Poverty, Sexual and Reproductive Health and Human Rights

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Introduction

This document aims to present epidemiological and human rights arguments to show that public health policies built upon analytical approaches taking into account the social inequalities generated by hierarchies constructed on categories such as gender, race/ethnic origin and age, can work as strategies for poverty reduction and social inclusion.

The commitment of countries to the reduction of poverty, based on the framework of human rights, signifies a huge challenge for the United Nations system, and especially for UNFPA, which is involved with sexual and reproductive health, so closely linked to the development and the human rights of the population. The Human Rights Commission, in a document prepared for promoting the dialogue "Human Rights and Poverty: Towards a Rights-Based Approach" (1), declares that poverty is the social phenomenon that works most strongly against the exercise of human rights. Poverty hinders the exercise of economic, social and cultural rights, affects civil and political rights, such as the right to political participation, to human security and access to justice. It is also, together with wars, one of the main factors determining levels of health-illness, mortality and the suffering of women and men in all the countries of the world. Different epidemiological studies have shown that people's health levels are directly related to their socio-economic situation. Poverty is thus a social condition with ethical implications and a matter of social justice. The strategies aimed at reducing or eliminating it must therefore be closely linked with current social frameworks in the field of human rights.

The commitment of the countries and of the United Nations system to the Millennium Goals reinforced the agreements and targets set out previously in the text of the Programme of Action of the Cairo and Beijing Conferences and their 5- and 10-year reviews. The International Conference on Population and Development (ICPD - Cairo) had already defined in 1994 the priority action areas to manage to reduce poverty before 2015, through reaching goals such as to increase universal access to sexual and reproductive health services; diminish the 1990 maternal mortality rate by half before 2000, and by half again by 2015; reduce the mortality rate in under-fives to less than 35 per thousand live births, as well as to increase life expectancy at birth to 75 years or more before 2015 (2). However, starting from the commitments made in the Millennium Summit (2000), the United Nations system as a whole established agreements to support countries in achieving the eradication of extreme poverty and hunger; universal primary teaching: gender equality and the empowerment of women; the reduction of mortality among children under 5 years of age; the improvement of maternal health; the fight against HIV/AIDS, malaria and tuberculosis; the sustainability of the environment, encouraging a world alliance for development.

There is consensus in that, in order to achieve the Millennium Development Goals (MDG), it is necessary to anchor the strategies in the ICPD agenda and support them in some of the principles of human rights. In the health field, this implies promoting sexual health, eliminating unsafe abortions, diminishing maternal mortality, improving prenatal and post-partum care, intensifying perinatal and new-born care, combating STI (Sexually Transmitted Infections), including HIV, reproductive tract infections, cervical cancer and other gynaecological diseases and also providing quality services in family planning and infertility (3). In addition, the centrality of gender equality and of the empowerment of women for achieving all the goals has been indicated as a core strategy in this process.

It was the organizations in charge of supporting the development of health systems, such as the World Bank and the IDB, which placed poverty in the focus of the discussions, but through a definition restricted only to economic conditions and, in many cases, to a rigid perspective. The debate on poverty and health has come up again recently, starting from fresh theoretical questioning based on the gradual growth of health costs. The first is economic in nature: Is it worth investing in health? Even though nobody would deny that poverty is a clear determinant of disease and death, evidence is needed to be able to show that health strategies could contribute to poverty reduction. If it is indispensable to reduce poverty in order to achieve something in the health area, can health improvement strategies reduce the poverty of the different disadvantaged groups?

To advance in this debate it is crucial to have an initial discussion on what conceptions of poverty should be taken into consideration. There are currently various approaches to the subject of poverty. Some are based on the marginalist economic theory that emphasises questions of economic well-being, others on aspects of social justice, or on the maximisation principle that implies providing the greatest benefit to the greatest possible number of people. This diversity of concepts implies a need for greater debate and conceptual development, to which this paper hopes to contribute.

The paper is organised in four chapters. In the first chapter, some of the definitions of poverty that appear in contemporary literature are reviewed and discussed. The discussion emphasises the approaches of Amartya Sen (4, 5, 6) and of social participation. Both of these are relevant for understanding how different sexual practices and

reproductive decisions can play a decisive role in the life of both adult and young men and women, creating choices and capabilities for their human development. In this way, social participation and the increase of certain capabilities are seen as core determinants of the processes of ameliorating or reducing poverty.

The second chapter analyses the different conditions of access to sexual and reproductive health and reproductive rights according to the social determinants of gender, ethnic origin/race, and age. Examples are given to help to identify the differences between some indicators of sexual and reproductive health and social inequality.

The third chapter discusses the limitations of the measurement indicators for disease load for quantifying sexual and reproductive health. It also explores some cases in which evidence is related that possibly supports the argument that investment in sexual and reproductive health, as a strategy for reducing maternal mortality, can help in the reduction of poverty.

The fourth chapter is dedicated to adolescents and young people, who represent one of the populations most affected by poverty, and towards whom sexual and reproductive health policies should be directed as a priority. It identifies social inequalities and processes of educational, social and political exclusion, and at that same time shows the link between sexual and reproductive health, identity and reproductive rights.

1 Poverty, health and human rights

The debate that takes place between economists and social scientists on poverty reduction strategies starts, generally, from the approach behind the concept of poverty. According to the arguments of Laderchi et al. (7), each approach contains arbitrary and subjective elements, which in turn determine the policy strategies for its reduction. The writer defines four approaches to poverty: a) the monetary approach, with resolution policies centred on increasing monetary income, whether through economic growth or through distribution; b) the capabilities approach, aimed at stressing the provision of public goods and the satisfaction of needs; c) the social exclusion approach, that emphasises the elimination of exclusion factors such as, for example, redistribution and anti-discrimination policies; d) the participation approach, that points up the need for the empowerment of the impoverished population.

1.1. THE CONCEPTS OF POVERTY AND THEIR POLICY IMPLICATIONS

The two most commonly used models nowadays to look at poverty are the monetary/utilitarian model and the capabilities model. The monetary/utilitarian model aims at the search for well-being and the capabilities approach at building social justice. Both approaches start from a perspective centred on the individual, since the concepts they use, either lack of utility in one, or lack of capabilities in the other, are characteristics referring to the person and not to social groups. The approach to poverty centred in income as an indicator limits the concept of poverty to satisfactory economic performance. However, a reduction in monetary poverty does not necessarily translate into greater satisfaction of basic human needs, nor does an adequate level of human development guarantee the elimination of monetary poverty (8).

Utilitarianism is based on the principle of maximising utility, i.e., giving the greatest benefit to the greatest number of persons. The criticism of this points out that, following this approach, some decisions could turn out to be arbitrary, e.g., when the interests of a few are considered less important than those of the majority (8).

The capabilities perspective (4, 5, 6) argues that monetary income cannot be the only measure of well-being, given that poverty is defined by the existing deficiencies in terms of health, education and other areas related to the quality of life. Sen's criticism of the other approaches is that they put the emphasis on the results, and not on the means used to achieve the satisfaction of needs, arguing that the degree of satisfaction varies in function of personal characteristics, goods and the social environment (8).

Hakkert (8), based on concepts from Amartya Sen, enumerates some elements that should be taken as basic human capabilities, such as achieving a normal duration of life (according to the life expectancy in the region in which one is living); access to bodily health (having good health, adequate food and shelter); the absence of apparent risks of harm to physical integrity; having the use of reason, thinking and imagination; being able to develop the emotions (be attached to other human beings, places, settings and animals); being able to enjoy the benefits of affiliation, i.e., interact socially under the protection of institutions or congregations; being able to live free from discrimination by sex, race, ethnicity, religion or national origin, i.e., participate in the construction of a collective identity, as well as a personal one; developing the capacity for play and skills for enjoying recreational activities; having the possibility to act through participation in political decisions; the right to ownership; the right to look for work in conditions of equality with others; etc. Of course, this long list could be increased or shortened as a result of reflection about which capabilities are important for the individuals in particular, and, in general, for their social groups. That is, the human capabilities considered to be basic cannot be generalised, since the social, economic, political and personal conditions are particular to each cultural and individual context, although some of these elements should always be considered (8).

Undoubtedly, one interesting approach of Sen's ideas to the topic of social justice is that developed about freedom, understanding it as the capability of each person to guide their own life in function of what is highly valued by them. This is a recognition that capabilities are influenced by the characteristics of each individual, i.e., that it is not only the material resources one has that are important, but also the personal resources. The capabilities approach thus links up with the participation approach, since, in order for persons to act, their capabilities need to be developed, and it must be borne in mind that certain variables, such as sex, the social class in which they are born, their educational and work opportunities, their belonging to a social or ethnic group, and age, can generate inequalities that will, to different extents, make the realisation of their aspirations difficult.

Sen distinguishes between capabilities and functionings or realisations, and this is useful since it is complicated in practice to measure capabilities directly; instead, the means for satisfying needs can be measured easily, and these are expressed more clearly in functionings or realisations. "Realizations refers to the different living conditions, the different dimensions between being and doing, that may or may not be reached, while capabilities refers to our ability to

achieve these living conditions. A realization is an achievement, while a capability is the ability to achieve it". Poverty is, in Sen's approach, the privation of the basic capabilities that make a human being's development possible, regardless of monetary income. The difference between a monetarist and a capabilities approach is that while the former only stresses the low amount of personal and family income, the latter emphasises the privation of capabilities, without underestimating the economic component, since it considers that the impact of income on capabilities is contingent and conditional, whereas the use of the income is subject to the capability each person has to distribute the resources in an optimum way, i.e., to convert the income into functionings (4).

Poverty understood as privation of capabilities is different from poverty linked to low income because, at least in theory, someone with access to education or health will have greater capabilities to resolve the problem of low income. An individual with high income who has poor health will not be poor in economic terms, but will be so in function of the capability of enjoying a full healthy life with greater quality (8). It is in exactly this sense that it can be considered that the development of capabilities in the field of sexuality and reproduction depends, among other factors, on the sexual and reproductive health conditions that are promoted in the population, especially in the female population, given that the woman's body is totally involved when it is a matter of exercising her decisions with relation to sexuality and reproduction.

Among the philosophical systems underlying these models are Bentham's utilitarianism, which props up one part of the so-called marginalist economic theory in relation to well-being and, on the other hand, Rawls' impartial social justice theory (10, 11), based on the idea of contract, i.e., it supposes that the principles of social choice, and so those of justice, are the object of an original agreement. Thus, a just social system defines beforehand the ambit in which women and men have to develop their objectives, and at the same time provides a framework of opportunities and rights on the basis of which each person can achieve particular ends equitably. Another concept from Rawls' theory is that of primary social goods, i.e., the things that any rational person would want to possess, such as rights, opportunities, liberties, the access to income and wealth, or those social bases that can aid comprehensive human development or some of its components.

The participation approach, different from the monetary/utilitarian and capabilities approaches, has the advantage of including in its evaluation the people involved. The World Bank has published a document about this called "Voices of the poor. Can anyone hear us?" (12) which includes testimony from women and men from some twenty countries, representative of different regions of the developing world. The main findings are about the perception of poverty as a multidimensional phenomenon, related above all with the lack of what is necessary for achieving well-being, i.e., for acquiring mainly foodstuffs, housing and land. For the interviewees, poverty involves psychological aspects that lead them to perceive a lack of power in decision-making, a lack of autonomy and, above all, a lack of economic resources to continue maintaining the cultural reproduction of certain practices persisting in their communities. In addition, poverty is seen as a stigma provoking humiliation, taking away power and giving rise to an incapacity to defend oneself from the exploitation to which one can be subjected. In countries such as India and Pakistan, people feel themselves defenceless if they have cash debts because they feel they are less autonomous (12). In the same document, women as well as men consider that poverty to a great extent determines the lack of access to health care services, and that many lives that could be saved are lost for the impossibility of reaching a clinic or hospital, mainly because of the lack of roads and of money to pay transport to take them to the health centre. The lack of basic services, such as drinking water, encourages diseases that could be avoided. They see poverty in terms of an absence of basic infrastructure such as roads, transport, water and hospitals, emphasising their greater vulnerability in the areas of health, education and culture, in comparison with those who are not poor (12): From this point of view, poor people stress that the reception of basic services can help to reduce poverty.

Life experiences in relation to poverty vary according to gender, race/ethnic origin, age, and/or socio-economic level. In Ghana, for example, men relate poverty to a lack of material goods, while women link it to a lack of food. This perception is also found between men and women in Guatemala. For adults, the possibility of escaping from poverty is found in the skills they have for carrying out agricultural tasks, while for young people it is found in the acquired capabilities which enable them to generate income in other activities, such as the possibility of emigrating and obtaining economic resources somewhere else. Many of the poor men and women in this study stress the achievement of an economic independence that enables them to have access to goods and services, above all, to foodstuffs (op. cit.).

From the perspective of the World Bank, confronting poverty implies promoting the development both of social capital (i.e., social networks, community building, etc.) as well as human capital (i.e., health, education, work). Those who consider that human capital should be promoted consider that "investment" in education and health can be profitable in the future based on an increase in work (from the quantity and quality point of view). Undoubtedly, these potential achievements, or the size of them, will depend on the particular conditions of each person, as well as on the historical, political and cultural context of each country. From this approach, it would be enough to "invest" sufficient time and money in education to achieve a good job and have a life of dignity. This idea based only on "investment" models could be enriched by incorporating the perspective of Amartya Sen (4, 5, 6), which sees the aim of development as

to give women and men the capabilities necessary for achieving realisations that give them satisfaction. UNFPA has also adopted the economist's definition to stress that poverty could be resolved by potentiating human capabilities. And one of these, perhaps the most important, is one's own life, which should be long and of good quality.

However, having the right to live a life with well-being does not guarantee that all women and men enjoy equality of opportunities. The participative approach considers that the greatest vulnerability of women and men is associated with their living conditions and with their access in terms of their human rights. This approach appears clearly expressed in the World Bank Report "World Development 2000/2001: Attacking Poverty" where the poor population are asked to characterise their living conditions. It is clear from these characterisations that the hardest dimension of poverty for the population involved in it is social and political impotence, since they are very rarely represented in the circles of power. Among the solutions proposed is the incorporation of the poor in the taking of policy decisions and an increase in their access to opportunities, security and empowerment, together with which is recommended the participation of a variety of public and private sectors – the States, civil society, companies, representative assemblies, donors – as well as the vulnerable groups, in activities that tend to achieve the reduction of inequality and poverty (13).

Poverty reduction generally translates into an improvement in the living conditions of women and men, given that this reduction implies achieving the satisfaction of the basic human needs (food, health and shelter), an increase in education and work opportunities for women and men, and finally these achievements have to be sustainable (4, 9). Given the priority of sexual and reproductive health, public policies have to be oriented towards the most vulnerable among the poor: women, adolescents and young people, and disadvantaged racial and ethnic groups. Once the needs are located, based on the definitions of the persons themselves in relation to human rights, improvements can be put forward, encouraging the development of human capabilities and the participation of individuals in community and social contexts, creating strategies that can help them to escape from poverty.

The approaches to poverty centred on capabilities and participation are important for conceptualising poverty as it is linked with sexual and reproductive health. For UNFPA, incorporating these perspectives means emphasising the achievement of human self-realizations and of decision-making power, bearing in mind the role as political actors and citizens that the people should have in the societies in which they live.

1.2. THE SITUATION OF POVERTY IN LATIN AMERICA AND THE CARIBBEAN

The reduction in poverty levels in Latin America and the Caribbean (LAC) has remained stuck for the past five years – with rates of poverty and of extreme poverty that have remained practically constant since 1997–– while the absolute number of poor people has increased – reaching 220 million (43.4%), of which 95 million (18.8%) live in extreme poverty (14) – and between 62.2% (15) and 81% (9) of the total population of the region live on less than two dollars a day. The LAC region is characterised for having the greatest disparity of income between poor and rich in the world, with Brazil being the country with the greatest inequality.

UNFPA (the United Nations Development Programme), the Economic Conference for Latin America and the Caribbean, and the Instituto de Pesquisa Económica Aplicada (IPEA) drew up a report called "Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean" (16) which, based on an innovative methodology, evaluated for the year 2015, the advances in meeting the reduction of the proportion of the population living with less than a dollar a day (international poverty line). The report attempts to answer the question if in the year 2015 each of the 18 selected countries of LAC will have managed to halve the rate of extreme poverty recorded in 1999. The methodology considers two scenarios: one, historical in nature, aims to extrapolate to the future the growth and dynamics of the inequality in the 90s; the other, an alternative scenario simulating the changes that would bring each country closer to a "regional ideal", which would be a more equitable and wealthier country than any country in LAC at the present moment, and which in the report is named "Maxiland" (16 p. 12). The conclusions coming out of the first scenario, i.e. the simulation based on the historical evolution, indicate that if the countries managed to maintain their economic growth and levels of inequality of the 90s, only seven countries would reach the goal of reducing poverty for 2015: Argentina (measured before the crisis of 2001), Chile, Colombia, Honduras, Panama, the Dominican Republic and Uruguay. Under the same conditions, only six countries would manage to reduce extreme poverty very slowly: Brazil, Costa Rica, El Salvador, Guatemala, Mexico and Nicaragua. In contrast, in the other five countries (Bolivia, Ecuador, Paraguay, Peru and Venezuela) poverty levels would rise, either due to an increase in inequality or to a drop in per capita income, or for both reasons together.

In the second scenario proposed, it was found that, in terms of the international poverty line, if an annual average per capita growth rate of the Gross Domestic Product (GDP) is maintained at 3% or less, with an accumulated fall in inequality (Gini coefficient) below 4%, 16 countries would reach the target (except Bolivia and El Salvador). In terms of the reduction of extreme poverty only two countries, Bolivia and Nicaragua, would need an annual average per capita GDP growth rate of more than 2% and a reduction of inequality of more than 5%. Thus, the most important conclusion of this study is that the high levels of inequality are an obstacle for achieving a dynamic economic growth (16) and reduction of poverty, which should be given close attention by those who take the national decisions.

1.3. POVERTY AND SEXUAL AND REPRODUCTIVE HEALTH

The sexual and reproductive health of the LAC region is strongly influenced by the social inequalities to which the population is subject. The marked socio-economic differences potentiate the inequities of gender, race/ethnicity and age, and the health systems and other social programmes that aim to attenuate social disadvantages do not manage to compensate for these. The concept of sexual and reproductive health agreed in IPCD-1994 obliges an examination of the whole set of health conditions in the different populations, as well as a review of the state of the services offered to the poorest in such aspects as supply, infrastructure and qualified staff, among others (17).

Social spending in the Latin American and Caribbean region grew in the 90s, in comparison with the 80s, but with great heterogeneity between the countries of the region. This investment has not been sufficient to resolve the severe inequalities seen in health matters (18). Nearly 16% of the social expenditure increase corresponds to the health sector and 51% to the extension of spending in social security, especially retirement and other pensions. In general terms, the limited investment in public health has been a determining factor in the deterioration of the sector (19). In 1999 the LAC region spent much less on health than the European Union: 7.3% and 9.3% of GDP, respectively. The difference is also seen in terms of public spending on health made by the central and local governments (43% and 74%). This perspective points up the importance of identifying the way in which changes in health in general and, specifically in sexual and reproductive health, can help to reduce poverty and diminish social inequalities in LAC countries, using as a core approach the perspective of gender and the dimensions of race/ethnicity and generation.

The conceptual links between reproductive health and poverty are historical and go back to the period in which the reduction in the fecundity rate was essentially considered the only or the most effective strategy for reducing poverty. This perspective has been reinterpreted using an human rights approach. Then, equality, gender equity and the empowerment of women began to be valued in sexual and reproductive health, as well as STI-HIV/AIDS prevention and reproductive rights, as topics that should be transformed into State policies and programmes, and become a concern for communities and individuals. So, as from the ICPD, reproductive choices are considered beyond the demographic and medical perspective, being incorporated as an issue involving sociocultural processes and thus values, attitudes, behaviours and beliefs installed in the different societies; it is also perceived as a right of women and men to enjoy a full sex life without unfavourable circumstances (20).

It is known nowadays that neither the neo-Malthusians nor their critics have the correct approaches in relation to specific strategies put forward for poverty reduction (21, 22), and that neither family planning nor the current models of the reduction of socio-economic inequalities will be sufficient to reduce it. To have an impact on that target, a combination is needed between a lower population growth rate and some degree of economic development, with the reduction of the socio-economic inequalities associated with gender, race/ethnicity and generational inequities. For this it is necessary to build up evidence and/or defend values that can show that an improvement in sexual and reproductive health – understood as a set of basic actions for promoting and defending reproductive rights as human rights – will translate into a reduction of poverty. Through these processes it will be possible to guide processes towards the building of individual and collective autonomy, and to generate a citizens' awareness around the exercise of the right to health for all.

1.4. THE RIGHT TO HEALTH AND REPRODUCTIVE RIGHTS AS HUMAN RIGHTS

The United Nations Commission on Human Rights has underlined the need for a review of the strategies implemented for attacking poverty, from a right-to-health point of view (23). From a human rights-based approach, health should operate without distinction of sex, race, socio-economic condition, age, language or religion, and every human being should be recognised as a person with rights. It is the responsibility of the State to watch over the right to health based on human rights and to fight against practices that discriminate against women, adolescent girls or boys, ethnic or racial groups, homosexual men or women, and people living with HIV (24, 25). In this area, the State has three obligations:

- *Respect* rights, i.e. abstain from interfering and value what each individual/group wishes.
- *Protect* rights, promulgating laws and codes to prevent their violation.
- *Enforce* rights with institutional procedures that favour their ownership.

Human rights must be promoted in different contexts, particularly in that of sexual and reproductive health (26). Reproductive rights are contained within the so-called third generation of rights (27) and include two dimensions, one individual and the other social. The first refers to the right of women and men to free choice of their partner, to privacy, intimacy, autonomy and the free exercise of these for reproductive purposes or otherwise. The second refers to the right of everyone to enjoy the benefits of public health policies, i.e., to receive information, sexual education, quality services, access to scientific and technological progress, to medicines and medical supplies, to programmes promoting the eradication of gender violence, and in general to all those activities that promote the sexual and reproductive health of the populations (24).

As from the International Convention on the Elimination of All Forms of Racial Discrimination (1965), the Conference on Human Rights of Vienna (1993), the International

Conference on Population and Development – Cairo (1994), the Conference on Women – Beijing (1995), the Convention on the Rights of the Child (1989) and other conventions and pacts, the rights were recognised of women, young people, girls and boys, ethnic communities and racial minorities, and other vulnerable groups to enjoy a life of dignity and free of discrimination, violence and coercion, including in the ambit of sexuality and reproduction. Reproductive rights were asserted as human rights for all people.

Reproductive rights, in a human rights-based approach, imply the principles of universality, indivisibility, diversity and the democratic principle (28); these are as much ethical as juridical values. They are universal because the simple fact of being human gives a person ownership: all human beings are born free and equal in dignity and rights. They are indivisible as they are part of all the other human rights (political, economic, civil, social, etc.) and are inherent to human dignity. They fall within the framework of diversity, based on the freedom of individuals to decide about their sexual and reproductive life, independently of their religious belief, sex, age, sexual orientation, ethnic/racial membership, physical disability, etc. Lastly, they are democratic since they are linked with the exercise of citizens' rights and the right to equality. Moreover, every person has the right not to be discriminated against, to participate in the decisions of the country in which they live and to be included in State policies. The exercise of reproductive rights from a human rights perspective demands emancipatory activity in the political and judicial ambit, and also requires an approach that is culturally sensitive. The document summarising the debate[1] (Campaign for the Inter-American Convention on Sexual and Reproductive Rights, 2004) around the proposal of the Inter-American Convention on Sexual and Reproductive Rights, explains the need to recognise cultural diversity, with a resignifying of the normative codes according to the norms proper to the men and women making up each society. What is called for is that it should be a norm with universal pretensions but also with the possibility of dialogue with particular contexts.

UNFPA, as part of the United Nations system, judges that the human rights approach is central to its mandate, and also looks at it from a perspective that aims to be culturally sensitive. This means that, despite responding to universalist premises, the human rights framework must start from the needs of the population, locate the nature and extent of health problems in women, adolescents and young people of both sexes, and the ethnic and racial communities, introducing these into its cultural frameworks and norms and, from this position, produce changes promoting their empowerment and their social participation in their specific contexts.

To reach high levels of physical and mental health, as well as of sexual and reproductive health, it is not enough to provide health care services, but more actions are needed to reverse structural, legal and cultural inequities, as well as to study the barriers – of all types – that prevent people enjoying the right to health. An analysis has to be made to identify the structural, mediate and immediate causes that impede the exercise of human rights; and as a consequence, carry out the activities for developing the capacity to exercise them.

Cottingham (29) suggests how to operate in a perspective based on human rights: it implies paying attention to a set of internationally recognised norms, equally applicable to all people in the whole world. The international laws on human rights are a set of legal standards that the signatory countries agree to follow and meet. The countries thus have the obligation to carry out activities in order to fully respect, protect and pay attention to these rights. Cottingham (29) points out how, in the case of health, all the countries of the world have signed at least one international treaty that establishes rights related to health, and this guarantees the possibility of going ahead with equitable activities in this area, i.e., of maintaining ethical principles which aim to distribute social justice. Human rights help to understand how laws, social norms, traditions and institutional practices affect people, positively or negatively, in the exercise of their rights and in the principles inherent in these (26). One of the principles they have emphasised is the inalienability of human rights, which confers on every individual natural rights that must be recognised, respected and guaranteed obligatorily. This possession or ownership of the rights implies being able to enjoy security, education, privacy, dignified treatment in any circumstances, lack of discrimination, equality in access to health care services and to having good health based on equity. The ownership of rights, although it is defended in the forums of the different Conferences and Conventions promoted by the UN, is influenced by gender, racial/ethnic or generational inequities.

Sexual and reproductive health, as well as the set of health conditions that include but are not limited to the provision of services nor to the idea of a lack of disease, and that involve above all, the capability for enjoying a full sexual life, without unfavourable circumstances, can serve as a platform for the empowerment of the exercise of citizenship. The implementation of policies that are able to achieve greater gender, race/ethnicity and generational equity, which in turn promote respect for the ownership of rights, with the view of defending sexual and reproductive health as a universal human right, can act as dimensions that collaborate in poverty reduction in LAC.

1. During the year 2004 a virtual debate was held on the Manifesto of the Inter-American Convention on Sexual and Reproductive Rights, with the aim of collecting opinions of interested organizations, networks and persons. The debate centred around the following core topics: a) Foundation, concept and focus of rights; b) The sexual rights and the reproductive rights; c) Responsibility of the State and the new social contract; and d) The topics of sexuality and reproduction.

2 Social inequalities, health policies and rights

Operating in the framework of human rights in the fields of health, sexual health and of reproductive health implies identifying and recognising inequalities in the levels of health within populations and identifying their causes. To promote changes starting from the principle of equity in health and pushing for recognition by the States of these inequalities implies producing, for example, an analysis of how the hierarchies of gender, race/ethnicity, and age are socio-cultural determinants of health that have importance. These determinants are structural axes of the organization of contemporary societies, that are mutually reinforcing and explain the inequalities in access to health, and so also the inequities in human rights in this field, including sexual and reproductive health.

At the centre of the debate on the role of the States and the commitment of the United Nations in the struggle to reduce and/or alleviate poverty are found the concepts of social equity and of inclusion. Although up to now the only consensus that can be seen in relation to the concept of equity is that there is a component of justice in its definition, the topic of equity in health goes hand in hand with the discussion on ethical principles. This implies incorporating, as a component of the defence of human rights, a concern for reducing the inequity of opportunities in health arising from belonging to less privileged social groups (the poor, ethnic or religious minorities, women, rural residents, adolescents and young people and senior citizens) (32), keeping in mind at the same time that these social disadvantages act synergistically.

Very often, in order to act according to the principle of equity, a social justice approach is used based on the minimum levels that should exist in health. Health policies designed from this perspective tend to guarantee the poor population a basic minimum level of health care, and urge that the other demands be met by the market. These are the policies adopted by the World Bank, for which the funadamental thing is to finance the minimum packages of services that are more efficient in terms of cost-effectiveness with public funds, leaving the individual free to cover the rest of the services privately, among which are included curative care (13).

This policy of individual financing is inequitable for those unable to pay the costs of the health care services, as is beginning to be seen in specific studies showing its repercussions in the area of sexual and reproductive health and human rights. The public sectors moreover show severe problems in relation to the efficiency, coverage and quality of care (19), maintaining an inequality in access to services that is obvious when different localities, regions or social groups are compared.

Sector reforms in the field of health policies within the context of development strategies, according to Nanda (33), are one way of dealing with health and poverty from a "supply-side" point of view (adapting the responses of the health system to the needs of the poor or vulnerable). The concept of "services" in the agenda of sexual and reproductive health and of human rights is thus broadened to attend both "supply" and "demand" in the health-poverty schema (care is improved at the same time as emphasising the empowerment and well-being of individuals, especially of women). In this way, national health systems manage to be promoters of equity within the reform processes in the region.

It was the first epidemiological studies on morbi-mortality of transmitted diseases which showed the greater vulnerability of the poor in the face of disease and death. The demonstration that the living conditions of women and men are a determinant of levels of health was the origin of public health as a science of the collective at the start of the last century, so that the activity of health workers has been associated with social matters from its very beginnings. The health systems of different countries were thus organized on the basis of a perspective of health as a collective matter, justified in the formulation of "equal treatment for equal needs".

But, more recently, claims have been made to the right to difference or diversity, stressing that if we are all really born equal, the needs of societies, groups and persons are different, as they are related to sociocultural, political and economic contexts. "Those who are unequal, i.e., who are different, need to be treated unequally [since] it would be unfair to treat unequal people in the same way". (34). Stressing the criterion of equity, it is important to mention that, even though it is necessary to increase access to health for the population as a whole (for reasons of equality), the specific conditions have to be faced up to (for reasons of difference).

Information contained in the so-called atlases of inequities in health has managed to highlight some of the differences in access to health and well-being between regions and cities within countries, between populations with different socio-economic levels, between men and women, and lastly, between generations. However, the information they provide is limited, since it is based on health management models centred on promoting access to health care services. The data they present do not give the real,

proportional weight to such contextual interventions as public policies and those related with self-care decisions or the influence of the life context of people on their health.

If we consider the topic of equity in the funding of health systems, we can speak of horizontal equity (equal treatment for equals, i.e., those who have equal resources make equal spending, independently of their sex, place of residence, civil status, etc.) and of a vertical equity (unequal treatment for unequal people, i.e., those who have unequal capabilities and so spend unequally in health terms), which could justify some vertical programmes that are still functioning in the sexual and reproductive health field.

Examples are given below of some inequalities in socio-economic, gender, race/ethnicity, and generational conditions, and from the double stigma represented by having a diverse sexual orientation and living with HIV/AIDS, in relation to certain sexual and reproductive health indicators in the LAC population.

2.1. SOCIO-ECONOMIC INEQUALITIES

It is known that economically disadvantaged groups have a greater risk worldwide of suffering various types of cancer. Among those which are most strongly associated with a low socio-economic state are cervical cancer, as well as cancer of the lungs and stomach (35).

Mexican American and Puerto Rican immigrants who live in the USA have an incidence of cervical cancer up to three times greater than that of non-Hispanic whites (36). In LAC, most of the women who die of cervical cancer are of a low socio-economic level and have limited access to quality gynaecological care and to education for preventing diseases (37).

In global terms, the mortality statistics for cervical cancer for the region have a rising trend for most of the countries. (37). It is estimated that more than 30 thousand women died in the year 2000, and nearly 80 thousand new cases were diagnosed (35). The incidence and mortality rates for cervical cancer vary significantly between regions, as can be seen in chart (A). The rate of mortality from cervical cancer is high in: Barbados 29, Paraguay 24, Nicaragua 23 (these are values per hundred thousand women); and is low in: the Cayman Islands 3, Antigua and Barbuda 4, Belize 7 (38). In a study of the Mexican situation, it was found that the risk of death from cervical cancer is three times higher in rural than in urban zones, and that the women who live in regions where socio-economic development is lower have the highest risks of mortality (39).

Chart (A) Cervical Cancer – Incidence and mortality rates (per 100,000 persons) standardised by age for different regions of the world in 2000

Región	Incidence rate	Mortality rate
East Africa	44.3	24.2
Central Africa	25.1	14.2
North Africa	16.8	9.1
Southern Africa	30.3	16.5
Western Africa	20.3	10.9
The Caribbean	35.8	16.8
Central America	40.3	17.0
South America	30.9	12.0
North America	7.9	3.2
Eastern Asia	6.4	3.2
South-East Asia	18.3	9.7
South Asia	26.5	15.0
West Asia	4.8	2.5
East Europe	16.8	6.2
Northern Europe	9.8	4.0
Southern Europe	10.2	3.3
Western Europe	10.4	3.7
Australia	7.7	2.7
Melanesia	43.8	23.8
Micronesia	12.3	6.2
Polynesia	29.0	15.2

Source: *ISIS (2002) citing Globocan 2000. International Agency for Research on Cancer. Reproduced in PAHO 2001. A brief snapshot of the situation: Cervical cancer in Latin America and the Caribbean, 2001. Available in:* www.paho.org/Englixh/HCP/HCN/CCBriefSnapshot.htm

Deaths from cervical cancer are related to factors determining poverty such as low levels of schooling, unemployment, lack of access to quality health care services and the possibility of a timely diagnosis and treatment, as well as residence in rural areas. Women with greater risk of suffering cervical cancer are those with lower opportunities of access to timely diagnosis and treatment, i.e., those who have no resources to face their adverse situation, and so, in order to reverse this trend, investment is needed in sexual and reproductive health, so that better health conditions are created, which would in turn operate as a poverty reduction strategy.

2.2. GENDER INEQUALITIES

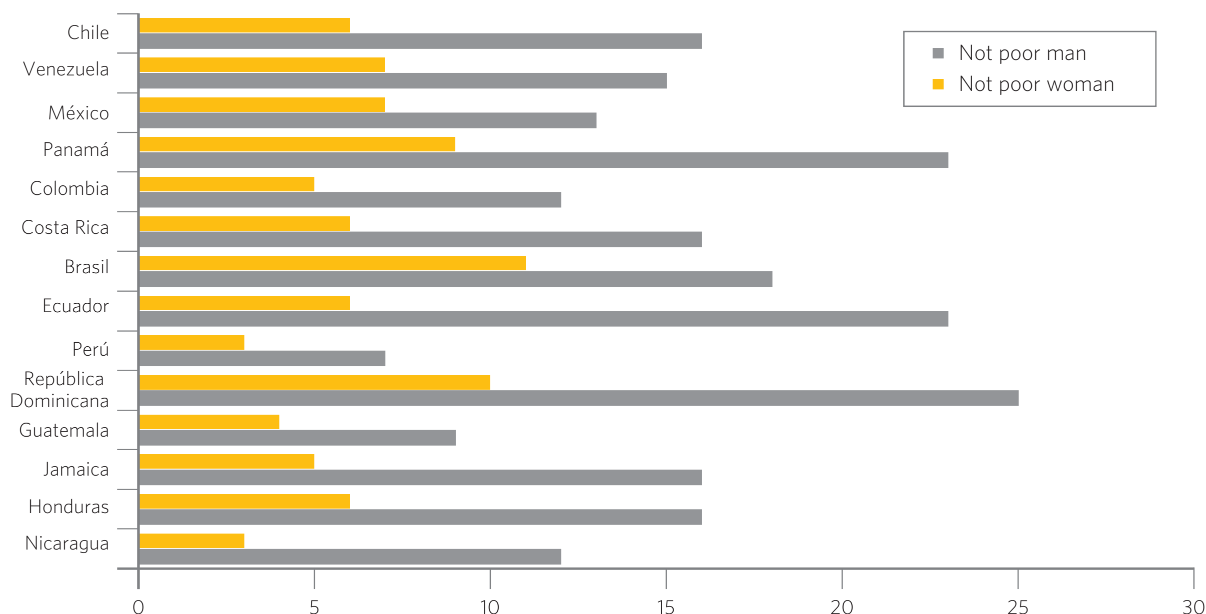
As Gómez indicates (40), the category of gender is central in the micro-psychological ambit of the formation of subjectivity, of interpersonal relationships and in the macrosocial level of the allocation and distribution of

resources and powers in societies that are hierarchical. This hierarchization also has an impact on people's health level since needs, even those of health, are influenced by the unequal power relations that exist between men and women (or between the male and female social ambits). So an adequate understanding is needed about the ways in which these power differences impact on resources, epidemiological profiles and on "consumption" and "production" processes in health (40).

The category of gender makes it possible to explore and understand how differentiated symbolic spaces are built for men and women. In the health field, gender influences the health situation of women in many ways, for example: exposure and vulnerability; the nature, severity and frequency of health problems; ways in which the symptoms are perceived; access to health services; possibilities of following the treatments indicated; long-term social and health consequences (41). Moreover, it is women who have traditionally had the task of caring for and attending to the health of their families and communities, often leaving aside their own needs. It is in this sense, for example, that maternal mortality may occur or increase from negative aspects associated with gender. Another important sign of the evident influence of gender hierarchies on health levels in the population is that of HIV/AIDS prevention, given that the sexual practices of men and women of all ages and race/ethnicity are highly determined by the power of gender. On the other hand, men are excluded – and also exclude themselves – from the ambit of sexual and reproductive health, and one reason for this is the cultural ideas and beliefs that assert a body image of strength and less vulnerability. This can bring as a consequence that, despite suffering pain and/or diseases, men show themselves in general terms less likely to resort to the health care services or to care for the health of themselves and of others. There are also gender prejudices that prevent many men going to periodic check-ups to prevent diseases such as prostate cancer in adulthood or testicle cancer in adolescence. What is more, masculine values, behaviours and attitudes have constituted a significant factor of vulnerability, since maleness is considered a significant health risk factor exposing men to avoidable health problems (42).

Incorporating the discussion of gender into sexual and reproductive health leads to talking about autonomy and empowerment and so about the decisions and choices that women and men take in the ambits of sexuality and reproduction. But it also leads to talking about the co-relation of gender with other social determinants such as social class/poverty, for example. The effect that poverty has on general mortality in women and men can be appreciated looking at the data from a study made by the WHO in certain countries of the LAC. For the group of *non*-poor people, the probability of death is greater among men than women; in several countries it can be seen that the risk among men is more than double that of women (Chart B).

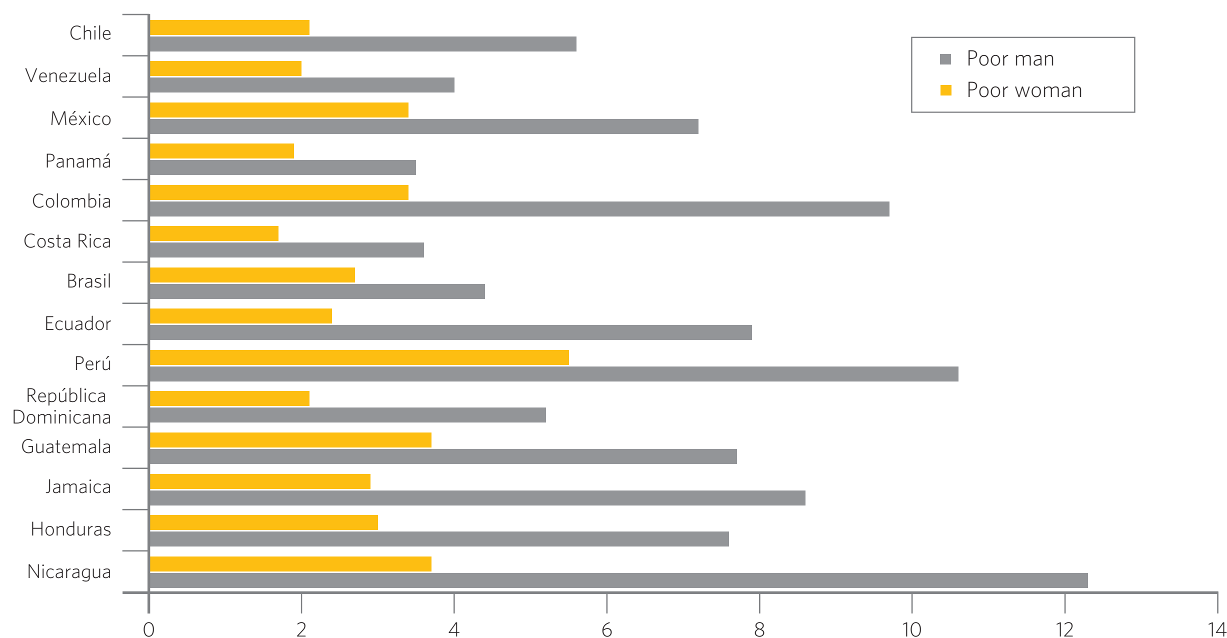
Chart (B) Probability of death (by 100) for men and women not classed as poor, aged between 15 and 59, in selected countries of the LAC region



Source: WHO The World Health Report 1999.

Taking into account, on the other hand, the population in conditions of poverty, the sex-related probabilities of death are inverted and, in seven of the fourteen countries selected the probability of female death is twice the risk of men (Chart C).

Chart (C) Probability of death (by 100) for poor men and women, aged between 15 and 59, in selected countries of the LAC region



Source: WHO The World Health Report 1999.

The relation between sex and poverty is also reflected in violence against women and girls. Some of its effects are seen in unplanned pregnancies, unsafe abortion, sexually transmitted diseases (HIV/AIDS), which, combined with the lack of access to counselling and health services contributes to the high rates of mortality among poor women in this stage of their lives (37).

The impact of violence on the sexual and reproductive health indicators for LAC can be illustrated with various examples taken from the World Report on Violence and Health (43), among which the case of Mexico stands out, where up to 18% of women who report a rape have become pregnant as a consequence. The same report points out that up to 15% of the women who have had a partner at some time, were mistreated physically or sexually during pregnancy, generally by their partner himself, a finding which is based on several studies made in Canada, Chile, Egypt and Nicaragua. This data coincides with other reports from some countries of LAC which suggest that physical mistreatment within the couple is quite common, reported in up to 30% of the cases (44).

2.3. INEQUALITIES OF RACE/ETHNICITY

Another dimension to consider is race/ethnicity. This dimension constitutes a core imperative for the subject of health and sexual and reproductive health in the region. In particular, in association with other social determinants of health, such as gender, this dimension has elements to be analysed and acted upon in relation to the rights of indigenous populations and descendants of Africans. These are actually the ethnic groups most affected in their quality of life. The causes of this situation are found in the historical roots of each country, and involve cultural, social and economic aspects that are extremely important in determining people's levels of health. A recent World Bank study (45) points out that the differences in participation, power and influence depend in great measure on the economic inequalities between people and social groups; justice and equity are consolidated to the extent that there are greater opportunities and capabilities. These are very restricted for indigenous and African-origin communities living in LAC. People of indigenous origin in the region number some 50 million, while those of African origin are between 150 and 200 million. Together they represent 25% of the total population of the region. There are other minority

groups of people living in LAC like the Indian and Asian immigrants, especially in the Caribbean, and these should also be taken into account. The indigenous population in LAC is among the poorest in the area. In Mexico as well as Peru, 80% of the indigenous people are below the threshold of poverty, measured by the World Bank Poverty Line (less than two dollars per capita per day). The situations are similar in Bolivia, Guatemala and Paraguay, as well as Brazil with its population of African origin (46).

Racial and ethnic discrimination encourage inequalities in health between individuals and groups, and hinder access to services. In Brazil, for example, the great disadvantages of women and men of African descent in comparison with the white population who live in the country are well-known (47). The indigenous people in LAC generally live in rural zones in which equitable development has not been generated in health infrastructure. When these populations manage to have services in their own communities, these are of lower quality or do not provide consultations and hospitalisations in the second or third level of complexity (48). On the other hand, a broader conception of sexual and reproductive health, visible in government policies and programmes, and incorporating the subjects of empowerment and rights, is unlikely to reach the indigenous and African origin populations, and if it does, it is not adapted to their specific cultural contexts.

Although it is difficult to separate out the data about health by race/ethnicity, some figures help to appreciate the inequalities between regions. A direct association has been found in Guatemala between life expectancy at birth and the distribution of the population by ethnic group. There is a 10 year difference between people born in Totonicapán (96% of indigenous population) and those born in the capital (45). Maternal mortality figures are another indicator that clearly illustrates the differences between ethnic/racial groups. In Alta Verapaz, where a large proportion of the indigenous population of the country live, maternal mortality is 250 maternal deaths for every 1000 live births, a figure five times higher than the national average for 1998 (48). The risk of giving birth to a dead foetus is 50% greater among indigenous women than among non-indigenous women (49) and it is estimated that 74% of indigenous women do not attend prenatal check-ups with a doctor (or do so rarely), in the health centre or with the midwives, while 67% of non-indigenous women do have this type of check-up (48).

A recent study on the health of the indigenous population in Mexico showed that among the populations with greater density of indigenous people, the maternal mortality rate is 4.6 times higher than in the municipalities with greater mestizo population (50). In Paraná, Brasil, the risk of maternal mortality is five times higher for women of Asiatic descent and 7.4 times higher for those of black race, compared with white women (Martins, cited by 51).

The causes of the high mortality rates in indigenous women in the region are various. A recently published document on the health and well-being of indigenous groups (52) describes how in many of these communities the services and emergency care have limited resources, including obstetric care. Some people have to travel long distances to be attended and, in general, have scarce information about their right to receive free health care.

This is the testimony, collected by Bristow (52), of a traditional midwife belonging to the k'iche' xesalac ethnic group in the Municipality of Santa Lucía la Reforma, Department of Totonicapán, Guatemala, that illustrates cultural and gender aspects that can affect maternal mortality:

"I had a case of a pregnant woman in Gualtux who had been in labour for two days. The baby was positioned backwards. The family had already been advised by the Traditional Midwife (TM) and by the employees of the Health Centre, but in my opinion the problem of that family was machismo. The fact is that the husband did not want his wife to go to the hospital because he did not want his wife's body (genitals) to be exposed to the doctors.

They called me late, and I arrived at the same time as the TM. The first thing I did was to blame the TM, because I knew she had received education, but the TM told me that it wasn't her fault, since she had already warned the woman. She had told the family that they had to go to the hospital, but both the husband and the father of the woman were against it.

When I arrived, the woman shouted: "Help me, I'm going to die!" Her mother was crying too, and shouted: "My daughter's dying! And it's all the fault of her husband and her father who won't let us take her to the hospital!

I tried to calm them all down, and told the woman that she wasn't going to die, and that we would take her to the hospital at once. Meanwhile I was evaluating her condition, and her waters broke with meconium and the baby's hand came out. I began to clean her and at the same time I told her husband to go and get a pick-up to be able to take her to the hospital, and four men who could carry the woman in their arms. I asked the family members to bring me clothes for the woman and we looked for a sheet to take her in. We took her to the hospital. Both the mother and the baby survived, but they had to stay in the hospital for a long time for treatment".

In some countries of the LAC region, the place of residence of a woman about to give birth affects the care she will receive in childbirth, and this will, undoubtedly, condition the possibilities of her dying or not in the course of it. The deficient coverage and quality of sexual and reproductive health services, the low priority in allocation of resources for marginal areas, and the inequitable accessibility of these services to many women belonging to geographically less favourable groups, which in general are the ethnic groups living in rural areas, are causes of the high mortality rates in childbirth.

High maternal mortality indices have persisted for decades, deaths that often occur in regions where qualified care in childbirth is below 50% of cases as, for example, in Guatemala, Peru and Bolivia (53), where a good proportion of the population lives in rural areas. Women living in the countryside tend to have fewer childbirths attended by qualified personnel than urban women, as is seen in the set of countries in the following chart. Contrasts can be marked in some cases such as that of Haiti, where qualified attention in urban areas is approximately 4 times higher than in rural areas.

Chart (D) Percentage of childbirths attended by qualified personnel by area of residence of the mother for some countries of the LAC region (ORC Macro, Surveys of Demography and Health 1996/2001)

Country	Residence	
	Urban	Rural
Bolivia (1998)	77	31
Brasil (1996)	92	73
Colombia (2000)	94	70
Dominican Republic (1999)	98	97
Guatemala (1998-99)	66	25
Haiti (2000)	52	11
Nicaragua (2001)	89	46
Peru (2000)	69	20

Source: *Gender, health and development in the Americas 2003, PAHO.*

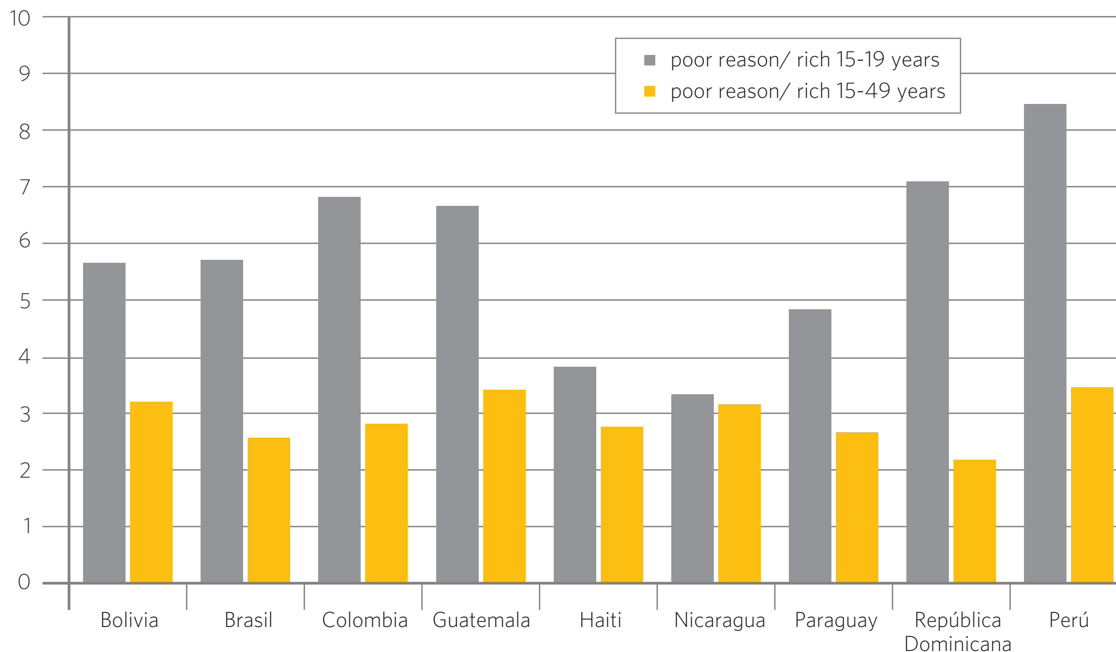
2.4. GENERATIONAL INEQUALITIES

Another dimension that is considered important to analyse in terms of social hierarchy is the generational, stressing the tension between the needs and rights of different age groups such as adolescents and older adults who, in the sexual and reproductive health field, are displaced by the groups of adult women of fertile age.

The age range of adolescence, both female and male, is also affected by the socio-economic inequalities and the differences in power in relation to the adult world. Many rights that have been recognised for other age groups are argued over when adolescents are concerned. The health systems in the region have had restrictions for presenting proposals aimed at adolescents, especially with the implementation of sexual and reproductive health policies. Health sector reform processes do not include adolescent girls and boys as a population to be considered. Adolescent boys and girls mainly enjoy good health, so to think about a network of services for them implies a structural transformation in the supply of health care, a transformation in the provision model from curative to promotional and primary preventive; above all, it implies thinking of adolescents as subjects of human rights, with autonomy in their decisions about their health.

The age differences potentiate the effects that the socio-economic level has on the sexual and reproductive health indicators. Chart E includes a selection of Latin American countries, comparing the ratio of fecundity for the poorest quintile and the richest quintile in adolescent girls (15-19 years of age) and in the total of women of fertile age (15-49 years of age). This shows how the well-known potentiating effect of poverty on fecundity rates is magnified for the group of adolescent girls. Given the importance of the topic of the inequities to which adolescent girls and young women are subject, Chapter 4 gives a broader treatment to this subject.

Chart (E) Fertility rates by 1,000 women. Ratio of 20% for the lowest income group and 20% for the highest income group, according to age group, in certain countries of the LAC region



Source: World Bank, 2000.

Inequalities in sexual and reproductive health are also seen among older women. In first place, the existence of an active sexual life is disregarded. Older women are excluded as subjects of sexual and reproductive health policies in virtue of the fact that they have ended their reproductive stage, even though menopause and climacteric are considered as events that should be attended from an sexual and reproductive health perspective. In Mexico, for example, there are strategies and lines of action in national programmes such as that of reproductive health for attending older women; however, these very rarely materialise into concrete actions (54). In LAC, the *papanicolau* test is most practiced in women under 30 years of age since it is performed, above all, through the family planning programmes, and so the vast majority of women likely to suffer cervical cancer (from 26 to 60 years of age) are left without access to early diagnosis (55).

Generational inequalities and their synergies when associated with gender are also clearly seen in other aspects. For example, even though women live for more years, their quality of life in old age is frequently worse than that of men; in older men, sexual and reproductive health problems such as prostate cancer are not detected in time because there is no culture of prevention.

Current conditions in health matters in LAC block the promotion of a concept of "active ageing" that would enable older adults to be empowered and to demand an enforcement of their right to health and to sexual health (56).

3 Elements for a reflection about maternal mortality: evidence and measurement in sexual and reproductive health

From a human rights perspective, health institutions must attend the poorest people, providing services of quality and helping to change the conditions that create, exacerbate and perpetuate poverty and marginalisation (32), and this cannot be done without more accurate diagnoses of the determinants of the situation.

Making diagnoses about the sexual and reproductive health inequities for LAC with the aim of producing evidence presents difficulties since the national indicators are very diverse, and frequently the regional and local statistical data include different variables. However, even in the absence of conclusive evidence about positive cost/benefit indicators, attending the needs of the poor from a perspective of equity in health implies an ethical commitment (32). In this paper we want to stress that the reproductive rights of all citizens must be located in the centre of the debate on poverty and health, and at the same time encourage research to generate evidence to corroborate the hypothesis that it is possible to attenuate poverty by investing in sexual and reproductive health.

As was mentioned earlier, the methods for measuring poverty are related to the definition that is accepted of this phenomenon. To measure poverty from an sexual and reproductive health perspective, instruments need to be created to find out how the lack of goods, resources and health care services operates and impacts on poverty. These instruments have not been constructed yet, but in order to develop them very special consideration must be given to the opinions of the users of the services, if the idea is for the proposals to be inclusive and to take into account the voices of the poor. Currently, none of the methods for measuring poverty [Poverty Line (PL), Unsatisfied Basic Needs (UBN), Standard Basket of Essential Satisfiers (SBES), Standard Food Basket (SFB)] take into consideration the dimensions of health in general nor those of sexual and reproductive health in particular.

3.1. SEARCH FOR EVIDENCE AND QUANTIFYING SEXUAL AND REPRODUCTIVE HEALTH

As from the 60s, with the observation that the modification of health patterns was sensitive to preventive and curative measures, morbidity statistics became important as health indicators. At that time, the need was detected to design measurements that would complement the mortality indicators with information about morbidity (and other health conditions that do not end in death) within a single numerical index. These instruments are those that are nowadays known as summary measures of population health (SMPH) and their uses can be grouped into two categories (61):

- Description (comparison of the health of different populations, describing the changes in the health of a population over time or the distribution of health within a single population).
- Prioritisation of problems and allocation of resources (quantifying the relative contributions of the different diseases, accidents and risk factors to the total health of the population).

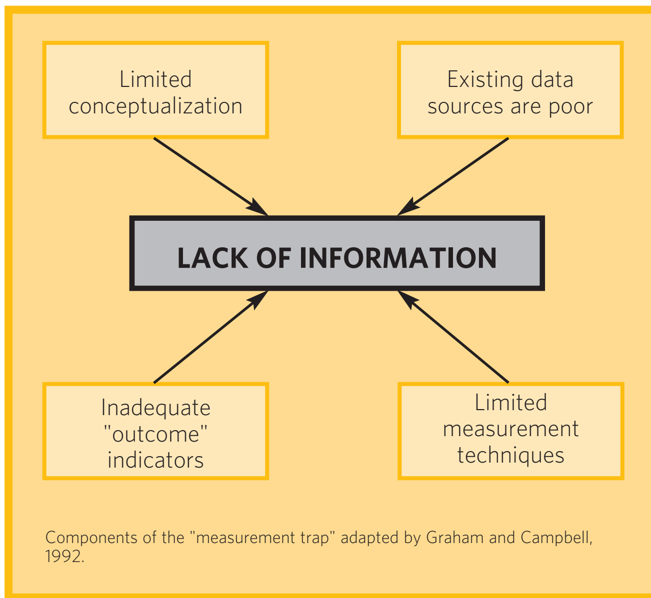
Within the framework of sexual and reproductive health, this paper takes DALYs[2] as an example of SMPH. This measure has been widely used and analysed on the basis of the World Development Report of the World Bank in 1993 that dealt with the Global Burden of Disease (GBD)[3] and its ability to measure sexual and reproductive health has been particularly explored.

Even though DALYs are one of the few existing tools capable of allowing the quantification of sexual and reproductive health in the world health context, its utility is still controversial, as it shows serious deficiencies, particularly in the case of measuring sexual and reproductive health in women. The results of two informal WHO consultations (62, 63) conclude that there is an underestimate of the weight attributed to sexual and reproductive health within the GBD. From this perspective, the criticisms of the use of the DALYs for quantifying sexual and reproductive

2. Disability Adjusted Life Years.
3. The GBD is the sum of DALYs lost for all reasons at all ages for all the regions of the world (World Development Report, World Bank 1993).

health centre on two subjects: its conceptual weaknesses and its technical deficiencies.

The first of these criticisms refers specifically to the lack of sensitivity of the DALYs to cover the definition of what is understood nowadays by sexual and reproductive health. Even before the publication of the World Development Report 1993, Graham and Campbell (64) had already detected conceptual weaknesses in the area of sexual and reproductive health measurement, and described, analysing the particular topic of maternal health, what they called a "measurement trap". For these writers, the low priority given to women's health, joined to the limited amount of information available for describing it, created a vicious circle in which both situations reinforced each other negatively. In this context, they describe a fragile conceptual framework (see figure below) in which maternal health is considered reduced to a state of negativity, characterised by physical manifestations (focused on pregnancy, childbirth and puerperium), ignoring the components of the social and mental manifestations of health. On the other hand, proposing the universal use of a definition of sexual and reproductive health in terms of health and well-being, to substitute for the one centred in avoiding death and disease, the hole in the usefulness of the SMPH has been magnified and a greater challenge has been created for its measurement (63).



Components of the "measurement trap" adapted by Graham and Campbell, 1992.

In addition, the technical difficulties within the design itself of the study of the GBD and of the construction of the DALYs biases the evaluation of the weight of sexual and reproductive health. These failings refer to the particularities of each of the components of the indicator. Since it is not the aim of this paper to repeat the analyses that others have published (61, 63, 62, 65, 66), just a few examples are presented below of the limitations already described.

Firstly, the measuring instruments refer only to the interventions of the health care services related with the reduction of diseases. Most of the consultations made by women in the health care services are to do with preventive activities such as pregnancy control, prevention of gynaecological or breast cancer, etc., which are not included in the calculation of the DALYs. Moreover, the GBD measures the reduction to the ideal state of health attributable to a single disease and underestimates the links and connections between the various diseases.

Likewise, the diseases that were added to calculate the GBD attributable to sexual and reproductive health were obtained from the International Classification of Diseases (ICD-9),[4] which omitted from the list multiple conditions classifiable as sexual and reproductive health if a broad definition of this is used. For example, the ICD-9 did not include conditions like the indirect obstetric diseases (malaria, anaemia, diabetes or hypertension) nor gynaecological morbidity like menstrual disturbances, benign tumours and morbidity from various vaginal infections; nor did it take into account psychological morbidity like post-partum depression, or co-morbidity from HIV. In the case of men, erectile dysfunction or prostate cancer were entities that were excluded from the list. In addition, since the lost DALYs are counted on the basis of a living being, the losses in the case of the birth of a dead foetus were not considered.[5]

Looking at the construction of the DALYs, there are biases in terms of the information used in registering deaths attributed to sexual and reproductive health for developing countries, whose mortality statistics are usually poorly defined; the deaths in under-fives were registered as deaths from transmitted diseases, while, in adults the deaths were registered as non-transmitted diseases. It is thought that with this handling of the information records, many deaths from AIDS and other STIs were badly classified and their burden was no longer measured within the heading of sexual and reproductive health.

The component of years of life lived with disability is composed by multiplying two factors: a) the duration of the disability and b) the gravity of the disability. For the former (the period passed until remission of the disease or death), the DALYs do not permit a distinction between states of temporary and permanent disability. For example, the same weight is given to a vaginal infection from herpes as for a candidiasis, without distinguishing between the permanent and incapacitating duration of the former and the easy remission of the second. For the second component, a disability value was given to the diseases considered within the GBD study. These values were assigned by a limited group

4. ICD - 9: ICD-9 (International Classification of Diseases, ninth edition) which, in this case, has been used to codify and classify mortality data based on death certificates.
5. Death is understood as a stillborn fetus.

of 12 health experts, who evaluated only 22 diseases (from the complete list of more than 400 diseases classified in the ICD-9), and these values were extrapolated to the rest of the list. With this methodology, the value that common people would give to the health conditions that they themselves suffer was not taken into consideration, thus omitting the social, cultural and economic context that could influence these assessments. Weightings were not given for sex, to reflect the differences in disease burden depending on the differentiated disability that certain conditions can create. For example, infertility in some social contexts has a different weight if it presents in men or in women (63).

According to a World Bank Report (67), the sexual and reproductive health disease burden is 22% for women, while for men it is 3%, differences which could be linked to issues related to their practices of sexuality and other sociocultural aspects. Maternal health is the dominant burden in sexual and reproductive health disease for women and in LAC represents 11.3% of the total disease burden. The sexual and reproductive health disease burden is not limited to the effects on the woman herself, but also has intergenerational effects: perinatal causes are 10% of the total of DALYs lost associated with reproductive disease.

The document "Health Dimensions of Sex and Reproduction" (68), in which the DALYs are used to quantify the global burden attributed to reproductive health-disease, mentions that this is between 5 and 15% at world level and that the main entities that contribute to this burden are:

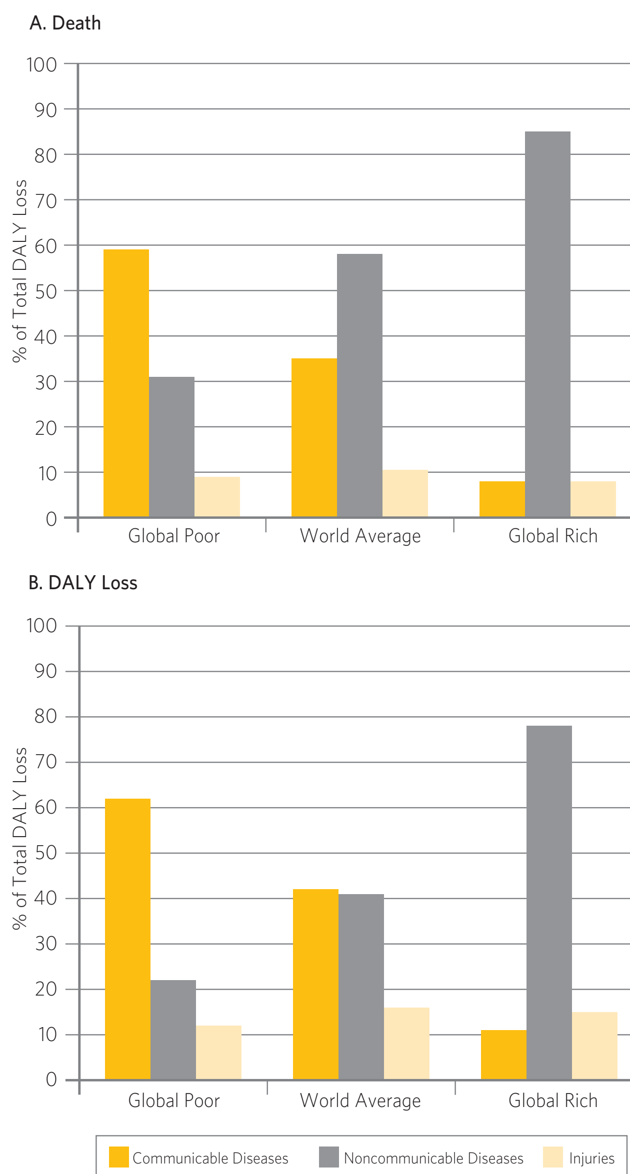
- Death and disability from pregnancy and childbirth
- STIs, including HIV/AIDS
- Cancer of the genital tract.

The document mentions that, in women of reproductive age, 12% of the deaths and 15% of the DALYs lost are the result of unsafe sex. Most of the consequences of unsafe sex fall on the women, who suffer inflammatory pelvic disease, cervical cancer, infertility and complications from unsafe abortions. In men, the disease load for unsafe sex is also high due to the high proportion of AIDS cases registered.

The DALYs have been used as a methodology for various types of analysis. In a study of GBD by levels of poverty (69), it can be inferred that mortality from deficient sexual and reproductive health (where maternal mortality and mortality from STIs are quantified within transmitted diseases) has a greater weight within the causes of death of the poor at world level (Chart F, figure A). This observation is accentuated when the loss of DALYs for the same causes is tabulated (Chart F, figure B) and it can be seen how the weight of mortality for sexual and reproductive health conditions is proportionally greater for the group of poor than when only gross mortality rates are considered.

Chart (F) Weight of Diseases among the poor, on a global scale

Figure 1 Causes of Death and Disability, 1990



Source: *Gwatkin and Guillot, 1999.*

Despite the many limitations described in the interpretation and use of the DALYs to quantify sexual and reproductive health, it is undeniable that these measures have their uses. If the variables used are kept constant, they can constitute indicators that describe health trends in the long term, and they can be used to make future estimates. Projections over 10 years suggest that reproductive health-disease will be the major global cause of death and disability (70). It is known that deficiencies in sexual and reproductive health will cause a million deaths (2% of all adult deaths) and almost 50 million DALYs (3.5% of the total lost).

However, it is indispensable to improve the quality of the sexual and reproductive health indicators. Braverman and Gruskin (32) state that improving routine monitoring of the indicators in the health sector could maximise impact on poverty, equity and human rights. To attend to the principles of equity and human rights, it is necessary to systematically break down the health data obtained, by socio-economic group, sex and race/ethnicity, so that they reflect the situation of poverty and of social disadvantage. In addition, the quantitative data must be complemented (also as a matter of routine) with qualitative information on the situation of the poor and disadvantaged groups in order to describe unattended needs, their perceptions of the quality of the services and the obstacles to receiving them.

There is bibliometric evidence (19) that, despite the fact that accumulated research on inequity in health in LAC has increased in the past 30 years, the implementation of the gender perspective (which is not the same as breaking down data by sex) is still being omitted. It is also necessary to group the health data according to the dimensions of race/ethnicity, since these are indispensable for understanding the determinants of the differences observed in the sexual and reproductive health indicators. What should always be looked for is the synergy that these variables present in the creation of inequalities.

3.2. MATERNAL MORTALITY AS AN INDICATOR OF THE VICISSITUDES OF THE SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN WHO CHOSE TO BE MOTHERS

Historically, mortality statistics have been the basis for quantifying population health, and maternal mortality is the measure that has been most used to quantify sexual and reproductive health. Even though to speak of mortality is to qualify an extreme of "health", maternal mortality may be considered a reflection of the state of health of women of reproductive age, as well as of their access to health care services and the quality of the care they receive (71, 72). The following table illustrates how maternal deaths at world level are found to be concentrated, almost one hundred per cent, in the developing regions.

Chart (G) Estimates of Maternal Mortality by Regions of the World for 2000

Región	Maternal nortality rate (maternal deaths per 100,000 live births)	Number of maternal deaths	Risk of maternal death during life (one in:)
WORLD TOTAL	400	529.000	74
Developed Regions	20	2,500	2,800
Europe	24	1,700	2,400
Developing Regions	440	527,000	61
Africa	830	251,000	20
North Africa	130	4,600	210
Sub-Saharan Africa	920	247,000	16
Asia	330	253,000	94
Eastern Asia	55	11,000	840
South-central Asia	520	207,000	46
South-east Asia	210	25,000	140
West Asia	190	9,800	120
Latin America and the Caribbean	190	22,000	160
Oceania	240	530	83

Source: *AbouZahr and Wardlaw (s.f.).*

The maternal mortality rate (the possibility of dying once a woman is pregnant) is an indicator that expresses maternal deaths[6] by the number of live births and quantifies exclusively the risk of each isolated obstetric event. That is, it does not distinguish the size of the effect for repeated contingency (multiple pregnancies) to which women in countries with high fecundity are exposed. Thus, if the probability of dying when pregnant is quantified together with the probability of dying as a result of the accumulation of pregnancies during the reproductive life of a woman, this shows the true magnitude of the differences between the figures of maternal mortality in industrialised countries and in developing countries (charts J and K). This way of assessing the contingency of death is a fairer and more objective measure of the extreme risks to which women are

6. Maternal death is understood as the death a woman during pregnancy or within 42 days following its termination, regardless of the pregnancy duration or location, for any reason related to or exacerbated by the pregnancy or its treatment, but not resulting from an accident or traumatism. (ICD-10)

exposed during their reproductive lives (72). There are great disparities between the figures of maternal mortality in the different countries making up the LAC region where, on average, one woman in each 160 may die during her reproductive life. There are marked differences, however; in Chile, for example, the risk is of one woman in 490, whereas in Bolivia it is one woman in 26 (see chart H).

Chart (H) Maternal mortality for different regions of the world and some countries of Latin America and the Caribbean

	Maternal mortality (per 100 000 live births)	Risk of maternal death during reproductive (one in X women)
Europe*	**24**	**2400**
Africa*	**830**	**20**
Asia*	**330**	**94**
LAC*	**190**	**160**
**Argentina	50	290
Bolivia	650	26
Brazil	220	130
Colombia	100	300
Chile	44	490
Ecuador	150	150
El Salvador	300	65
Mexico	110	220
Nicaragua	160	100
Paraguay	160	120
Peru	280	85
Dominican Rep.	110	230
Oceania*	**240**	**83**

Sources: ** Maternal mortality in 2000, OMS,** Langer 2001.*

A document published by the PAHO (73) illustrates the marked differences in the estimates of maternal mortality rates within each LAC country. For example, in Honduras, for the year 1990, maternal mortality in the department of Gracias a Dios (878 per 100,000 live births) was nearly 8 times higher than in the department of Islas de la Bahía (116 per 100.000 live births). Likewise, in Alta Verapaz, Guatemala, the maternal mortality rate of 214 per 100,000 live births is markedly different from that of El Progreso, estimated at 53 per 100.000 live births. In Mexico, of every 21 women who die per day from complications in childbirth in the State of Veracruz, 14 are indigenous (74), indicating the degree of vulnerability of certain groups and the regional differences.

It is important to note that the official figures of maternal mortality for many countries are, to different extents, an under-recording of the real numbers (75). For countries with adequate life records, the accuracy in quantifying maternal mortality depends on the percentage of hospital care of childbirths (the more hospital care, the more accuracy). However, in these countries, records can be lower than the reality, considering that, on occasions, the pregnancy is not known and so pregnancy is omitted from the causes of death, or when there is a primary cause of death (such as haemorrhage or pulmonary embolism) the pregnancy is not registered as a secondary cause of the death. In some societies there is under-recording for religious or cultural reasons (for example, when the death from abortion may bring shame to the woman's surviving family). On the other hand, in those countries where the data collection systems of causes of death are inaccurate, those of maternal mortality are constructed on the basis of estimates obtained through experimental designs (household surveys, verbal autopsy, samplings of prenatal care clinical histories, etc.) It should be stressed that the underestimate of maternal mortality figures is marked in the more vulnerable groups of women (for ethnicity, poverty, disability, etc.). In the case of LAC, it is estimated that under-recording of maternal deaths may be around 60% (76).

Globally, one can speak of a "stagnation" in the reduction of maternal mortality figures for LAC. According to a document that describes the trends in reducing maternal mortality throughout history (77), the information on Latin America permits the subject to be analysed only as from the second half of the 20th century. From that time on, the most significant reductions were achieved in such countries as Cuba and Costa Rica, that had well-organized and accessible health care services. Mora and Yunes (73) attribute the stagnation of the figures to the persistence of social inequities in access to quality health care services, as well as to the legislation that limits access to safe abortion. Moreover, in the case of Haiti, the maternal mortality rate is not only the highest in the region, but suffered an increase from 457 to 523 per 100,000 live births between 1996 and the year 2000 (78).

Maternal mortality is a phenomenon that is closely linked to women's rights and to poverty. In the LAC region, the causes of maternal mortality reflect "a lack of political will to confront the factors that provoke it on the part of those who take (or fail to take) the decisions in the countries of the region" (79). In addition, despite the fact that maternal mortality affects all social strata, its greatest concentration among the women of the low socio-economic groups inserts it as a problem rooted in poverty (79).

The percentage of maternal mortality attributed to abortion varies in every country; for example, in Mexico it is recorded as 8%, while in Argentina it is 37%, and in Trinidad and Tobago it reaches 50% (80). Induced abortion is "certainly the cause of maternal death that has the most significant

under-recording… [and] between 4 and 11 thousand women die per year in the region for this reason.” (79). It is estimated that 40% of the women in LAC who have an abortion experience health complications (81). Unsafe abortion, which takes place in unhealthy conditions (see chart I), increases the numbers of maternal mortality, and there is also a significant statistical underestimation in this field. The PAHO has noted that maternal deaths from abortion are not always classified as such; there are no reliable data about infertility provoked by such badly-performed abortions, nor about the link of violence with abortion, although it is known that blows to a woman can induce it, and that, the converse, practicing an abortion can provoke acts of violence against the woman (81).

Chart (I) Amount of induced abortions for each region of the developing world and the set of developed countries

Region of the world	Africa	Latin America and the Caribbean	Asia	All the developed contries together
Rate of unsafe abortion for every 1000 women of reproductive age	27	30	11	3
Ratio of unsafe abortion for every 100 live births	16	36	13	7

Source: *WHO. Unsafe abortion. Global and regional estimates of incidence of and mortality due to unsafe abortion, with a listing or available country data. Geneva, 1998. In Espinoza y Lopez-Carrillo 2003.*

Access to safe abortion is possible in Puerto Rico, Guyana and Cuba, while in Chile, El Salvador and Honduras it is forbidden. In the rest of the LAC countries, it is accepted in certain circumstances such as rape, danger to health and the possibility of the women’s death, malformations of the foetus, for reasons of accidents or lack of prudence, due to insemination without consent or for economic reasons (for example, in Yucatán, Mexico).

The statistics of maternal mortality and of abortion are closely linked to situations of violence, but there are serious limitations about this that must be considered when interpreting them. “Violence is a significant cause of maternal mortality to which little importance has been given” (Heise cited by 71). Although the evidence shows the importance of this problem, the International Classification of Diseases excludes accidental deaths from the definition of maternal mortality. For example, in a descriptive study to evaluate violence during pregnancy as a cause of death in women in Bangladesh (82) it was found that pregnant women (or those with a recent childbirth), with ages ranging between 15 and 19, had three times more chances of dying from traumatisms than women of the same age who were not pregnant or had not had a child recently. Women within that age group presented significantly greater possibilities of death from traumatisms than pregnant women who were older.

As has been seen, the evidence allows the inequalities that persist in the field of sexual and reproductive health to be stressed. Nowadays it is increasingly accepted that maternal mortality is new indicator of development for this millennium, substituting for others such as Gross Domestic Product (GDP) (83), since, according to the World Health Organization, this is a more sensitive health indicator than the socio-economic differences (37, 84) and is therefore important for expressing inequities and poverty.

The idea of these reflections and examples is to point out that in order to broaden people’s capabilities and to have an effect on the reduction of poverty, it is necessary to give priority to the most vulnerable, especially women, resolve their basic needs in the areas of sexuality and reproduction, guaranteeing their rights, and ensure the sustainability of actions for improving their situations and the achievements made in the area of public policies.

4 Adolescence, poverty and social inequalities

In this section we will look more deeply into the analysis of how social inequalities are produced by different determinants that potentiate each other, considering the situation of adolescence. In Latin America and the Caribbean there are more than 100 million adolescents[7] (25) and approximately half of them in conditions of poverty

Children and adolescents can be considered the poorest among the poor, since they have the highest rates of poverty of all age groups. Based on calculations from Demography and Health Surveys, only in Nicaragua, Guatemala, Costa Rica, Bolivia and Chile it is estimated that 45% of adolescents live in conditions of poverty. In the year 2000, almost a quarter of young people, i.e., some 238 million, were living with less than one dollar per day and 462 million lived on less than two dollars. Mexico and Brazil are the countries of Latin America with the greatest concentration of adolescents and the greatest proportion of adolescents living in extreme poverty (25).

Up to 80% of the youth population of the region is concentrated in the Latin American cities, mainly in the poverty belts. This generates conditions for a lack of capabilities, above all those proper to an educational context (neurocognitive development, development of life skills, etc.), which reduces their possibilities of insertion in the labour market (14).

A large proportion of Latin American adolescents live with only one parent, generally just with their mother. According to the findings of a study made in nine countries of the English-speaking Caribbean, only 48% of the adolescents were living with both parents (85) (WHO/PAHO, 2000) and 17% lived alone or with other adolescents. This implies that a large proportion of adolescents are in a disadvantageous social situation for their development.

Due to socio-economic and political conditions, a good proportion of the young poor people find themselves obliged to migrate in search of better work conditions. In Mexico, Nicaragua and El Salvador young people of both sexes are one of the groups most found in the migratory flows towards the United States, making up one third of the net migration to that country, which in absolute figures reaches 142 thousand people per year (86). Migration towards other countries, or from a rural to an urban environment, increases vulnerability and hinders access to health care services. At the same time, many migrant adolescents and young people, men and women, live in situations that put their sexual and reproductive health at risk, exposing them to sexual violence and/or STIs, HIV/AIDS (25).

4.1. DIVERSITY AND INEQUALITY

Adolescents of both sexes are a highly heterogeneous group, with profound inequalities and with diverse spaces for decision-making. A few adolescents belong to high or middle socio-economic levels, but the vast majority survive in poverty. The population is made up of adolescents of both sexes, with different sexual orientations, in unions or married, single or separated; they live in cities either in the central areas or in the outskirts, or in rural environments, in scarcely or densely populated areas, belonging to a diversity of ethnic communities; many study, others only work and a large group neither study nor work. However, among all the adolescents, men and women, there is a common denominator that is the so-called *inequality for generation,* i.e., the lack of power that they suffer for the age that they find themselves at, a situation that strengthens their social exclusion.

4.1.1. INEQUALITIES OF ACCESS TO FORMAL EDUCATION

There are still great inequalities in the region in access to schooling, especially marked for those who are poorer. Educational exclusion, as well as being a determinant of disadvantage in adolescence, has direct implications in their sexual and reproductive health. Educational achievement has been described as a predictive variable for sexual and reproductive health results such as pregnancy, fecundity and the use of the condom (Magnani and Behrman, cited by 87). It has been shown that the competencies for taking informed decisions in the prevention of HIV/AIDS appears substantially based on literacy and levels of education reached. Formal education strengthens the learning of the competencies required for understanding HIV/AIDS and to get the meaning of the prevention messages. So, increasing access to a permanence in schooling are in themselves an important strategy for promoting sexual and reproductive health (Badcock-Walters, N. and Görgens 2004 cited by (88)).

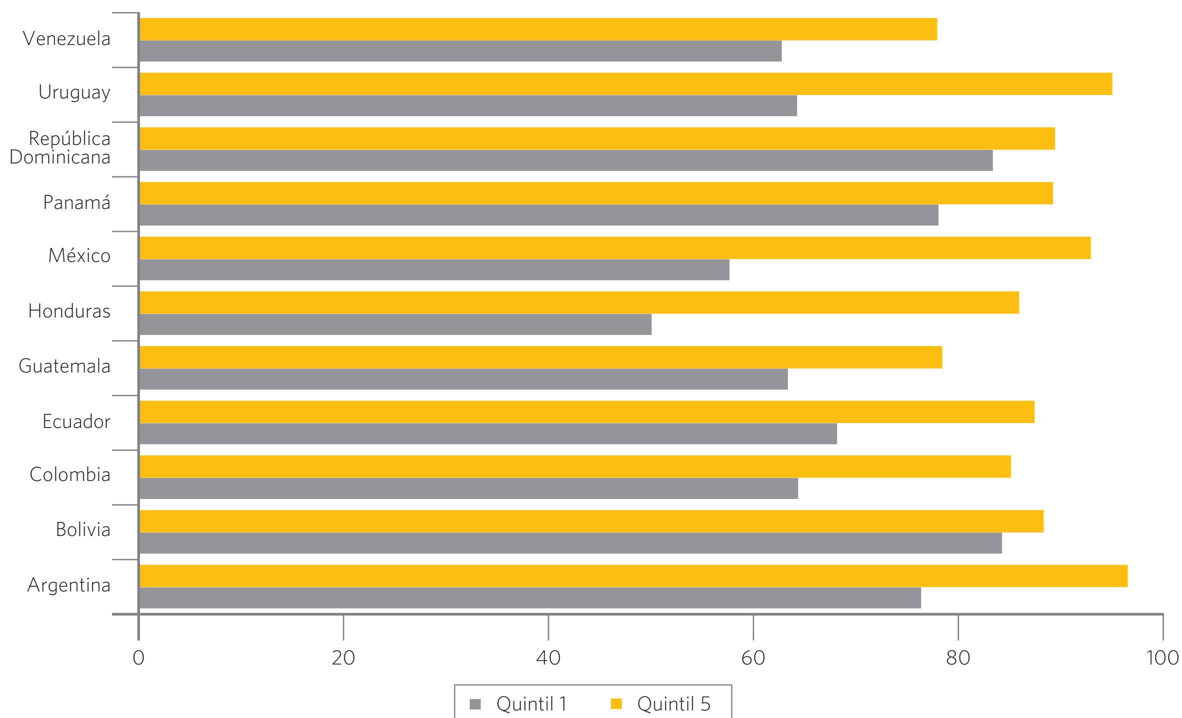
Since the year 1980 and 1996, overall educational indicators have improved, since basic education coverage is over 100% of that projected for both sexes and in secondary it reaches 60%. Despite the notable progress made, the right to education is still not evenly met. In the region, the socio-

7. Adolescents are considered as persons belonging to the 10 to 19-year age group; young people belonging to the 15 to 24-year age group and those belonging to the 10 to 24-year age group.

economic and gender differences as well as those of race/ethnicity and of place of residence still influence the opportunities that adolescent girls and boys have to gain access to education. For example, one characteristic of the region, different from what is seen in other parts of the world, is that boys are at a disadvantage for obtaining levels of secondary education as compared with girls. Indices of access to secondary education in Latin America and the Caribbean are 30% higher for girls (89).

Participation in secondary and higher education programmes in the region is still dominated by the higher income groups (90). The following graph (Chart J) illustrates the relation between household income and school attendance of female and male adolescents in the urban environment of some countries of the region, in which the disadvantage of the poorer adolescent boys and girls is always evident.

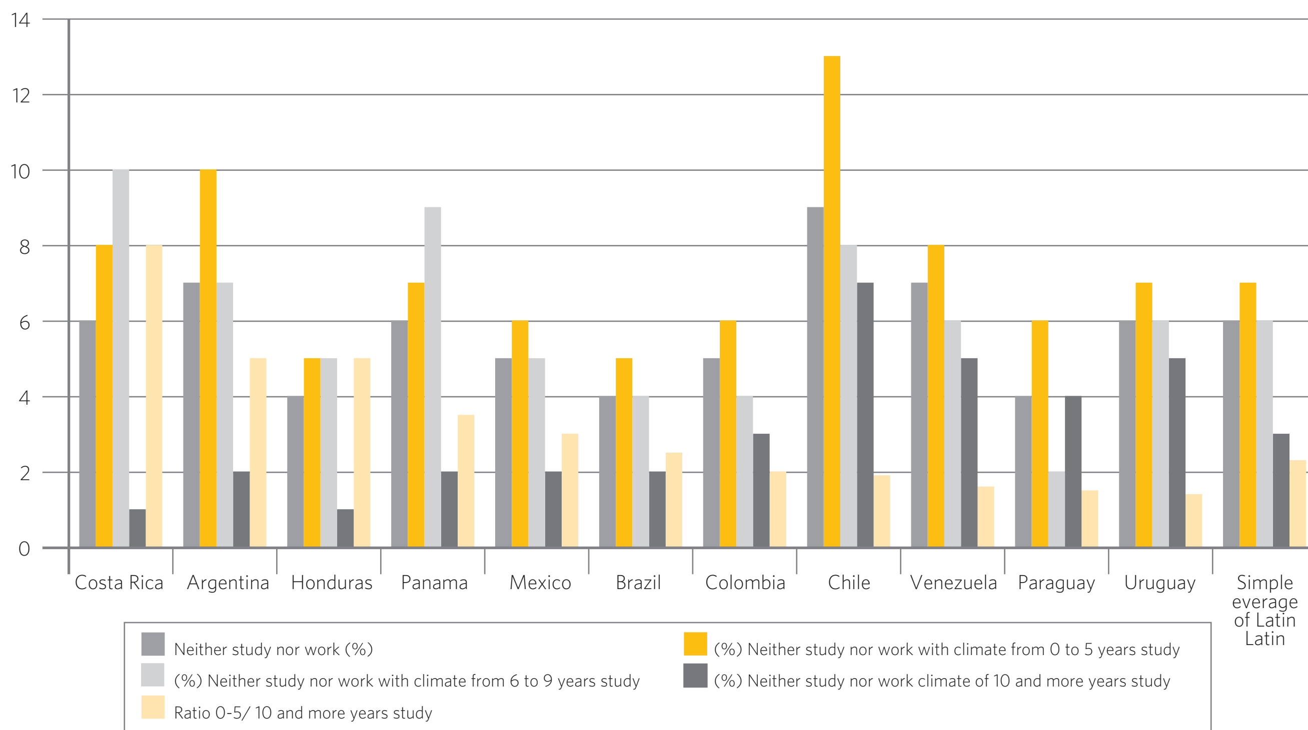
Chart (J) School attendance (%) of the lowest and highest home per capita income quintiles, for adolescents aged between 13 and 19 in urban areas of selected LAC region countries in 2004

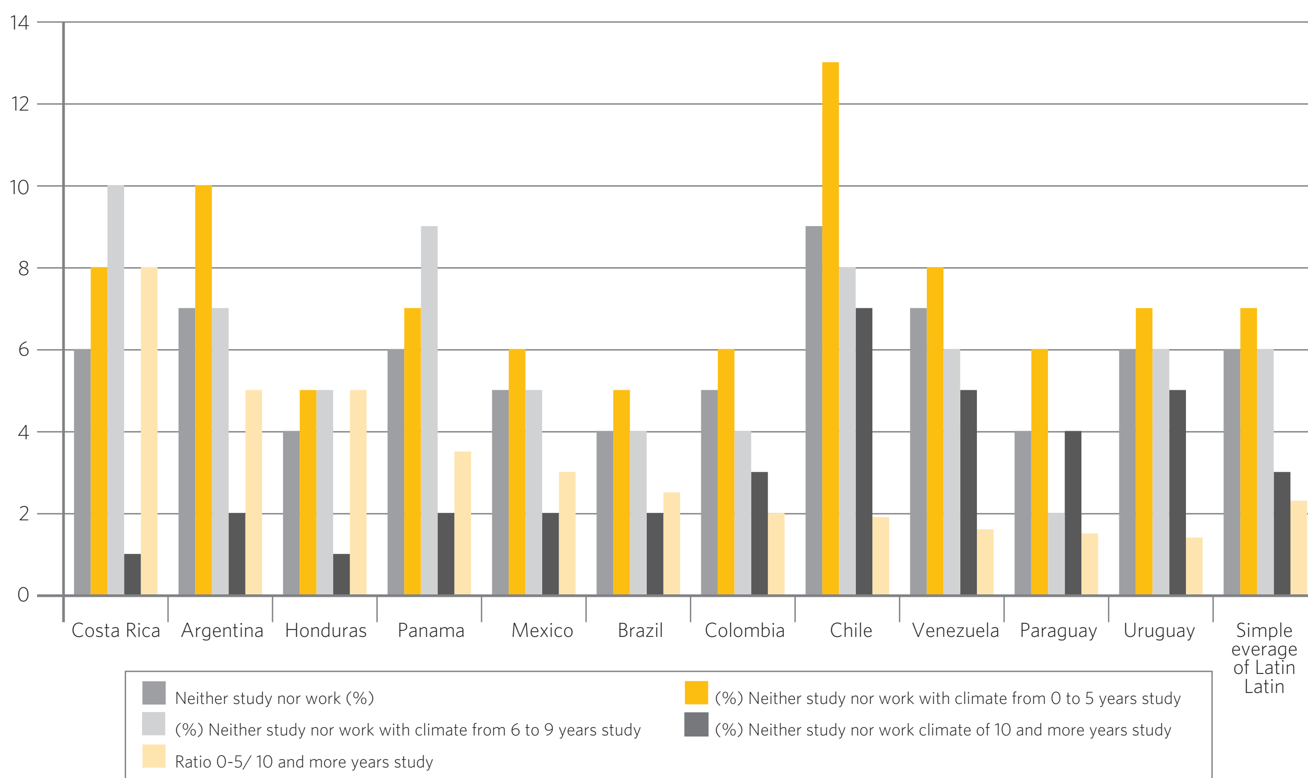


Source: BADEINSO: Social Indicators and Statistics Base, Social Statistics Unit, Statistics and Economic Forecasts Division, ECLAC

The number of years of study is associated with the family's educational environment, which generates advantages for adolescents of both sexes coming from families with high educational context. Looking at the percentages of youths of 15 to 19 years of age in the region who neither study nor work, a higher proportion of them can be seen in all the countries of the region in households with a lower educational atmosphere, especially among boys. This is the case, for example of Chile and Argentina, where the proportion of socially excluded young men who neither study nor work is from 8 to 1.4 times higher in the household with less educational atmosphere; for women it is from 8 to 0.3 (Charts K and L).

Charts (K and L) Percentage of boys and girls between 15-19 years of age who neither study nor work, depending on educational climate of household, urban zones of 11 LAC countries 1994





Source: *ECLAC, on the basis of special tabulations of household surveys of the respective countries. In Panorama Social de América Latina, 1997.*

The social determinants of remaining in school are multifactorial, but among the reasons for which adolescents of both sexes are excluded from school are found the their need to obtain economic resources from working. Educational systems in the region do not take this situation into account and, in general, do not adapt to their living conditions, so that they continue reproducing socio-economic inequality, social exclusion, inequity and poverty. According to UNICEF estimates (90), children and adolescents of both sexes who work have an average of two years less of education than those who do not work. This deficit in years of schooling is reflected in the long-term, since on average they receive 20% less monthly income throughout their working lives (90). On the other hand, access to work opportunities is increasingly dependent not only on the educational level achieved, but also on the educational quality received (91), a fact reflected in the growing levels of youth unemployment that is double general unemployment in nearly all the countries of Latin America and the Caribbean (14).

The poor in rural zones are also at a greater disadvantage due to their geographical isolation and to the fact that the organization of farm-work still favours family farming for self-consumption. This creates the need for adolescent girls and boys to work on the farm and, faced with an educational system that does not permit combining education with employment, the first thing to be abandoned is the school. The data show that 71% of adolescent boys and girls who work in rural zones of the region have given up the educational system (14). The differences in schooling between the rural and urban environments are marked from the basic levels of education; it is estimated that 40% of the children in the rural zones of Latin America do not finish primary schooling (or do so some two years late), in comparison with 17% in urban areas. Figures for the population from 15 to 24 years of age show that, with the exception of Chile and Panama, access to education for females and males from the cities is up to three times higher than in rural zones (89).

Educational inequity is also evident for indigenous populations. The following chart (M) shows from data from Brazil how illiteracy rates are concentrated in certain ethnic/racial groups.

Chart (M) Illiteracy rate in Brazilian youths by sex and race, 2001

	Males			Females		
	Total	Whites	African descent	Total	Whites	African descent
10-14 years	5.3	2.4	8.1	3.1	1.5	4.5
15-24 years	5.3	2.7	7.9	3.1	1.5	4.8

Source: *IBGE/PNAD in Sant'Anna 2003.*

There are also problems at institutional level that, although they have been identified, have not managed to be entirely solved (such as the lack of bilingual teaching programmes). Educational systems frequently do not respect the heterogeneity of the young people in their ethnic/racial, socio-economic, gender differences, and even less in their personal differences. Formal education tends to homogenise adolescent girls and boys, hinders certain expressions of their individuality, of their group or ethnicity, or reinforce gender stereotypes, which is unsuitable for encouraging the exercise of rights and the exercise of full citizenship.

4.1.2. INEQUALITIES IN ACCESS TO SOCIAL PARTICIPATION

The social exclusion to which many poor adolescent girls and boys are subject goes beyond the educational and work environments; the spaces for participating and exercising citizenship are also reduced, especially for adolescent girls, but not only they but also the boys of this age range do not feel represented either by the systems of by the political actors. In the field of rights, they perceive great discrimination in access to work as well as exclusions from urban contexts such as suitable housing, sports and recreational facilities, etc. Some data taken from Youth Surveys in Mexico, Chile and Colombia (98) show that the spaces for participation that young women and men choose are different from those the adult world would expect.

It is also seen that adolescent girls and boys look down in political organizations but not on human rights agencies, and that they participate more in sports and religious associations than in those that are political in nature (100). Some young men and women of scarce economic resources join groups of "graffiti artists", "ska", "darketos", among others, depending on their inclinations and their cultural context. These groups, in which it is generally mostly males who participate, have in informal structure that, nevertheless tends to generate collective identities.

Other organizations in which young poor people associate are those that fight for the rights of indigenous people (for example, the Zapatistas in Mexico) (93). In this type of groupings, young men and women have the opportunity to develop the capability of exercising citizenship, and to struggle for the recognition of their human rights by asserting the processes that conform identity.

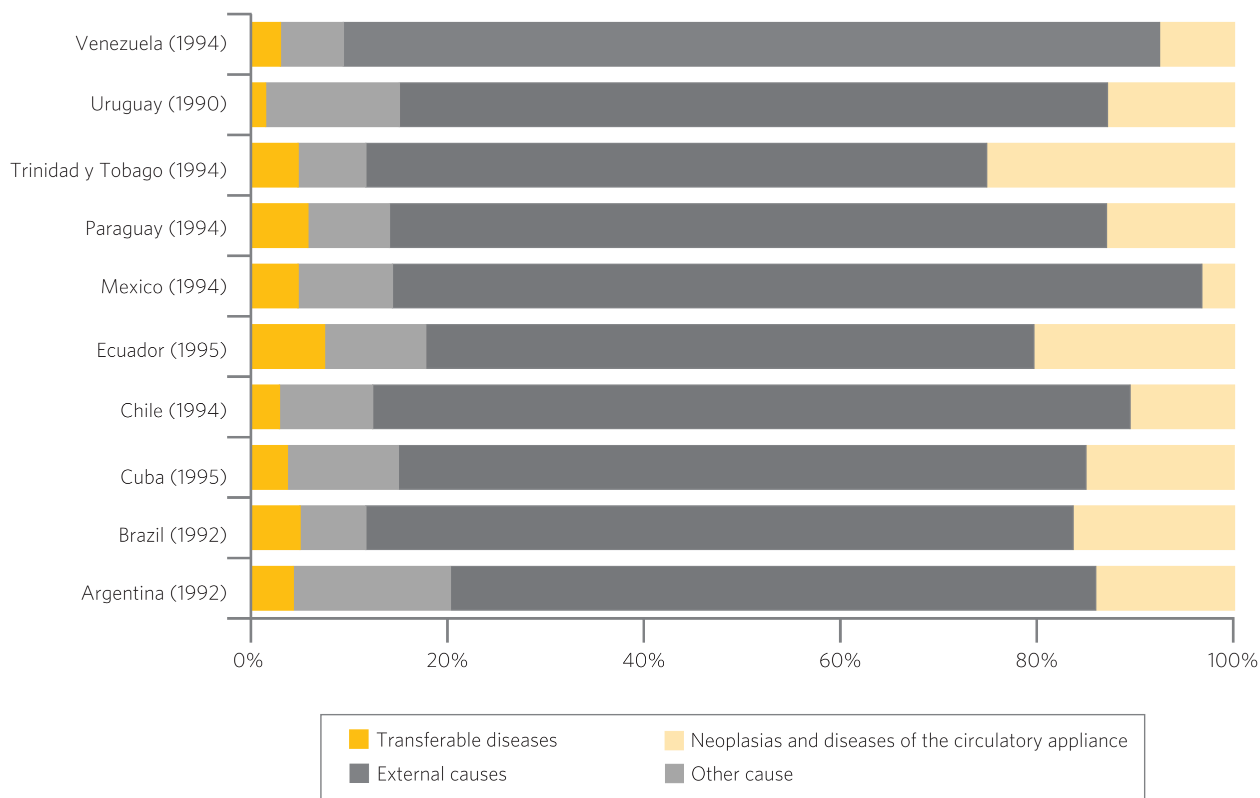
4.1.3. INEQUALITIES OF GENDER

The lower possibilities of participation, representation and power of adolescent women is a known fact, both in government youth areas and in civil society organizations. Frequently, the cultural proposal for adolescent women is based on building an identity centred on motherhood, where fecundity is a prerequisite for access to an adult situation and its rights – access to the health network and social recognition – but also its obligations – thinking about the

care of the other and not only thinking in herself (94). Situations such as gender violence and partners or marriages with wide age differences between older men and adolescent women urge reflection on how society validates women's lack of power from early ages.

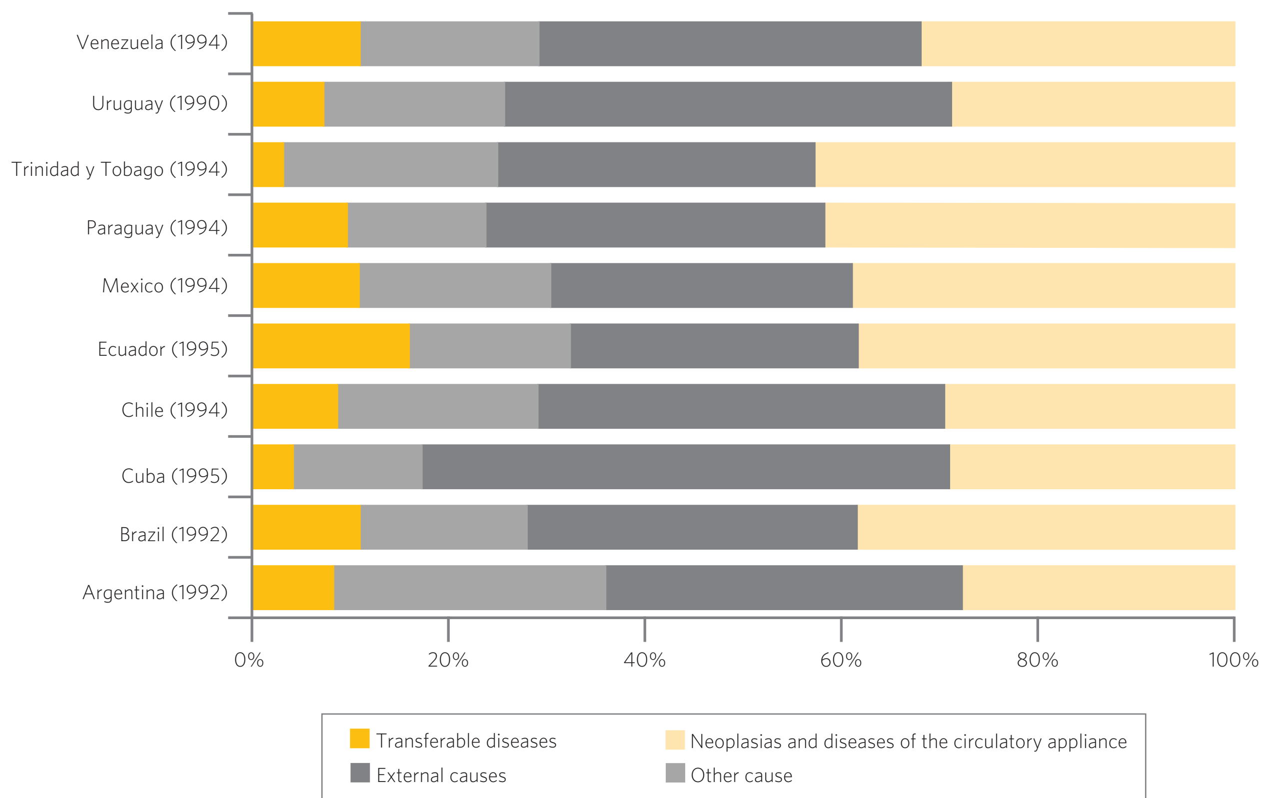
It is these gender inequalities (Charts N and O) that explain the differences in risk and causes of death between adolescent men and women. Among men, the possibility of death is strongly associated with stereotypes of masculinity that lead them to expose themselves to risks to show bravery (deaths from external causes – accidents and violence – are up to four times more frequent among men). Among adolescent women, the highest risks of death are found related with reproductive life.

Chart (N) General mortality rate by cause (%) in young men aged between 15 and 24



Fuente: *Cálculos basados en datos de OPS, 1995 y CELADE, 1997 citados en CEPAL 2003b.*

Chart (O) General mortality rate by cause (%) in young women aged between 15 and 24 during the 1990s



Source: *Calculations based on data from PAHO, 1995 and CELADE 1997, cited in ECLAC 2003 (15)*

4.2. ADOLESCENCE, IDENTITY AND SEXUALITY

As it is still relatively recent, the concept of adolescence, as a stage of life with specific characteristics and its own rights, is the subject of debate. There is a current of thinking that defines adolescence by absence: it is neither childhood nor adulthood, but the conflictive and ambiguous passing from one to the other, at the end of which is expected the resolution of emotional and economic dependence on the family of origin. The term adolescence has even been the subject of arguments and questioning as to whether it is a stage proper to Western cultures, and what might be its duration and specificity within these cultures.

Another group of social scientists defines adolescence as a stage of "social moratorium for development", to which everyone has a right regardless of sex, social condition and racial/ethnic belonging, although in different cultures it has a different function and each experience has a different meaning in function of the culture to which it belongs (94, 95).

In Western cultures some common dimensions to the adolescent period have been pointed out, despite its great diversity. It has been characterised by specific psychological, socio-cultural and biological factors. Among the common aspects is a constant and continuous process of construction and reconstruction of personal identity, the sense of belonging to peer groups, the exploration of meaning of oneself, the projection of possible futures, and by the exploration of the world outside the family context, and the construction as a moral subject with personal positions about values and ideals. From this perspective, it is conceived as a stage of development of potentialities, of creative capability and of learning, and the aim of this is to transcend the "adult-centred", paternalist perspective that conceives it as an "age of risk".

The process of construction of identity comes up against the development of sexuality, which is governed by social norms and differentiated for women and men. Masculinity and femininity are the result of historical production based on a process of culturally produced symbolisation. In some cultures there are rites of "passage", like the demonstrations of virility (for example, having the first sexual relationship with a sex-worker) or of femininity (for example, be able to

be a mother in order to assert female identity). Fecundity is a culturally valued condition and many adolescents of both sexes seek to have children as a way of rising in the social scale. Among men, there is a constant struggle to show to the others and to himself that he is not as vulnerable as a woman, but is brave, even leading to practices of daring that, many times, put at risk the person's well-being and life.

The process of structuring gender identity is complex since psychological and social factors intervene through which individuals construct themselves, but not as a deliberate, free, conscious act, but through a power written in the body, with schema of perception and inclinations that induce to specific ways of being. Gender identity, its recognition and its exercise are not an effect of the so-called "coming to awareness", as they result from "the inscription of social structures in bodies" (96 page 57).

4.3. REPRODUCTIVE RIGHTS OF ADOLESCENTS AND YOUNG PEOPLE OF BOTH SEXES

During the past decade and as from the ICPD and its 5- and 10-year revisions, the commitment of the States was ratified, recognising and respecting the rights of adolescent girls and boys to receive sexual and reproductive health information, education and services, and to carry out activities aiming to reduce unplanned pregnancies and to prevent STIs and HIV (97). But only recently have young people begun to be considered a priority in health policies and programmes, understanding the political value that the development of adolescent boys and girls has in the social, political and economic development of the countries.

Nonetheless, the field of reproductive rights continues to be limited in its recognition and guarantees. The Convention on the Rights of the Child, which ratified adolescents as subjects of rights and the obligation of the State, parents and legal guardians to guarantee their protection, included sexual and reproductive health within the rights to health, but left a vacuum about the explicit recognition of reproductive rights in the field that goes beyond the right to health, including that of identity. This conceptual vacuum has encouraged the ethical dilemma about *who should decide on the reproductive rights of persons in the stage of adolescence*.

As we asserted earlier, reproductive rights are constructed in diverse cultural contexts in which the perceptions, traditions, and social and religious norms have a determining influence on their exercise. It is still considered in various parts of the region that the sexual expressions of adolescents should be watched over by their parents, thus encouraging the fact that many adults do not recognise *the ownership of rights of adolescents of both sexes*. Particularly in the field of health care services, the effectors assume adult-centred postures that put at risk the exercise of the autonomy of adolescents of both sexes for taking decisions about their sexuality and reproduction.

From a human rights perspective, all adolescent women and men have the right to receive education on human sexuality, have the right to intimacy and to be attended with quality and warmth by the health care services in the framework of non-discrimination for reasons either of generation or of gender. The perception of the ownership of human rights and, especially, of reproductive rights is a core factor in the construction of identity of citizens immersed in a participative democracy. However, in some countries there are legal or administrative barriers to providing contraceptive methods to adolescents, or prejudices prevail that locate young people as minors and, so, as beings incapable of taking decisions on their sexual and reproductive life (53).

The innumerable violations of human rights of adolescents in the areas of sexuality and reproduction should be analysed on the basis of the inequalities produced by generational, socio-economic, gender and race/ethnicity hierarchies, among others. Young poor women are the least respected in their right to decide when, how and with whom they want to have sexual relations, and among them, unplanned pregnancy in adolescence, unsafe abortion or sexual violence are more frequent than among young women of another socio-economic level.

The implementation of public policies based on the increase in the social significance that the culture grants to adolescents – women and men – as owners of human rights, is a road that still has to be trod.

4.4. INEQUALITIES IN SEXUAL AND REPRODUCTIVE HEALTH

The construction of identity is one of the principal "tasks" during adolescence and within it sexuality occupies a central position. Sexual health has been defined as the experience of a continuous process of physical, psychological and socio-cultural well-being related to sexuality and involving sexual identity,[8] gender identity, eroticism and the affective link that is established with others. Identity is linked with the perception of selfness in a particular socio-cultural medium, the identification with sexes and the distancing from the other, which is a process of gradual determination of sexual identity and of gender identity.

The term sexual and reproductive health includes "... the capacity to enjoy sexual and reproductive activities regulated on the basis of a personal and social ethic... [as well as] the absence of psychological factors as affective elements (fear, shame, guilt) or cognitive elements (unfounded beliefs, myths, prejudices) that inhibit sexual well-being or perturb the sexual relations and the absence of organic disorders,

8. Undoubtedly, the various theoretical frameworks that are part of psychology (cognitivism, psychoanalysis, humanism, etc.) give different explanations for the makeup of sexual identity and gender.

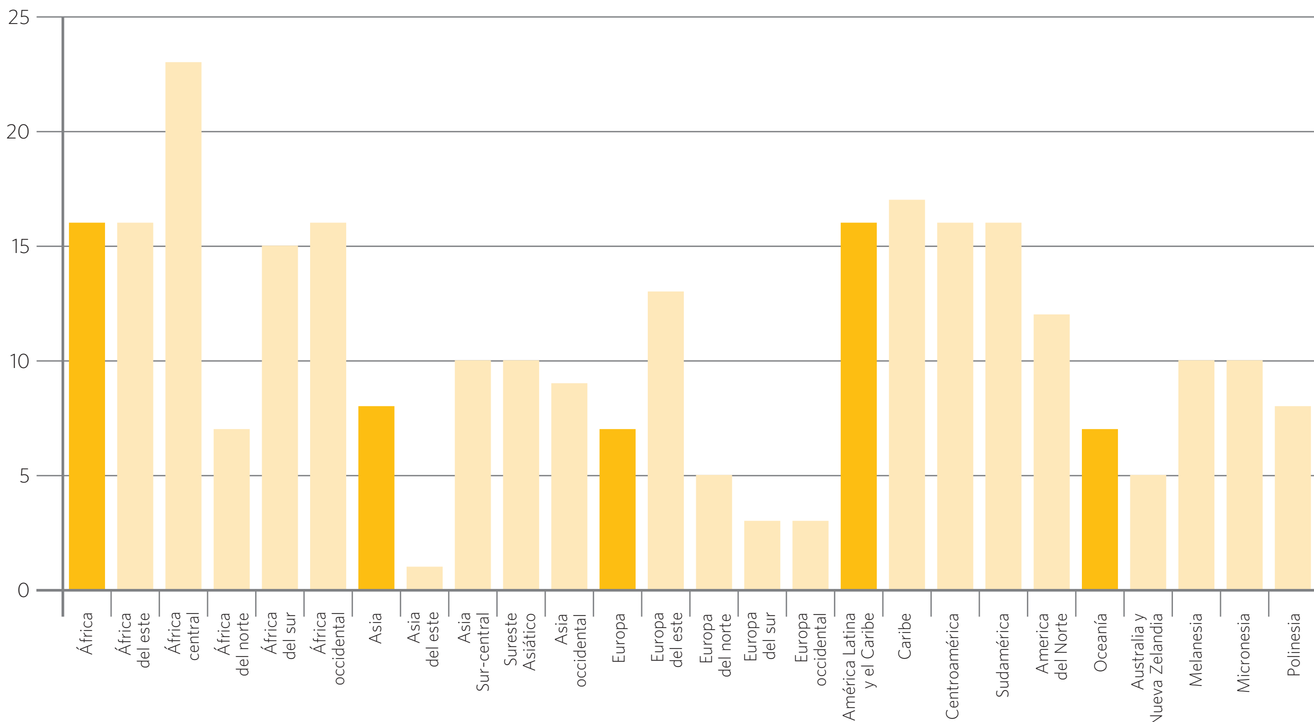
diseases and deficiencies that hamper or block sexual and reproductive activity" (99).

Sexuality involves ideas, practices, feelings, emotions, fantasies, eroticism and affective interaction with other persons and social recognition. The full exercise of sexuality, based on well-being, forms part of a comprehensive view of human development. Even though, as from the HIV/AIDS epidemic, information and publicity about the topic of sexuality increased among adolescent women and men, in general there has been a predominant approach based on the *risks* that sexuality generates. This view of the *danger* of sexual practices, that creates fears among adolescents, limits the development of identity.

The data shown below represent only an approximation to the state of the inequalities of young people in the region in the sexual and reproductive health field, since the information is frequently not differentiated by living conditions (18). In the region, the average age for the first sexual relationship for boys is 16.9 years, while the first union is formed at 24.5 years of age. The percentage of sexually active boys using the condom is associated with schooling. For example, in Brazil, 31% of the young men who have reached secondary level use it, in contrast to 18% of those with less schooling. In the Dominican Republic the percentage is 51% and 19% respectively, while in Nicaragua it is 11% and 7%, and in Peru 25% and 4% (101).

Together with Africa, the LAC region has the highest rates of adolescent fecundity in the world, and it is constant within the various sub-regions of the Caribbean and Latin America (Chart P). According to a study by Singh (102), more than 50% of those under 17 years of age have already had sexual relations (103). In an analysis that included eleven Latin American countries, it was found that, for ten of them, around one third of the women between 20 and 24 had had their first child before they were 20 years of age. This figure goes up to 50% of the women in the same age range in countries like Guatemala (104), as well as in Honduras and Ecuador (38). It is known that women who have a first child in adolescence will have two to three more children than women who have their first pregnancy as from the age of 20 (105). This phenomenon is accentuated in rural zones where adolescent fecundity rates are the highest in the region (106).

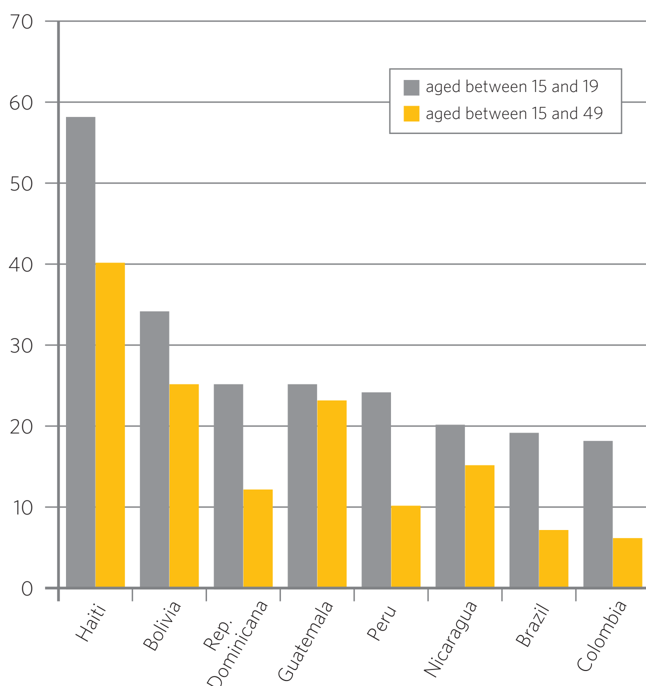
Chart (P) Percentage of total births involving women under the age of 20 in different world regions and subregions in 2002



It is calculated that half the pregnancies in adolescents in the LAC region are unplanned (81). This situation will have an impact on their future development, obliging them early to take on adult responsibilities, such as the care of children and the need to obtain work, among others. The social vulnerability to which pregnant women are exposed is reflected in the estimates of abortions; according to Singh (102), 20% of the hospitalisations for this reason in Latin America correspond to young women.

Generational inequalities arising from the lack of recognition of the rights of adolescents of both sexes are clear in some sexual and reproductive health indicators. The unsatisfied need for contraception shows the disadvantage that adolescent women have compared with adult women, even considering only those who are in unions. The women of the region between 15 and 49 years of age have an unsatisfied need for access to contraception of between 5% and 40%, while in adolescents, even taking into account only those in unions, this need is significantly greater (Chart Q).

Chart (Q) Percentage of women, by age group, in relationships with unsatisfied family-planning requirements in certain countries of the Latin American region – 1996-2001



Source: *Género, Salud y Desarrollo en las Américas, 2003, with data from ORC, Macro, Encuestas Demográficas y de Salud (1996/2001).*

Another indicator shows how these inequalities reinforce eath other when they are crossed with the socio-economic condition. The ratio between the first and the fifth quintile in the fecundity rates shows the disadvantages of poor adolescent women compared with poor adult women. According to DHS data, the 20% poorest of adult women have 3.2 greater fecundity than the 20% richest. This figure is doubled in the case of adolescents, where the poorest quintile has 5.6 times more fecundity than the richest 20%. The greatest differences in adolescent fecundity in the first and fifth quintile of income are found in Peru, the Dominican Republic and Colombia (Chart R).

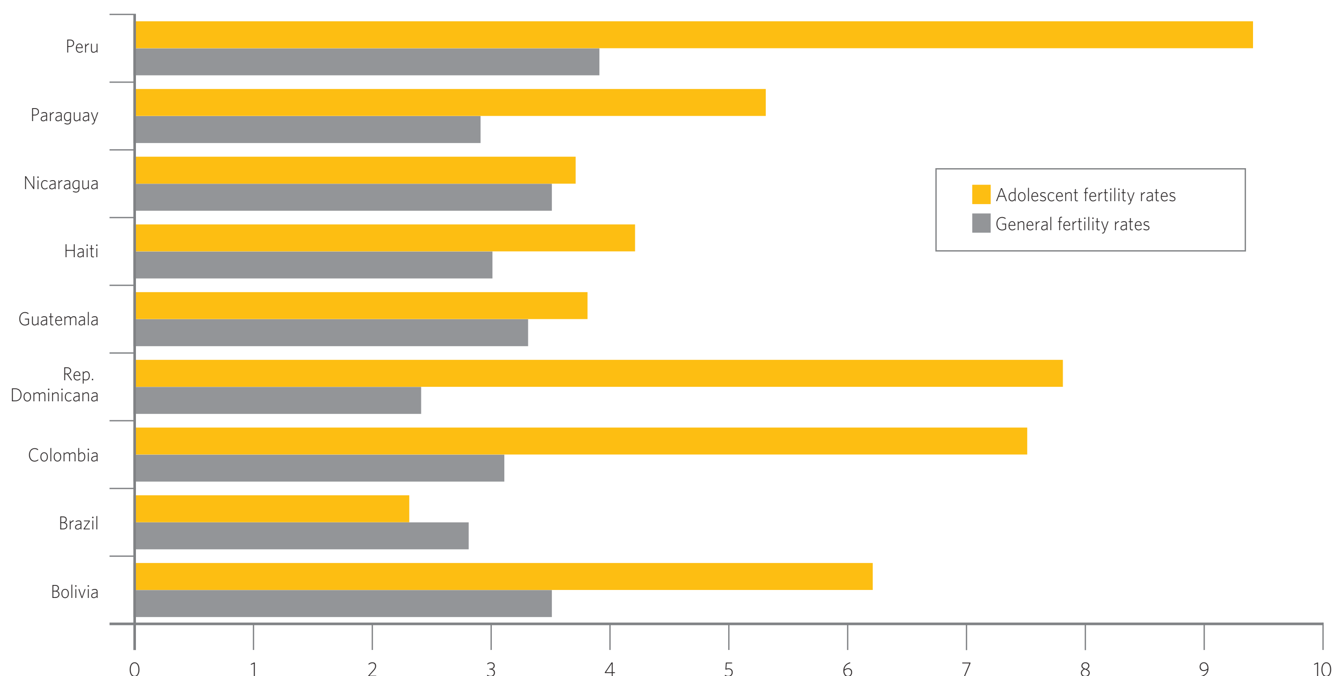
In LAC, the global rate of desired fecundity, i.e., that including only the births that were planned, is generally lower than the observed fecundity, since the women have more children than those they really want. This situation goes against the reproductive rights agreed in Cairo, since it indicates the lack of access to information and to contraception; but it also expresses the lack of power of women to enforce their rights in decisions within the couple, in matters of sexuality and reproduction. Unplanned fecundity among adolescents underlines the phenomenon of imposed maternity and also constitutes one of the indicators of gender inequities. It has been documented that there are differences in the number of children desired by men and by women, with a greater need for children among men with scarcer resources, which is probably related to the value that male identity places on procreation.

The generational dimension affects adolescent women and men differently. For example, among those who live as a couple according to certain social mandates – that vary from one society to another – the man is usually older than the woman, which can favour relationships of inequality of power.

Violence, as a factor of sexual and reproductive vulnerability, is linked with gender identity to the extent that some social stereotypes tend to support the construction of the male identity on the basis of a strong, rough character of men, in contrast to the submission of the women. These stereotypes favour violent relationships and have a marked effect on adolescents in the region. For example, in Jamaica, a study showed that 40% of a group of girls of 11 to 15 years of age expressed that the reason for which they had had their first sexual relation was “force” (90). For the Caribbean region in general, one third of adolescents of both sexes have an active sexual life and, of this third, half the women have indicated that their first sexual relation was by force (107). Various surveys cited by Guzman (106) show the magnitude of the problem of sexual violence, indicating that in countries such as Nicaragua, Barbados and Jamaica this can reach 30% of the women under 18 years of age. Pregnancies, as a result of sexual abuse, have effects beyond the pregnancy itself and show themselves in the long term in damage to the physical and mental health of the woman victim (Heise, cited by 108).

In terms of the HIV/AIDS epidemic, adolescent girls are among the high vulnerability groups (14). Up to December

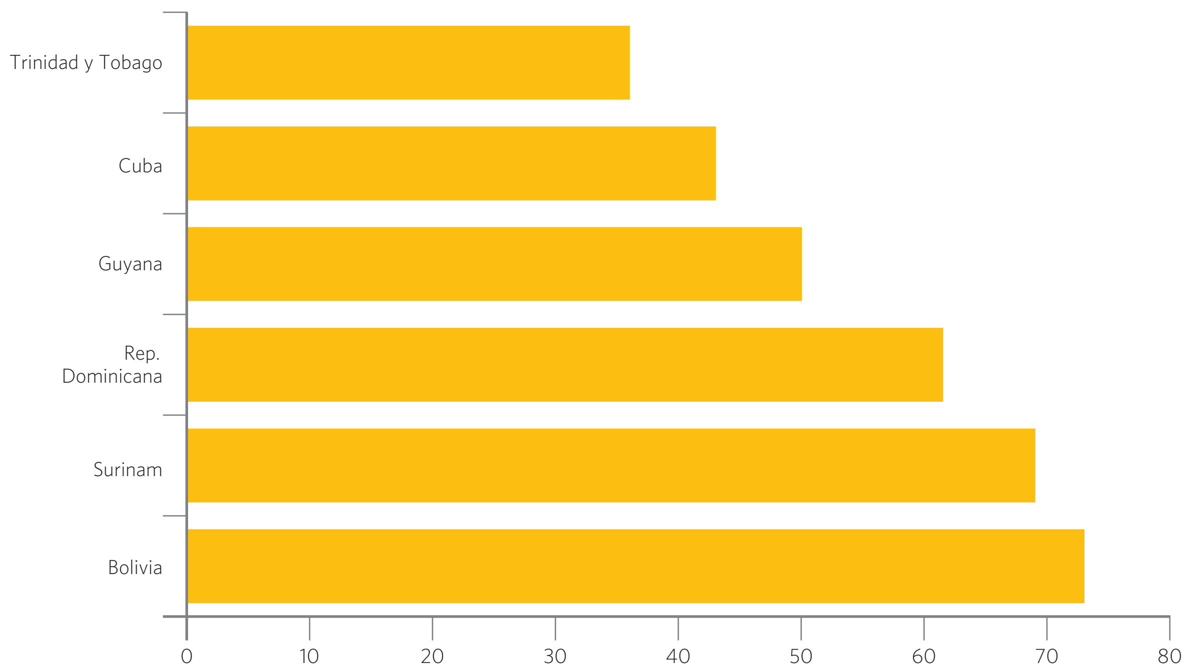
Chart (R) Ratio of 20% of the lowest income group and 20% of the highest income group in terms of general fertility and adolescent fertility rates



Source: *OPS, 2003.*

2001, there was a total of 1,820,000 people living with HIV in LAC (60) and the prevalence in young women and men at the end of that year was estimated as 240,000 and 320,000 cases, respectively. In the Caribbean (the second region in the world most affected by the epidemic) 2.3% of those over 15 years old have contracted the virus and most of the new cases of HIV occur in women between 15 and 24 years of age (109). In Trinidad and Tobago, women are five times more vulnerable to infection than men and in Jamaica young pregnant women have an incidence rate almost double that of older women (90). The growth of the epidemic among young people can be attributed to various reasons, among which are the lack of opportunities for development seen in exclusions in health, education and employment. The design and implementation of public policies for young people constitutes a concern that the governments are handling with the support of international agencies (25). For some LAC countries, the lack of knowledge among young people about HIV/AIDS (Chart S) is quite evident. It is estimated that between a fourth and half of adolescents between 15 and 19 in Guatemala, Peru, Haiti and Brazil do not know that a person with HIV can show no symptoms of AIDS for quite some time (110).

Chart (S) Women aged between 15 and 19 with at least a mistaken notion of HIV/AIDS, or who have never heard of the illness, in selected countries of the Latin American and Caribbean region



Source: *UNICEF/MICS, DHS, 1999-2001, en UNICEF, ONUSIDA, OMS, 2002.*

Even though the epidemic in LAC still shows low endemicity – concentrated in men having sex with men, intravenous drug-users of both sexes, sex workers of both sexes, male and female prisoners, and people with sexually transmitted infections – it is among adolescents, especially the poor, street-children and youths, and male and female migrants that greatest vulnerability to HIV/AIDS is seen (111). Young pregnant women, living with HIV, are doubly discriminated: firstly, from the stigma of being a carrier, and then for the condition of pregnancy. In various parts of the world cases have been documented of forced abortions due to the condition of seropositivity (112).

4.5. SEXUAL AND REPRODUCTIVE HEALTH IN THE CONTEXT OF DEVELOPMENT

As from the five- and ten-year reviews after the ICPD, Cairo 1994, adolescents began to be one of the strategic priorities of UNFPA for achieving its mission in the field of population development. So an Adolescent Task Force was organized between the Technical Support Division and the Technical Support Teams of the different regions, Focal Points were designated in each Country Office, and the Regional Programme of LAC 2004-2007 established six specific results to be achieved in the area of adolescents and young people.

A study carried out by The Alan Guttmacher Institute (AGI) (101), comparing the rates of unplanned pregnancy between adolescents of various countries of Europe and the United States found that, even considering the relative decline in unplanned pregnancy rates in the United States, the European countries show better results. These figures seem to be strongly associated with the European policies in the youth area that ensure better opportunities of development and lower levels of inequality.

It is not possible to separate the sexual and reproductive health of adolescent women and men from their living conditions, local culture and the development opportunities offered to them. The interventions implemented for achieving better levels of rights and sexual and reproductive health for adolescents tend to facilitate the transformation of the contexts of their lives – among which are the conditions of poverty and social exclusion – in which the adolescents of both sexes make their choices about sexuality and reproduction.

In a global survey carried out by the World Bank in May 2003 about the barriers to building possible positive futures, poverty turned out to be the main concern of young people of both sexes, followed by lack of employment and low-quality education. The commitments made by the States for poverty reduction, as Millennium Development Goals, eight of which refer to the group from 15 to 24 years of age, also stress the association between social development and the development

opportunities of young people. Adolescents of both sexes demand the acquisition of competencies that strengthen their human development. Even though investment in education is what has by far the best cost-effectiveness ratio, educational models should potentiate the capability of young people in relation to the transformation of the environments they live in, strengthening their critical capability.

This requires public policies that recognise adolescent men and women as owners of rights in a participative democracy. Sexual and reproductive health interventions that construct subjects of rights, i.e. that facilitate the empowerment of adolescents in terms of their citizen's rights, make development possible and so can be converted into poverty reduction strategies.

To the inequality of power of persons at this stage of life compared to adult men and women, is added their lack of economic resources, which deepens generational inequality. Many adolescent men and women work for their own family – in a rural, domestic or service context – or are unemployed. The unemployment rate for young men and women is 2.5 points higher than that of adults. This is a point where Amartya Sen's approach to poverty blends with the field of human rights. If poverty is the lack of freedom to exercise capabilities, the interventions that enable the achievement of capabilities can be effective means for reducing poverty. Education, but also the world of work, are the privileged spaces for developing these competencies and for empowerment. Interventions related to empowerment on citizen's rights should be associated with strategies the generate resources through employment and/or self-employment.

5 Final reflections

This paper has tried to indicate a way in which the connections between poverty, sexual and reproductive health and human rights can be regarded, seeking to get beyond the monetarist approach underlying some poverty reduction proposals and showing how, to operate with equity in the field of human rights, it is necessary to consider the human right to health of all persons. It has also suggested how knowing the realities of the health and development of populations (including in this an analysis of the hierarchies of gender, race/ethnicity, generations and their combinations) enables strategies to be defined for promoting the development of the populations of the world. Acting in the field of sexual and reproductive health implies knowing and operating at a macroeconomic level and accompanying the design and implementation of social policies, especially those of health and education. Sexual and reproductive health receives the impact of decisions taken in the ambit of health systems and, obviously, access to health is co-generated centrally by the social determinants of gender, race/ethnicity, age and socio-economic position.

UNFPA's activity must be aimed both at supporting and at the make-up of national health systems, including the design of policies, as much as at the task of encouraging social participation and increasing the capabilities that lead people to assert their identity, especially among young women and men, contributing to developing the sense of citizenship and its performance that result from empowerment processes. As has been seen throughout this paper, there are situations of inequity in sexual and reproductive health that affect women and men or, specifically, adolescent and young women and men. Encouraging capabilities in people that lead them to assert their identity can contribute to developing empowerment. Joined to this, investment in sexual and reproductive health can help to reduce poverty through an approach based on human rights and on promoting people's reproductive rights, especially those of adolescent and young women. The action strategies should be designed on the basis of diagnoses that are effective for visualising the socio-cultural perspectives of each society and of each community, and that are also effective for the promotion, respect for and defence of human rights. So, in the context of UNFPA, a minimum set of fundamental ideas should bear in mind that:

1. The design and implementation of government policies and programmes can directly and indirectly have a positive impact on the marginalisation, vulnerability, discrimination and stigma present in contemporary societies, including the population of adolescents and young people. For this reason, the make-up of national health systems and social policies in general must respond effectively to the elimination of social inequalities and the promotion of human rights.
2. Monitoring social inequities in health, taking into consideration their social determinants – such as poverty, gender, race/ethnicity and age – can help to identify and monitor the presence of activities centred within the framework of human rights.
3. The allocation of resources and expenses in health, especially in sexual and reproductive health, analysed according to the social determinants of health and using qualitative and quantitative information, can be a valuable instrument and make possible conjoint activities in UNFPA, both inter-agency and inter-governmental and in dialogue with the civil society.
4. Achieving the reduction of poverty is a multi-causal phenomenon and so the solution strategies elaborated must also be multi-determined, through mechanisms specifically designed for that purpose which will also have to include the active presence of the civil society in processes of dialogue and agreement with the State.

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