for the management and coordination of care across different health providers, community health services and health institutions 2. Better exchange of knowledge among policy makers, practitioners and advocacy groups 3. Rapid and coordinated response to disasters and disease events
Information for policy and action: measuring progress, tracking quality and trend analysis	<ol style="list-style-type: none"> 1. ICT for collecting, organizing and disseminating public health evidence and information for advocacy, practice and policy 2. Improved ability to describe, model, analyze and monitor trends on health status, income, employment and service coverage, and disaggregate by gender 3. Support for research on policy effectiveness
Health education and training	<ol style="list-style-type: none"> 1. Direct support to education and training for health professionals and workers, including both pre-service education and in-service training and resources 2. Improved efficiency and effectiveness of education delivery through strategic application of ICT and ICT-enabled skill development 3. Improved availability of quality educational resources through ICT 4. Outreach to special populations (girls and women) using appropriate technologies 5. Enhanced delivery of basic and in-service education
Public accountability through greater flow of information	<ol style="list-style-type: none"> 1. Greater transparency, accountability and accessibility in delivery of public services
Delivery of health services	<ol style="list-style-type: none"> 2. Improved enforcement of regulations and performance monitoring of decentralized services 1. Prevention of disease, health education and promotion, and support for diagnosis and treatment 2. Establishment of health registries and health information systems 3. Extension of care to rural and remote areas through telemedicine applications; increased access of rural health workers to specialist support and consultation

Source: Dzenowagis, J. 2009:n/p

Localization & Decentralization

It is a myth that globalization has placated all expressions and cultural differences in the building of a “unique global culture”. In many cases, the advancement of cultural globalization has coincided and coexisted dynamically with the recurrence of ethnic identity and local differences. Furthermore, cultural globalization has acquired many forms and meanings that express how local appropriations, interpretations and reinterpretations. Thus, globalization has not implied the loss of cultural identities, at the same time that the irruption of local identities has not impeded the development of transnational identities. According to Xavier Albó (2006:n/p), globalization not only allows but also increases knowledge, recognition and respect for cultural diversity beyond local and national borders. Thus, the dilemma between globalization and localization is a “false dilemma” that does not respond effectively adequately and usefully to the challenge of understanding cultural dynamics.

In the region, widespread decentralization policies derive from the recognition of local particularities and potential for good governance, effective, efficient and sustainable solutions. According to Camacho *et al.*, “...the process of implementing decentralization represents an important space so that public policies respond more to the cultural and social context. Moreover, decentralization should favor the local participation of the women. It is necessary to delve further into the mechanisms of the decentralization in health and to evaluate how this process can help to strengthen the rights of women” (2006: 362).

“Local participation optimizes the likelihood of sustainability, particularly since experience shows that in Ecuador, community-based assessments and participation shift responsibility to the communities. The community-based approach represents a practical and viable alternative to planning, implementing, and evaluating actions that respond to local needs, especially in partnership with local NGOs and universities.”

(Waters 2006: n/p)

Without neglecting potential opportunities brought by decentralization, the Decentralization Thematic Group of the World Bank, points out that “the general argument for decentralizing health care is the potential for improved service quality and coverage; yet the issues of, one, exactly how these benefits can be realized, and two, the specific impact of different health system reforms are not well understood. Since decentralization in the health sector is often politically driven, the theoretical benefits tend to get more attention than the more concrete facts of actual experiences in other countries, which is mixed. Without proper planning and acknowledgment of the lessons learned by other countries, decentralization of health care can

be disappointing at best and detrimental at worst” (<http://www.ciesin.org/decentralization/English/Issues/Health.html>). The article lists the following promises expected of decentralization and emphasizes the lack of information to address the extent to which such results have been achieved in different contexts and under distinct decentralization policies.



The Decentralization Working Group highlights three key issues to consider in relation to decentralization in the health sector (<http://www.ciesin.org/decentralization/English/Issues/Health.html>):

1. Local government's freedom to adapt to local conditions must be balanced by a common vision about the goals of the health sector and the purpose of decentralization in furthering these goals. Decentralization policy should include some coordinating mechanism.
2. Adequate financing and clear delineation of new financial flow mechanisms is essential.
3. Capacity constraints cannot be ignored in either central and decentralized management levels.

For the author of this paper, the importance of a common vision and existing information/capacities is extensive to civil society/community. Additionally, issues like local/internal power relations, exclusions and conflicts need to be taken into account. An idealized vision of community participation has oftentimes brought more problems than solutions.

Migration and urbanization

According to the report on the *State of World's Indigenous Peoples*, for the first time in human history, the majority of humanity lives in urban areas. According to Rodríguez and Busso, in Latin America the proportion of inhabitants that live in urban areas is the second highest in the world after North America, and one of every three live in city with more than a million people (Qtd. in Lora et al. 2009:92).

As the 2004 Human Development Report emphasizes, migration has increased cultural diversity within countries, and has thus posed new challenges for policy design, implementation and service provision. This includes rural-urban internal migration, that has brought the indigenous world to the cities, and also migration between countries even from different continents. In the region, migration in its different forms and expressions (rural-urban; immigration; circular migration) is certainly one of the processes that has caused major social, economic and cultural impacts.

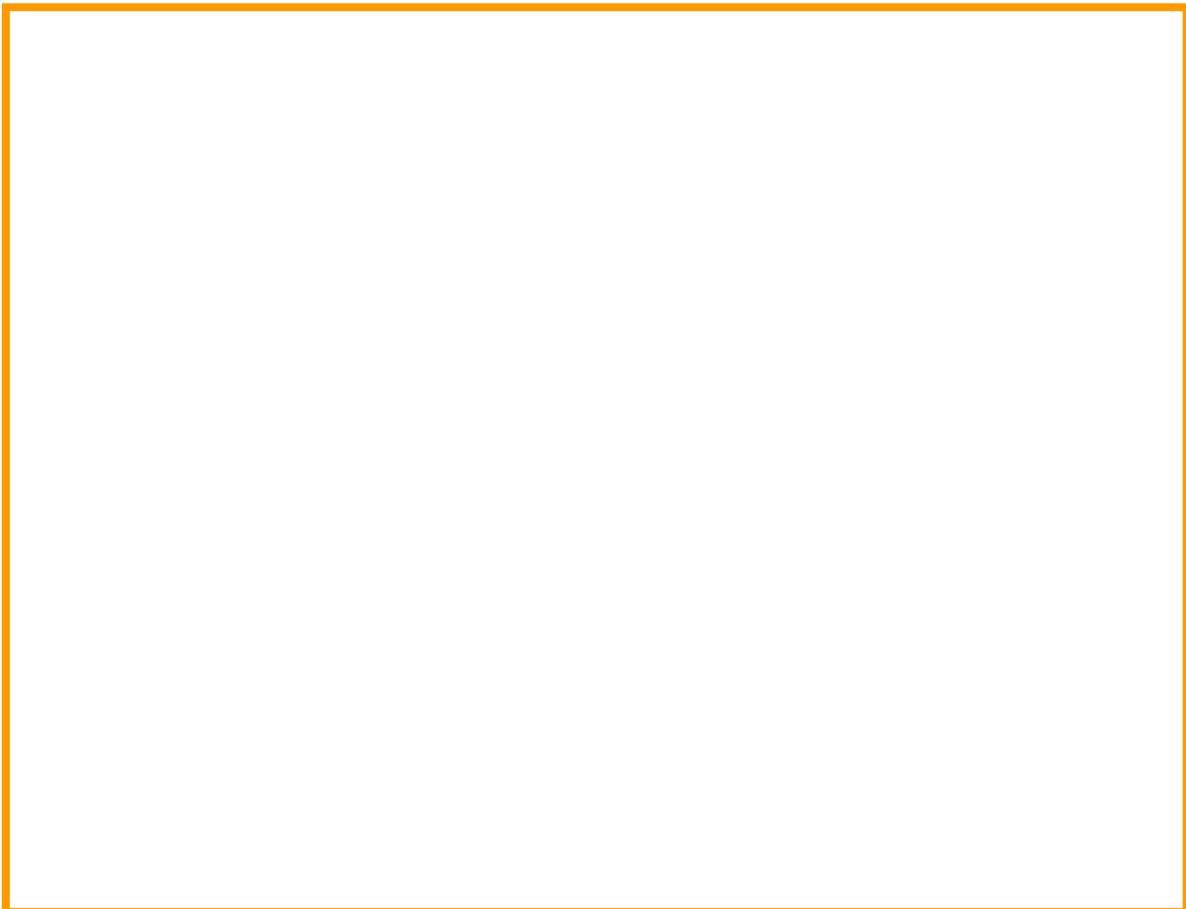
Migration has altered age and sex/gender composition in rural areas and has also modified the ethnic composition of urban centres. In general terms, historically migration in the region has had a feminine, youth and educational bias. In relation to female migrants, different studies account for motivations beyond the economic dimension, like the desire to escape from oppressive families and partners (Qtd. in Lora *et al.* 2009: 95).

In relation to indigenous populations, "although available data indicates that the majority of the world's indigenous peoples still live in rural areas, there is increasing evidence that indigenous peoples are part of a global trend towards urbanization, that this trend is irreversible and occurring in both developed and undeveloped regions". In some Latin American countries like Bolivia, Brazil and Chile, the majority of the indigenous people reside in urban areas (Trask 2009:231).

"UN-Habitat has found that indigenous peoples who move to urban areas are often disadvantaged when it comes to employment opportunities and face numerous obstacles in accessing credit to start business or income-generating activities. Indigenous migrants have frequently become the slum dwellers of the cities. As such, they are more prone to disease, more at risk of HIV/AIDS and suffer as much from hunger and malnutrition as rural indigenous people."

(Trask 2009:232).

According to Comelles, in contexts where the underlying meanings and functioning of the health systems are unquestioned and automatically accepted, "the effect of immigration has the value of calling attention about the need to co-produce and manage the cultural variables" (2004:24). Thus, "cultural diversity, associated to immigration, represents elements of reorganization of the health culture among the global population" (Comelles 2004:24). It also implies the need to go beyond binary concepts and models (e.g. indigenous-non-indigenous populations):



Although migration is usually associated to increased health risks, including violence and sexual exploitation, it is important to promote a more holistic study and balanced approach, beyond common thought and stereotypes that include the new options and opportunities that oftentimes result of migration processes, including easier access to health services. Perceptions of the different actors directly and indirectly involved in migrations processes are crucial for a better understanding of the problems, hazards and opportunities. For example, the study on sexual and reproductive health of indigenous populations of Bolivia sponsored by UNFPA and FCI Bolivia (2008) shows that migration of indigenous youths:

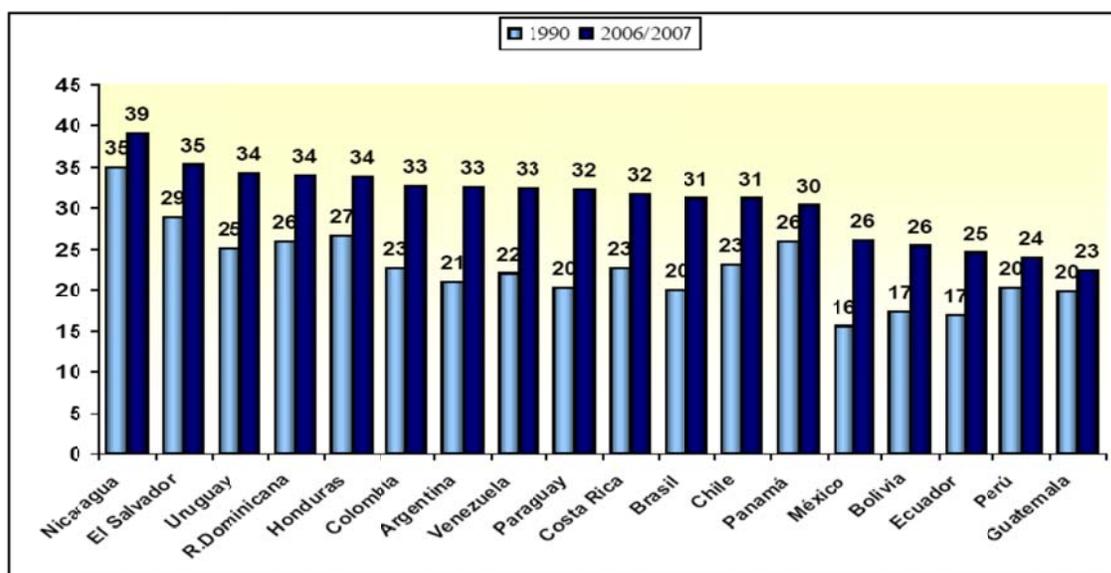
- Increased their knowledge about their body, contraceptive methods and STIs.
- Modified their ideas about age of marriage, number of children and other issues related to the exercise of sexuality.
- Changed their expectations and life project, giving more importance to education, professionalization and the economic dimension.

Gender relations and family transformations

Social, economic and cultural changes linked to globalization, migration, greater flexibility of some gender roles and an increased importance attributed to individual rights represent today a diversification of gender relations, life styles and family forms, which determine new challenges in relation to the emergence of new issues and the manifestations of “old issues” in particular new situations. Within this framework, while some patterns that differentiate indigenous, afrodescendant and white Western populations can be identified, internal diversity gains increased notoriety and becomes more and more relevant for the design of effective and efficient policies/programmes/projects and service provision.

In relation to changes and new family models, some expressions of the increased diversity and options are the single-parent families, one-person homes, factual unions, young people who don't constitute families, recomposed families, extended families, complex families beyond the biological linkage, long-distance and transnational families. Regional data for 2005 reported by ECLAC presents 20.9% of traditional nuclear families; 10.5% of monoparental nuclear families headed by women and 1.7% by men; 28.3% other nuclear families with double income; 23.7% extended and composed families; and 14.9% of unipersonal homes with no nucleus (Qtd. in Arriágada 2009:16).

Undoubtedly, migration processes have brought important modifications in the domestic and individual realm, affecting the cultural gender and intergenerational relations, while at the same time some observed changes have not necessarily meant deeper transformations in the family concept and relations. As Anderson analyzes, “family separation, economic responsibility of the migrant women with respect to their families and the country of origin and the delegation of childcare, has generated a new type of transnational family home. This family remains cohesive around the agreements established by its members but now functions without the mother being present in the daily childcare” (Qtd. in Lora *et al.* 2009:92). On the other hand, data of 18 countries for 2008 reflects an increase in female-headed urban households:



Source: ECLAC, qtd. in Arriágada 2009:16

In terms of the gender situation, the region presents some important social, economic and political changes, while gender gaps, exclusion and discrimination patterns have in essence remained untouched and inhibit a great proportion of women in the region – particularly indigenous, younger and older women- to exercise their rights. Furthermore, positive changes have demonstrated to be highly vulnerable and frequently unsustainable.

Thus, despite the fact that many social and economic changes have determined modifications in the traditional gender roles, cultural ideas that underlie the construction of female and male identities and their sexuality remain quite unchanged and play a key negative influential role in relation to reproductive health:

Femininity and Female Sexuality

“The term *Marianismo* originates from the Virgin Mary or “Maria” and portrays the ideal woman as being modest, pure, dependant, weak, acquiescent, vulnerable and abstinent until marriage, at which point the woman becomes subordinate to and obedient of her spouse¹⁷. These assigned characteristics are accompanied by a series of cultural norms and expectations. In terms of defining female sexuality, “femininity” implies that a woman must be innocent and self-sacrificing, placing the needs and desires of her male partner before her own. She is expected to remain silent and acquiescent regarding her desires and her pain.

Masculinity and Male Sexuality

Machismo, the male counterpart to *Marianismo*, applies to the typical construction of “masculinity” in the LAC region, depicting the male as the provider, independent, strong, willing to face danger, and dominant¹⁹. This social construction of masculinity defines male sexuality as heterosexual, virile and even promiscuous, knowledgeable, aggressive and in control of his environment, including the women around him.”

Quoted in *The UNGASS, Gender and Women’s Vulnerability to HIV/AIDS in Latin America and the Caribbean.*

(Pan American Health Organization, 2002:4)

While the general femininity and masculinity models have thus remained unchanged in essence, it is also important to highlight the emergence of alternative referents and a progressive diversification of understandings of what being female and male implies. Globalization certainly contributes to expand “cultural freedom” in relation to gender options. Gender power relations are thus nuanced by the agency possibilities of particular women and men who can exercise different degrees of freedom and resistance, find new meanings and provoke changes in the individual subjectivities and power representations (Nostas and Sanabria 2009:18).

Furthermore, since realities are usually not “black or white”, frequently traditional male and female patterns coexist with practices today considered modern and/or desirable. This is the case, for example, of

indigenous men in rural areas. While at the community and family level, they have very traditional ethnic patterns and gender hierarchies, this seems to change during child birth when male participation and involvement

Among others, gender identities influence of have an effect on:

- ✚ The establishment of sexual relations mediated by the notion of male supremacy and authority.
- ✚ Sex differences in the perceptions about risks of unprotected sexual practices and their consequences.
- ✚ Differentiated expectations and behaviors about sexuality of female and male adolescents that influence their attitudes towards protection.
- ✚ Sexual initiation mediated by violence that deeply impact on the total experience of sexuality.

essentially expresses companionship, solidarity and co-responsibility.

The study on adolescent pregnancy in the Andean Region by Lora, Castro and Salinas, identifies that gender identities influences the male-authority based sexual relations; the different perceptions on risk; the expectations and behaviours about sexuality among adolescents and consequent attitudes towards protection; and sexual initiation mediated by violence (2009:86).

In the last years, interest and concern related to the role, participation and involvement of men in initiatives including a gender approach has increased. Addressing masculinities undoubtedly generates new alternatives for effective changes in the relations between men and women. However, political, theoretical, methodological and operational conditions and implications need to be carefully taken into account. It is not just an issue of including men in activities designed for women. While the general, macro goal of gender equity and equal opportunities is for both the starting point, changes and processes that men and women have to undergo is complementary though not identical.

Educational gaps and achievements

In general, in the region today young people have increased access to education and higher education levels but less access to full employment. On the one hand this is related to increased and more complex levels of education demanded by the labour market, and on the other hand to a progressive reduction of stable jobs.

A report prepared in 2008 by ECLAC and the International Youths' Organization, emphasizes that secondary education is today a critical factor that determines probabilities in the labor market (Qtd. in Lora *et al.* 2009:34). Within this framework, between 1990 and 2006 the percentage of young people that finalized secondary education in the region increased from 27% to 51%. Despite this considerable improvement, additional targets need to be reached to comply with present, increasingly competitive labor market requirements.

Prevailing education challenges also refer to social disparities; while 20.4% of youngsters (20-24 years old) of the first quintile finished secondary education, a 78.6% of the fifth quintile did. Among indigenous and afrodescendant young people a 35.1% concluded, in relation to a 50.6% among the other population groups. Other percentages show 56.4% for urban youths, 46.3% among men and 51.8% among women; 31.7% among

young people with parents with incomplete education, in comparison to a 91.4% with parents with complete university education (Qtd. in Lora *et al.* 2009:31).



According to Patrinos (2006), Bolivia, Peru, Guatemala, Mexico and Ecuador, present schooling gaps in years for indigenous vs. non-indigenous population older than 15 years old range between 3.7 (Bolivia) and 2.3 (Peru) (qtd. in Champagne 2009:132). In addition, Champagne (2009:137) presents the following data, which makes more visible that with the exception of Brazil, Chile and Honduras, indigenous girls are the most excluded and marginalized.

Countries and date of census	Percentage of youth aged 15 to 19 that completed primary school						Gender ratio (per 100)	
	Indigenous			Non-Indigenous			Indigenous	Non-Indigenous
	Total	Men	Women	Total	Men	Women		
Bolivia 2001	73.7	79.5	68.4	86.4	86.6	86.3	116.2	100.3
Brazil 2000	63.7	63.0	64.4	78.6	74.6	82.9	97.8	89.9
Chile 2002	93.3	92.5	94.0	95.5	95.1	96.1	98.4	99.0
Costa Rica 2000	55.7	56.1	55.2	86.3	84.5	88.0	101.6	96.1
Ecuador 2001	70.2	74.1	66.7	74.2	72.3	76.2	111.1	94.8
Guatemala 2002	36.3	42.9	30.0	68.7	64.6	72.7	142.9	88.9
Honduras 2001	45.1	42.3	47.6	81.6	77.4	85.6	89.8	90.5
México 2000	68.7	72.4	65.0	90.0	89.7	90.2	111.3	99.4
Panamá 2000	55.8	61.2	50.2	93.3	92.0	94.7	121.8	97.1
Paraguay 2002	21.4	25.5	16.8	82.8	82.0	83.7	151.9	97.9

Source: ECLAC/CEPAL (2006), 61.

Mother-tongue teaching starts with the first grade and continues throughout primary education, while Spanish is introduced gradually. The key strategies of the project were linguistic standardization to develop written forms of the indigenous languages involved, training of national human resources for the administration of the programs in the framework of the project, participation of parents, and coordination of efforts among the State, NGOs, and indigenous organizations. The latter remained actively involved throughout all stages of the project, from planning to evaluation.

The outcomes of the project included higher performance in reading and writing in the early years, better academic averages overall, greater self-esteem, better performance on the part of girls, and less disciplinary action in schools. The number of schools involved in the project increased because of demand from parents and communities.

Sources: UNICEF (2003) and d'Emilio (2001).

Increasingly, national and local authorities are recognizing the importance of involving indigenous people in the design and implementation of education policies and curricula. Within this framework, one initiative that Champagne highlights (2009:145) is the Bilingual Education in Bolivia. Although some other analyses have been critical, particularly with respect to the limited implementation of the "intercultural" component, doubtless Bolivia has been a pioneer country in addressing indigenous identity and rights in education.

So, despite all limitations and prevailing challenges, "formal education has made it possible for some indigenous leaders and civil society organizations representing indigenous peoples to gain access to the state. Formal education has also helped to improve the status of indigenous women, enabling them to become more active participants in decision making that affects their lives" (Champagne 2009:141).

V. CULTURE, RELIGION AND REPRODUCTIVE HEALTH

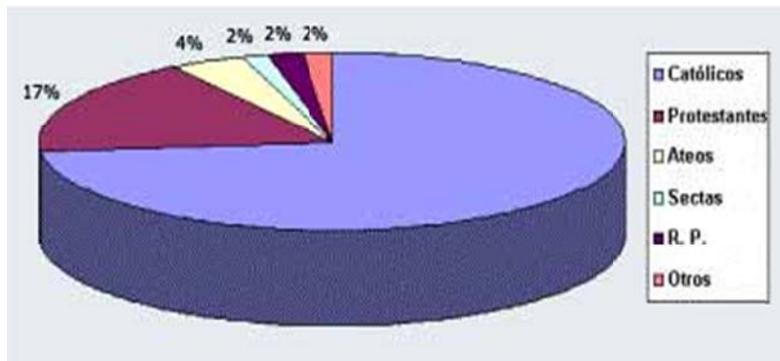
V.1. BRIEF OVERVIEW OF THE REGIONAL SITUATION

Cultural diversity in the region certainly finds one of its main expressions in religion: "Religion is central to many people's lives and an important dimension of culture which influences the most intimate decisions and actions" (UNFPA 2008a:4). Consequently, "faith as part of culture is an important determinant of value systems, at both the individual and community levels" (UNFPA 2008b:10). Consequently, "FBOs, religious



leaders and religious institutions, as the gatekeepers and interpreters of religious text and thus impacting culture, are important partners in the process of development, particularly when it comes to influencing behaviour, attitudes and perceptions" (UNFPA 2008b:10).

The vast majority of Latin Americans are Christians, mostly Roman Catholics, although membership in Protestant denominations is increasing particularly some countries like Brazil, Chile, Guatemala, and Puerto Rico (http://en.wikipedia.org/wiki/Religion_in_Latin_America). Although Catholic religion represents the main creed – over 70% of the people in the region consider themselves Catholic- and is in many countries even official state religion, other non-Catholic religions including traditional, indigenous and afro-descendant faiths also have an important representation.



Source: www.protestantedigital.com

Indigenous creeds and rituals are still practiced in countries with large percentages of Amerindians, such as Bolivia, Guatemala, Mexico, and Peru. Various Afro-Latin American traditions such as Santería, Candomblé, Umbanda, Macumba, and tribal-voodoo religions are also practiced, mainly in Cuba, Brazil, and Haiti (http://en.wikipedia.org/wiki/Religion_in_Latin_America).

However, the religious panorama in the region is far more complex and less “pure” due to the religious syncretism or fusion of different systems of belief resulted from a long history of multicultural coexistence and interactions. Thus Catholic manifestations are pervaded by indigenous and afro-descendant influences, generating hybrid versions that combine heterogeneity and even overcome apparent contradictions.

On the other hand, Latin American history has also resulted in a kind of “religious mobility” or dual religiosity, meaning that Catholic practitioners don’t necessarily see a problem in also participating in indigenous or afro-descendant religious rituals and vice-versa. Furthermore, the region has not followed the expected secularization process; as Vaggione highlights, “the global spread of feminist and pro-gay/lesbian identities has not been accompanied, at least in Latin America, by a decline in religious beliefs. On the contrary, religion remains a crucial identity dimension, one that coexists with homodesire and the rights to one’s own body in more sophisticated and creative ways than the secular/religious antagonism can capture” (2002:4-5). Religious identity is thus complex, multidimensional, dynamic, and transcends formal analysis and data.

Undoubtedly, “religion is an important part of culture and vice versa, and harmful cultural practices rooted or assumed to be rooted in religious values and/or interpretations may be some of the most difficult to change” (UNPFA 2008a:17). In the region, global religious, political, ethnic and cultural fundamentalisms merge with local fundamentalisms and create adverse contexts for SRH.

However, addressing the relation between culture and religion for the benefit of SRH also requires a shift in approach, from a static, homogenous negative perception with emphasis on obstacles and bottlenecks, to a more dynamic, strategic and context-specific approximation that fosters the identification of opportunities that can be used to develop alliances, complementarities and synergies with religious actors and faith-based organizations. Several experiences acknowledge that such strategic and attitudinal change can bring positive results.

V.2. SOCIAL AND CULTURAL FACTORS: OPPORTUNITIES AND CHALLENGES FOR ADDRESSING RELIGION

"Issues of sexuality and sexual and reproductive health and rights in predominantly Catholic Latin America are inevitably seen as sensitive, in spite of the relatively liberal stands adopted by the region's governments in recent global forums."
(Chavkin and Chesler, qtd. in Castro *et al.* n/d:127)

Diversity within religion

Religions, religious institutions and organizations are not homogenous bodies; diversity exists within religious currents implying even radical differences; for example in Catholicism the conservationist Opus Dei is the opposed pole of the Liberation Theology.

"Opus Dei, formally known as **The Prelature of the Holy Cross and Opus Dei**, is an organization of the Catholic Church that teaches that everyone is called to holiness and that ordinary life is a path to sanctity. The majority of its membership are lay people, with secular priests under the governance of a prelate (bishop) appointed by the pope. Opus Dei is Latin for "Work of God", hence the organization is often referred to by members and supporters as "the Work"."

"Opus Dei has been described as the most controversial force within the Catholic Church...Controversies about Opus Dei have centered around criticisms of its alleged secretiveness, its recruiting methods, the alleged strict rules governing members, the practice by celibate members of mortification of the flesh, its alleged elitism and misogyny, the alleged right-leaning politics of most of its members, and the alleged participation by some in authoritarian or extreme right-wing governments, especially the Francoist Government of Spain until 1978. Within the Catholic Church, Opus Dei is also criticized for allegedly seeking independence and more influence."

(http://en.wikipedia.org/wiki/Opus_Dei)

"Liberation theology is a movement in Christian theology which interprets the teachings of Jesus Christ in terms of a liberation from unjust economic, political, or social conditions. It has been described by proponents as "an interpretation of Christian faith through the poor's suffering, their struggle and hope, and a critique of society and the Catholic faith and Christianity through the eyes of the poor", and by detractors as Christianity influenced by Marxism and Communism.

Although liberation theology has grown into an international and inter-denominational movement, it began as a movement within the Roman Catholic church in Latin America in the 1950s - 1960s. Liberation theology arose principally as a moral reaction to the poverty caused by social injustice in that region."

"The influence of liberation theology diminished after proponents using Marxist concepts were admonished by the Vatican's Congregation for the Doctrine of the Faith (CDF) in 1984 and 1986. The Vatican criticized certain strains of Liberation Theology for focusing on institutional dimensions of sin to the exclusion of the individual; and for allegedly misidentifying the church hierarchy as members of the privileged class."

http://en.wikipedia.org/wiki/Liberation_theology

UNFPA has also elaborated a typology that shows the different categories of faith-based organizations:

Box 1. Faith-based Organizations—UNFPA Typology³

FBOs are defined as religious or faith-based groups or congregations, and officially registered non-governmental or governmental institutions that have a religious character or mandate.

Categories of Faith-based Organizations

1. Faith-based and/or faith-inspired development organizations, (e.g., Islamic Relief, Christian Aid, Catholic Relief Services, and their national, regional, and international chapters);
2. Interfaith- or multi-faith-based organizations: Organizations that come together for a common cause guided by common values derived from different religious traditions, and provide services that are beyond the scope of a single congregation;
3. Local congregations: People who worship together and reach out socially (e.g., organizing food pantries, clothing donations, in-home visits and assistance to the elderly);
4. Ministries of religious affairs (particularly, but not only, in countries where non-governmental organizations may, for whatever reason, find it difficult to register or function).

Source: UNFPA 2008b:14.

Acknowledging religious diversity invites for more specific, context-related analysis of religious actors for each particular case.

The role and potential of FBOs in providing reproductive health services

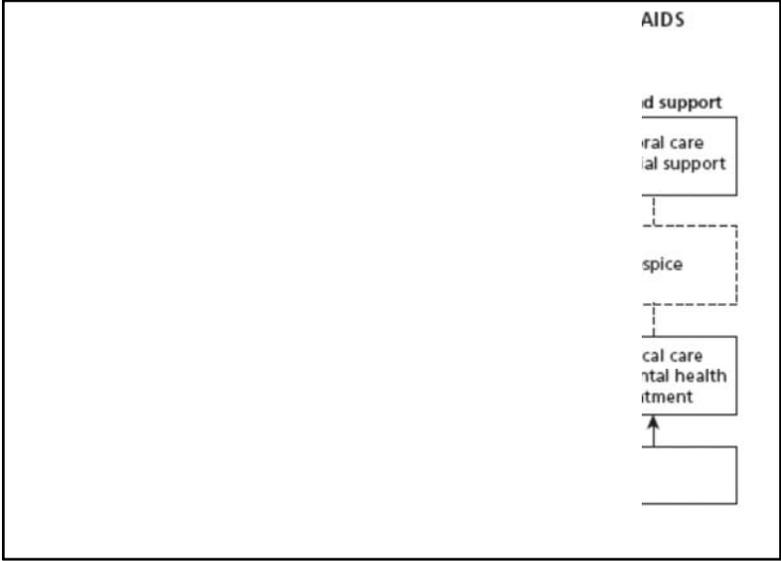
UNFPA recognizes that “at a time when basic needs are becoming increasingly harder to provide for more than half of the world’s population, we can no longer avoid acknowledging these parallel faith-based actions and development interventions that reach so many and provide so much. These are critical pools of outreach and service delivery” (UNPFA 2008a:76). In many countries in the region religious organizations (mainly of the Catholic Church) play a key role in the provision of health and social services, mainly in remote rural areas unreached by state providers.

For example, a study in Belize, Guatemala and Honduras on the *Role of Faith-Based Organizations in*



Source: UNFPA 2008b:15

HIV Prevention and Care in Central America shows for that FBOs were “already engaging in some activities related to HIV prevention and testing, care and support services, and stigma reduction and advocacy” (Pitkin Derose *et al.* 2010:xii).



Broad reach and influence are considered the main advantages and potential for FBOs key role in health service provision, while several challenges are also identified (Pitkin Derose *et al.* 2010:57).

Challenges to FBO Involvement in HIV/AIDS, as Reported by Health and FBO Leaders		
Reported Challenges to FBO Involvement	Health	FBO
FBO attitudes and beliefs		
See HIV as divine punishment	✓	✓
Encourage PLWH to stop meds and to rely on prayer	✓	✓
Have difficulty discussing sex and HIV (stigma)	✓	✓
Condemn MSM, sex workers	✓	
Prohibit condom use or say not effective	✓	
FBO organizational barriers		
No formal structure/divided/not well organized	✓	✓
Not enough pastors trained in HIV		✓
Resources		
Many churches are small and/or lack resources		✓
Lack of health care in rural areas		✓
Lack of funding for abstinence/be faithful strategies		✓
Lack of evidence regarding FBO impact		
No follow-up after trainings of FBO leaders	✓	
Abstinence/be faithful strategies not effective	✓	
No valuation/assessment of FBO efforts	✓	
NOTE: Leaders were classified by their affiliated organization type (health/secular versus FBO), regardless of other affiliations they may have had.		

As an overall conclusion, “the findings of this study suggest that leaders in the public health sector might find it worthwhile to think creatively about ways to make effective use of the strengths and capabilities of FBOs in addressing some of the critical needs posed by the HIV epidemic. Donor organizations can also play a critical role in fostering collaboration between FBOs and public agencies by providing the funds to evaluate and sustain such partnerships” (Pitkin Derosé et al. 2010:xvi). Within this framework, a focus on collaboration and complementarities is suggested as an essential approach to increase the potential roles and results, suggesting a series of activities FBOs can implement in relation with the health care system:

- *Complement* the activities of others by addressing gaps outside the scope of others' missions or that others are unable to complete, e.g., by establishing housing projects for PLWH and hospices and facilitating income-generating activities in which PLWH could engage once their health has been stabilized by ARV.
 - *Reinforce* the activities undertaken by others, e.g., by reinforcing prevention messages, counseling congregations on safe sex practices, and encouraging people to get tested.
 - *Facilitate* the activities of other organizations, e.g., by offering opportunities for health leaders to promote the use of condoms in conjunction with other activities that FBOs are directly responsible for organizing.
 - *Support* the activities undertaken by others, e.g., by recognizing the efforts of others and encouraging people to support other organizations' programs.
- (Pitkin Derose et al. 2010:xvi)

Gender, sexuality and religion

As Caballero and Suazo emphasize, "Catholic religion molds many aspects in people's lives, as an important factor of mentality construction or thinking in relation to happenings that arise in the world and life of men and women.... where

results of human actions are a result of divine power and not of social relations" (Qtd. in UNFPA 2004:35). Within this framework, Cáceres *et al.* present a very critical position

"The Church stated that sex should be confined to marriage and only for the purposes of extending the family. It is also interesting to note that the Peruvian Episcopal Commission alludes to freedom of choice: 'The Catholic Church considers morally unacceptable...family planning services that do not respect the freedom of married couples, or the dignity and human rights of participants'. However, its conception of human rights regards the couple as a legally recognized unit with specific rights and it does not recognize the power relations that exist within couples; thus, the Church defends matrimony as indissoluble."

(Cáceres, Cueto and Palomino n/d:143).

from a gender perspective in relation to the influential role the Church has played over the last 30 years in SRH policy-making: "Even before the surge of a feminist discourse on these issues the Church hierarchy and conservative Catholic leaders sought to stir up fears that modern contraception would encourage sexual promiscuity and destroy family values. Throughout the years this position has not changed; in fact this conservative stance remains alive and active in current policy debates" (Cáceres, Cueto and Palomino n/d:135). Consequently, "policies on women's bodies, sexuality, and reproductive capacities have corresponded more to the interests of the state and other powerful entities,

such as the Catholic Church and conservative groups, than to the needs and rights of women" (Cáceres, Cueto and Palomino n/d:133).

However, while this religious conservative position towards women's, sexual and reproductive rights certainly represents the religious mainstreaming, it is also important to recognize that "the existence, at the level of civil society, of religious organizations aiming to confront and change patriarchy and heteronormativity in religious official doctrines is not a new phenomenon.... Specifically within the Catholic Church there are several pro-change groups -such as Dignity, Women's Ordination Conference, Association for the Rights of Catholics within the Church, Catholics Speak out, and Catholics for a Free Choice - aiming to redefine some aspects of the catholic doctrine while affirming their identification as Catholics" (Vaggione 2002:11). Thus, "CFFC provides public narratives where a catholic identity appears integrated with certain feminist standpoints such as abortion, reproductive rights and desire. CFFC retains the core identity of the Catholic Doctrine, though reinscribed with a different understanding of gender and sexuality, basing their integrative position on counter-doctrinal theologian interpretation" (Vaggione 2002:12).

Religion and RH risks

The religious ideal of womanhood intrinsically linked to motherhood, and the restricted vision of sexuality in terms of reproduction, can paradoxically increase the exposure of women -and particularly young women- to unwanted pregnancies and to the risk of STIs and HIV/AIDS. Religious ideals and prohibitions most frequently don't inhibit sexual interactions among adolescents but create "moral barriers" that limit the individuals' capacities to decide, negotiate and protect themselves. For example, "The Surgeons General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior" (United States of America, July 2001), reports that for adolescents who are sexually active, frequency of attendance to religious services is associated with decreased use of contraceptive methods among girls (9).

Mass media, academia and religion

Religion coexists with the academia and the mass media as influential factors that interact and are reflected in the cultural constructions of gender, sexuality and health. The coexistence of such forces implies "the incorporation of new ideas distinct to these believes, so generating diverse forms of thoughts and different communities of belonging and identification" (UNFPA 2004:35). Generally though not always, the mass

media and academia are more influential among youth, more educated and urban populations, fostering more autonomous and “modern” lines of thought. On the other hand, it is important to consider that individuals usually don’t represent a compact, coherent and homogenous line of thought. Thus, traditional and modern ideas, attitudes and practices tend to coexist in one person, which also gives room for self-reflection, learning and change.

Religion, secularization and the states

Religious conservatism is intrinsically linked to political conservatism; this “explosive” combination certainly represents great risk for SRH and rights, as can be clearly analyzed from the Peruvian quite recent experience:

“The AIDS program became a “risk reduction” activity with a low profile. In 2002, Carbone attempted to reduce public trust in condoms, the key HIV prevention device. Taking advantage of recent news on the detrimental effects of the spermicidal nonoxynol-9 in condom protective effects against sexually transmitted infections, Carbone appeared in the media encouraging people to rely on abstinence and fidelity rather than on condoms for HIV/STD prevention” (Cáceres, Cueto and Palomino n/d:152).

In many Latin American countries and despite some recent changes (e.g. Ecuador and Bolivia), Constitutions still establish a special, privileged status for Catholic religion. Catholicism is in some countries considered the official state religion. Many progressive religious and non-religious groups advocate for secularization of the state as a crucial measure to ensure sexual and reproductive rights.

However, throughout Latin American history, “religion has permeated the public sphere and not necessarily in an anti-modern or anti-democratic way. In some countries, such as Brazil or Chile, it has been an important counter-authoritarian force in the transition to democracy articulating a voice and a social space against human right violations” (Vaggione 2002:5). Thus “paradoxically the ‘same’ Church that incarnates a fundamentalist position toward gender and sexuality is also the one that publicly intervenes favoring democracy, denouncing class exclusions or articulating public dialogue”. Consequently, “the public interventions of the Catholic Church cannot be fully captured by the progressive/conservative or democratic/anti-democratic dichotomies” (Vaggione 2002:5).

On the other hand, secularism and religiosity coexist in the everyday decisions individuals take to respond to their particular situations and possibilities regarding sexual and reproductive health:

“Opposition from the Church is considered normal and not taken into account for personal decisions. This view extends to contraception in general, including sterilization; as long as people receive adequate information and are allowed to choose, they value the existence of contraceptive methods and will use them regardless of religious criticisms”.

(Cáceres, Cueto and Palomino n/d: 164)

The other side of the coin refers to advancements in the legal, formal domain that are not really appropriated or owned and exercised by the population: “the gap between legal rights and popular endorsement of those rights, identified earlier with respect to abortion, exists throughout” (Nathanson, Sember and Parker n/d:402).

Taking into consideration these complex and ambiguous realities and the endurance of religion as a key dimension of identity beyond normative changes, some analysts suggest “counter- intuitively” that “it is not by privatizing religion that its patriarchal and homophobic components can be reduced but by fully including it in public debates” (Vaggione 2002:3).

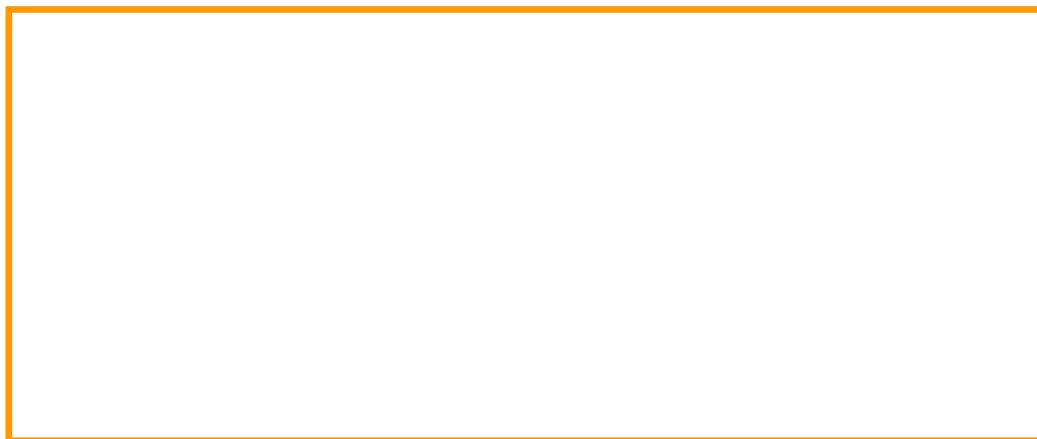
V.3. CAPITALIZING EXPERIENCE: PROMISING PRACTICES, LESSONS LEARNED AND INSPIRING EXAMPLES⁵

✓ Context specific mapping and research on religious actors

“Faith-based organizations (FBOs) have historically played an important role in delivering health and social services in developing countries; however, little research has been done on their role in HIV prevention and care, particularly in Latin America. The HIV Outreach in Latin America (HOLA) project aimed to address this gap by conducting an exploratory, qualitative study of FBO involvement in HIV/AIDS in three Central American countries hard hit by the HIV/AIDS epidemic: Belize, Guatemala, and Honduras” (Pitkin Derosé et al. 2010:n/p).

⁵ “There is as yet no agreement on assessment criteria of ‘good practices’. Whether a practice is ‘good’, ‘promising’ or ‘effective’ depends both on the standards that are used in evaluation and on the local context” (United Nations Secretary-General 2006:81)

Based on that experience a set of key questions are proposed to map the presence and study the role, facilitators and barriers of FBOs and their potential contribution to RH in each particular regional, national and/or sub-national context.



Source : Pitkin Derose et al. 2010:74-75

✓ **Finding common ground and goals**

From Colombia: Human Rights, including Reproductive Rights

In Colombia, a predominantly Catholic country ridden by conflict, UNFPA and the Catholic Church found common ground and goals. Shared principles on human rights and the conviction that there is an urgent need to create peace was the basis for this partnership.

UNFPA and the Church developed an awareness of individual rights by initializing talks of reproductive rights. One of the benefits of the collaboration was the opportunity to engage armed groups, who were less threatened by talk of reproductive rights than of human rights. Thus, armed groups willingly participated in reproductive health workshops, which then became opportunities to discuss human rights. The entry point was reproductive health, which led to a discussion on respect for life and for the dignity and freedom of people.

Different experiences have demonstrated that it is possible to find common ground and set shared goals between sexual and reproductive health and rights organizations and FBOs. Traditionally the starting point to approach religious organizations has emphasized on differences, discrepancies and even antagonistic views. Frequently such perceptions have been based on general homogenous knowledge and not on contextual evidence. The challenge now is to shift to an open minded and strategic identification of a human rights' based vision that privileges health and wellbeing of women and men and builds complementarities on each organizations' comparative advantages.

Source: UNFPA 2008b:15

Base on this approach “communities can be encouraged to incorporate universally recognized rights into their own realities through an exploration of how human rights and gender issues contribute to the well-being of men, women, young people and families. (See the example of Honduras and Costa Rica on page 72.) (UNFPA 2008b:10).

✓ **Building partnerships**

Building partnerships implies art and power, particularly when the starting point is diversity and complementarity and not homogeneity. Within this framework, “effective negotiation requires an understanding of the interests of diverse stakeholders—from political leaders to FBOs, cultural leaders and the private sector. Instances of successful partnership demonstrate that the interests of these stakeholders can be

Honduras

- Based on the previous efforts of the Ministry of Health, UNFPA created the Inter-ecclesiastical Committee on HIV and AIDS Prevention. This committee co-coordinates with the Ministry of Health and allows for the Ministry’s direct partnership with representatives of the Catholic, Evangelical, Episcopal and Adventist Churches, as well as the Theological Community of Honduras, an ecumenical academic institution. UNFPA distributes a grant to each FBO partner for HIV-prevention activities such as educational seminars and youth peer educational workshops.

just as critical as political and economic concerns, and once these are clearly understood, the necessary common ground is established, with a clear respect for each other’s particular space when and where necessary” (UNFPA 2008B:10). Source: UNFPA 2008b:72

✓ **Sensitizing and influencing actors**

Actors are not fixed and unchangeable; the different positions and agendas can always be influenced and modified. It is like culture; actors are historical and contextual, and respond to external and internal influential factors. Within this framework, partnerships create a favorable environment for exchange, dialogue, analysis, reflection and sensitization. Based on common grounds, mutual respect and confidence, partnerships also represent an opportunity for developing or strengthening capacities and evidence that contribute to sensitization and awareness, as has been demonstrated in the Colombian and Guatemalan experience:

GUATEMALA:

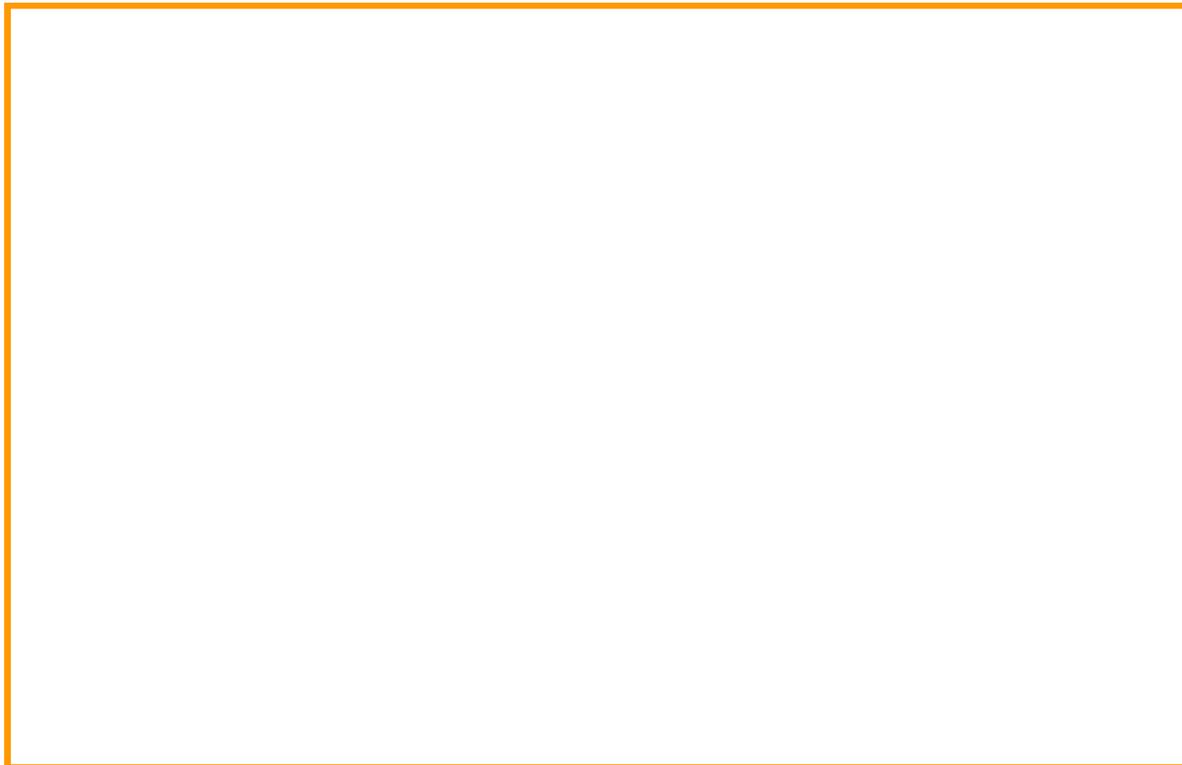
- UNFPA engaged the Episcopal Conference and the Catholic and Evangelical Churches, as well as the private business sector and the Coordinating Committee of Agricultural, Commercial, Industrial and Financial Associations. The partnerships centred around the issues of reproductive health, maternal and infant mortality, and population and demographics. Activities focused on mobilization of religious leaders through knowledge sharing, as well as capacity-building and trainings designed for advocacy, skills and resource mobilization.

Source: UNFPA 2008b:71

COLOMBIA:

- UNFPA has provided the Catholic Church with the technical knowledge and the necessary resources to create awareness about problems related to sexual and reproductive health in order to carry out effective activities that meet the needs of its parishioners. The partnership between UNFPA and the local Catholic Church has been enabled through finding common ground and goals, such as striving for a respect for life, for the dignity and freedom of people, and for the education of the young in the practice of safe and responsible sexuality.

Source: UNFPA 2008b:69



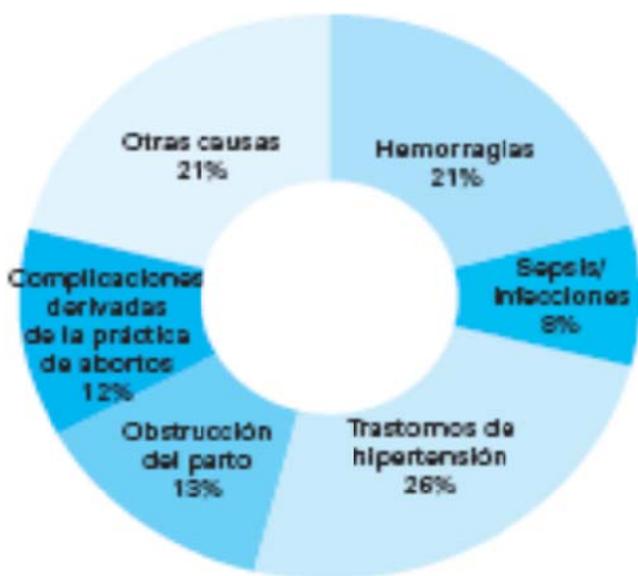
VI. MATERNAL HEALTH⁶

VI.1. BRIEF OVERVIEW OF THE REGIONAL SITUATION

Although maternal health has many facades and dimensions, the magnitude of the maternal mortality problem in many countries of the region has set the issue of reducing maternal health as a priority. According to information co-produced and published by WHO, UNFPA, UNICEF and the WB, during the year 2005 a total of 150,000 maternal deaths occurred in the Latin American and Caribbean region, accounting for 3% of the total maternal deaths worldwide. Following the global trend (with the exception of Sub Saharan Africa), the maternal mortality rate decreased in the region from 180 to 130 women for every 100,000 born alive in the period between 1990 and 2005 (qtd. in UNICEF 2008:6).

Most deaths have to do with obstetric complications and happen during the third pregnancy trimester and the first week after childbirth, with the exception of deaths that result from abortions (qtd. in UNICEF 2008:9). According to the same UNICEF report on maternal and neonatal health, main direct causes of maternal mortality in the region are haemorrhages,

problems related to hypertension and delivery obstruction (17). Other health factors like anaemia have an indirect influence.



América Latina y el Caribe

Approximately 4 million unsecure abortions take place in Latin America and the Caribbean every year. Around 33 abortions occur for every 1000 pregnant women between 15 and 44 years old, the highest rate of all regions. Induced abortions account for around 15% of maternal deaths,

⁶ Adolescent pregnancy and motherhood is addressed in the next chapter.

making this region the one with the most maternal deaths attributed to abortion (Espinoza, qtd. In Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna 2010:14). While the percentage of women with unsatisfied contraceptive needs descended from 12.5% to 10.5% in the 1995-2005 decade, this still remains an important regional challenge, particularly considering that adolescents are among the age groups with highest unsatisfied needs (CEPAL/UNFPA 2010B:10-11).

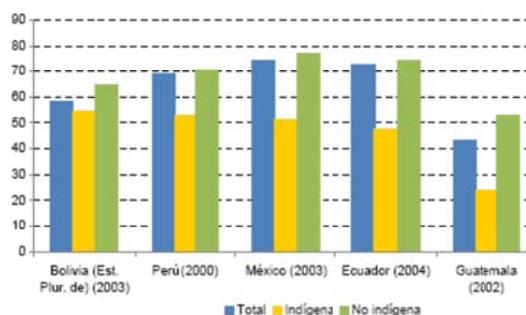
Beyond the general trend and average data, the joint report (WHO, UNICEF, UNDP and the World Bank) highlights extreme disparities between countries in the region, with Chile, Barbados and the Bahamas presenting some of the lowest mortality rates among the developing countries (16), and Haiti with 670 deaths for every 100,000 born alive. The document produced by Women Deliver on the achievement of MDG 5, also makes visible regional heterogeneity regarding maternal mortality:

País	Mortalidad Materna (por cada 100,000 nacidos vivos)	Mortalidad Infantil (por cada 1,000 nacidos vivos)
Haití	670	430
Bolivia	290	1.010
Honduras	280	1.349
Perú	240	2.663
Nicaragua	170	870
República Dominicana	150	3.320
Colombia	130	3.281
Brasil	110	4.604
Argentina	77	4.569
México	60	7.889

Source: Women Deliver n/d: n/p)

In addition to direct determinants of maternal deaths, key influential factors at family/community and district level are recognized, as well as more structural causes at societal level closely linked to poverty. Social exclusion and gender discrimination are not directly or exclusively linked to pregnancy and childbirth, but

AMÉRICA LATINA Y EL CARIBE (PAÍSES SELECCIONADOS): PREVALENCIA DEL USO DE ANTICONCEPTIVOS SEGÚN CONDICIÓN ÉTNICA, ALREDEDOR DE 2000
(Ordenados según brecha)



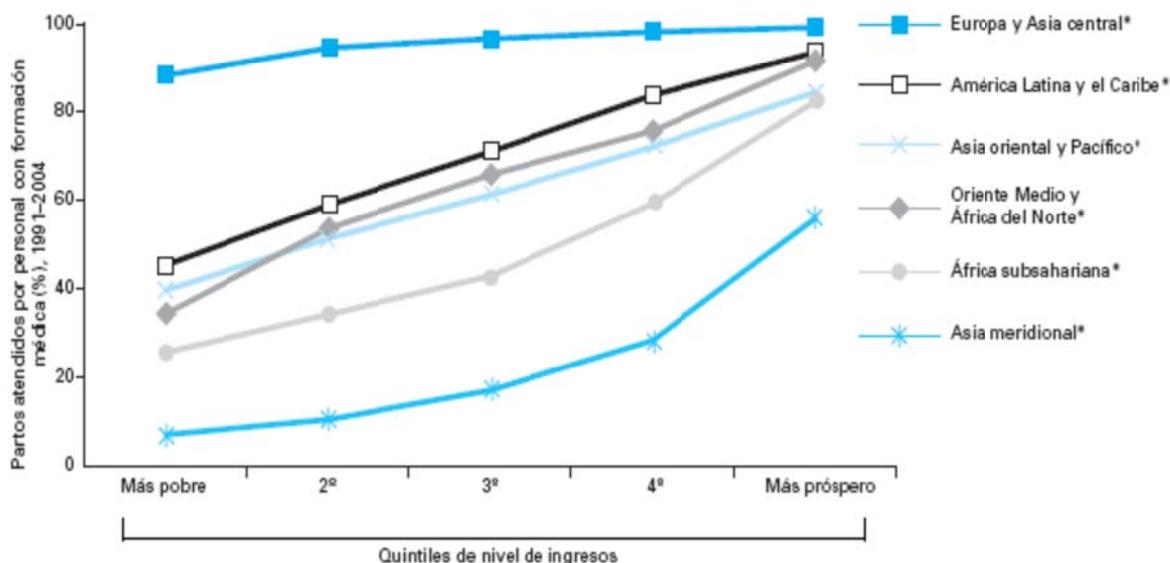
Fuente: Ana María Oyarce, Malva Pedrero y Bruno Ribotta, "Salud materno-infantil de pueblos indígenas y afrodescendientes de América Latina: una relectura desde el enfoque de derechos", Santiago, 2009, inédito.

exacerbate the direct and indirect causes of maternal deaths (UNICEF 2008:14). So, beyond inequalities between countries, several studies emphasize socioeconomic, ethnic, age, residential and geographical factors that determine the risk, vulnerability patterns and distribution of maternal deaths, accounting for even extreme disparities within countries. For example, in Guatemala, during 2002, while 47% of women living in urban areas used a modern contraceptive method, only 26% in the rural areas did (Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna 2010:14). In general, in Latin America, unsatisfied contraceptive needs in the poorest quintile double those of the most prosperous quintile (Cleland *et al.* 2006:76). Linked to the previous, notable access in inequities can be observed in the relationship between indigenous vs. non-indigenous women.

A recent document published by ECLAC and UNFPA informs that the actual global fertility rate is 2.4 children. The annual volume of childbirths reached its maximum in the 1990-1995 period, with 11 million and since then it is descending. The heterogeneity of situations between and within countries is the rule, with cases where the average is 2.1 children per woman, and others with 3.1 and a third group with 3.2 and more. Fertility has decreased in all countries and all age groups and is concentrated in the most fertile ages (20-34 years). The descent has been particularly important among women older than 35, while adolescents have increased their contribution to total fertility to 14.3% in the 2000-2005 period (2010a:32). This represents a serious problem, considering additionally that death probability is much higher in the case of girls and adolescent mothers; globally women younger than 15 have five times more probabilities of dying during delivery than those older than 20 (Qtd. in UNICEF 2008:30).

Furthermore, despite the notable increase in the percentage of women that give birth in a health centre from 73% to 86% between 1990 and 2005, the following figure shows a direct inverse relation between poverty and deliveries attended by qualified personnel (Qtd. in UNICEF 2008:38); approximately 40% for the poorest quintile and around 90% for the richest for the region:

Madres que recibieron asistencia de personal capacitado en el parto, por quintiles de ingresos y regiones



* Véase la página 108 de la sección Referencias.

Source: Gwatkin, D. R., et al., *Socio-economic differences in health, nutrition, and population within developing countries: An overview, Health, Nutrition and Population*, Banco Mundial, Washington, D.C., septiembre de 2007, págs. 123-124.

It must be noted that due to the weaknesses in service provision, institutional births do not always have a clear positive impact on the reduction of maternal deaths, as is the case in the Dominican Republic, where almost 100% of women give birth in a health centre (Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna 2010:15). This also brings additional elements to the discussions about the right and capacity of women to decide where and with whom to give birth.

So, despite increases in terms of institutional deliveries and the highest rate in antenatal care worldwide with 94% of pregnant women that visit a health centre at least once before delivery, problems related to access and quality of health services (unqualified personnel, distance, costs), linked to ethnocentric, urban male, adult and religious biases in service-provision, persist and are some of the manifestations of the complex and multidimensional causes of maternal mortality in the region and worldwide. This even implies that improvements are not always sustainable, as has been recently recognized in Bolivia after the 2008 National Health and Demography Survey.

Many studies on factors that influence access to health services in relation to maternal mortality have explicitly and implicitly reproduced such hegemonic lines of thought, for example by addressing cultural issues just in terms of barriers and "indigenous vs. Western" confrontation, and by

ignoring the role of men in relation to pregnancy and childbirth: “in general, men have a scarce presence in publications and information related to maternal and neonatal health” (UNICEF 2010:44).

VI.2. SOCIAL AND CULTURAL FACTORS: OPPORTUNITIES AND CHALLENGES FOR MATERNAL HEALTH

Fertility, motherhood and female identities: gender constructions

As Camacho *et al.* emphasized, “the development of the feminine identity centers around the ability to reproduce, and the definition of what is feminine as being for others and of a woman’s body as a body for others, has important implications for self-esteem, social value and the capacity of a woman to make decisions and act for her own benefit” (2006:359).

Not only in rural settings, traditionally womanhood is directly related to motherhood, and being mothers is perceived as the main if not unique life project and meaning for women. Particularly in rural and indigenous settings, such expectations, implicit and explicit cultural norms are linked to feminine prestige (BID 2010:28), and also impact on the partner’s male prestige. In many contexts the pressure is not only over the number but on the sex of the children; boys are socially, culturally and economically higher valued. This implies that women “must” have at least one boy. Even in urban cases this frequently implies that women are pressured to have more children until a boy is born. It must be noted, however, that cultural norms are not always or necessarily represented in negative terms; on the contrary, a large family with many children is frequently associated to plenitude, happiness, security, protection.

Nevertheless, the implicit and/or explicit pressure, aggravated by educational, economic and social disadvantages of women, limit their real alternatives to make decisions regarding their reproductive life and health; furthermore, “oftentimes it is their spouses, uncles, mothers-in-law or even neighbors and health workers that make decisions for them” (Camacho *et al.* 2006:361).

In apparent contradiction, many studies emphasize that responsibility over pregnancy (including prevention) is conceived exclusively women’s. So, responsibility is not encompassed by the recognition of women’s capacity and right to decide.

On the other hand, “a low obstetric risk perception in indigenous communities is the result of their worldview and their way of understanding

pregnancy and delivery as a natural event" (BID 2010:18). This is linked to the idea that women are "mothers by nature": "Gender discrimination is also found in the health services, strengthening the stereotype that women's role is to reproduce and provide caretaking for the entire family" (Camacho et al. 2006:360).

However, cultural changes are usually slower than social transformations. For example, in most countries, fertility reduction has a direct inverse correlation with women's increased participation in the labour market.

Fatherhood and male identities: traditional gender constructions and male involvement

As mentioned, social changes have not always implied cultural changes. Male migration, women's increased participation in the labour market and in the political arena, higher education levels for females, among several actual social and economic transformations, have rarely been accompanied by changes in the private sphere and gender power relations.

Frequently, traditional masculinity is associated to a lack of involvement in reproductive health issues, considered of women's concern and responsibility. However, the other side of the coin is male (and even community) participation and involvement linked to decision-making and control over women's bodies: "For example, decision-making related to contraceptive use, birth and obstetric emergencies, is influenced by males or other family members. This situation is reinforced at health services where the husband's authorization may be requested for an IUD insertion or tubal ligation or other types of contraception, and the woman's opinion is solicited infrequently (Camacho *et al.* 2006:360).

Today manifestations of traditional masculinities are diverse; modern and traditional, represented in the presence, absence and even omnipresence of men in processes and circumstances linked to women's reproductive health. For example, an article based on the Uruguayan case on the presence and accompanying role of fathers during delivery, mentions cultural, educational and generational differences (Güida 2007:16). On the other hand, another related document emphasizes that during delivery the accompanying father "does not have a clearly assigned role....accompanying is a concept that can be interpreted in diverse forms" (Programa Nacional Salud de la Mujer y Género 2005:19).

Salinas also highlighted some interesting findings in relation to male “omnipresence” for some rural areas in Bolivia: “An illustrative example was provided in Achacachi, where doctors from the hospital mentioned that men who migrate temporarily want to keep their wives permanently pregnant to ensure their fidelity” (Salinas 1998:322).

New masculinities

While traditional masculinities persist as a mainstreaming, it is also important to consider that new expressions of manhood are emerging in response to social and economic changes, new family configurations, as well as individual questioning of cultural mandates. Different organizations and movements in the region emphasize, within this framework, that maleness and femaleness are learned and that it is possible to change gender roles and identities. Changes promoted are mainly related to the private realm, domestic roles and family relations that impact, however, the public performance, opportunities and decisions of men and women. Key topics relate to sexuality and reproduction, paternity and the democratization of domestic and family responsibilities; initiatives include among others research, legal changes related to maternity and paternity rights, reconciling work and family policies, education approaches, public campaigns and gender deconstruction processes with men.

Extended families and communities

Despite the mentioned negative implications over women’s rights and capacity to decide, the strong involvement of the extended family and community actors in relation to reproductive health must also be addressed in terms of shared social responsibility over reproduction, accompaniment and increased resolution capacity. Thus, while expressing a strategy of cultural dominance, extended participation in “private” reproductive health issues also increases the potential of joint action to address risks and problems.

Ethnic and social reproduction

Among indigenous communities, gender and related fertility norms are intrinsically linked to ethnic continuity strategies. According to the Inter-American Development Bank, “survival of indigenous people proves that reproductive health planning has been very efficient” (BID 2010:24) and

that these groups have also practiced contraceptive and even abortion methods.

Traditionally, in rural the contexts, children -and particularly boys- have played a role as members in the workforce and caretakers of their aging parents. However, migration and urbanization dynamics are strongly modifying such intergenerational expectations and assumptions, thus “reducing pressure” on women over their fertility.

Intergenerational improvements, challenges and aspirations: education and employment

Between 1990 and 2006 poverty among young people has decreased in the region in almost 10%, reaching 35%. Percentages are higher among rural, indigenous and afrodescendant groups Qtd. in Lora, Castro and Salinas 2010:29-30).

In general, young people have improved access to education but have less full and decent employment opportunities (30-31). Between 1990 and 2006 the percentage of young people that finished secondary education increased from 27% to 51%. In terms of gender, females have reached a higher percentage of secondary schooling with 51.8% vs. 46.3% for males (Qtd. in Lora, Castro and Salinas 2010:30-31); this implies a positive achievement in terms of closing the gender education gap and potentially influences positively the expectations and life projects of young women, making them think beyond marriage and maternity. However, in an increasingly competitive labour market, the problem and key obstacle for a better relation between education improvements and employment opportunities continues to be quality of education, including social and cultural relevance and demand orientation.

VI.3. CAPITALIZING EXPERIENCE: PROMISING PRACTICES, INSPIRING EXAMPLES AND LESSONS LEARNED

✓ Community organization and participation

Innumerable examples throughout the region highlight the important role that community organization and participation can have for maternal health in terms surveillance, resolution capacity and ownership. Active involvement of the community in planning, service provision, monitoring

and evaluation definitively increases the relevance, cultural pertinence, effectiveness and sustainability potential of almost any initiative.

✓ **Introducing SH issues in the agendas of social organizations and movements**

Historically, the agendas of female social organizations and movements were considered incompatible with gender and reproductive health issues; political, social and cultural demands were addressed as independent and “superior” in relation to private issues,

“Women social networks and particularly other women of the community with whom they have daily linkages, have a fundamental role in the configuration of their reproductive and contraceptive preferences... Furthermore, other women constitute for most of them the main source of information on the existence, functioning and contraceptive methods Access locations”

reproducing the public-private gap and class barriers between women. Furthermore, gender agendas were interpreted as distracters and obstacles of major struggles, generating resistance. However, initiatives developed in different countries have demonstrated that: a) alliances among different expressions of the women’s movement towards common goals are possible; b) working with indigenous, afrodescendant and social movements is a must for development initiatives, particularly considering the social and political contexts of countries like Ecuador, Brazil and Bolivia; c) it is possible to build intercultural dialogues with social organizations and movements to incorporate RH issues in their agendas; d) such interactions generate, at the same time, new inputs and RH topics that nourish and increase relevance of the development agenda from different social and cultural perspectives; e) female social actors are increasingly recognizing their participation and protagonism in wider social and political transformations is closely linked to gender struggles and demands related to the private realm.

More than 50 peasant, indigenous and afro Bolivian women met in the city of Trinidad, Bolivia to initiate an information and training process of for leaders and authorities. Ana Guasase, indigenous leader of the lowlands, said: “Only in this way we are able to inform ourselves and know our rights. Afterwards the most important issue is that we have to exercise our rights and strive for the respect of our families and communities, because until now we are only guests, we are not taken into account. This has to change...”

<http://www.bartolinasisa.org/sitio.shtml?apc=l1----&x=1362435>

✓ **Legitimizing the concept of smaller families through the mass media**

Countervailing the prevailing large family model, a small family model can be progressively mainstreamed and legitimized through the mass media:

“Brazil is a good example of a country where massive demand for smaller families emerged spontaneously from previous descents in infant mortality and changes in aspirations and opportunities. Unconsciously, the massification of television with its enormously popular soap operas showing small families can have been crucial in the diffusion of new ideas in favour of family planning.”

(Cleland *at al.* 2006:75)

While the Brazilian experience reflects a positive “unexpected result”, some organizations in the region like the Nicaraguan “Puntos de Encuentro” have already started to produce social soap operas as key component of communication strategies to promote social and cultural changes. The concept of “edutainment”, which means “education an entertainment”, has brought new opportunities and options to address social change in sexual and reproductive health using television, one of the most consumed media worldwide. Actually, the soap opera “Sixth Sense” (“Sexto Sentido”) is being transmitted in different countries regionally, promoted by a consortium of organizations linked to RH.

✓ **Campaigns to promote new masculinities, fatherhood and family constellations**

Several campaigns are emerging in the region to promote alternative masculinities. The initiatives respond to different actors – male activists, feminist organizations, gender projects- and thus represent distinct concepts and approaches but under a shared goal. In Ecuador a campaign has been organized called “Responsible Fatherhood: Their right, your responsibility”. Another recent example if from Bolivia where the feminist NGO IFFI (“Instituto de Formación Femenina Integral”) campaigned during July to promote domestic valorization and co-responsibility under the slogan “Sharing is wining”. And interesting aspect of this latter initiative is that it was supported by the municipal government.

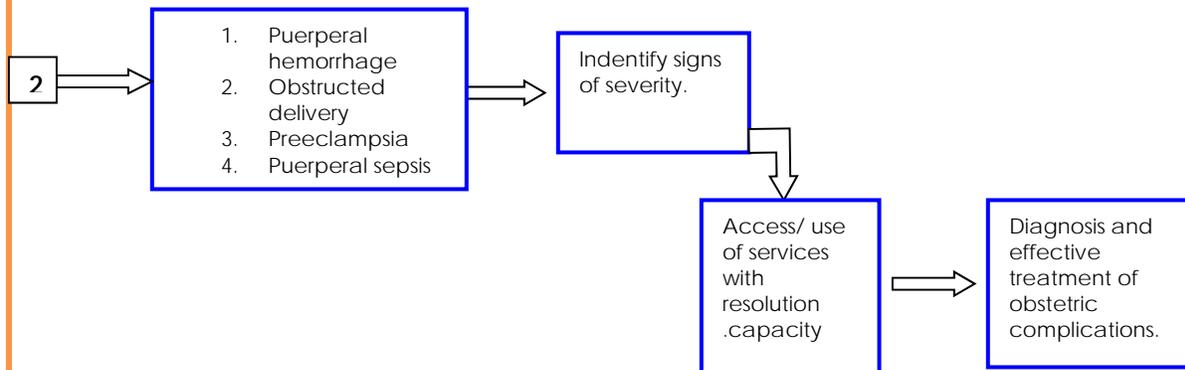
✓ Different worldviews and health models but shared risk factors and concern

Generally, studies and approximations to Western and non-Western worldviews and health models have focused on the differences, particularities and potential conflict: "Having their origin in different worldviews, the traditional and the Western health system rapidly conflict"(BID 2010:18). However, an alternative strategically crucial approach is to identify similarities or shared objectives. This is the case in relation to maternal mortality risk factors and risk detection and implies an open and respectful attitude towards traditional healthy practices:

In general, "women refer to risk situations, phenomena or behaviors that are valid for traditional medicine and their cultural universe, but that are not recognized as such but academic medicine. But indigenous women also consider key factors for a healthy maternity that are shared by Western medicine: good nutrition; no excessive, hard work; no alcohol; good relations and psychological health. They also refer to risk factors linked to their living conditions, gender roles in the family and the relationships with their partners."
(BID 2010: 31-32)

The cultural factor in relation to maternal mortality

Cultural interpretations related to Obstetric complications



Source: BID 2010:68

✓ **Healthy traditions and cultural approaches towards pregnancy and birth**

Different studies have confirmed that while not sharing the same logic, cultural and scientific background, many traditional practices are not harmful and could be integrated in the “Western” health services to attain better results in service provision, women’s satisfaction and wellbeing. Changes like the acceptance of vertical delivery, the active participation of husbands during prenatal care and childbirth, the utilization of herbs and handing over the placenta to the family, have contributed to eliminate some resistance in the use of formal health services.

✓ **Training and empowering midwives and obstetric nurses**

Although discussions remain in the different countries about whether it is adequate, pertinent and viable in terms of integration to the particular health systems, it is important to mention the different initiatives developed in relation to training and empowering “alternative” actors like traditional midwives and obstetric nurses that can make a difference in relation to maternal health and mortality, particularly in remote rural areas where service provision is scarce, of poor quality and with weak resolution capacity: “The meta analysis if Sibley, which included seventy studies, concluded that training traditional midwives demonstrated an considerable improvement in the performance and reduction of mortality. There were 8% less deaths in women attended by traditional women” (RELACAHUPAN 2007:n/p).

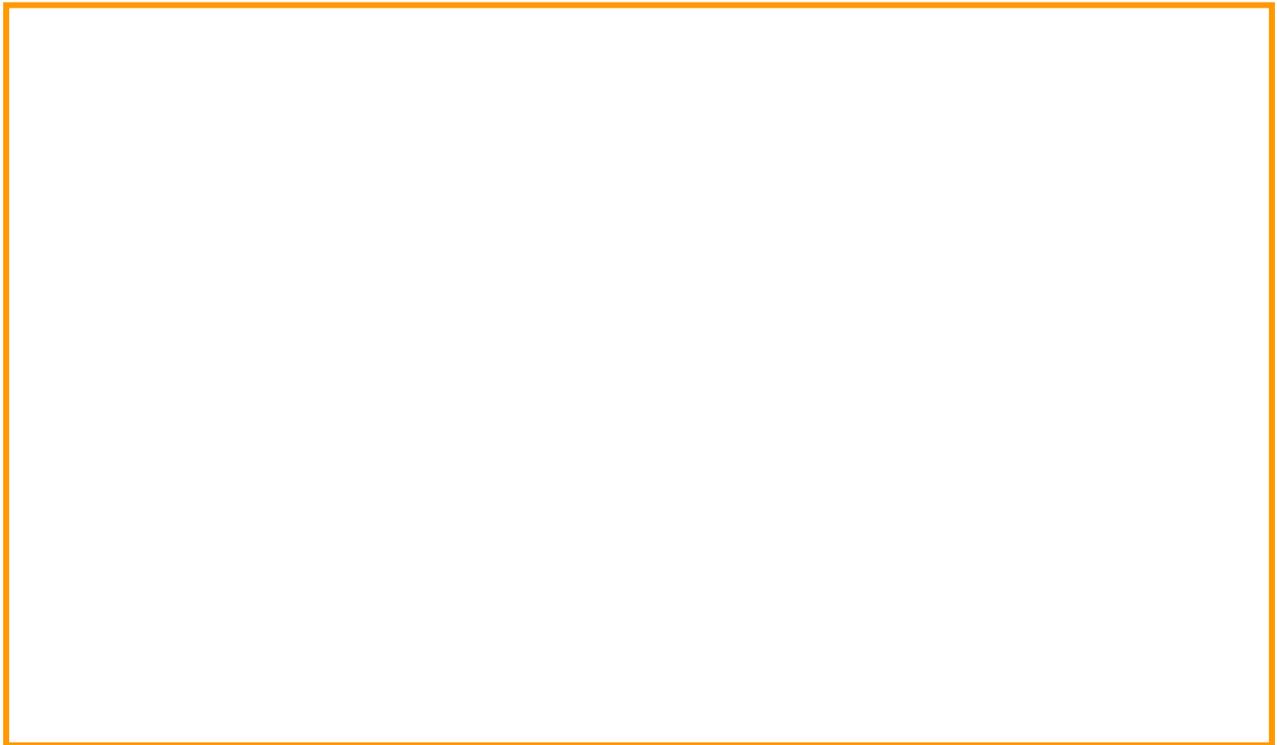


In 2009 a first International Meeting of Obstetric Nurses took place in Nicaragua and discussed several issues, including their role within family and community health attention models and in treating to obstetric emergencies (http://www.el19digital.com/index.php?option=com_content&view=article&catid=23:nacionales&id=7019:primer-encuentro-internacional-de-enfermeras-obstetras-en-nicaragua&Itemid=12).

✓ **Promoting RH through bi-literacy methodologies**

To contribute to the development of a Regional Strategy for the Reduction of Peasant and Indigenous Poverty, ECLAC has tested a methodology involving local participation in various countries of the Region. This project

involves the implementation of the innovative bi-literacy method for adults, based alternatively on the subjects of micro-management and productive development, protection of the environment, gender equity, civil rights, and community health (with an emphasis on sexual and reproductive health and the prevention of HIV/AIDS). This methodology has been called Bi-literacy in Production, the Environment, Gender, and Community Health and is initially implemented in Mexico, Guatemala, Peru, Paraguay, and Chile due to their large peasant and indigenous population.





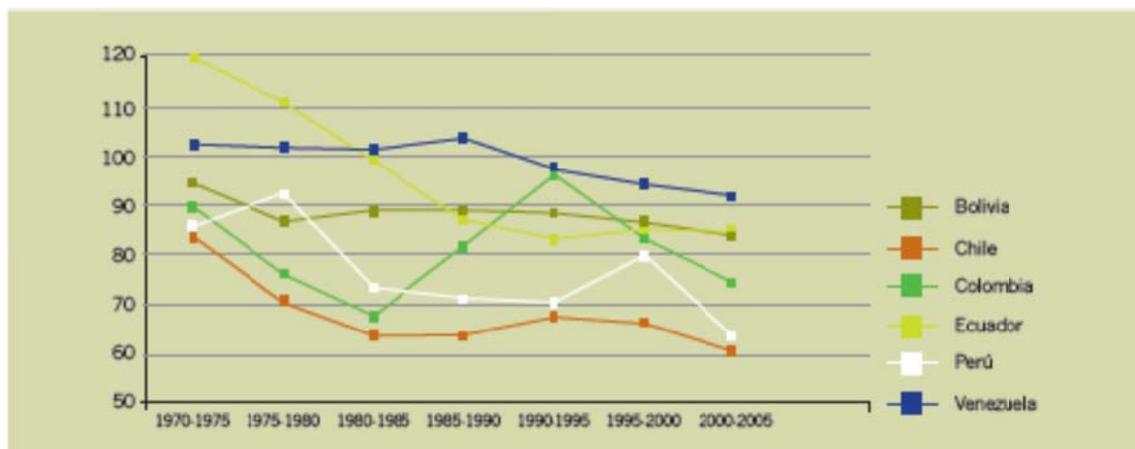
VII. ADOLESCENT AND YOUTH HEALTH

V.1. BRIEF OVERVIEW OF THE REGIONAL SITUATION

It is estimated that in the region people between 15 and 29 years old (youths) will be more than 153 millions in 2010. It is also predicted that the absolute number of youths will continue growing until 2030. Most of the young people live in urban areas and such trend will also continue increasing.

Poverty and extreme poverty among young people vary drastically between countries; for example, in Chile 12.1% of the youth are considered poor, while the Honduran percentage reaches 66.3% (CEPAL/UNFPA 2010a: 86). While educational achievements have increased, this is not translated in improved employment opportunities and conditions; on the contrary, it is considered that situation of young people today is worse than 15 years ago.

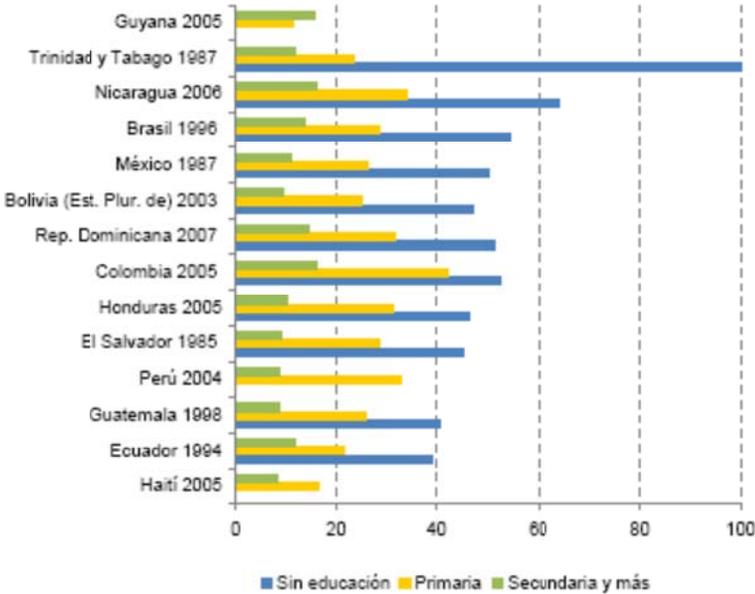
As already mentioned, fertility rates among adolescent women have neither followed the descending global trend nor the reductions observed among other age groups in the region: "In the period between 2004 and 2007 between 12% and 25% of women between 15 and 19 years old were already mothers" (CEPAL/UNFPA 2010b:11). This represents around 1 million of the 7 million women between 15 and 19 years old in the region. This trend does not follow global patterns. The following graphic presents historical data produced by CELADE/ECLAC on adolescent fertility in selected countries for the period 1970-2005:



Proyecciones de CELADE. http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm

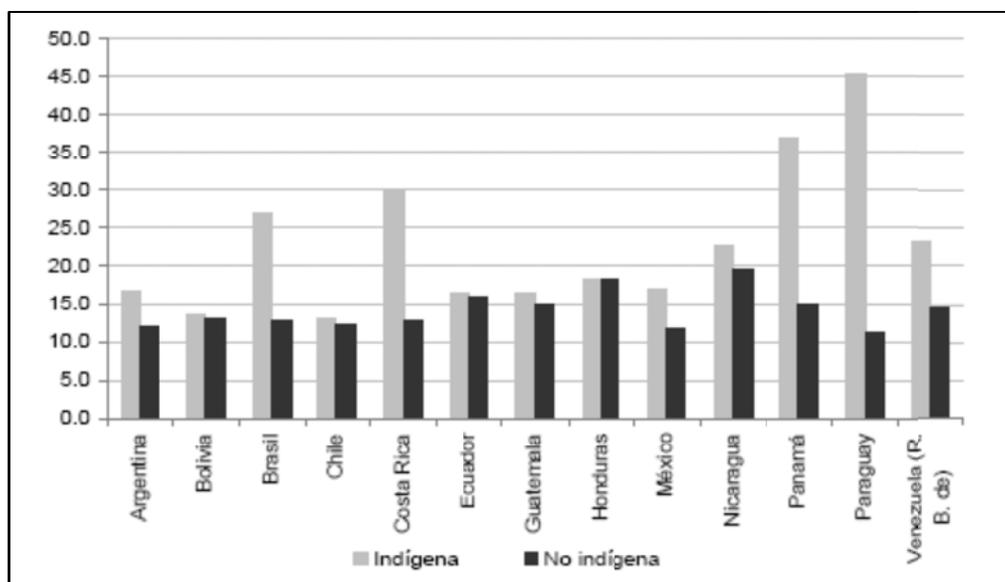
Most adolescent pregnancies are unplanned. Adolescent pregnancy is at the same cause and result of socioeconomic, ethnic, generational and gender inequities and contributes to inter-generational poverty transmission. According to the United Nations, "it is important to highlight that the prevention of unwanted pregnancies could alone prevent one fourth of maternal deaths, including those caused by clandestine abortions" (Qtd. in CEPAL/UNFPA 2007:6).

In an unpublished document on the progress in relation to the health targets of the ICPD in Latin America and the Caribbean, data is provided on the proportion of adolescent pregnancies in relation to education levels for different countries in the region, showing a direct and positive correlation (CELADE/CEPAL y UNPFA:15):



Fuente: Centro Latinoamericano y Caribeño de Demografía/Comisión Económica para América Latina y el Caribe y Fondo de Población de las Naciones Unidas (CELADE/CEPAL-UNFPA), *Grado de avance de las metas de la Conferencia Internacional sobre la Población y el Desarrollo relacionadas a la salud en América Latina y el Caribe*, 2009, inédito.

A special mention needs to be made with respect to indigenous adolescents, given the higher proportion of adolescent maternity that reveals ethnic-related unequal access to reproductive rights. The document produced by CELADE/CEPAL and UNFPA highlights such ethnic gaps for adolescent maternity:



Source: CELADE/CEPAL and UNFPA 2009:16

While it is true that indigenous values and cultural meanings of adolescent maternity are not the same as urban, Western interpretations, and that early maternity can be part of women's life projects in some social and cultural contexts, it is also evident that pregnancy among indigenous adolescents also reflects structural inequities and little cultural sensitivity in the concept and provision of health services. In general terms, the increase of adolescent pregnancy is higher for the poorest quintile -today educated and urban- at the same time that the rural-urban gap still remains with at least 30% more adolescent rural pregnancies.

Information, but particularly the capacity to use of such information to make healthy and empowered decisions, is still insufficient and presents marked social and ethnic disparities, despite the several programs and initiatives that target adolescent and young population. An illustrative example is the proportion of unprotected sexual initiations, which is contradictory with the increasing trend of earlier sexual initiation and without reproductive purposes (CEPAL/UNFPA 2010b:16). Wellings *et al.* (2006:50) present the following data on sexual initiation and first marriage for some selected countries in the region, including the Caribbean (Bolivia, Brazil, Chile, Colombia, Dominican Republic, Guatemala, Haiti, Nicaragua and Peru):



Several studies emphasize that despite increased information availability, and access, sexual initiation cannot be associated to deliberate actions and decision-making processes; it happens in “response” to given, unpredictable situations, relations and “opportunities”, is thus unplanned, mostly unprotected and frequently associated to gender-patters and violent behavior. González and Londoño stress that for men, sexual initiation is related to a more general pattern of experiencing sexuality as “taking advantage of an opportunity to experiment, somehow linked to hazard and secrecy; an event that happens in a quick manner and without planning. There is a tension between the life project and the cultural virility mandate”. On the contrary (or complementary), female notions of sexuality are romantic, idyllic and associated with love, but also represent vulnerability and risk predisposition (Qtd. in Lora, Castro and Salinas 2010: 74).

The gap between information and use of information is thus one of the key unsolved topics and relates to far more complex issues that deal with gender and inter-generational power relations and cultural norms. Data for the Andean Subregion reveals for example that with the exception of Colombia and Chile, in the other countries less than 50% of the adolescents use contraceptive methods but over 90% are informed. While accessibility barriers persist, other cultural and social obstacles are apparently of greater importance.

Donas explains that the health risk approach has been recently incorporated to address adolescent health. Risk is defined as “the probability that an unwanted event occurs that affects a persons’ or group”. The concept is mainly applied to sexual and reproductive health – pregnancy and perinatal risk, cervical and mammary cancer- and mental health – drugs, smoking, alcoholism, suicide (Qtd. in Lora, Castro and Salinas

2010:34). The risk approach links disease, as a social and biological phenomenon, with a set of factors, mainly cultural, that favor or inhibit the appearance of the disease.

In many countries in the region the prevalence of young male deaths is alarming; of every male 100 deaths, 77 can be attributed to violent causes, in comparison to 38 among female youngsters, thus reflecting prevailing male chauvinism (Qtd. in Lora, Castro and Salinas 2010:34).

In relation to HIV/AIDS prevalence, data for 2005 shows Honduras with the highest rate between 90 and 150 for every 10.000 youths, while Bolivia and Nicaragua present the lowest rate of 6-10 cases for every 10.000. According to the Ibero American Youth Cooperation and Integration Plan (2008), the accelerated spread of HIV/AIDS, particularly among female heterosexual youngsters does not only respond to lack of information but is the result of cultural factors that operate against prevention (Qtd. in Lora, Castro and Salinas 2010:34).

While adolescents' reproductive health has gained importance in the agendas, this is not automatically expressed in more and better health services; the document by Lora, Castro and Salinas on adolescent pregnancy summarizes the following barriers that limit access of adolescents to health services including counseling (2010:115):

- ✓ Fear and shame.
- ✓ The inexistence of specific services for adolescents.
- ✓ Rejection attitudes, prejudices and discrimination of the health professionals in relation to adolescents.
- ✓ Inadequate attention times in relation to study and work.
- ✓ No money to pay for services received.
- ✓ Untrained personnel.

A final comment refers to criticism on the medicalization of daily adolescent life issues; daily life problems become health problems

VII.2. SOCIAL AND CULTURAL FACTORS: OPPORTUNITIES AND CHALLENGES FOR ADOLESCENT AND YOUTH HEALTH

Adolescence: a cultural construction

Adolescence is not a global, trans-cultural and homogeneous concept. Sociologically, adolescence refers to a transition period between childhood and adulthood but as the anthropologist Ruth Benedict (1954) emphasized,

this transition from infant dependence to adult independence “is produced in different ways in distinct cultures, so that none can be considered as natural and universal” (Qtd. in Lora, Castro and Salinas 2010:17). In the Western world this change is associated with discontinuity and transition, while in non-Western indigenous societies continuity is emphasized and no major changes are expected during this life period. Furthermore, adolescence as a concept does not exist in the majority of non-Western populations and their languages.

The key message is that adolescence is not universal and that it is mainly a transformable cultural construction with particular meanings depending of the specific contexts. This implies that experience and interpretation of physiological, sexual, social, economic and political changes associated to this age can be modified to favor empowerment and wellbeing.

Family structure vs. family functioning

In a study on behavior, attitudes and practices in a Colombian adolescent school population, one of the key findings was that adolescents’ perceptions about the functioning of their families – meaning perceptions of support received, affection, participation and coexistence- highly influence their sexual behavior (González 2009:20). According to the research findings, family dysfunctions are more influential on sexual behavior and risk than actual family structure, composition and model. These findings are particularly interesting given the increased diversification of family models and constellations that apparently does not affect the possibility of creating positive and supportive family environments for adolescents.

In the same line, Flórez emphasizes that the main determinant factor of adolescent’s sexual behavior are the family context (atmosphere and supervision) and the educational climate (2005:368).

Socialization, gender patterns and risk

In general, adolescent socialization reproduces traditional patterns in terms of female and male roles and values. Thus, it does not respond to emerging social and cultural contexts, needs and opportunities that young people face today, strongly lacking relevance and pertinence, while also hindering gender transformations in the cultural realm needed to accompany already given social changes.

For example, a research among Guatemalan young population points out the following prevailing gender “cultural dimensions”:



Form these gender views and expectations, it can be concluded that gender socialization directly increases risk behaviors among both, young men and women. For example, independently of the degree of information and knowledge possessed, women with stable relations avoid the use of condoms because they believe it is opposed to romantic love: “Risk perception of infection...is influenced by the sense of honorability of the sexual partner” (Qtd in UNFPA 2004:57). The use of condoms is consequently associated to infidelity.

Adolescent paternity: paradoxes

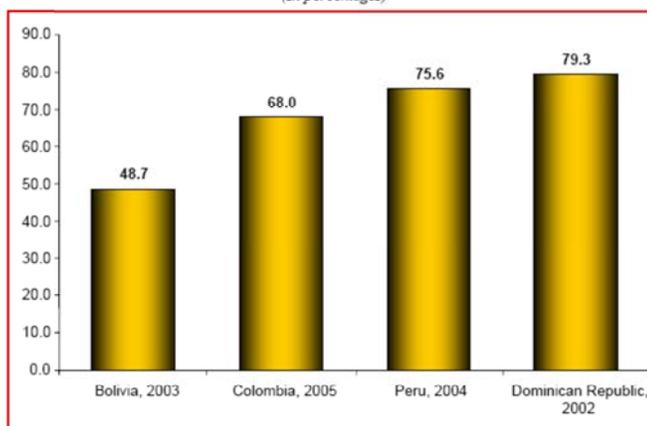
The notion of masculinity deeply associated to paternity is already installed in the identity pillars of adolescents and youths. However and despite of this vision, several studies have confirmed that male adolescents usually don't take responsibility for unexpected pregnancies that reinforce their masculinity but are of female responsibility. Paradoxically, “the relevance of paternity in the construction of their masculinity is not accompanied by a responsible conception of such condition” (UNFPA 2004:30).

Violence against girls and female adolescents

According to the ECLAC report on violence against women in the Latin American and Caribbean region (2007:40), “in violence against girl children and adolescents (UNICEF, 2005b and 2005c) the discriminatory patterns for gender and age are combined, sustaining the figures which show they are twice as likely to be the victims of sexual violence. Girls are particularly

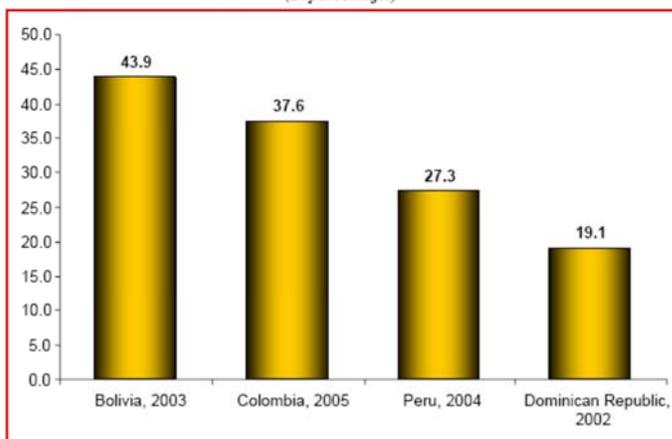
vulnerable to violence by adults who can combine the cultural undervaluation sustained in gender relations with abuse of their greater physical strength, authority, economic capacity or social position, as well as trust, to produce cases of physical and sexual abuse in the home and at school. The situation of violence against girl children, boy children and adolescents is

Young women aged 15 to 19 years-old victims of emotional violence
(In percentages)



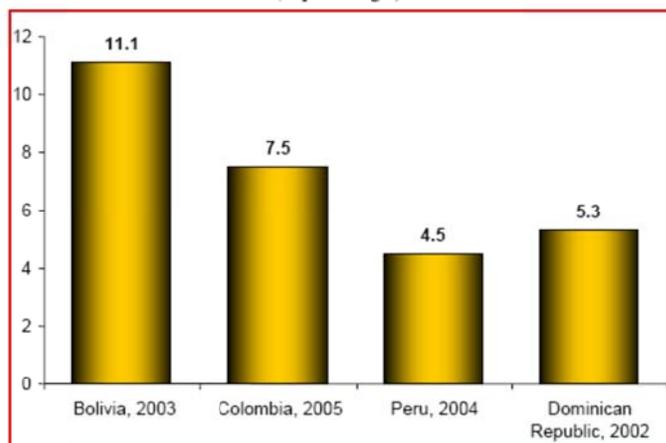
Source: Demographic and Health Surveys (DHS):
 Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
 Colombia [online], http://www.measuredhs.com/pubs/pdf/oc.cfm?ID=282&PgName=country.cfm&ctry_id=6, 2005.
 Dominican Republic [online], <http://www.measuredhs.com/pubs/pdf/FR146/12Capitulo12.pdf>, 2002.
 Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004.

Young women aged 15 to 19 years-old victims of physical violence
(In percentages)



Source: Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
 Colombia [online], http://www.measuredhs.com/pubs/pdf/oc.cfm?ID=282&PgName=country.cfm&ctry_id=6, 2005.
 Dominican Republic [online], <http://www.measuredhs.com/pubs/pdf/FR146/12Capitulo12.pdf>, 2002.
 Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004.

Young women aged 15 to 19 years-old victims of sexual violence by their partners
(In percentages)



Source: Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
 Colombia [online], http://www.measuredhs.com/pubs/pdf/oc.cfm?ID=282&PgName=country.cfm&ctry_id=6, 2005.
 Dominican Republic [online], <http://www.measuredhs.com/pubs/pdf/FR146/12Capitulo12.pdf>, 2002.
 Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004.

heterogeneous, fed by a combination of high levels of inequality and discrimination, poverty and social violence. Both in Latin America and the Caribbean, the relationship of violence against girl children with poverty and the lack of social protection results in the denial or limitation of opportunities for the full development of their potential from very early age (UNICEF, 2004a).

Globalization, mass media, NICTs and cultural transitions

The mass media and the New Information and Communication Technologies are inserting the younger population in a globalized world, with new paradigms, referents and ideals, creating at the same time health opportunities and hazards, depending mainly on the individual contexts and conditions.

In general globalization implies a certain family loss of control over the individual adolescent/youth and his/her confrontation with different, frequently more modern and liberal ideas, also regarding gender patterns and sexuality. Usually, the confrontation to such an open and unlimited world of ideas is an individual and lonely process, which can imply serious challenges on terms of processing the information and making responsible and information-based healthy decisions. The lack of participation, involvement and communication with parents, teachers and other influential adult actors increases risks and does not contribute to take advantage of globalization for adolescent/youth health. It oftentimes results in an uncritical interpretation of the information and alternatives offered and/or uncertainty about the correct path to take linked to life projects.

Migration: opportunities and challenges for adolescents and youths

While a specific session in this document already discusses the main dimensions and effects of migration processes at community, family and individual level, some aspects are emphasized here in relation to adolescents and youths:

- Migration processes within the family represent important changes in the lives and opportunities of adolescents and youths, generally linked to new roles and responsibilities.
- When the adolescent/young person is the migrant, this usually allows him/her increased access to information and services.
- When the migrant is the father and/or mother, it is expected that the older children substitute them, assuming their adult roles and responsibilities, sometimes sacrificing own activities and projects (e.g school).
- Revenues sent by migrant parents are frequently directed to improve education alternatives of their children and can be crucial, for example, to enable adolescents/youths access to higher education.

Intergenerational communication gaps

Intergenerational communication gaps negatively affect the possibilities of key adult actors – parents, teachers- to influence the sexual behavior of adolescents, while at the same inhibiting access of the younger to adult advise, information and support. The gap is originated in different factors and circumstances, including generational prejudice, adulthood, information and knowledge gaps, lack of competencies and skills for establishing intergenerational dialogue.

According to Suazo and Caballero, sexual education in the family is either inexistent or moral. It is believed that talking openly to the children about contraceptive methods fosters early initiation of sexual relations. In general sexuality is a taboo topic, so young females are usually predestinated to remain ignorant, while young men only address selected topics with friends, in a context where peer to peer communication and information has progressively substituted the family and school roles in sexual education. This leads frequently to myths and distorted information; for example, condom use is believed to imply infidelity, diminish pleasure, provoke sterility and cause STIs (Qtd. in UNFPA 2004:48).

“In the Guatemalan family sexuality is a taboo topic for the youths; parents usually do not talk with their children because they lack preparation, are uncomfortable or feel ashamed. Additionally, under the male chauvinist perspective, men do not talk about sexuality because this can be perceived as a sign of male insecurity and weakness.”

(UNFPA 2004:112).

Overall, the communication gap hinders adolescents’ “access to fundamental means (information, knowledge, affection) for a good health and wellbeing, particularly in sexual and reproductive health. These resources are essential do not restrain young women and mean to establish relationships and start their sexual activities. However, they leave them vulnerable and exposed to unwanted risks and consequences” (Salinas 2001:325).

Organizations and identities

Today the constellation of organizations that bring together adolescent and young people is far more diverse, complex and challenging, even implying the construction of transnational shared identities that overcome traditional ethnic, class and national referrals. The emergence and increased relevance of an extremely wide range of juvenile groups, movements and

cultures poses questions, implies opportunities and risks for the sexual and reproductive health of adolescents and youths. Given the diversity it is not possible to provide a generic profile, but particular attention needs to be paid to prevailing peer to peer interactions and influences, gender relations and violence patterns within the context of conflict situations, exclusion, family ruptures, search for cohesion and deterioration of the social fabric that adolescents and youths are experiencing (Qtd. in Lora, Castro and Salinas 2010:61).

VII.3. CAPITALIZING EXPERIENCE: PROMISING PRACTICES, INSPIRING EXAMPLES AND LESSONS LEARNED

✓ *From fragmentation and paternalism to and integrated rights approach in adolescent policies and programs*

Historically, adolescent policies and programs have shifted from responses centered on education and free time, which benefited essentially integrated adolescents and youths in the context of dynamic economies with effective social mobility mechanisms, to an increased concern about excluded youths and their needs in terms of technical education and employment. More recently, through the implementation of a risk approach, attention is shifting to violence and citizen issues among adolescents and youths, but without promoting their active involvement and participation (Mocharetti n/d:83).

In general, public policies for adolescents and youths have presented fragmented responses within paternalistic, problem and risk-oriented approaches. But some initiatives (e.g. UNFPA Bolivia) have emerged under a rights umbrella, integrating a holistic approach, articulating sectors and actors, and mainly recognizing adolescents and youths as social actors capable of formulating, implementing and evaluating public policies for their specific group but also for the whole society (Qtd. In Moacharetti n/d:84).

✓ *Building capacities for participation in public policy design*

As a consequence of the mentioned changes in the work paradigm, experiences in different countries have shown the potential of adolescent and young people to take responsibility and be actively involved in diagnosis and planning concerning public policies. For example, in the Dominican Republic 147 youngsters were trained to participate in the implementation of a survey to identify needs in the main youth policy areas:

education, health, environment, work, use of free time, participation and family relations. They interviewed 3271 males and females between 15 and 24 years old in eight municipalities. With the gathered information municipal multi-actor forums took place to identify priorities for the Youth Municipal Plans (Family Care International 2007:11).

Experiences have usually included broader technical and political training for effective participation in the design and implementation processes of public policies: Development of evidence-based proposals; strengthening the arguing and demand capacity; developing advocacy and negotiation skills.

✓ *Education in sexuality: The importance of quality, integrality and timing*

Education in sexuality (or sexual education) “allows improving consciousness about risk and knowledge about risk reducing strategies, at the same time that increases effectiveness levels and strengthens the will to adopt safer sexual behavior; it also delays instead of accelerating the initiation of sexual activity (Wellings *et al.* 2006:56).

Within this framework, early information and sexual education for adolescents are privileged whenever possible. However, some studies (González 2007) have questioned the pertinence and effectiveness of this early practice. According to the author, when the information is provided at a too early age, particularly information on contraceptive methods, adolescents are not interested, don't understand, don't find it useful, are not able to make relevant questions to solve their doubts and underestimate the importance of the condom as a protective measure (González 2007:22). Thus, when, how and what is taught are key influential factors that impact on the effectiveness (in terms of relevance and use) of sexual education.

Other experiences are valuable to nourish discussions over the most adequate approaches in sexual education:

The HIV/Aids Prevention Program in Schools, implemented since 2007 by the Ministry of Education and the Ministry of Health in Argentina, emphasized the importance of an integrated approach in sexual education beyond the biological medical approach and focus on genitalia. The Program addressed prejudices in relation to sexuality during adolescence and focused on training teachers.
(CEPAL/UNFPA 2010a: 66)

It is important to highlight that education in sexuality also covers informal education, where many successful experiences have been anchored at local level. This is the case of the Education in Population and Sexuality program implemented in 8 Nicaraguan municipalities between 2002 and 2006 with the support of UNFPA. A total of 8980 young people and 4800 families were reached outside the formal education system (Qtd. in CEPAL/UNFPA 2010a:70).

✓ **Involving and building capacities of parents and teachers**

As has been mentioned and also emphasized by different authors (e.g. Pacheco-Sánchez *et al.* 2007:50), the generational communication gap also implies that neither parents nor teachers know how to communicate with adolescents/youths, and particularly so in relation to RH issues, where they not only feel they lack the communication skills but also the required knowledge.

Different inter-generational initiatives to promote dialogue, confidence and “legitimacy”, combined with specific affirmative actions to strengthen the knowledge, roles and attitudes of the different generational groups of actors involved and develop their communication and negotiation skills, have demonstrated positive results. Nevertheless, while in general terms an intergenerational approach is increasingly mainstreamed, efforts and resources to work with parents (mainly) are still insufficient. Within this framework it is important to recognize that work with adult populations requires particular knowledge and capacities that those responsible of initiatives with adolescents and youths not necessarily or automatically have.

✓ **Joint planning, monitoring and evaluation of adolescent health services**

At the same time that increased participation of adolescents and youths in the design, implementation, monitoring and evaluation of public policies and programs is promoted, their involvement in relation to health service provision is crucial to guarantee that achievements in the public policy realm are effectively implemented. This has to do mainly with social control and monitoring roles. Some specific methodologies have been developed for this purpose, like the one implemented by Save the Children in Bolivia. In the case of this NGO, the process is initiated with a joint planning phase where improvements and compromises are agreed between the health

service providers and the adolescents/youths. The resulting plan is the key document and reference for monitoring and evaluation.

✓ *Special programs for pregnant adolescents and mothers*

In some countries, public and private programs have developed to attend to specific needs and conditions of pregnant adolescents and mothers. Such is the case, for example, of the Costa Rican program “Building Opportunities” to ensure their access to public health services (Qtd. in CEPAL/UNFPA 2010a: 88). Save the Children in Bolivia also implements activities directed to this particular group and has over the time developed a specific integrated methodological approach. Articulating these initiatives to economic alternatives for the young mothers has been proven as a good practice to provide integrated options to respond to their needs and concerns.

✓ *NTICs*

The increased, “vital” importance of New Information and Communication Technologies particularly for the younger generations has already been discussed. In coherence with this general and inevitable trend, different adolescents and youth programs have visualized opportunities to increase their relevance and effectiveness by integrating these technologies as part of their strategies and methodologies, achieving very positive results. Initiatives include Webpages, (social) networks, virtual education programs and other interactive options that combine activities limited to a particular, pre-defined group, with others that enable open contact and exchange with other adolescents and youngsters nation- and even worldwide. Increased accessibility of rural adolescents and youths to the internet progressively democratize these options and build virtual rural-urban intercultural communication bridges.

✓ *Generating and using information*

The lack of quality and disaggregated (e.g. age, ethnic identity, sex, residence) data is a serious problem in most Latin American countries that has negative effects on the design, monitoring and evaluation of relevant, effective and efficient policies and programs. Youth Laws have to a certain extent contributed to organize and modernize existing regulations regarding the production and management of official information on adolescents and youths in different countries. In some cases the approach

has been systemic and has lead to the institutionalization of surveys, situational diagnosis, observatories, policy monitoring and evaluation processes, linked to a key role of adolescent and youth organizations in processing and disseminating the information on and for the young population.

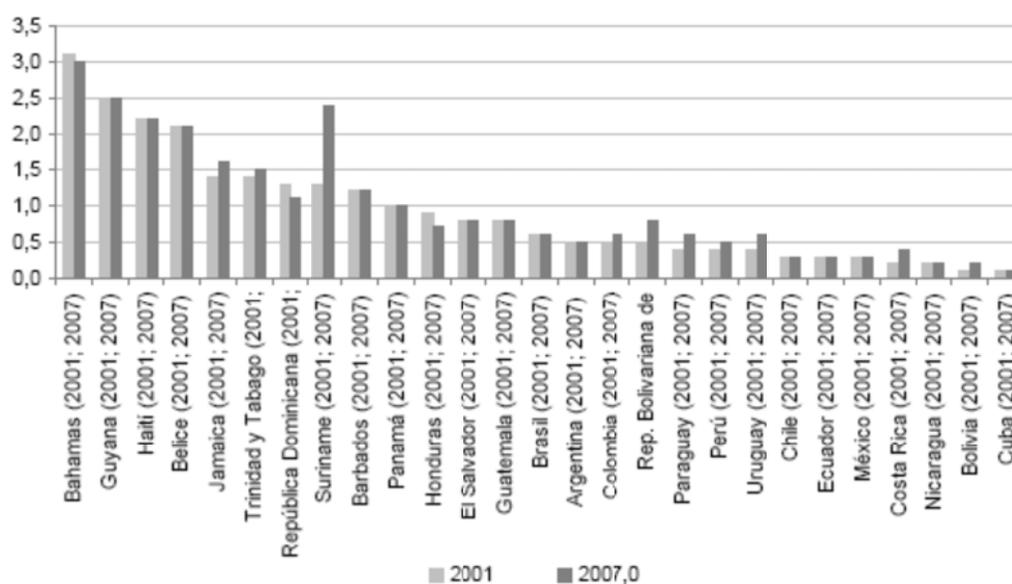


VIII. HIV PREVENTION

VIII.1. BRIEF OVERVIEW OF THE REGIONAL SITUATION

Between 2002 and 2007, the number of people living with HIV and AIDS in the region stabilized. The region has also made significant improvements towards providing diagnosis, attention and treatment to people living with HIV, reaching a 62% in 2007, the highest percentage in the developing world (CEPAL/UNFPA 2010b:11). Less encouraging are the results in terms of prevention.

The following graph presents for a group of countries, data provided by CELADE/ECLAC and UNFPA about HIV prevalence among population in reproductive age for the years 2001 and 2007, showing the trend for every country (2009: 13):

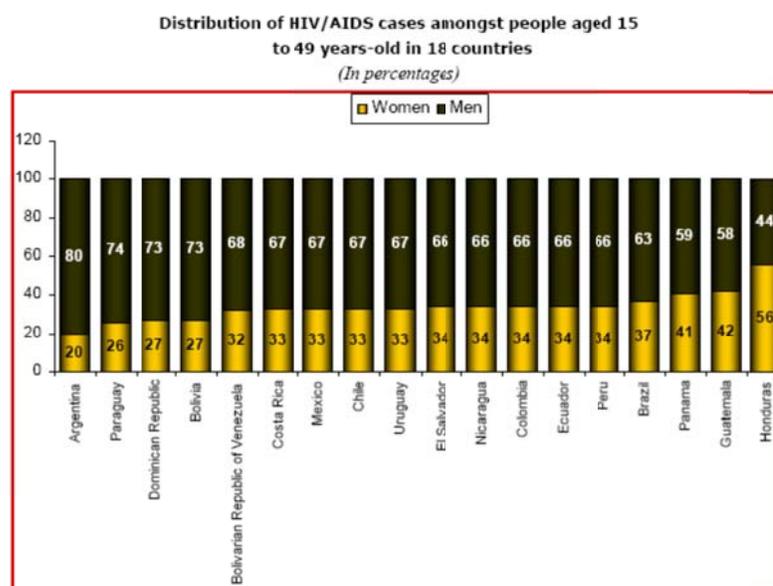


Source: CELADE/ECLAC and UNFPA 2009:13

According to the *Analysis of the Population Situation for Latin America and the Caribbean* in 2006, AIDS produced 65,000 deaths in the region; 140,000 people were infected during that year and 1.7 million people, including one third women, live with the illness. "HIV transmission is produced in a context characterized by poverty, insufficient information on trends in the epidemic to make decisions and a marked homophobia" (Qtd. in CEPAL/UNFPA 2010a:64). The increase of HIV affects all populations and the increase in the numbers of infected women and young people is of high concern. (CEPAL/UNFPA 2010b:11). Several studies also highlight the greater

vulnerability and risk prevailing among afro descendant populations (Urrea-Giraldo *et al.* n/d).

According to Pan American Health Organization (2002:1), at the end of 1999, women made up 25% of HIV positive adults in Latin America, and 30% in the Caribbean. Three years later, those percentages had increased to 30% in Latin America and 50% in the Caribbean. ONUSIDA, on the other hand, informs that women, particularly young women between 15 and 24 years old, have the highest risk of HIV/AIDS infection, almost twice as high as male risk for the same age male population. And the ECLAC publication on violence against women provides the following male-female comparative data:



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), Report on the Global AIDS Epidemic 2004 (UNAIDS/04.16E), Geneva, 2004.

Gender vulnerability to HIV/AIDS derives from a compound of biological, cultural, social and economic factors and in the case of women is linked to (Pan American Health Organization 2002:4-6):

- Gender-based violence, including forced sex and unprotected sexual intercourse.
- Expected virginity until marriage that stigmatizes sexually active unmarried women, leads some of them to unhealthy sexual practices to maintain their virginity, and prevents their access to health services.
- Cultural taboos that inhibit open discussions on sexual and reproductive issues, particularly during adolescence and youth.
- Lack of accessible empowering information, particularly for women.

- Female sexual relations associated exclusively with reproduction, in opposition to men's need for sexual release.
- Stigmatization of lesbian and bisexual women.
- Significant age differences with male sexual partners.
- Economic deprivation and financial male dependency.

In general terms, poor rural and indigenous women suffer more acutely from these gender vulnerability factors.

In the case of men, gender norms and expectations also increase their vulnerability given the following (Pan American Health Organization 2002:6):

- Expected prolific sexual activity, frequently unprotected.
- Pressure towards early sexual initiation.
- Alcohol consumption linked to sexual relations.
- Increased trend towards sexual violence.
- Expected strength as a barrier to access to health services.
- Limited existence of specialized male services.

VIII.2. SOCIAL AND CULTURAL ISSUES

Gender constructions and risk

Gender has a significant impact on (1) the transmission of HIV/AIDS in both heterosexual and homosexual relationships, and (2) the differential experiences of infected and affected women and men (Pan American Health Organization 2002:1). "Women are at a disadvantage with respect to access to information about HIV/AIDS prevention, the ability to negotiate safe sexual encounters and access to treatment for HIV/AIDS once infected (Pan American Health Organization 2002:1). On the other hand, "men are less likely than women to seek health care and their reluctance to be tested or seek treatment for HIV or other STIs has obvious

"Women and girls are two to four times more likely to contract HIV during unprotected sex than men because their sexual physiology places them at a higher risk of injury, and because they are more likely to be at the receiving end of violent or coercive sexual intercourse" (Patterson *et al.* 2009:6). This includes marital sexual encounters: "Marriage does not guarantee sexual health status. For married women it is harder to negotiate safe sexual relations and the use of condom for family planning. Too early sexual experience within marriage can be coercitive and traumatic" (Wellings *et al.* 2006: 46)

negative repercussions for their sexual partners, be they male or female” (Pan American Health Organization 2002:13).

“Women and girls living with HIV often face discrimination at service points and have been forced to conceal their condition in order to access health care. Stories abound of HIV-positive women forced to wait for the one lab technician allocated to draw their blood, or the only obstetrician willing to attend to their births. It is common for women to be tested without their consent, then offered HIV services and treatment only for as long as they are pregnant, but not once they give birth.”

(Patterson *et al.* 2009:23).

Despite the recognition of the determinant influence of gender in relation to HIV/AIDS, few programs and projects addressing HIV/AIDS have taken into account the gender determinant. Gender roles, norms, identities and relations are crucial to understand and address the increased HIV/AIDS vulnerability of women vs. the greater risk of males that also derives from gender constructions. “Both are victims of the social construction of gender, but men’s risk of HIV infection is primarily determined by their own proactive behaviour, whereas women’s vulnerability to HIV infection is largely beyond” (Pan American Health Organization 2002: 2).

In Brazil, the United States, and Argentina 120 women indicated the existence of barriers to applying their knowledge about HIV/AIDS prevention, and to demanding the use of the condom. A study in Brazil revealed that some women chose sterilization over other contraceptives in order to avoid a discussion of contraceptives with their male partners (Pan American Health Organization 2002:16).

HIV and gender violence

There is apparently a direct positive correlation between violence and HIV/AIDS for women: “The Global Coalition on Women and AIDS (GCWA, 2005) indicated that women who have contracted the virus have a greater probability of suffering violence and, also, that women who have experienced violence run greater risks of contracting HIV/AIDS. Hence there is a direct and reciprocal relationship between violence and increased probabilities of contracting the virus, which affects women not only in terms of physical, mental and reproductive health, but also drives discrimination and stigmatization as carriers” (ECLAC 2007:54). Furthermore, as Patterson *at al.* explain “the threat of violence is a barrier to accessing HIV testing and counseling services, as well as to HIV disclosure. Without the knowledge of

their HIV-positive status, or ability to access treatment and care services, women may fall ill or die unnecessarily”.

Migration and HIV

Frequently, “the marginalized status of migrants increases their vulnerability to HIV. Poverty, language barriers and lack of social support and insurance mean that many migrants do not have access to health information or services” (Pan American Health Organization 2002:10). Thus, “male and female migrants are isolated from family and community relations and social support networks, and may engage in sexual activity with sex-workers and/or multiple partners, exposing themselves and by association their partners at home to HIV infection” (Pan American Health Organization 2002:10).

Institutional battles

In most countries in the region, private-health organizations, including NGOs and FBOs, play a fundamental role in the provision of health services particularly in areas where the state doesn’t reach. On one hand there is always the discussion on how “healthy” and sustainable it is to meet the State’s obligations. However, the issue also has other facades related to political stands and positioning in relation to some SR health issues that don’t allow finding common ground and promoting coordinated action. The case of Peru is illustrative for this situation: “The history of tensions between the state and private-health organizations underlines the difficulties in undertaking joint health efforts against sexually transmitted diseases (STDs) in Peru” (Cáceres, Cueto and Palomino n/d:150).

Globalization, communication and STIs

A frequent assumption that has oftentimes guided initiatives to prevent HIV is that the dissemination of information, particularly among teenagers and youngsters, would lead to “rational”, evidence-based behaviour and decision-making. Such premise does not take into account the multiplicity of factors and power issues that are implied in sexual relations and choices. If people would do what they know, the situation would be considerably different. But there are important gaps between having and using information and knowledge; such is the case, for example, in relation to contraceptive methods and particularly to the condom.

From a stigmatized homosexual issue to a general concern/problem

As Cáceres, Cueto and Palomino report, “while cultural norms around sexual diversity have a long way to go to become truly inclusive, the visibility and legitimacy of those who are sexually different has significantly improved in the last two decades”. Furthermore, while stigma and discrimination undoubtedly persist in relation to people with HIV and AIDS limiting their full rights’ exercise, it is also important to recognize that “public perceptions of people living with HIV/AIDS have also improved. All these cultural changes both reflect and influence legal and political changes” (n/d:159)

These changes, however, are also linked to other more debateable ones, particularly to the shift in HIV/AIDS approach from a moral/political issue to a medical/chronic disease issue (Nathanson, Sember and Parker n/d:404).

Political mobilization and organizational tradition

In Peru during the 90’s “the re-emergence of the social movement towards the end of the decade also established the basis for a renewed, diversified LGBT movement” (Cáceres, Cueto and Palomino n/d:155), visibilizing the strong linkage between the political atmosphere, “general” civil society mobilization dynamics and the specific presence of SRH and rights movements.

“Building of alliances with a variety of actors including women’s organizations, sexual health NGOs, PLWHA organizations, and human rights institutions. These alliances departed from the positive experience of social mobilization that led to the fall of Fujimori in 2000.”

(Cáceres, Cueto and Palomino n/d:156)

VIII.3. CAPITALIZING EXPERIENCE: PROMISING PRACTICES, INSPIRING EXAMPLES AND LESSONS LEARNED

✓ From homosexual to LGBT rights and common agendas

Although combating medical prejudice against homosexuality and sexual diversity in general terms is a big challenge, countries like Brazil have made important legal and policy changes in building shared

“Throughout 2005 LGBT and feminist groups, committed to building a common agenda, held a series of strategic dialogues. Though these meetings were sometimes marked by tension between transgender and feminist militants, they presented an opportunity to strengthen the commitment of gay militants to the abortion cause, and to bring sex workers and feminists together.”

(Vianna and Carrara, n/d:51)

agendas among LGBT’s and other activist groups that have certainly impacted positively on how HIV is prevented and treated.

In Peru, “the HIV/AIDS agenda experienced unprecedented progress once the focus changed from prevention to access to treatment. In a country where access to expensive chronic therapies is still limited by work and economic status, international support for increased access, as well as the desexualization of persons living with HIV, contributed to the operation of a well-organized campaign for access. While this campaign spoke of health rights, consensus was easier to the extent that even the religious conservatives could connect from a charity standpoint” (Cáceres, Cueto and Palomino n/d:166).

The LGBT movement has also played a crucial role in promoting important changes in addressing civil society and modifying prejudicial and discriminatory conceptions about sexual diversities and the relation to HIV.

“In 2005, the Republican Presidency General Bureau launched a competition among public institutions and NGOs to design projects aimed at combating and preventing homophobia, to include the provision of legal and psychosocial advice for victims, guidelines on taking legal action, and conflict management and mediation. Also in 2005, the Ministry of Education launched a competition for projects to qualify education professionals to advise people on sexual orientation and gender identity.”

(Vianna and Carrara n/d:49)

✓ Campaigning towards prevention, human rights and specific audiences

“Progressive change in the fight against HIV/AIDS is also discernible in the advertising campaigns launched by the Ministry of Health. Early advertisements were widely criticized for engendering fear of the virus (and of the patients). Over time the ads began to incorporate prevention models developed by organizations like ABIA, and to target specific groups like women, teenagers, lorry drivers, drug addicts, sex professionals, and gay men. Besides being committed to defending the human rights of HIV-positive people, these new campaigns have excelled in using plain language about sexuality, and in promoting the use of condoms. The messages, shown on TV and posters, have a light and playful tone.”

(Vianna and Carrara n/d:38)

Focalizing on particularities and differences among groups that share a condition or situation has a danger: extreme fragmentation and potential loss of joint political power. Therefore, it is recommended that effective communication from a perspective of the particular needs is combined with communication/campaigning directed to build bridges between different groups that share a common cause.

“In this sense, beyond specific demands, the greatest development in the struggle for sexual rights in Brazil has been the reshaping of alliances among different groups of activists.”

(Vianna and Carrara, n/d:38)

✓ Participative diagnosis: building capacities and knowledge towards empowerment and effectiveness

As already mentioned, specific knowledge and actors' leadership are two key factors for successful action. Within this framework, some experiences have been developed that combined both elements. An interesting and first-time example is the initiative of the “Diagnosis of the Trans Population that is Dedicated to Sexual Work” supported by UNFPA Bolivia. The experience included training trans people as researchers and the delegation of the main responsibility of the study to their organization, promoting ownership as an important condition for empowerment. The study aims to “contribute to public policy development for the prevention of HIV and STIs and also contributes to respect of the Human and Sexual Rights of the trans population, determining a baseline for future interventions with this population” (UNFPA and MTN 2010:n/p).

✓ *Gender and HIV*

Due to their relevance and interest as proven practices and inspiring cases, the following “recommendations” and examples have all been extracted and literally copied from the document titled The UNGASS Gender and Vulnerability to HIV/AIDS in Latin America and the Caribbean, published by the Women, Health and Development Program of the Pan American Health Organization in 2002 (18-19):

✓ *Recommendation 1*

Empower couples to communicate and negotiate openly about sexual needs, desires and perceived risks, challenging gender norms which privilege men’s decisions and pleasure in sexual relations.

✓ *Recommendation 2*

Empower girls and boys, women and men by increasing their access to education, literacy and information about sexual and reproductive health. Comprehensive and appropriate sexual education should explore gender relations, masculinity, femininity and their effect on sexual behaviour and health

Box 2 – Women’s Life Collective

WLC, an NGO in Brazil, works to develop a new relationship between women and men, by targeting young women’s self-esteem and sexual identity, which are crucial to understanding women’s vulnerability to HIV. The main focus of the program is violence prevention. Emphasis is placed on reaching young women who work in the sex trade, or are at risk of joining. Additionally, the program encompasses an educational component which gives young women the opportunity to take foreign language, theatre or professional classes, including computer repair. Results have been positive. Participants have shown improved school performance and self-esteem. A key factor in the success of this program has been its holistic nature – it addresses the multiple complex needs of young women that involve family relations, work, school, drugs, and sexuality.

✓ *Recommendation 3*

Work with men to explore the effects of masculinity, violence, power and control on relationships and sexual health. Though men are the driving force behind the HIV/AIDS epidemic, the responsibility and capacity that is an essential component of masculinity could be used to fight the epidemic as well.

✓ *Recommendation 4*

Improve sexual and reproductive health services for all, their coverage, accessibility and gender sensitivity. Create more male-friendly sexual and reproductive health services (see box 3). Women and men should be

encouraged to access health services and monitor their own risk factors and behaviour.

Box 3 – ReproSalud

ReproSalud in Peru targets the poorest women (15-49), living in the Andean highlands and the Amazon basin. It emphasizes factors that fuel women's vulnerability: limited power to negotiate within sexual relationships, social isolation, violence, lack of access to financial resources, and low self-esteem.

This project led participants to prioritize reproductive health matters and design and implement appropriate strategies. The involvement of men, initiated on the demands of women, allowed communication between partners about risk behaviours more often associated with men, yet which affect both women and men: alcoholism, violence and forced sex.

✓ ***Recommendation 5***

Empower women to participate in community and national decision-making about HIV/AIDS issues.

✓ ***Recommendation 6***

Incorporate a gender perspective and sexual and reproductive health services into crisis response plans, in order to ensure that a crisis does not worsen the spread of HIV.

✓ ***Recommendation 7***

Increase the advocacy for microbicides because the technology is needed sooner rather than later. Develop more female-controlled prevention methods which can be used regardless of a woman's relationship with her partner, and which will be accessible to even the poorest women.

✓ ***Recommendation 8***

Address the impact of gender norms and stereotypes on women living with HIV/AIDS and the barriers to services which they face. Improve health workers understanding of HIV positive women's distinct physical and psychological needs (see box 4).

Box 4 – International Planned Parenthood Federation

Program affiliates of IPPF in **Brazil** (BEMFAM), **Honduras** (ASHONPLAFA) and **Jamaica** (FAMPLAN) have applied a gender perspective to their counseling programs. The new approach compliments technical training on HIV/AIDS with awareness of sexual health and gender issues that influence vulnerability to STIs, such as the power to negotiate with partners. The experience of the planners led them to conclude that, in order to be an effective HIV/AIDS counselor, it is crucial to address individual risks and circumstances of clients' sexual lives in a nonjudgmental manner. The programs reaped the benefits of including sexuality in counselor training as the unique needs of each client became more readily and rapidly apparent.

✓ ***Recommendation 9***

Acknowledge that women are the primary caregivers within the family and community, and that this work is unpaid. The financial, physical and psychological burden placed on women by the HIV/AIDS epidemic has a significant impact not only on her health, but on the well-being of her family and the national economy.

✓ ***Recommendation 10***

Approach women's health from a holistic perspective. Women's vulnerability to HIV/AIDS is not merely physiological, but situational, it is directly related to her gendered social status (see box 5).

Box 5 – Casa de la Mujer

Casa de la Mujer in Bolivia applies a holistic perspective to women's reproductive health, taking relationships, politics, economics and culture into account. As a result, Casa de la Mujer offers not only reproductive health services, but legal services (for domestic violence and child support cases), psychological care, education (literacy training and educating women about rights and citizenship), access to water, nutrition, primary and preventive health, the environment, and labour training.

✓ ***Recommendation 11***

Work with key population groups which are at a high risk for HIV transmission. This includes sex-workers, intravenous drug users, men who have sex with men and adolescents (see box 6).

Box 6 – 100 Percent Condom Program

In the Dominican Republic, the Horizons 100 Percent Condom Program works with commercial sex-workers and sex establishment owners to promote the mandatory use of condoms in every commercial sex act. Condoms were made available and posters were put up in every room of the establishment. The same program was implemented in Thailand in 1991, with impressive results. Participating sex

establishments reported a 76 percent increase in condom use, and a 79 percent decrease in STIs among male clients.

Source – Horizons Report, May 2002 (Population Council)

Women, Health and Development Programme Gender, Women and HIV/AIDS in
LAC 19



IX. GENDER-BASED VIOLENCE

IX.1. BRIEF OVERVIEW OF THE REGIONAL SITUATION

Violence against Women

"Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

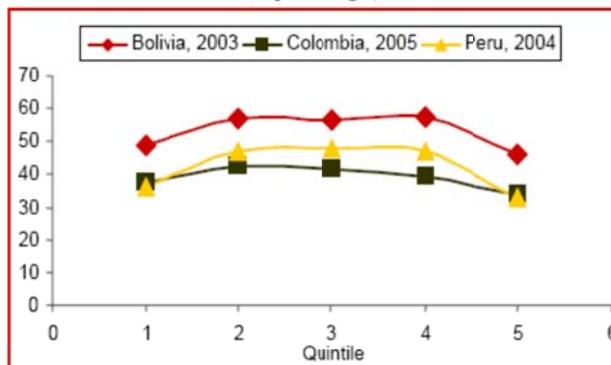
UN Declaration on the Elimination of Violence against Women

In 2007 ECLAC produced a report on violence against women in Latin America and the Caribbean, emphasizing that "the culture of inequality which harbours violence is inscribed in the already violent inequality of opportunities, unequal access to resources and justice services, discrimination in employment and pay as well as the unequal distribution of power and time between women and men. Inequality is also expressed in the inequitable access of women to justice, disparity in treatment by public services and the evidence of impunity indicated in the in-depth study by the Secretary General's office and regional studies by human rights bodies" (ECLAC 2007:16). Within this context of inequality, discrimination and impunity that "gender-based

violence appears out as a systemic and systematic violation of human rights and as an obstacle to economic, social and democratic development in all countries".

Furthermore, "the intersection of male dominance with race, ethnicity, age, caste, religion, culture, language, sexual orientation, migrant and refugee status and disability — frequently termed "intersectionality" — operates at many levels in relation to violence against women. Multiple discrimination shapes the forms of violence that a woman experiences. It makes some women more likely to be targeted for certain forms of violence because they have less social status than other women and because perpetrators know

Women 15 to 49 years-old, victims of physical violence, per income quintile
(In percentages)



Source: Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
Colombia [online], http://www.measuredhs.com/pubs/pdf/oc.cfm?ID=282&PgName=country.cfm0ctry_id=6, 2005.
Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004.

such women have fewer options for seeking assistance or reporting” (United Nations Secretary-General 2006:101).

Women in Latin America “have succeeded in making gender violence visible and in securing legislation against it, but enforcement remains a problem” (UNFPA 2008a:3). As is emphasized by the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights, while certainly efforts have been made in the legal and policy realm, these have been insufficient and ineffective to address the magnitude of the problem.

Access to Justice: The Situation of Women Victims of Violence

A recent report from the Rapporteur on the rights of Women of the Inter-American Commission on Human Rights (IACHR) reveals that women victims of violence frequently do not obtain timely and effective access to resources, guarantees and legal protection. After reporting the facts they commonly suffer from discriminatory treatment by the legal authorities and cases mostly end with no sanctions imposed, in a common climate of impunity. Also many countries lack effective preventive protection mechanisms which should react urgently at the first signs of alert anticipating violent behaviours in the family or social ambits. In many cases women are fatally attacked after having sought State protection, some of whom were actually under inadequately implemented and unsupervised protection measures at the time.

The Rapporteur’s office considers there is a wide breach between the incidence and seriousness of the problem of violence against women and the quality of the political and legal response offered in the countries. Even though the Rapporteur’s office recognizes efforts made by the States in adopting a legal and political framework to tackle gender violence - including a range of resources and legal protection authorities - an enormous gap exists between the formal availability of certain resources and their effective application.

Source: ECLAC 2007:23

Several obstacles hinder an accurate appreciation of the magnitude of the problem, ranging from data inexistence, underrepresentation of complaints and technical problems with data registration and information management. Despite these limitations, existing data is sufficient to highlight the extreme gravity of gender domestic/family violence in the region, qualified as “an extremely damaging form of female disempowerment” (2002:8).

Women 15 to 49 years-old victims of physical, sexual or emotional violence by a current or previous partner			
<i>(In percentages)</i>			
Country	Physical violence	Sexual violence	Emotional violence
Bolivia, 2003	52.3	15.2	53.8
Colombia, 2005	39.0	11.5	65.7
Dominican Republic, 2002	21.7	6.4	67.5
Ecuador, 2004	31.0	12.0	41.0
Haiti, 2000	18.2	17.0	27.3
Mexico, 2003	9.3	7.8	38.4
Peru, 2004	42.3	9.8	68.2

Source: Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
Colombia [online], http://www.measuredhs.com/pubs/pdf/toc.cfm?ID=282&PgName=country.cfm0ctry_id=6, 2005.
Dominican Republic [online], <http://www.measuredhs.com/pubs/pdf/FR146/12Capitulo12.pdf>, 2002.
Ecuador [online], ENDEMAIN 2004, 2005.
Haiti [online], <http://www.measuredhs.com/pubs/pdf/FR121/17chapitre.pdf>, 2000.
Mexico [online], ENDIREH 2003, 2003.
Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004.

Source: ECLAC 2007:31

As UNFPA highlights, “some social and cultural norms and traditions perpetuate gender-based violence, and women and men can both learn to turn a blind eye or accept it. Indeed, women may defend the structures that oppress them” (UNFPA 2008a:3).

IX.2. SOCIAL AND CULTURAL ISSUES

The naturalization of (gender) violence

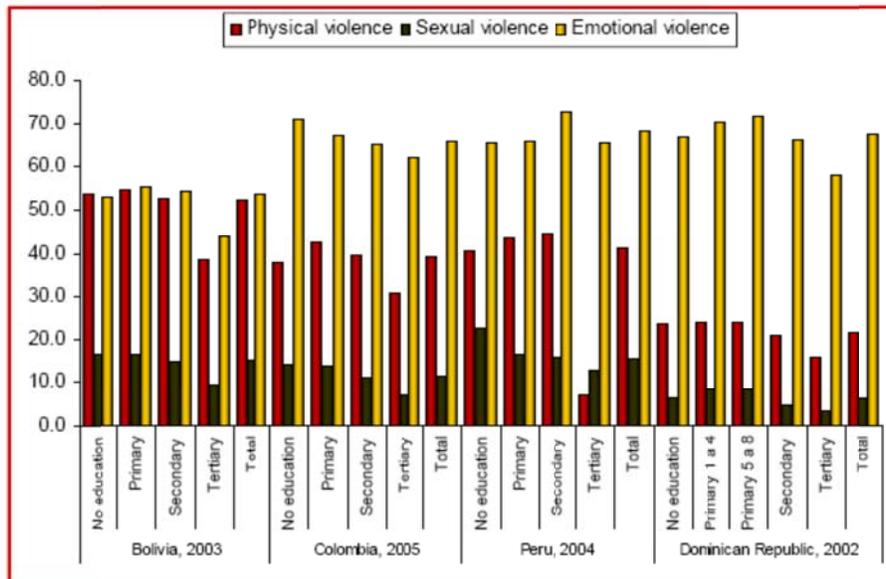
According to Barren and Lowenstein (Qtd. In UNFPA 2004:107), many young men consider violence an uncontrollable and socially acceptable reaction when facing a difficult situation. Not finding other alternatives of expressing their emotions, young males see violence as an appropriate option to get rid of frustration: “Like male sexuality, male violence is often seen as uncontrollable and thus under many circumstances acceptable or at least explainable”.

The naturalization of violence, and particularly gender violence, is a generalized social problem that affects all men and women and structures their identities and relations. Naturalization is the key obstacle for effective cultural transformation since people ultimately believe that violent relations are the only way men and women can relate and that “no other life is possible”, quoting a victim of gender violence (personal conversation).

Educational impact on the prevalence of violence

The following graph extracted from the ECLAC report on gender violence in the region (2007:37) presents data on the different types of violence, related to the educational level of the female victims, differentiating four educational levels ranging from women with no education to women with tertiary education.

Women between 15 and 49 years-old, victims of physical, sexual or emotional violence by a partner, by educational level
(In percentages)



Source: Bolivia [online], <http://www.measuredhs.com/pubs/pdf/FR159/12Chapter12.pdf>, 2003.
Colombia [online] http://www.measuredhs.com/pubs/pdf/oc.cfm?ID=282&PgName=country.cfm0ctry_id=6, 2005
Dominican Republic [online] <http://www.measuredhs.com/pubs/pdf/FR146/12Capitulo12.pdf>, 2002
Peru [online], <http://www.measuredhs.com/pubs/pdf/FR120/12Chapter12.pdf>, 2004

The report concludes that “despite broadly disseminated opinions to the contrary, the data suggest that education is not a protection factor against violence even though the magnitude of physical violence diminishes with more learning. When considering the importance of education in the transmission of values, the data available leads to conclusions that education in the region has not managed to modify models of patriarchal domination and the widespread idea of male superiority. Moreover... violence against women in its various expressions affects all educational levels and all income quintiles” (ECLAC 2007:37). These evidence-based findings certainly question usual class and ethnic associations with gender violence and reinforce the general challenge to address gender violence beyond educational inequities, as generalized structural problem of society.

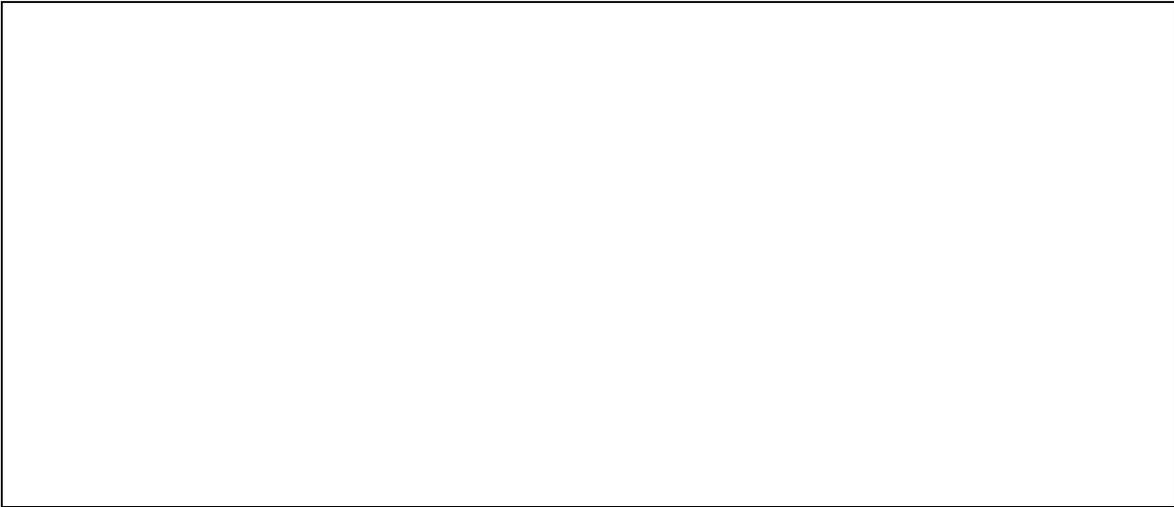
Violence against indigenous women

Despite the previous conclusion on the general character of gender violence, the particular disadvantaged conditions of indigenous women in the region need to be considered as -influential though not determinant-factors: "A study into the situation of indigenous people in Bolivia, Brazil, Ecuador, Guatemala and Panama implied that there were generally higher rates of illiteracy and lower educational levels amongst these groups, than in non-indigenous populations. Meanwhile, being an indigenous women in any of the five countries implies an even worse situation of illiteracy and insufficient education than that seen amongst indigenous men and non indigenous women – a factor which has implications on vulnerability to violence, especially physical violence, even though it is not a determining factor (Qtd. in ECLAC 2007:65).

With less information and resources, indigenous women face additional barriers when they seek help from institutions and health services, which implies less possibilities and a reduced resolution capacity from the start: "Recent research has reported cultural and linguistic exclusion and discriminatory treatment, a situation which is even worse for women from a rural and poor background" (ECLAC 2007:65).

Social effects and costs of violence against women

Increased attentions and efforts are dedicated to quantify and visibilize the social effects of gender violence that reach far beyond the individual victim. As the ECLAC report emphasizes, "the consequences of violence against women are many, the human and social costs must be considered alongside the economic costs. The associated features of violent behaviour constantly cross frontiers between the individual, the family and society. The personal costs (physical, psychological and social) have a considerable effect in terms of disabling women, which can result in insufficient social or labour participation, or both, low productivity and mental health problems. This, in turn, reduces their participation in decision-making, limits interpersonal networks and relationships, reduces geographical mobility and self esteem, and, generally leads to a deterioration in the quality of life of the victim, affects her opportunities to choose and exercise control over her own life and resources" (ECLAC 2007:77).



IX.3. CAPITALIZING EXPERIENCE: PROMISING PRACTICES, INSPIRING EXAMPLES AND LESSONS LEARNED

✓ *Evidence-based conceptual and legal achievements*

A recent ECLAC and UNFPA document highlights the achievements in the legal arena that the fight against violence against women has had in the region: “In the last five years a third generation of laws against gender violence has emerged, an indicator of the social relevance of the topic in the region” (CEPAL/UNFPA 2010A:111). This generation of norms takes into consideration the wide and diverse state and non-governmental experience in addressing violence against women, recuperates lessons learned and, on that basis, typifies new situations of gender violence in and outside women’s homes. An interesting example is related to gender-based political violence and harassment, an issue that gained visibility and status as an unexpected effect of affirmative actions that promoted women’s political participation. Bolivia was the first country to address this form of gender violence followed by other countries like Ecuador where the problem also become evident; as a consequence, different legal proposals have been developed to address this form of violence, which is located in the public sphere but deeply articulated to women’s subordination in the private realm and other familiar and domestic forms of violence. This example highlights also a progressive trend towards a more ample and integrated approach towards gender violence.

Permanent research and experience-based reflection, systematization and innovation in relation to concrete models and practice dealing with gender violence have nourished and are probably a good example to illustrate the

benefits of knowledge management to improve relevance, pertinence and effectiveness of public policies.

✓ *Former victims, today's local activists and promoters*

Years of experience in providing legal and psychological service to female victims of violence have led some NGOs to move a step forward and expand their vision on expected results and multiplier effects beyond individual case resolution. In the experience of the Bolivian NGO "Centro de Promoción de la Mujer Gregoria Apaza", the "model" has evolved to include a final stage where former victims are trained to exercise a voluntary role as local activists and promoters, whose main mission is to inform, encourage victims, provide emotional support based on own life experience, as well as basic legal and institutional guidance. Although the experience is relatively new, the motivating and encouraging effect of personal testimonies to convince women to denounce seems enormous, while at the same time former victims emphasize that this experience gives another social perspective and value to their suffering, allowing them to emerge as promoters of vital changes in other women's lives (personal interviews).

✓ *Men's voices and actions*

According to Olavarria, "the incipient solidarity of men with women who have suffered violence is slowly growing as part of an increasing rejection of 'sexist' and 'heterosexist masculinity' (wherein heterosexuals are considered "normal" in relation to homosexuals)" (Qtd. in ECLAC 2007:92).

"Men's capacity to exercise physical violence because of the strength of their bodies is denounced as a resource of power granted by the hegemonic model of patriarchal masculinity: 'Bodies of males are – potentially – aggressive in the various public and private spaces where women and the 'weak' move about: in their homes, with their partners and children, boys and girls; in the street, with women out 'alone' unaccompanied by adult males, with children, old people and homosexuals; at work, sexually harassing women; at war, as trophies of war, in mass rapes, gender 'cleansing' and genocides'."

(Qtd. in ECLAC 2007:92)

The roots of a men's movement initiated in 1991 with the White Ribbon Campaign, launched in Canada following the Montreal Massacre, and

spread across many countries under the banner of “Men working to end men’s violence against women”. In Latin America and the Caribbean, the campaign has been publicly supported by groups in Argentina, the Bolivarian Republic of Venezuela, Brazil, Colombia, El Salvador, Mexico, Nicaragua, Panama, Peru and Trinidad and Tobago, while similar events have occurred in other countries like Costa Rica, Honduras, Uruguay and Saint Kitts and Nevis in the Caribbean. “Since 2002, many of them have signed the Manifesto of Latin American Men Against Violence towards Women, which aims to make men aware of the role they play in this problem, to foster respectful relationships between men and women and to encourage active participation in the campaign” (ECLAC 2007: 92).

Nicaragua: first Latin American experience

In Nicaragua, a group of men and women created in 1991 the Fundación Puntos de Encuentro (Meeting Points Foundation) to work for the human rights of young women and men and gender equity, with special emphasis on violence against women.^a

Then, in 1993, the Group of Men Against Violence (GHCV) began to form under the banner of ‘Violence impoverishes the lives of men’ to work for ‘change in male chauvinistic attitudes, values and behaviours of men’.^b

The first collective group was formed in Managua and others began to appear across the country. In 1997, a national meeting was held to discuss masculinity and the GHCV groups participated from 1997 to 1998 in research entitled ‘Swimming Against the Current’, which sought ways to prevent male violence within the couple to be used in an educational campaign aimed at men to prevent and counter violence in their couple relationships with women.

During 1999, the campaign ‘Violence against women: a disaster that men YES we can avoid’, planned and coordinated by Puntos de Encuentro (Meeting Points), was the first mass action in Central America which aimed to raise men’s awareness of the issue of intrafamily violence as well as their consciousness of their responsibility.

Since these first initiatives, Puntos de Encuentro has developed a large range of activities on awareness-raising and communication – including a television series and a radio programme, as well as publications, workshops, conferences, debates, cultural promotion days and contributions to the media.

Sources: Ernest Cañada, Los grupos de hombres contra la violencia de Nicaragua: aprendiendo a construir una nueva masculinidad [on line], <http://www.sodepaz.org/nicaragua/GHCV.htm>; Puntos de Encuentro website at <http://www.puntos.org.ni/default.php>.

^a See <http://www.puntos.org.ni/default.php>.

^b According to an interview with Jairo Sequeiro, coordinator of the Group of Men against Violence [on line], <http://www.undp.org/rolac/gender/campaign-spanish/hombres.htm>.

✓ Participatory research

Involving the community, women and men, in doing research, finding out, confronting, reflecting, analyzing violence in their own context is a very interesting, powerful and empowering experience, for the local researchers, for the participants and for the whole community. While learning about qualitative methodologies and participative tools, researchers become advocates. Recently a research coordinated by Rance (2010) in El Alto, Bolivia, presented the publication of the results of a participative action-research initiative on violence and rights that involved multiple local actors – NGOs, service providers, women leaders and former victims and diverse

community members. The project resulted in a) key evidence to guide the design of local-municipal policies against violence, one of the main problems of this city; b) key inputs and feedback for service providers; c) increased consciousness on the dimensions and characteristics of the problem; d) strengthened research capacities for the NGO and participant researchers.

✓ Integrated approaches to address VAWG and HIV/AIDS

A document published by UNDP and Action Aid in 2009 emphasizes that “because violence against women and HIV&AIDS are mutually reinforcing pandemics, the need and the opportunity for integrated approaches addressing their intersection is increasingly evident” (Patterson *et al.* 2009:4). Four broad-based strategies for tackling the intersection are identified as: a) community mobilization to transform harmful gender norms; b) engagement of marginalized groups that are often more vulnerable to the twin pandemics; c) development of integrated approaches to support and care; and d) advocacy for greater accountability among funding agencies and policy makers. The report also highlights, however, that such articulated approaches are quite few and generally small-scale.

In Latin America “promising”⁷ experiences that represent two of these four strategies have been included in the abovementioned report. One is represented by Brazil’s Criola, an organization that works with groups disproportionately affected by both pandemics, thus focusing on how women’s vulnerability to violence and HIV&AIDS is rooted not only in gender inequalities, but in social disparities based on race, class, ethnicity, age, sexual orientation and other factors (Patterson *et al.* 2009:4). Criola’s experience certainly highlights the potential of ancestral culture and tradition, as empowering factors for women.

⁷ According to UNDP and Action Aid , “promising practices” are rooted in a human rights framework, focus on promoting, protecting and fulfilling the rights of women and girls, contribute to gender equality, are evidence-based, sustainable and can be replicated, serving as models for other organizations. Additionally, profiled practices reach one or more of the six following standards: 1. address root causes of both pandemics; 2. empower excluded sectors of society; 3. promote community ownership; 4. enable civil society groups to hold policy makers accountable; 5. promote holistic responses; 6. build bridges between the movements to address HIV & AIDS, and to stem the tide of violence against women and girls. (Patterson *et al.* 2009:9-10).

ADDRESSING WOMEN OF COLOUR IN THEIR OWN COMMUNITIES: BRAZIL'S CRIOLA

"Criola utilizes African descendant cultures to restructure, reorganize and empower black women in their communities. Their tactics have emphasized the value and usefulness of African cultural legacy to understand these women's health conditions and to challenge the way health policies, care and practices are implemented in Brazil."

As the first developing country to implement an HIV&AIDS plan, Brazil has become a model for addressing the pandemic. Despite its international reputation, however, government policies and programs have one major shortcoming: Services are not readily accessible to Afro-Brazilian women and girls, whose vulnerability to HIV and violence is growing.

According Jerema Werneck of Criola, the problem relies on the premise that underlies the policy framework: "The policy framework emerged from an approach based on the notion that HIV&AIDS was only affecting white [men who have sex with men] (MSM). The epidemiology was understood from that premise and the approach translated into use of condoms and medication to take at certain times."

Criola fills an important gap in access to services and information for many favela dwellers by bringing such services to women where they live. In fact, Criola's practices can be considered promising specifically because they operate in areas where the state refuses to tread. The organization develops tools to help women and girls deal with violence, raise their self-esteem, advocate for their rights and embrace their Afro-Brazilian heritage. In addition to practical skills, such as income generation or negotiation of safe sex, Criola builds a sense of pride among favela women. Led by black women of a variety of backgrounds, staff members serve as role models for young girls who know little outside of favela life. Training materials incorporate elements of traditional Afro-Brazilian culture and religion to strengthen self-respect among girls and women often disconnected from both mainstream Brazilian culture as well as their own African heritage.

In addition, Criola's work also serves a larger advocacy purpose. The organization produces data on the disproportionate effects of HIV on blacks in Brazil as evidence to lobby for more resources for black women's health. A parallel strategy used is to facilitate the political participation of black women and girls, in the hope they can develop better policies to address the needs of their sisters.

Patterson *et al.* (2002): *Together we must! End Violence against Women and Girls and HIV & AIDS*. United States Development Fund and Action Aid

The second strategy regionally represented focuses on the creation of integrated approaches, linking health responses to violence and HIV&AIDS to comprehensive social services. One "promising practice" is based in Argentina, where the Fundación para el Estudio e Investigación de la Mujer (FEIM) integrates protocols around VAWG and HIV&AIDS into standard medical practice, using health care as an entry point to comprehensively address the two pandemics as they affect poor women and girls (Patterson *et al.* 2009:4). The Argentina experience emphasizes the importance of specific approaches and tools to allow the translation of theory and policies into concrete services.

Creating protocols to address the intersection: Argentina's FEIM

Legislation in Argentina has guaranteed sexual and reproductive health care for all women since 2002. Yet implementation of the law falls far short in reality.

Founded in 1989, FEIM addresses the intersection of the two pandemics in the public hospitals of Buenos Aires. Since no such standards existed in Argentine hospitals, FEIM advocated for the creation of a protocol to specifically address linkages between violence and HIV&AIDS. FEIM worked with the city's Ministry of Health and the Chief of the Ministry's HIV Unit to put pressure on hospitals to implement these new gender-friendly policies as well as to dispel the stigma and discrimination that women and girls living with HIV often face at service points, being forced to conceal their condition in order to access health care.

The protocol includes a standard set of questions for patients, the provision of emergency contraception for preventing pregnancy, and post-exposure prophylaxis (PEP) for HIV. There is now a focus on comprehensive care, including psychological and legal services. Psychologists and social workers are taught to pay attention to the plight of survivors of violence, especially those who have contracted HIV. The protocol encourages hospital workers to follow up with patients for several months to help provide emotional support and track the patient's progress. According to Ms. Bianco, director of FEIM, without this follow-up, survivors of violence were often "lost in the system". At the suggestion of FEIM, the Sexual and Reproductive Health Unit and the HIV/AIDS Unit created a simplified methodology to facilitate the implementation of this protocol in all services.

FEIM's advocacy with the Buenos Aires Ministry of Health also promoted the incorporation of gender-based violence analysis into services provided to women living with HIV/AIDS. Likewise, the study of HIV status was incorporated into the care for all victims of violence in public health care services in the city of Buenos Aires.

Protocols and procedures around the dual pandemics are only effective if health care professionals, from doctors to technicians, understand and appreciate the linkages between violence and HIV&AIDS. FEIM trains doctors on the sexual and reproductive rights of women living with HIV&AIDS. In so doing, they not only challenge prejudices in the emergency room, but they also develop a cadre of champions within the health care system who are equipped to carry out the mandated protocols.

FEIM is beginning to assess the experience of violence survivors before and after the implementation of the protocols to demonstrate the importance of integrated and long-term service provision. By analyzing patients' clinical histories through a human rights framework, they offer hospital staff a new perspective on the ways in which social issues such as gender-power relations influence women and girls' vulnerability to violence and HIV&AIDS.

Patterson *at al.* (2002): *Together we must! End Violence against Women and Girls and HIV & AIDS*. United States Development Fund and Action Aid

The United Nations Secretary-General's "In-depth study on all forms of violence against women" (2006), identifies the following "promising practices" in the Latin American region:



The ECLAC 2007 report also highlights the role and good practices implemented by national institutions for human rights and violence against women:

National institutions for human rights and violence against women

The National Human Rights Institutions (INDH) in Latin America have taken action in the following areas:

Reception of complaints and advice to victims

In Colombia, the Ombudsman signed an inter-institutional agreement for the formation of a centre for integrated responses to domestic violence. It has stated its commitment from the outset to the establishment and functioning of the Centre, as well as to take a part in its development and execution, in order to provide direct and effective attention to people involved in behaviours which threaten family harmony and unity, in a quest for adequate and timely protection and reestablishment of their rights. Activities included the designation of five public attorneys for the attention centre, and 1,010 municipal staff were provided nationwide with training on domestic violence, sexual violence and human rights of victims of human trafficking in coordination with the United Nations and the Ombudsman's office.

In Argentina, in order to provide a tool which would allow an adequate fight against gender violence, the Human Rights Adjunct of the Attorney General in the City of Buenos Aires organized in 2003 the production of a guide book listing resources for attention to gender-based violence, compiled together with the Public Prosecutor's offices of Avelaneda and Vicente López, supported by the British Council of Argentina..

Recompilation of data and preparation of studies/research

In Guatemala, the Human Rights Ombudsman has created a statistical register of violent deaths amongst women. Since 2003, it has published an annual report containing figures of deaths for the year, which cite the age, form of death, occupation and nationality of the victims, amongst other data.

Monitoring/Evaluation of the application of legislation and actions of public institutions in dealing with cases of violence and formulation of recommendations

In Panama, in 2005, the Ombudsman monitored application of Law 38 on Domestic Violence through the public prosecutor's offices in six of the nine provinces of the country. This process provided information on ignorance of the law amongst the authorities; conflicts between the Public Ministry and administrative authorities; conciliation between aggressors and victims - which is not contemplated in the legislation; the dropping of cases; the failure to remit cases to the competent authorities; the failure to apply protection measures and the lack of attention protocols.

In Mexico, the National Commission for Human Rights (CNDH) examined elements contained in all the records it could obtain on cases of murder or disappearance of women within the municipal area of Juárez (Chihuahua) from 1993 to June 2003. A special report was presented to public opinion due to the importance and seriousness of the case.

Counsel for the formulation of laws, programmes and policies on gender violence

In Bolivia, the Ombudsman ran an official investigation into the operation of the Family Protection Brigades (BPF) in relation to domestic violence. The investigation covered 14 major cities in the country and culminated in the *Resolución Defensorial* (Ombudsman's Ruling) RD/LPZ/87/2001/AP 18, which formulates a series of recommendations for the Police, the Ministries of Sustainable Development and Planning and Justice and Human Rights. The institution continued to monitor the situation until October 2003, when many of the recommendations had been fulfilled. For example, the Police assigned greater resources to the Brigades, increased the number of female police officers, and, from 2002, included domestic violence within the training curriculum.

In Costa Rica, the Ombudsman actively participated in production of and lobbying for approval of the Law against Domestic Violence, as well as the Law for the Criminalization of Violence against Women.

Sources: Central American Council of Human Rights Ombudsmen (CCPDH)/Technical Secretariat, Inter-American Institute of Human Rights (IIHR), *Regional Report: Situation and Analysis of Femicide in the Central American Region*, August 2006; Ibero-American Ombudsman Federation (FIO), *Second Report on Human Rights (Women's Rights)*, 2004.

Source: ECLAC 2007:95



X. STRATEGIC LEARNING ON HOW TO ADDRESS SOCIAL AND CULTURAL FACTORS THAT INFLUENCE REPRODUCTIVE HEALTH: FROM THE SPECIFIC TO THE GENERAL

While certainly some of the good and practices and learning addressed in the context in relation to a particular topic is certainly useful for another theme or even in general terms, this chapter focuses on sharing some more general and not topic-specific good practices and lessons learned that are considered useful and relevant for any of the five themes addressed in this study.

Disaggregated data and analysis

Averages hide even extreme disparities. For example, in the few instances where States have collected and disaggregated data on indigenous peoples, the statistics verify that indigenous peoples face a significantly wider gap than others in society in the eight areas identified as MDG priorities” (Trask 2009:221). Understanding these ethnic and cultural inequalities and using such evidence for decision-making has enabled countries like Mexico to design and implement effective policies to address these issues, reduce the gaps and impact positively of indigenous RH and poverty reduction.

“In Mexico, where disaggregated data indicated that indigenous women had the highest national rates of maternal mortality and that indigenous child mortality was 300 per cent higher than the national average (Goal 4), the government is undertaking specific actions to overcome the high incidence of preventable diseases (Goal 6) suffered by indigenous peoples in order to have an impact on infant and maternal mortality rates”

(Trask 2009:221).

FCI and PAHO promoted during 2009 a research based on secondary sources on the health situation – with emphasis on SRH- of adolescents and youth indigenous peoples in Bolivia. The study evidenced the statistical and knowledge invisibility of indigenous adolescents and youths, questioned the homogenous perception of this population group, warned about ethnic discrimination as one of the main causes of health inequities and exclusions, and stressed that indigenous issues are increasingly urban.

(Salinas 2010)

Innovative methodological and analytical approaches

Throughout the document several methodological and analytical innovations have been shared. The main idea is that changes in “what is done” have to be accompanied by changes in “how it is done”, from a culturally sensitive, intercultural perspective.

As part of its Health of Indigenous Peoples Initiative, PAHO uses a socio-cultural analysis approach to harmonize indigenous health systems with state health systems:

“This approach seeks to encourage recognition, respect and an understanding of the social and cultural differences between peoples, their knowledge and their resources to improve health strategies by incorporating their perspectives, medicines and therapies into the national health systems. This process requires the application of a legal framework that facilitates social participation, indigenous practices, and the protection and conservation of indigenous knowledge and resources. It similarly requires the generation of knowledge and paradigms that expand conceptual frameworks and facilitate an understanding of indigenous knowledge and its incorporation into the training and development of human resources.”

(Qtd. in Cunningham 2009:175)

Towards intercultural dialogue, negotiation and knowledge exchange

“Participation” is an opportunity to establish intercultural dialogue and negotiation, which aim beyond mere assimilation of marginal populations as clients of the public health services (Bant n/d:7). Community members must be recognized not only as “patients” but also as legitimate knowledge sources and propositional actors.

Bolivia: integrating traditional healers into the public health system

After establishing that 60% of the population goes to traditional healers, the Bolivian health system recognized them officially as health providers and incorporated their practices and medicines.

(Bant n/d:7)

It is important to highlight that intercultural dialogues don’t just happen; they require the design and implementation of intercultural methodologies to promote an open attitudes towards exchange, active listening, joint and individual reflection and, finally, learning and new knowledge production..

Strengthening demand: Empowering organizations

Strengthening women's organizations has effects over the leadership and management styles of mixed community organizations, making them more democratic, inclusive and gender-sensitive. It generates positive conditions for negotiation, community mobilization and male involvement in promoting women's interests, health and sexual and reproductive rights (Bant n/d:8). It contributes to strengthen and qualify the demand and, consequently, to more effective interactions and negotiations with the health providers and even policy makers.

In more general terms, experiences along the region have confirmed the key role of civil society in relation to reproductive health. Demand, social control, advocacy and the capacity to develop evidence-based and culturally sensitive proposals are complementary and strategically crucial to motivate, ensure and maintain sustainable changes in the supply side.

As examples, the following chart highlights some of the roles and strategies that civil society has implemented throughout the region in relation to violence against women:

Some strategies of civil society eradicate violence against women in Latin America

Strategy	Organization
Promote legal reform (penal codes and special laws against violence)	Uruguayan Network against Domestic and Sexual Violence (Uruguay), Venezuelan Association for an Alternative Sexual Education (AVESA) (Bolivarian Republic of Venezuela), Corporación Humanas (Chile)
Promote the design and application of national plans against violence	Venezuelan Network on Violence against Women (REVIMU), Venezuelan University Network of Women's Studies (REUVEM) and Women's Studies of the Institute of Philosophy and Law at the University of Zulia (Bolivarian Republic of Venezuela)
Ensure access to justice for abused women in contexts of both peace and war	Ecuadorian Centre for Women's Advancement and Action (CEPAM) Quito and CEPAM Guayaquil (Ecuador) Human Rights Commission (COMISEDH), Manuela Ramos Movement and Centre for the Defence of Women's Rights (DEMUS) (Peru), Institute of Women and Society (Uruguay); Corporación Humanas (Chile)
Encourage cooperation between lawyers and doctors in giving support to victims regarding legal framework, medical certificate, training, participation in legal processes	Medico-Legal Research and Action Unit (URAMEL) (Haiti)
Train staff of women's commissaries and legal operators, offer integral services and training of community defence volunteers	Women's Institute (Chile), Entre Mujeres Foundation (El Salvador), Legal Defence Institute (IDL) (Peru) ^a
Strengthen citizen monitoring to guarantee the fulfilment and due diligence of the State in the protection of women and girls against people trafficking.	Women's Initiative Group (Chile); Aquelarre Support Centre (CEAPA) and Development Connections (DVCN) have worked together to create the National Observatory on the Migration and Trafficking of Women and Girls (Dominican Republic)
Create and support networks for attention to and prevention of violence against women	CEPAM Guayaquil (Ecuador), Network of Women Against Violence (El Salvador), National Network against Violence towards Women and the Family (Panama); La Unión Women's Centre (Uruguay)
Place the issue of violence against women on public agendas related to citizen security	Flora Tristán Peruvian Women's Centre (Peru), Chilean Network against Domestic and Sexual Violence (Chile)
Carry out prevention activities with specific groups ^b	Gregoria Apaza Women's Centre for the Promotion of Women (Bolivia), CoEscucha Community and the Puntos de Encuentro (Meeting Points Foundation) (El Salvador)
Carry out mass campaigns to raise awareness and disseminate information	Institute of Gender, Law and Development; Institute for Women's Social and Legal Studies INDESO-Mujer (Argentina); Corporación Humanas (Colombia); Association of Women for Dignity and Life – Las Dignas (El Salvador), Chilean Network against Domestic and Sexual Violence (Chile)
Introduce consideration on the violence issue in indigenous communities	Flora Tristán Peruvian Women's Centre (Peru)
Relate the HIV issue to violence as a cause and consequence	Minga Perú (Peru), Open Forum on Reproductive Health and Rights (Chile)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information from the United Nations Development Fund for Women (UNIFEM), Andean Region; Development Connections (DVCN), Bulletin DVCN, March 2007, Vol.1, Nº1 [on line], www.dvcn.org; United Nations Development Programme (UNDP), National organizations working on the issue of violence against women and girls [on line], <http://www.undp.org/rblac/gender/campaign-spanish/natorg.htm>; Medico-Legal Research and Action Unit (URAMEL) (2006) [on line], 'L'URAMEL dans la construction de l'état de droit en Haiti', Press release, 30 November 2006; see also [on line], http://www.simas.org.ni/_experiencia/CasosLas_Dignas.pdf.

^a This initiative won the first prize in the 2006 ECLAC-Kellogg Foundation contest 'Experiences in social innovation in Latin America and the Caribbean' which seeks to promote simple and inexpensive strategies, which in this case allow the justice system to reach very distant places that would be beyond their reach.

^b More information on actions by men's organizations will be covered in the next section.

Non-governmental organizations and women's and feminist organizations have used their power for articulation and coordination to gain political influence with national governments, international cooperation entities and with public opinion. This has earned them the position of valid interlocutors in processes such as the adoption of legislation, the outline of plans to counter violence and the monitoring of the fulfilment of international commitments accepted by the States. These NGOs set themselves up as national and regional networks focussed not only on violence against women but also on a series of gender issues such as sexual and reproductive rights and human rights from a broader perspective.

The power of coalitions; from the national to the international level

According to Petcheski, “the momentum, energy, and experience of the country-based movements for sexual and gender rights have been the formative basis for achievements at the international level” (n/d:21). From this perspective, some well-known examples are:

- ✓ Peru’s exposure and defeat of forced sterilization;
- ✓ Brazil’s campaigns for treatment access for all HIV+ people as a human right and for “Brazil without Homophobia;” and the advances of sexual rights language in the United Nations.

Intercultural health models

Some strategies and already implemented intercultural health models in different countries of the region have already proven to be successful and should be considered as potentially replicable or at least inspiring and guiding ideas:

- ✓ *The promotion of the use of medicinal plants:* “This approach has been generalized. It has been implemented in response to WHO guidelines in terms of giving priority to the use of medicinal plants, assuring their scientific validation. Generally, this has served as a first step in the efforts to find an intercultural health model. This has been combined with the organization of traditional therapists and the delivery of both health systems in the same facilities. A review of the different experiences shows that emphasis has been placed on carrying out studies to “scientifically” validate the plants that are used in the communities, thereby concurring with the position of WHO. A growing tendency to legalize the use of medicinal plants can be noted, although very often, laws fail to recognize the property rights of indigenous peoples—those who carry their ancestral knowledge with them. They become reduced to marginal actors in implementation of the norms” (Cunningham 2009:177).
- ✓ *Joint delivery of official and indigenous medicine in the same health facilities:* “Various countries have adopted another modality by which to organize their intercultural health systems, delivering Western and indigenous health services through the same assistance center.

In the Ecuadorian case, the goals set out for this modality were to a) link indigenous and Western medicine by treating both the indigenous and non-indigenous population, b) deliver health services in harmony with the world vision of different peoples, and c) recover and re-validate indigenous medicine and the role of its representatives.

People are offered the choice of using both health systems as they share the same health infrastructure. Referrals between both systems take place within the same health unit in accordance with the diagnosis. Western doctors are trained to diagnose cases whereby referral to indigenous medical practice is required. One of the most developed areas within this concept has been the institutionalization of traditional births, for which rural doctors have been trained and health units have been oriented. In many cases, the presence of traditional midwives is accepted. This has contributed to reducing maternal mortality rates. Among the lessons learned is that these experiences facilitate the access of non-indigenous people to the indigenous health system and facilitate a “dialogue of wisdoms” between men and women practitioners in the health systems” (Cunningham 2009:177-178).

The Jambi Huasi clinic in Ecuador

In 1994, a local organization established the health clinic *Jambi Huasi* (“Health House” in Kichwa), designed to meet the health needs of the indigenous peoples living in the Andean city of Otavalo. Over 1,000 people come to the clinic seeking health care every month. *Jambi Huasi* offers care using both Western and indigenous traditional medicine, and while it focuses on family planning and reproductive health services, it also offers traditional healing with native plants, as well as general medicine and dentistry. In addition to direct health care services, the clinic also conducts outreach and educational programmes, and all of its services are rooted in an understanding of the culture, language, customs and values of the local indigenous communities. The staff includes indigenous doctors, other health practitioners trained in working with the local population, and a full-time specialist in communication and education.

While *Jambi Huasi* started out by concentrating on meeting the health needs of the local indigenous communities, it has since grown into a care facility for other populations as well. In addition, it has now branched out into developing programmes focused on gender, discrimination, and violence, and programmes focused on youth and adolescents. *Jambi Huasi* has been supported by the United Nations Population Fund (UNFPA), which recognizes it as having the potential to influence national health policy.

Source: UNFPA (2006).

- ✓ **The complementarity approach between the indigenous and official health systems:** “Intercultural health experiences have led to

mechanisms for coordination between indigenous and official health systems even where they do not share the same facilities. The coordination is based on referral and counter-referral agreements. The lessons learned are that promoting indigenous medicine enhances the self-esteem of its practitioners and strengthens indigenous identity. Moreover, it responds to social-cultural illnesses because it facilitates complementary therapy for patients. In addition, it increases community members' confidence in the official health system because they see that their beliefs are respected. It also facilitates relations of respect on the part of staff from the official health system because they get to know and understand indigenous health concepts and practices" (Cunningham 2009:178).

Mainstreaming intercultural health in laws, public policy and state programs

Quoting Cunningham, "intercultural health aims to influence laws and public policy so that they can transform health systems, and there are some experiences where this has been the main emphasis. These experiences combine some of the above-mentioned approaches; they are also aimed at changing power relations within health ministries—whether through decentralization, promotion of national laws and programmes, gathering of data with information ethnically disaggregated, or establishing more inclusive forms of participation of indigenous communities and peoples. Another method has been applied in countries such as Ecuador, Bolivia and Venezuela, where vice-ministries or National Commissions of Indigenous and Intercultural Health have been created. These entities have promoted indigenous health either as a cross-cutting axis or as a specific programme. In the case of Nicaragua, the 1987 approval of an autonomous regime for indigenous peoples and ethnic communities legally transferred the administration of health services to the autonomous regional authorities.⁷⁶ This approach enabled indigenous organizations and authorities to take the lead in a large number of political initiatives. The generally held stigma and perception of incapacity in relation to indigenous peoples changed. The channelling of public resources to indigenous programmes improved. Administrative and management experience was gained at different levels, and this reflected positively in other areas of work" (2009:179).

Addressing social health determinants

Another approach being promoted in the delivery of health services to indigenous peoples recognizes that to achieve structural changes, it is necessary to respond to the specific factors determining their health

situation. The social determinants can be grouped into the following categories: socio-economic circumstances, physical and environmental circumstances, infant development, personal health practices, the individual capacities and skills of those in power, and investment in biological and genetic research and health services. These social health determinants deal with peoples' life and work circumstances and their lifestyles, with how social and economic policies impact on the lives and health of individuals.

Some common measures to implement this analytical approach have included: a) education of official health staff about cultural diversity and indigenous rights; b) coordination with traditional women and men therapists, especially midwives; c) discussion around indicators, especially regarding ethnic disaggregation, and the inclusion of social illnesses in health records; and d) efforts to improve forms of community participation and decentralization of services (Cunningham 2009:179).

Multi-actor initiatives and commissions

Initiatives that involve different relevant and complementary state, civil society, international cooperation and even private sectors and actors increase the social legitimacy of the agenda, the advocacy potential and effectiveness, generate countervailing powers and allow integrated, systemic solutions.

Support to tripartite platforms

The United Nations Population Fund (UNFPA) has brought about strategic actions in the international and regional spheres establishing tripartite platforms against gender violence (government, civil society and international cooperation organizations) and supporting the development and application of projects and programmes seeking to mainstream the gender perspective and the prevention of violence against women, in association with various Women's Offices. Foremost amongst these are:

- Support to IPAS in the production of an integrated model for the prevention of sexual violence which has been applied in selected countries of the region (Bolivia, Brazil, Mexico and Nicaragua).
- Support to the University of Central American (UCA) of Managua in the realization of a regional study on Masculinities and Paternity in Central America (Costa Rica, El Salvador, Honduras and Nicaragua) which integrates a research crux on matters of gender violence.
- In association with the German Technical Cooperation Agency (GTZ), support was provided for a webpage on public budgets and gender in Latin America and the Caribbean², which gathers regional experiences related to public budgets and prevention of domestic violence and violence against women.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of responses sent by ECLAC to organizations within the United Nations system, December 2005 and January 2006.

² <http://www.presupuestoygenero.net/s28/index.htm>.



A Brazilian Example

"In 2005 came an unprecedented initiative; for the first time, a tripartite commission was formed to examine and revise all abortion legislation. The commission included representatives of the executive and legislative branches of government as well as social movements. This initiative resulted in the National Policies Plan for Women. Launched in December 2004 this national plan was based on the agreements reached at the Cairo and Beijing conferences.

(Vianna and Carrara, n/d:34)

However, as the same authors (Vianna and Carrara) warn, a critical perspective must ensure that these initiatives don't entail a potential weakening of the demanding role of civil society: "If, on the one hand, closer ties between civil society organizations and the state can empower these organizations, it can also curb their critical potential, creating situations of patronage and cooptation" (50).

Low profile: effective strategy at times of political upheaval and religious opposition

Different inspiring examples highlight the importance of political context analysis and strategic thinking, visualizing different effective strategies depending on the moment. These include times of low profile that do not imply, however, silence of marginality but effective political action:

"That discursive marginality, however, made it possible for some positive changes to take place when a low-profile strategy was adopted. At times of greater visibility, such as the discussion around the Brazilian resolution or the debate on same-sex marriage generated by the 2005 Spanish law on this topic, the Church has reacted strongly against sexual diversity rights. Even its furious opposition to a discourse on gender is portrayed as resulting from the 'secret purpose' of creating new genders, a direct allusion to transgender persons and homosexuality."

(Cáceres, Cueto y Palomino n/d:161)

XI. RECOMMENDATIONS

"Culture should be integrated as a prerequisite and a basis for development project design in order to build 'development with identity', respecting people's way of life and building sustainable human development."

Program of Action for the Second International Decade of the World's
Indigenous Peoples

The following general "umbrella" recommendations can be identified on the basis of this study:

- Address new cultural situations and RH needs that emerge from present contextual changes, including the emergence and construction of new local, national and transnational identities.
- Consider actors' and context specificities to enhance relevance and effectiveness of policies and programs. Apply decentralized approaches and consider diversity within cultures ("subcultures").
- At the same time, articulate diverse actors and issues building alliances around shared agendas, activities and common goals.
- Strengthen the participation and roles of the particular actors in RH and development processes, increasing their demand and proposing capacities.
- Develop conditions and capacities for intercultural and intergenerational bridges.
- Promote integrated approaches and systemic analysis to address the interrelations between issues, dimensions, actors and capacities.
- Develop and implement culturally/diversity sensitive quantitative and qualitative monitoring and evaluation systems.
- Promote knowledge management policies within organizations to ensure that: a) experiences are systematized as a source for learning; b) that experience-based evidence is gathered to understand particular contexts and cultural expressions; c) that the design and implementation of policies and programs is evidence-based.
- Continuously gather and analyze best practices to apply/adequate already proven models and strategies and increase efficiency.

KNOWLEDGE

- ✓ Strengthen national information systems and promote the generation of disaggregated data.
- ✓ Contribute to the improvement of maternal mortality information systems.
- ✓ Develop quantitative and qualitative research to gather data regarding urban and rural indigenous communities.
- ✓ Develop/strengthen monitoring and evaluation systems that incorporate quantitative and qualitative culturally sensitive indicators and procedures.
- ✓ Promote participatory research, based on developing local research capacities and appropriate methodologies.
- ✓ Translate research results (information, knowledge) into policy inputs/implications.
- ✓ Stimulate the generation of quality information and disaggregated data for specific population groups, issues and sub national geographic areas.
- ✓ Promote a regional monitoring system that allows quality and comparable information on the situation of young people.
- ✓ Take advantage of new information and communication technologies to promote knowledge banks, including the recuperation and dissemination of best practices and lessons learned.
- ✓ Promote multi-actor learning communities and virtual forums.
- ✓ Contribute to the creation and re-creation of intercultural health models by promoting “knowledge dialogues” between practitioners.
- ✓ Mainstream culturally sensitive approaches in the health-related curricula of universities.
- ✓ Improve the gender violence reporting and information systems, including the development of indicators to measure effects of violence at different levels.
- ✓ Develop agreements with universities for promoting multidisciplinary studies on RH.

CAPACITY BUILDING

- ✓ Develop RH educational/training initiatives that are not limited to the provision of information but addressed from the perspective of discussing and generating “life options”. As Wellings *et al.* point out, effectiveness increases when information is complemented with the development of abilities and orientation, like the use of condoms and negotiation to have safe sexual relations (2006: 56). This is linked to an empowerment approach and aims to increase resourcefulness.

- ✓ Generate culturally-sensitive capacity assessment methodologies, monitoring and evaluation systems.
- ✓ Innovate on topics and methods.
- ✓ Address particularities of specific social and cultural groups to respond to their independent needs and interests.
- ✓ Strengthen the “demand capacities” of actors– information, negotiation, monitoring and evaluation.
- ✓ Strengthen the proposition capacities of particular key actors.
- ✓ Build intercultural and intergenerational skills of different related actors.
- ✓ Innovate on informal education approaches using new information and communication technologies.
- ✓ Develop intercultural e-learning opportunities on RH.
- ✓ Design and implement culturally sensitive information, education and communication programs for service providers and community authorities.

ADVOCACY

- ✓ Promote evidence-based policies that respond to diverse cultural contexts and needs.
- ✓ To develop and implement methodologies for the design of intercultural RH policies that enable the exchange, selection and integration of best practices based on the concept of “cultural strengths”.
- ✓ Enhance the capacities of researchers to communicate their findings to policy makers, and enhance the capacities of policy makers to use research findings.
- ✓ Address underlying, oftentimes indirect structural determinants that have a crucial impact on the real possibilities to exercise reproductive rights (e.g. literacy, basic citizen documentation).
- ✓ Develop capacities for political action among different actors.
- ✓ Promote and apply truly and coherently participative methodologies throughout the “policy cycle”.
- ✓ Stimulate ample coalitions that involve usually not involved actors, particularly religious, traditional and professional leaders.
- ✓ Systematize and analyse different successful advocacy strategies to understand the underlying logics and key success factors.
- ✓ Implement participative observatories and policy monitoring systems, involving academic, government actors and civil society (social organizations, NGOs)

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