Conclusion, Regional Trends

Women of the World:

Laws and Policies Affecting Their Reproductive Lives

Latin America and the Caribbean

The Center for Reproductive Law and Policy
DEMUS, Estudio para la Defensa de los Derechos de la Mujer

In collaboration with partners in

Argentina Bolivia Brazil Colombia El Salvador
Guatemala Jamaica México Perú

Regional Trends in Reproductive Rights

By identifying the trends in reproductive rights and women's empowerment that emerge from a review of nine Latin American and Caribbean nations, this chapter provides an invaluable guide for assessing the effort required to promote reproductive rights and to focus attention on the laws and policies that are necessary to achieve these rights. The analysis of regional trends identifies, where appropriate, laws that can serve as a basis for regional reform efforts. Draft bills and policies still under consideration are also mentioned. Finally, this chapter notes those instances where governments have not enacted regulations and where access to information is restricted.

The regional trends described in this chapter are based exclusively on an analysis of the content of national laws and policies. It does not take into account the procedures, if any, established to implement these laws and policies and the extent to which such laws and policies may be executed. While we regard such information as critical to securing reproductive rights, we also believe in the need to determine the legal and political framework before exploring other equally important factors that affect women's reproductive lives. We hope that the regional trends identified in this chapter serve not as a conclusion but as a preface to multiple and diverse initiatives for the promotion of women's reproductive rights by governments, international agencies, and nongovernmental organizations.

I. Setting the Stage: the Legal and Political Framework

All the Latin American countries covered in this report, with the exception of Brazil, achieved independence from the Spanish monarchy during the first half of the nineteenth century. Brazil gained its independence from the Portuguese crown toward the end of that century. A legacy of the Portuguese colonization of Brazil is the use of Portuguese as the national language. This fact sets Brazil apart from the remainder of the region, which has adopted Spanish as its primary language. Moreover, since slavery was not abolished until 1888, Brazil has the largest population of people of African descent in all of Latin America. Jamaica gained its independence from the British crown in 1962; it remains a member of the British Commonwealth and regards Queen Elizabeth II as its head of state.

Latin America's common cultural heritage, a consequence of Spanish and Portuguese colonization, has resulted in various shared characteristics between these nations. For the purposes of this report, the most relevant of these characteristics is the existence of a shared legal system, derived from ancient Rome, known as *Corpus Juris Civilis*, or the civil law system. In this legal system, the role of the courts is to interpret the written law for each case. Judicial precedent has no value except in rare cases and only when the law itself so determines. Jamaica, on the other hand, as a former English colony, inherited England's ancient legal system — the common law. The common-law system comprises the body of principles and rules of action that derive their authority solely from usage and customs of immemorial antiquity, particularly the ancient unwritten law of England as well as court judgments and decrees. In the common-law system, courts are able to formulate and develop legal doctrines.

In all the countries studied, as well as in the remainder of Latin America and the Caribbean, both these legal systems coexist alongside legal norms and justice systems derived from ancient rules and customs unique to the indigenous populations. Most of the regional constitutions recognize and protect ethnic diversity and the various customs of indigenous people within their territorial jurisdictions. However, not all nations recognize indigenous customary norms as valid legal systems, much less give equal status to these norms alongside the formal legal system. Only Bolivia and Peru recognize indigenous customary norms as a source of law. Bolivia considers the application of customary law and procedures to indigenous or peasant groups by their own authorities as an "alternative mechanism for conflict resolution." Peru recognizes customary law, and authorizes indigenous, native, and peasant authorities to

exercise "special jurisdiction." Nevertheless, in Peru, such jurisdiction is limited to those cases that the civil legal system fails to cover. Like Bolivia and Guatemala, Peru establishes that these customary laws and their enforcement must respect human rights. Colombia grants indigenous peoples the right to administer justice within their territories in accordance with their customary norms, without recognizing such norms as a source of law or their legal system as an alternative to the civil legal system. In Mexico, the Constitution protects the "legal practices" of the native population.

The social and political context of a particular country has a direct effect on its legislation, on the enforcement of laws and on the stability of its policies. Military and civil dictatorships, as well as lengthy periods of civil war, are two primary characteristics affecting the recent history of several Latin American countries. Each new dictatorship, as well as the ensuing return to democracy, and even the initiation of each new democratic government, has resulted in a traumatic readjustment of the political and legal landscape. The result is either a series of incongruent shifts in laws and policies or their fragmented or partial application. Most governments in the region, except for Jamaica and Mexico, are elected for a period ranging from four to five years. Thus, all policies, including those dealing with population, reproductive health, and family planning, are in effect for a similar period of time.

A. THE STRUCTURE OF NATIONAL GOVERNMENTS

The constitutions of each of the countries covered by this report define themselves as republics. Jamaica, a parliamentary monarchy, is the exception to this general trend. As republics, Latin American nations adhere to a political system known as "representative democracy," that is, the government and its authorities represent the people and derive their power from the people. Jamaica is a democratic parliamentary monarchy. The highest authority in that country is the British-appointed representative of the queen. However, members of the democratically elected House of Representatives form the executive branch of government.

In all of the nations covered by this report, the governments have three branches; the executive, the legislative, and the judicial. The administrative regime, however, varies in each country. Argentina, Brazil, and Mexico are federal governments and thus consist of a federation of states that are independent in terms of most executive, legislative and judicial functions. But, in such nations, local states are subject to a national constitution. Although Bolivia, Colombia, El Salvador, Guatemala, Jamaica, and Peru have centralized and unitary governments, each has numerous levels of decentralized administration. Each of the countries profiled in this report has a government bureau dedicated to the promotion of equal rights for women. In six of these countries — Argentina, Bolivia, Brazil, Colombia, El Salvador, and Peru — women's bureaus administer their own budgets and, to varying degrees, are important components of the executive branch of government. In the remaining three countries, women's bureaus have limited decision-making powers, and do not have their own budgets. In terms of women's participation in the political structure, Argentina and Brazil are the only two countries among the nine studied that have affirmative action legislation to promote women's participation in political parties. In Argentina, the Constitution contains an affirmative action provision that requires all political parties and the bodies and procedures that regulate elections to adopt measures that ensure real equality and political participation of women. In Brazil, the *Ley de Cuotas* (Law No. 9100) decrees that at least 20% of all candidates presented by each party or political group for municipal elections must be women. Statistics indicate that these measures have had a significant positive impact on the political participation of women.

Executive Branch

In Latin American nations, the executive branch of government is in charge of the economic and political administration of the country and foreign policy and foreign relations. In all of these countries, except Jamaica, the president is the head of the executive branch. In Jamaica, the queen of England is the head of the executive branch and is represented by her appointed governor general. In practice, however, the prime minister and his or her cabinet run the government. Cabinet ministers are in charge of the elaboration and implementation of public policy for a particular sector, including health and population. In every country, in accordance with its constitution, presidents and cabinet ministers are subject to varying degrees of control by the legislative and judicial branches of government.

Legislative Branch

In Latin American nations, the legislative branch is generally known as the *Congreso Nacional* (National Congress), *Asamblea Legislativa* (Legislative Assembly), or *Parlamento* (Parliament). The most important function of the legislative branch is to enact laws. With the exception of El Salvador, Guatemala, Jamaica, and Peru, the countries studied have a bicameral congress. The Jamaican Parliament is composed of the governor general, who represents the queen; the Senate; and the House of Representatives. El Salvador, Guatemala, and Peru have single-chamber congresses, each composed of more than 100 representatives.

The process by which most Latin American nations enact laws is similar. Once a bill is discussed, revised, and approved by

a majority, Congress forwards the bill to the president for final approval and publication. The publication of a new law is mandatory in all nations. The president has the right to veto and to amend a law, but final decisions regarding a bill rest with the Congress. If a law approved by Congress is vetoed by the president, the percentage of congressional votes required to override the veto increases significantly. For example, El Salvador and Guatemala require a two-thirds vote of Congress to override a presidential veto. It is important to note that in three countries — Brazil, Colombia, and Peru — citizens may propose legislation directly to the Congress so long as they follow the appropriate rules and regulations. In the remaining nations, citizens' proposals are indirect in that they must be presented through those persons or entities prescribed by the Constitution.

Most national legislatures have the ability to enact laws in almost all arenas. However, in the federal republics — Argentina, Brazil, and Mexico — the Constitution reserves only certain areas of legislation to the national legislative bodies and entrusts the remainder to each state's legislative body. For example, in Argentina, the Constitution specifically establishes which laws are within the purview of the national Congress, such as the civil, commercial, penal, mining, labor, and social security codes. In Mexico, certain areas of penal and civil law are regulated at the federal level, while others, such as marriage and sex crimes, are the province of state legislatures.

Judicial Branch

In all of the nations profiled in this report, with the exception of Jamaica, the Supreme Court is the highest tribunal in the judicial system. Jamaica has two high courts, each with jurisdiction over different arenas. Most Latin American nations have a lower court system comprised of *juzgados de paz* (peace courts), which are often presided over by lawyers. But anyone elected by a community to resolve its conflicts can be a justice of the peace. The law stipulates the issues over which justices of the peace have jurisdiction. In Bolivia, Colombia, Mexico, and Peru, peasant, native, and indigenous authorities may also function as courts of law.

B. SOURCES OF LAW

Domestic sources of law

The sources of law vary with the nature of the legal system. In Jamaica's common-law system, judicial decisions constitute one of the most important sources of law. In the civil law tradition of Latin American nations, the primary source of law is legislative norms, while judicial decisions constitute mandatory jurisprudence only when so stated in the written law.

In every country, the constitution is the most important domestic source of law. Formal sources of law constitute a pyramid in which the national or federal constitution — depending on the administrative regime — is at the top. In Argentina, Brazil, and Guatemala, the constitution shares its status as the highest law of the land with international human rights treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women and other regional human rights instruments, including those that protect women's rights. In Jamaica, the decisions of the courts and laws and regulations issued by the legislature are both subordinate to the Constitution.

Secondary sources of law also exist. In Colombia, the *fuentes auxiliares* (auxiliary sources) of domestic law are the principle of equality, the general principles of law, jurisprudence, and the well-established opinion of legal experts. Custom and usage — which is not the same as customary law of the indigenous peoples — constitute a valid source of law in El Salvador and Guatemala. In Guatemala and Peru, jurisprudence is also a source of law. In Peru, courts apply general principles of law when legislation does not address a specific issue, particularly in matters concerning health. In Mexico, such general principles apply only when there is no relevant legislation, and they then apply only in civil matters.

International sources of law

International treaties constitute the most important international source of law in all of the nine countries studied. All of the nine nations profiled in this report have adopted major international human rights treaties. The national constitutions almost always have superior status to international treaties, except in Argentina, Brazil, and Guatemala, where international human rights treaties are equal in status to the national constitution. Thus, in these three nations, the Convention on the Elimination of All Forms of Discrimination Against Women and the Inter-American Convention to Prevent, Sanction, and Eradicate Violence Against Women (the Convention of Belém do Pará), both ratified by all nine countries in this report, are equivalent to constitutional norms. The importance of the constitutional status of human rights treaties in these countries lies not only in their superiority over domestic law but also in the fact that courts may apply these treaties to protect women's rights, even in the absence of specific national laws. Courts may also apply international human rights norms in situations where national level laws are inconsistent with such norms. Nonetheless, Argentina, Brazil, and Guatemala continue to maintain domestic legislation that discriminates against women or hinders their reproductive rights.

There are two general regional trends regarding the relationship between international treaties and domestic law. First, there are those nations that accord treaties — other than human rights treaties in the case of Argentina — a status lower than the

constitution, but higher than that of domestic law. This is true of Argentina and Colombia. In the latter situation, however, only non-human rights treaties are accorded this status.

A second set of nations regard international treaties as being equivalent in status to domestic laws. This is the case in Bolivia, Brazil, El Salvador, Guatemala, and Peru. Mexico is an exception to these trends. While it does not explicitly bestow constitutional status on treaties, it regards treaties as "ley suprema" de la nación ("supreme law" of the nation) and places them alongside the Constitution. Some countries make the supremacy of the constitution over international treaties more explicit than others do. In El Salvador, for example, the government is barred from signing treaties that effect or limit the norms of the Constitution. The judicial system also has the power to declare these treaties null and void.

With the exception of Jamaica, the process by which nations adopt treaties is similar. The president generally signs the treaty, but the legislative branch must then approve it. This approval can occur either before or after the president signs it, depending on the subject of the treaty. Once the president and the legislature have approved the treaty, it becomes part of domestic law. In Jamaica, the signing or ratification of treaties is not subject to parliamentary debate and is a matter within the sole jurisdiction of the executive branch. Exceptions to this rule exist in special circumstances, such as when a treaty involves a limitation on the rights of citizens, increases the powers of the executive branch, or imposes an economic obligation upon the government.

II. Examining Health and Reproductive Rights

The nine Latin American and Caribbean nations that are the focus of this report have responded to reproductive health problems in varying degrees and with diverse strategies. As a result, there exists a significant array of relevant laws, policies, and programs. The intention of governments to promote reproductive health must be measured not only by the existence or absence of general laws and policies but also by the enforcement of specific programs and strategies. Most countries have constitutions that guarantee the right to health and a national health authority — a ministry or a secretariat — that is entrusted with the formulation and development of policies. However, very few mechanisms in the legal system guarantee this right. The Latin American and Caribbean region has also a considerable indigenous, native, and peasant population whose cultural and demographic characteristics differ from that of nonindigenous or urban populations. They are generally less able to access health care services. Yet laws regarding health and policy strategies rarely consider such differences. Some exceptions to this trend exist in the general health policies of Colombia and El Salvador and in the reproductive health policies of Mexico and Peru. In certain countries, policy documents indicate the existence of a direct relationship between poverty, lack of education, social alienation, discrimination, and neglect of reproductive health and maternal mortality. These studies also demonstrate that rural women are less able to exercise their rights under national laws and have more limited access to the services provided by the state.

A. HEALTH LAWS AND POLICIES

In all nine Latin American and Caribbean countries, the Ministry of Health, part of the executive branch, is responsible for the formulation of the health policy. In most cases, the ministry administers policies, but tends to decentralize services. However, "decentralization" of health care services does not have the same meaning in every country. For some governments, such as those of Bolivia, Brazil, Mexico, and Peru, decentralization means the legal independence of certain public offices, which enables them to have administrative autonomy and to control their own resources. There is no change in the ownership of the health care service infrastructure nor in responsibility for providing such services. In Bolivia, the municipal governments provide physical infrastructure, resources, and equipment; they also support health care services with municipal taxes. But the general laws and policies, as well as specialized health services, are all centralized in the capital. On the other hand, in countries such as Argentina, decentralization is a pseudonym for the privatization of health care services. Currently, all the governments in the countries profiled herein are directly involved in the provision of health care services. Nonetheless, they are in the process of transferring such responsibility either to the private sector or to health insurance services that depend upon the contributions of workers and others. Argentina is the most advanced in terms of the privatization of health care.

In all the countries, public health care systems coexist with health insurance systems supported by worker contributions. Although such insurance coverage varies, all nations face the shared challenge of expanding the coverage to those who are excluded from that system by not being formally employed.

Objectives of the health policies

The major objective of national health policy in all the countries examined is to meet the basic health needs of society's poorest segments. In all nine Latin American and Caribbean countries, policies focus, to differing degrees, on achieving better-quality health care services and on providing free or subsidized assistance to the poorest segments of society. In

Argentina, improvements in the quality of service are a priority, since, according to available statistics, this country has achieved optimal coverage levels. In Mexico and Peru, the quality and effectiveness of the health care sector are also essential government concerns, even though they have not yet succeeded in providing full coverage to their target groups. In the remaining countries — Bolivia, Colombia, El Salvador, and Guatemala — where a higher percentage of the population lacks access to basic health care, policies focus on enhancing access. In Colombia, for example, the national health policy is directed toward achieving free and compulsory basic health care. By the year 2000, the goal is to provide coverage to the whole population, including those groups that are unable to pay.

Brazil and Peru are regional models for health care because of their efforts to implement comprehensive health programs. The government of Brazil declared 1997 to be the Year for Health and has attempted to improve the population's health by involving federal, governmental, municipal, and private institutions in the achievement of these goals. Health and prevention programs developed by community-based health care workers focused on the provision of primary care and basic medical care, including women's and children's health and sexually transmissible infections ("STIs"). Peru is developing health policies and laws with special emphasis on reproductive health. This positive trend seeks to address women's reproductive health problems in the nation with the second-highest maternal mortality rate in South America. The Peruvian government has declared the present decade to be the decade for family planning and has established important objectives regarding women's reproductive health for the five-year period from 1995 to 2000.

Infrastructure of health services

In all nine Latin American and Caribbean countries, health care facilities belong mainly to the public health sector and are ultimately managed by ministries or secretariats of health. Even in countries like Argentina and Brazil, where an extensive network of private facilities are linked to those of the public health care system, the public sector's infrastructure continues to be more important than the private one. For example, in Brazil, there are 6,378 hospitals, of which only 2,877 are private.

In most countries where health services are centralized, there are varying degrees of sophistication between general medical facilities and basic health care centers or stations in rural areas. The latter provide only basic or primary care services. In Bolivia and Guatemala, as in other countries, the number of basic health stations is significantly higher than that of hospitals. In Bolivia, out of 1,651 health care establishments, 1,373 are basic health stations. In Guatemala, basic health stations constitute 68% of the total public health care infrastructure. Although the information collected for this report focuses on public services, it is important to note that, in some countries, nongovernmental organizations ("NGOs") play an important role in the provision of health care. In Bolivia, for example, in addition to public infrastructure, there are around 500 NGOs providing health care services, mainly in the rural areas.

Although the human resources available for health care differ considerably among the nine countries, they differ even more within each nation. Generally, there is a lack of health care providers in rural areas. Peru is a clear example of the marked difference between rural and urban areas in doctor-patient ratio. In 1992, there was one doctor for every 12,000 inhabitants in the most distant provinces, while the ratio for Lima, the capital, was of one doctor to 800 inhabitants. The Pan-American Health Organization recommends a doctor-patient ratio of one to 910 inhabitants. In Argentina, there is a doctor for every 376 inhabitants; in Brazil, one for every 486 inhabitants. Out of all nine Latin American and Caribbean countries profiled, the latter two countries appear to have more human resources within their health care system. Bolivia and Jamaica, on the other hand, have the most deficient global coverage levels, with a doctor-patient ratio of one to 2,941 and 1,700 inhabitants, respectively. Overall estimates indicate that in Colombia 97% of the population had access to primary health care in 1996, although such care was of low quality and was concentrated in urban areas. In Guatemala, the government recognizes that the low coverage of its health care services contributes to approximately 64% of all deaths.

Cost of Health Services

The World Health Organization ("WHO") recommends a minimum allocation of 10% of a country's total budget to its health system. In most countries that provide financial resources directly for health care, the trend has been to increase the investment in health. However, key information regarding the manner in which such funds are distributed is unavailable. For example, Guatemala spent 2.2% of its gross domestic product ("GDP") on health in 1996 but invested it mainly in the construction of hospital infrastructure rather than in the provision of health care. In 1996 El Salvador spent 7.3% of its national budget on health, Colombia spent 2.41% of its GDP, and Mexico 2% of its gross national product. From 1994 to the present, Peru increased its expenditures on health by more than 100%. Although the WHO standard is an important means by which to determine the priority a government has given to health, it must be considered in relation to each country's health system. For example, of all the nations discussed in this report, Argentina has the best coverage levels in health care

services. Yet, it spends only 3% of its national budget on health. In Argentina, private agents and other systems, such as workers' health insurance schemes, assume most of the costs related to health care.

The laws of all nine countries contain provisions that ensure free health care services in some or all cases. However, none of them clearly states which services are free, and most countries establish vague standards regarding exemptions from fees. Generally, these standards use terms such as "low income" and "lacking resources" to exempt persons from payment. In addition, countries such as Bolivia and Peru have introduced fees not through laws but either through administrative measures or directly in practice. In 1995, in Peru, resources derived from fees charged in public hospitals accounted for 65% of all hospitals' resources. In Mexico, fees cover up to 10% of total costs.

In most nations, governments continue to contribute to employee health insurance plans. However, governments are contributing fewer resources to such plans. In Mexico, the employer provides 70% of the contributions to work insurance, the employee 25%, and the government 5%. In Argentina, 80% of the social security budget comes from contributors to the social security system, but the government maintains a special fund for people with neither insurance nor resources. In Colombia, the Comprehensive Social Security System establishes subsidies for people who cannot pay their insurance contribution. In El Salvador, the Social Security Health Institute, financed by the state, provides services to insured workers and free care to people who cannot afford to pay.

Regulation of health care providers

All nine Latin American and Caribbean nations have laws that establish the requirements by which people qualify as medical professionals and that regulate the activities of health care providers. Although in all nine countries legal development in this arena has focused on physicians, Bolivia, Jamaica, and Peru have laws that regulate other health care professions more widely. In Bolivia, the Health Code requires doctors, dentists, nurses, nutritionists, and all others that provide health care to register with the government once they have complied with all legal requirements for training. In Peru, the General Health Act contains a chapter devoted to the regulation of the medical, dental, pharmaceutical, and other similar professions, as well as that of health care technicians and assistants. In Jamaica, there are three applicable statutes — the Medical Act, the Nurses and Midwives Act, and the Pharmacy Act — that create governing councils and establish their own judicial bodies. Of all nine countries, Bolivia, El Salvador, Mexico, and Peru have additional laws that regulate the health sector and establish official control mechanisms for health facilities and their professionals. These laws establish principles and obligations with which health care professionals, particularly doctors, must comply. Such obligations include confidentiality as well as civil and criminal liabilities stemming from negligence or from criminal offenses.

With the exception of Jamaica, registered medical professionals in all countries are also governed by a Medical Ethics Code and a professional council or tribunal that oversees the application of this code. These codes establish ethical obligations for health care providers, including respect for the life and dignity of patients, health care without discrimination, and patient confidentiality. Some of these codes, like those of Brazil and Guatemala, specifically refer to the doctor-patient relationship in reproductive health matters. The Brazilian Medical Ethics Code establishes a doctor's duty to respect the patient's right to freely choose a contraceptive or fertility method, as well as informing him or her about the consequences and risks of such methods. It also prohibits artificial insemination without the patient's consent. In Guatemala, the Ethics Code establishes that doctors must abstain, except during obstetric emergencies or with judicial approval, from examining the genitalia of female minors in the absence of parents, a guardian, or other legally responsible individual. Professional tribunals may punish medical providers by issuing official warnings, fines, suspensions, and expulsions from the relevant professional association. Although ethical codes establish rules of conduct for doctor-patient relationships, these codes generally do not have the force of law, unless explicitly provided by law. In Peru, for example, its General Health Act establishes that the punishment imposed upon health care providers for certain acts may be provided in the applicable Ethics Code. Guatemala provides an example of an instance in which an act or governmental policy is in conflict with the Ethics Code. The Ethics Code forbids doctors from performing sterilizations. Yet sterilization remains one of the most popular methods of contraception among married and cohabiting women and is mostly provided by public health care providers.

Except for Jamaica, the penal codes of all nations discussed herein punish a range of offenses that may be committed by health care providers. The most common offenses are injuries and death caused by negligence; the performance of abortions, which is generally illegal in all nine countries; infringement of patient confidentiality; crimes against public health; illegal trade of toxic substances; and unlawful prescription of drugs.

While the practice of alternative or traditional medicine is very common in the countries in the region, providers of such care are not regulated by the government. In Bolivia, although each traditional healer assists approximately 500 people per

year, legal regulations do not exist. In Peru, herbs and traditional medicine are used by 25% of the population. However, the General Health Act does not deal with traditional medical providers, except that there is a manual that establishes qualifications for traditional birth attendants.

Patients' rights

None of the nine Latin American and Caribbean nations described in this report has specific laws and effective regulations ensuring the protection of patients' rights. When the law grants such rights, the procedures by which to enforce such rights are practically nonexistent. In most cases, patients have rights that correlate to the duties imposed upon medical professionals and described in the previous section. Numerous health acts and ethics codes set forth patients' rights, which generally include assistance in case of emergency; informed consent; and the right to be treated with dignity and without discrimination. In all these countries, except Jamaica, the most effective mechanisms that patients may utilize when offenses are committed by health care personnel are those offered by the penal and civil judicial processes. In Jamaica, there are no legislative or regulatory provisions concerning damages and medical negligence, but common-law rules that regulate suspension of professional practice and civil liability are applicable. In Peru, health establishments have joint and several liability for crimes committed by medical practitioners.

Jamaica is the sole country out of the nine discussed in this report where the Medical Act empowers the relevant professional council to revoke the license of any medical practitioner that infringes the rules established by that law. It may also impose various disciplinary measures that may be appealed before a judicial body. Jamaica thus provides the only example of a nation where a law empowers a nonjudicial body to impose punishments. In all the other countries, professional tribunals may only impose disciplinary measures, including expulsion. No professional bodies are empowered to compensate victims for their claims.

B. POPULATION, REPRODUCTIVE HEALTH, AND FAMILY PLANNING

A review of population laws and policies in all nine Latin America and Caribbean countries indicates that their existing population policies mainly seek to balance population growth rates and an even distribution of the population with a rational use of available resources. The regional trend is toward abandoning the emphasis on population control in favor of such a balance. However, in four countries — El Salvador, Jamaica, Mexico, and Peru — limiting population growth remains a policy objective. There is also a trend to view population within the context of sustainable development. The 1994 Declaration of Principles on Population and Sustainable Development of Bolivia, reflecting this trend, states that population policies must not be regarded as instruments of demographic control. For example, the 1996 Family Planning Act of Brazil prohibits coercive family planning as a method of population control.

Population laws and policies

Not all the countries profiled in this publication have issued specific population laws and policies. Brazil, for example, deals with some population issues in its general social development plans or in social policies like those for employment and education. In addition, in Guatemala, population control is not a specific policy and is hardly mentioned in the government' s national program. As discussed previously, the laws and policies of El Salvador, Jamaica, Mexico, and Peru place greater emphasis on the need to decrease population growth rates. El Salvador has a population growth rate of 2.5%, one of the highest in Latin America. The government has declared that it has an "overpopulation" problem and it has elaborated strategies by which to address this issue. These strategies include women's education, the incorporation of women within development plans, and family planning. In Peru, the national population policy seeks to decrease the current annual growth rate of 1.8%, stating that such a reduction will take place without coercing, manipulating, or biasing people in favor of family planning. In Peru, the family planning program aims to achieve an average total fertility rate of 2.5 children per woman, as opposed to the current rate of 3.5. In Mexico, the National Planning Council is responsible for establishing the country's demographic policy. The goal is presently set at achieving a 1.75% population growth rate for the year 2000 and of 1.45% for the year 2005; the current population growth rate is 2.05%. In Jamaica, the government seeks to limit population growth to an annual rate of 0.8% over the next three decades; the current growth rate is 0.9%. Argentina, which has a pronatalist population policy, is an exception in the region.

Reproductive health and family planning laws and policies

All the nine Latin American and Caribbean countries that are the subject of this report are characterized by laws and policies that recognize the right to family planning and respect individual choice regarding the number and spacing of children. Likewise, recent policies and legislation in Bolivia, Brazil, and Peru regard reproductive health and family planning as fundamental human rights. For example, the law regarding family planning in Brazil declares that the exercise of family planning ensures men and women equality of rights with regard to the number and spacing of children.

This recognition and protection of rights through laws and policies offers a stark contrast to women's status and

reproductive health. Women's general subordination, alienation, and inequality affects their reproductive life, decisions regarding spacing of children and their ability to access reproductive health services. Laws and policies in reproductive health and family planning, however, generally do not address this linkage. Only Colombia and Peru aim directly to empower women or to improve their social situation in their reproductive health and family planning policies. In Colombia, the Comprehensive Health Program for Women seeks primarily to integrate poor women into the subsidized health care system and to encourage family coverage by health care insurance. Thus, the benefits of health care insurance are extended to spouses and permanent partners and the children of those workers who belong to the insurance system. In Peru, the Reproductive Health and Family Planning Program ("RHFPP") refers to gender equality and considers socioeconomic status to be a determining factor in women's reproductive health. This policy seeks to begin to remedy the current situation by creating subprograms that address gender issues, including the eradication of violence against girls and women.

There are two important regional trends in the development of policies relating to reproductive health and family planning. A recent trend in all countries, except Jamaica, is the formulation of policies that integrate reproductive health and family planning services. For example, in Bolivia, the government has declared that family planning is an important part of reproductive health. In addition, Peru's RHFPP has established that family planning is a "priority action" in reproductive health. A second trend is to propose policies and programs on either reproductive health or family planning that are not part of the general national health policies directed toward women. In Bolivia, Mexico, and Peru, there are specific policies or strategies regarding reproductive health and family planning. In Brazil and Colombia, these services are part of comprehensive women's health programs; in El Salvador, they are a component of overall national plans such as the Women's National Plan. In Jamaica, there is no legislation or policy regarding reproductive health; the government addresses only family planning. Only Bolivia has a program, known as the Sexual and Reproductive Health Strategy, that refers directly to sexual health. This policy is focused on the implementation and provision of family planning services.

The central objectives of the reproductive health programs in the eight Latin American nations described herein are numerous. They include the provision of assistance to improve women's reproductive health in all the stages of their lives; reduction in the number of unwanted pregnancies and abortions; detection and treatment of cervical and breast cancer; improvements in pre- and postnatal care as well as the rate of births assisted by medical practitioners; reduction of pregnancy risks among adolescents; and prevention of HIV/AIDS and STIs. Although there is no national family planning program in Argentina, there are information and training programs on maternal reproductive health, with a special emphasis on mother-child health. One of its main activities is training women as preventive health agents. To date, 60,000 women have been trained throughout Argentina. Since 1995, Peru has issued the most regulations and specific policies relating to women's reproductive lives. Nevertheless, Peru's maternal mortality rate is second only to that of Bolivia.

In all nine countries, except Argentina, governmental institutions at the national level are responsible for promoting and enforcing family planning and reproductive health policies. Brazil, however, has established that both public and private organizations may be responsible for family planning programs. Although Argentina's government has restored the right to family planning as well as the state's responsibility for providing information on this matter, it has not yet established the state's responsibility for the provision of contraceptives. Currently, the federal government in Argentina has no family planning policy and undertakes no related activities related.

Government delivery of family planning services

In most countries, except Argentina, laws and policies establish that governments must play a central role in the provision of family planning services. They seek to achieve this goal through the provision of information, contraceptives, and contraceptive services. However, in Argentina, in 1986, the government stipulated that public health care services were responsible for disseminating information and for counseling people regarding their right to decide on the number of children that they want. However, the government's mandate does not include the provision of family planning services and the distribution of contraceptives. Hence, although there are no legal or policy barriers, the absence of family planning services hinders the right of people to plan the number of children they wish to have. In Argentina, the private sector is the main provider of contraceptive services, which are provided for a fee. Argentine public hospitals that obtain pills and intrauterine devices paid for by the state must specify that these items will be used for purposes other than contraception, because there are no explicit provisions that authorize these hospitals to acquire or distribute contraceptives.

Governments vary in terms of the fees they charge to provide services. In Jamaica, family planning services are available through the public health care services. But such services are not free. The fee charged amounts to 5% of the market price for contraceptives and services. The Jamaican Family Planning

Board, the government agency that implements family planning services, ensures access to such services. However, in recent years, there has been a decrease in the number of pregnant women assisted by the public health care service and in the number of people using contraceptives supplied by public services. Mexico and Peru have guaranteed access to all family planning services free of charge.

The great majority of government programs include the distribution of contraceptives and the provision of information and services necessary for such distribution. Mexico presents one of the most outstanding examples of a government program that provides information, counseling, prescription, and contraceptive services free of charge to a large number of people. In 1995, 72% of Mexican women who used contraceptives obtained them from the public health service system. In Peru, the state supplies all types of contraceptives free of charge. In 1996, the Peruvian government established free services and supplies for family planning. Moreover, the Ministry of Health and the Peruvian Institute of Social Security provide contraception coverage to 70% of all women users. In El Salvador, the Ministry of Public Health and Social Action and the Salvadoran Social Security Institute provide most family planning services. A private institution called the Salvadoran Demographic Association provides a significant portion of these services. Together, these three institutions provide contraceptive coverage to 78.7% of all women users in El Salvador. There is insufficient information in Bolivia, Brazil, and Guatemala regarding the percentage of women who use public family planning services. In Bolivia, while family planning is a recognized part of reproductive health and a fundamental human right, the national health agency does not provide free family planning services. In Brazil, the Single Health System is the government agency responsible for providing family planning services and contraception. In Guatemala, the Reproductive Health Unit is the official agency responsible for the provision of medical supplies and family planning methods and for training professionals in the delivery of contraceptives.

Private and nongovernmental organizations play an important role in the provision of contraceptive methods in all the countries described herein. In some nations, they distribute more contraceptives than the government. In 1993, the Colombian government provided only 20% of the population with contraceptives. Although this situation persists, the Colombian government continues to consider family planning to be an integral component of its social security system's primary health care plan. In other words, the government has shown the political will to provide family planning services for low-income users in each public health center and hospital.

C. CONTRACEPTION

Prevalence of contraceptives

The prevalence of contraceptive methods varies from one country to another, ranging from an average rate of 32% of married and cohabiting women in Guatemala to 76.6% of the same group of women in Brazil. Bolivia and El Salvador have, after Guatemala, the lowest rates of contraceptive usage with only 45% and 53.3%, respectively, of married and cohabiting women using contraception. In the five remaining countries, the average rate of contraceptive use is over 60% of all women living with partners. The particular rates are as follows: 72% in Colombia; 68.9% in Argentina; 67% in Jamaica; 66.5% in Mexico; and 64% in Peru. In five of the nine Latin American and Caribbean countries described in this report, sterilization is the most popular method of contraception among women, with rates that are considerably higher than those of the second-most popular method. In Mexico, 43.3% of women that use a modern contraceptive method are sterilized. In Brazil, this percentage is 40%, in El Salvador 31.5%, and in Guatemala, 14.3%. Although no official figures for sterilization were found for Colombia, it is believed that sterilization is also the most popular method of contraception in this nation.

It is important to note that, in some countries, traditional methods such as periodic abstinence are much more popular than modern methods. In Bolivia, 18.3% of women use traditional methods while 11.9% use modern methods. In Peru, this situation has been changing in recent years.

Legal status of contraceptives

In all nine Latin American and Caribbean countries, contraception is legal. All governments state that contraception is a means by which people can exercise the right to family planning. However, Argentina is the only country where sterilization is illegal and punished by law. While the performance of most abortions constitutes a criminal offense in all nine countries, several nations also expressly reaffirm their prohibition on abortion as a method of family planning.

All nine nations regulate modern contraceptive methods. In all nine countries, there are official institutions responsible for quality control and registration of contraceptive products. Peru, the most advanced country in terms of legislation relating to contraceptives, is the only country that regulates emergency contraception. The *Manual on Reproductive Health* recognizes its use within seventy-two hours of unprotected sex for cases of "nonconsensual carnal intercourse" — such as rape — or for failures resulting from barrier contraceptives.

Regulation of information on contraception

Although not prohibited in any nation, regulation of information on contraception differs considerably from one

country to another. In Argentina, Bolivia, Brazil, El Salvador, and Jamaica, there is no particular law that regulates such information. However, the governments of these nations have made a commitment to disseminate information on family planning methods. In Colombia and Mexico, laws permit mass distribution only of drugs that do not require medical prescription. In Peru, according to the recent General Health Act, access to information on all available modern and traditional methods of contraception is a right of all women users, and the provision of it a corresponding duty of health care providers.

Sterilization

Sterilization is a legal and popular contraceptive method in all countries studied, except Argentina. In four of these nations — Brazil, Colombia, Mexico, and Peru — sterilization is subject to legal regulations and requires the informed, conscious, and willing consent of the patient. Jamaica does not regulate the performance of sterilizations. However, in practice, Jamaican hospital providers tend to perform such a procedure only when a woman has more than two children.

Although Brazil currently has the second-highest rate of sterilization among the nine countries covered in this report, the 1996 Family Planning Act referring to sterilization was vetoed by the president in August 1997. The vetoed sections included some provisions that protected the rights of patients, established requirements such as a written record of consent, elaborated conditions for eligibility, including having had two children, and being over 25 years old, and established a waiting period of sixty or more days between consent and surgery. The president revoked his veto in August 1997, prompted primarily by action undertaken by the Brazilian feminist movement. In El Salvador, sterilization is the most popular contraceptive method, although there is no specific legislation on the matter.

D. ABORTION

Although not reflected in official statistics, abortion remains one of the main causes of maternal mortality in several of the countries covered herein. Abortion is illegal in all nine nations. Yet, the rate of clandestine abortions is high. Brazil and Mexico have the highest rate of clandestine abortions, amounting to between 800,000 and 2 million per year. More than 80% of the abortions performed in Latin America and the Caribbean are performed in eight of the countries discussed in this report. The current legislative trend is toward more stringent regulation and punishment of abortion. Reproductive health and family planning programs aim to decrease clandestine abortion and to provide care for women suffering from abortion-related complications. Even so, these same countries also penalize health care providers and their women patients for obtaining abortions. There is thus a contradiction between policies and laws regarding abortion.

Legal status of abortion

In all nine countries studied, abortion is a felony punished by penal law. In many nations, illegal abortions performed in inadequate conditions have become a major public health concern. Abortion is one of the main public health problems in Bolivia. It contributes to a high rate of maternal death and to the increase in public hospital costs that arise from treating women suffering from abortion complications. In Guatemala, abortion remains one of women's most serious health problems. In Colombia and Peru, abortion is the second cause of maternal death. In Peru, patients suffering from abortion-related complications occupy 30% of gynecological beds in all public hospitals. In Jamaica, women suffering abortion-related complications occupy 20% of gynecological beds in public hospitals.

Requirements for obtaining legal abortion

In all nine countries, abortion is illegal. However, seven of the nations discussed in this publication, except Colombia and El Salvador, establish exceptional situations under which a woman may obtain an abortion. Under some exceptions, the individual's actions are not regarded as criminal and he or she is excused of any wrongdoing; other exceptions exempt the individual from punishment. This means that, depending on the legislative provision, a judge may decide that criminal prosecution of a woman who obtains an abortion or of others involved in performing or obtaining the abortion is not warranted. It can also mean that even if the prosecution is legally permissible, the consequent penalty may not be imposed because an exception requires immunity from punishment. In either case, the practical effect is that, under such exceptional circumstances, the persons involved in an abortion cannot be punished.

In most nations, abortion is permissible only in limited circumstances. In Argentina, Bolivia, Brazil, Guatemala, Jamaica, Mexico, and Peru, an abortion performed to save the mother's life (known as therapeutic abortion) is not punished. In Argentina and Peru, an abortion is not punished if the pregnancy poses a serious risk to either the mother's health or her mental and physical health. Jamaica also permits an abortion in the latter circumstance. In addition, in Bolivia, Brazil, Jamaica, and Mexico, abortion is not punished when a pregnancy is the result of rape; in Argentina, an abortion is not punished when it results from rape or a sexual act with a mentally handicapped or insane woman. In all cases, it is required that the abortion be performed by a medical practitioner and that there is certifying evidence of the existence of an exceptional circumstance. In Bolivia, the rape victim must request authorization to obtain an abortion from the judge assigned to the rape trial. In Brazil, although not so

provided by the penal code, the judicial branch has used writs to extend the exceptional circumstances for legal abortion to include those situations in which the fetus has incurred serious and irreversible abnormalities. Nine Mexican states also do not penalize abortion performed under such conditions. Only one Mexican state, Yucatan, permits abortions on serious economic grounds when a woman already has three children.

Penalties for abortion

Penalties for performing an illegal abortion differ considerably in the nine nations. Penalties depend both on the criteria defining abortion in legislation and on provisions therein defining aggravating and alleviating circumstances. Punishment also depends on the extent of the person's involvement in the crime and on whether the performer is a medical practitioner. Jamaica is the only country among the nine discussed herein where the penalty for abortion is life imprisonment.

Generally, the same penalty is imposed upon the woman who obtains an abortion and on the person who performs it, unless the pregnant woman did not consent to the procedure. Penalties vary from two to ten years of imprisonment, depending on aggravating circumstances such as in the case of an abortion that results in death or injury. In Peru, a person who performs an abortion suffers a harsher penalty than the woman who consents to the abortion. Peru also has specific provisions in its recent General Health Act that establish the duty of health care providers to report women who seek treatment for post-abortion complications to the authorities.

Some laws establish alleviating circumstances for abortion similar to the exceptional circumstances that merit "impunity" or "exoneration." For example, in Peru and Colombia, an alleviating circumstance occurs when the pregnancy is the result of rape. In Colombia, a risk to the mother's life or health is also an alleviating circumstance. In Bolivia and Mexico, the pregnant woman's "good" behavior is an alleviating circumstance.

E. HIV/AIDS AND SEXUALLY TRANSMISSIBLE INFECTIONS (STIs)

Laws affecting HIV/AIDS and STIs

All the Latin American and Caribbean countries covered in this report, except El Salvador and Jamaica, have laws concerning HIV/AIDS and STIs. In Argentina, Bolivia, Brazil, Colombia, Guatemala, Mexico, and Peru, the deliberate transmission of HIV/AIDS is a crime. In some countries, laws seek to protect the rights of persons with HIV/AIDS. In others, the law imposes duties on health care providers regarding the precautions necessary to prevent the transmission of diseases by blood transfusions and other means.

Laws recognize a range of rights for persons with HIV/AIDS. In most countries, the rights of patients with HIV or AIDS include confidentiality of test results; the right not to be discriminated against by medical providers; protection from employment discrimination and discrimination in certain aspects of their social lives; protection against wrongful disclosure of their medical information; respect for their human dignity; and the right to receive medical treatment. In Bolivia, people with HIV/AIDS may not be refused access to their work premises. In Bolivia and Colombia, a person suffering from HIV/AIDS is not required to inform his or her employer of his or her illness. In Peru, the dismissal of an employee suffering HIV/AIDS is not legal. Bolivia, Colombia, and Guatemala forbid compulsory testing for HIV/AIDS. In Bolivia, Brazil, Guatemala, and Peru, institutions or persons that perform HIV/AIDS detection tests are required to notify the authorities of positive results. These reports are strictly confidential.

In two nations, El Salvador and Jamaica, laws are not explicit in their protection of persons with HIV/AIDS. In El Salvador, the Health Code contains very restrictive regulations on HIV/AIDS that regard AIDS, like other STIs, as a disease about which health care providers must notify the authorities. A person with HIV/AIDS may be forced to submit to isolation, observation, and surveillance in a manner determined by the authorities in the Ministry of Public Health and Social Action. This law also prescribes the sterilization of the premises and objects with which the infected person has had contact. In Jamaica, there exist neither laws regulating this issue nor a specific prohibition against discrimination toward persons with HIV/AIDS.

Of all the laws that protect the rights of patients with HIV/AIDS, the Peruvian law that renders invalid the dismissal of a worker with HIV or AIDS merely because of his or her condition is the most important legal mechanism developed by a nation to protect persons with HIV/AIDS against employment discrimination.

Sexually transmitted infection legislation in the region is scarce. In Argentina, Bolivia, Colombia, Guatemala, Mexico, and Peru, laws do not deal specifically with STIs and mention them only in laws relating to HIV/AIDS. In Brazil, legislation declares only that it is in the public interest to eradicate STIs. In El Salvador, the same norms that apply to HIV/AIDS are also applied to STIs. In Jamaica, no specific laws address STIs. The Public Health Act states that the Ministry of Health must do whatever is necessary to stop the spread of these diseases.

Policies on prevention and treatment of HIV/AIDS and STIs

Most of the countries reported have governmental institutions or bodies that address AIDS prevention. In all nine Latin American and Caribbean countries, ministries or secretariats of health are in charge of policy management and enforcement

either directly or through a dependent institution. El Salvador is the only country that does not have a specific HIV/AIDS and STI policy, though the Women's National Plan seeks to review laws and regulations to ensure HIV/AIDS prevention. Only Argentina, Bolivia, Brazil, and Mexico have policies regarding the treatment of AIDS. Except in Mexico, HIV/AIDS and STI services are not integrated within reproductive health and family planning programs.

In nations where public services are available for HIV/AIDS, there is considerable variance in the range of such services. In Argentina, health care officials must provide medical, psychological, and pharmaceutical treatment for HIV/AIDS. However, the service is deficient, especially with regard to the provision of drugs. In Bolivia, the HIV/AIDS Prevention and Surveillance Program seeks to improve care, provide information and education, and maintain a team of professionals to assist AIDS patients. Brazil, a nation with one of the highest HIV/AIDS prevalence rates in the world, has been slow and deficient in its response to this health problem. The country's budgetary crisis has hampered the government's ability to undertake policies for the prevention and treatment of AIDS. The Unit for Sexually Transmissible Infections in the Ministry of Health develops the National STI/AIDS Program, which envisages two strategies: first, the strengthening of diagnosis and care; and second, the dissemination of information through educational and counseling campaigns. These campaigns have been undertaken in surgical centers at a federal level, as well as in universities and hospitals that undertake research on HIV/AIDS at a national level. These institutions, financed either by the federal government and/or international institutions, have successfully distributed condoms free of charge.

Mexico is the only country among the nine profiled herein that integrates its AIDS prevention and control program with its Reproductive Health and Family Planning Plan. The government's policy aims at reducing morbidity and mortality resulting from this disease and increasing access to information, diagnosis, prevention, and control services through communication programs, preventive actions, and AIDS assistance in primary health care facilities. The government's goal is to provide care to 80% of all HIV positive patients, reduce STIs by 30%, and reduce prenatal transmission of AIDS by 50%. Mexico's HIV/AIDS policy is the most comprehensive of any nation profiled in this report.

As expected, the policy objectives of HIV/AIDS programs vary. In Argentina, the National Program Against HIV/AIDS develops prevention and information campaigns in schools. In Colombia, the National AIDS Council and the National Executive Committee for the Prevention and Control of HIV/AIDS encourage healthy sexuality, prevention, and the provision of laboratories for the diagnosis of such diseases. In Guatemala, the National Commission for the Surveillance of AIDS undertakes epidemiological surveys, health promotion and counseling, distribution of information, and other activities that seek to control AIDS. In Jamaica, the National Program for HIV/AIDS Control and the 1997–2000 Medium-Term Plan establish that the Ministry of Health must improve condom-distribution plans, elaborate a policy for prison inmates, develop an AIDS policy for the workplace, and provide STI services within primary health care facilities. In Brazil, the promotion of civil society's participation in the prevention of HIV/AIDS is one of the most relevant governmental initiatives in the region.

III. Understanding the Exercise of Reproductive Rights: Women's Legal Status

Women's health and reproductive rights cannot be fully understood without considering women's social and legal status. All nine countries, except Jamaica, include in their national Constitutions provisions relating to equal rights and nondiscrimination. In Jamaica, freedom from discrimination based on sex or gender is not constitutionally protected. Although the Jamaican Constitution establishes that any action "affording different treatment to different persons, … on the basis of race, place of origin, political opinions, color or creed" is discriminatory, this provision does not mention gender. Argentina and Brazil mandate affirmative action measures to promote women's political participation. Argentina's Constitution includes an affirmative action provision that seeks to achieve women's equality in political participation. Brazilian national law establishes that all political parties must ensure that at least 20% of the candidates they propose are women. Other countries have important constitutional provisions regarding the legal and social status of women. In Colombia, the Constitution establishes the state's responsibility for the promotion of equal participation of women in political power. In Peru, the Constitution establishes the right of persons not to suffer moral, physical, or mental violence, which includes all forms of violence against women.

Although all nine Latin American and Caribbean countries made progress in their legislation advancing women's rights, there remain obsolete discriminatory civil and penal provisions that indicate the lack of political will to fully implement constitutional principles that protect women. Take, for example, Bolivia, Brazil, and Guatemala. In the civil codes of Brazil

and Guatemala and in the Family Code of Bolivia, men have rights in marriage that discriminate against women. Yet all nine countries profiled in this report have signed or ratified two key international instruments regarding women's human rights — the Convention on the Elimination of All Forms of Discrimination Against Women and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belem do Pará). One of the main obstacles affecting all women is the enormous gap between the rights granted by law and women's exercise of such rights. This gap is partially attributable to the absence of efficient, direct, and simple mechanisms by which women can exercise their rights. This problem is exacerbated for women in vulnerable situations, especially those who are low-income, rural, and indigenous. Native and rural women generally suffer discrimination in their community lives because custom and usage work against them. In such communities, not only are men in leadership positions but women are also legally entitled to inherit less land than men. This form of legal discrimination hinders their access to credit and their ability to improve their general economic condition.

Violence against women is a serious problem in most of the nine Latin American and Caribbean nations discussed in this report. Yet the extent of the problem is also very hard to prove because of the lack of reliable documentation and statistics in most countries. Based upon available information, it was possible to identify the following as the main acts of violence: sexual violence, domestic violence, and other forms of physical and mental violence. In Bolivia, 76.3% of the acts of violence against women were regarded as physical violence and 12% as sexual violence. Most of these acts occurred within the home. In Peru, in Lima alone, 6,244 cases of violence against women were reported to a special police unit; rape and other sexual aggressions are the third-most common national crime. In Jamaica, in 1992, 1,108 cases of rape were reported to the police.

Sexual harassment also continues to be a problem that governments have not yet addressed effectively. None of the nine Latin American and Caribbean countries profiled herein have specific laws regarding sexual harassment that protect women in all areas of their lives, including their domestic ones. Illiteracy among women in these countries ranges between 4% in Argentina to 50.3% in El Salvador. In the remaining seven countries, women generally have higher illiteracy rates than men. Illiteracy is usually highest among women in rural areas. For example, in Guatemala, the illiteracy rates for urban women is 13%, compared to 49% for women in rural areas.

A. CIVIL RIGHTS WITHIN MARRIAGE

In all of the nine Latin American and Caribbean countries studied in this publication, the trend is toward legislative amendments that seek to guarantee equal rights within marriage. Yet some countries are still under the influence of their recent past when a married woman was subject to her husband's custody. In Argentina, Bolivia, Brazil, and Guatemala, the constitutions establish equality in marriage. But in spite of this declaration, their civil codes contain discriminatory rules against women that infringe upon their fundamental rights. Even in some countries where the law does not discriminate against women, the regional trend towards equal rights must to be understood within a regional context of continuing violence and inequality. In Peru, for example, 60% of women are poor and have little knowledge of their rights. And, in most of the countries studied, domestic violence is a problem that has serious effects on women's health, including their reproductive health.

Marriage laws

All nine Latin American and Caribbean countries have similar legal systems regulating marriage. Civil codes and other civil laws proclaim equal rights and obligations between spouses. Except when otherwise established by spouses, the law recognizes a community property system and joint parental custody over children. Laws in all nine countries establish a series of reciprocal obligations between spouses, such as fidelity, mutual assistance, maintenance, and cohabitation. According to the common community property system, all property acquired during marriage is held jointly by both spouses. The exception to this rule is provided either by the existence of an alternative settlement stipulated in the civil law or by a joint agreement regarding a different property settlement. The liquidation of joint property in cases of death, divorce, or separation results in property held jointly being divided equally between spouses, in the case of death, among their heirs. In Jamaica, despite the existence of three marriage laws — the Marriage Act, the Hindu Marriage Act, and the Muslim Marriage Act — all three establish the same rights and obligations for both spouses. Nonetheless, the marriage laws of many nations discriminate against women. Only Colombia, El Salvador, Jamaica, and Peru have norms that do not discriminate in favor of or against one of the spouses. The remaining countries in this report still have obsolete provisions in force.

In Argentina, although the regulations regarding marriage contained in the Civil Code have recently been amended to eliminate discriminatory provisions against women, some discriminatory provisions still exist. For example, the law entrusts the husband with the administration of property of uncertain

origin, denies the mother the right to dispute her child's paternity, and includes the concept of so-called reverential fear that women owe their husbands. In Latin American jurisprudence, reverential fear has been used to invalidate the need for a married woman's consent in most situations because it is presumed that such consent was granted on the basis of the reverential fear the wife owed her husband. The Bolivian Family Code also contains discriminatory provisions. For example, the husband may restrict his wife's practice of a profession or trade on the grounds of either morality or when the woman's role within the home is affected.

In Brazil, the Civil Code establishes that the husband is the holder of all property held jointly by the spouses. He legally represents the family and holds sole parental authority over the children during marriage. The husband may even request the annulment of the marriage up to ten days after its celebration if he discovers that his wife was not a virgin. Brazilian civil law establishes that the married woman becomes her husband's partner, spouse, and companion and is responsible for the material and moral direction of the family. A wife needs her husband's authorization, duly recorded as an authenticated public record, to sell or mortgage her own personal property, to transfer property rights to third parties, and to incur debts that restrict joint property. The law presumes that wives that exercise their profession outside the home more than six months have their husbands' permission to do so. Husbands are entitled to administer joint property as well as their wives' property.

In Guatemala, despite civil and constitutional laws declaring equality of rights between spouses, the Civil Code establishes that only the husband may legally represent the couple in the administration of jointly owned property. In addition, it establishes differing obligations between spouses. It is the husband's obligation to supply the wife with the means necessary to support the home; it is also the wife's obligation to care and tend for their children when they are minors and to conduct household chores. The wife may work outside the home provided these activities do not damage the welfare and interests of her children and her household duties. In any case, a husband may oppose his wife's working as long as he can support the home. Until recently, penal law in Guatemala contained discriminatory provisions against married women. In March 1996, a group of women reformed laws that regarded adultery as a crime only when committed by a married woman. In Mexico, each state regulates marriage in its territory. No federal regulation of marriage exists. In the Mexican capital, the Federal District, the civil code follows the principle of equality between the spouses.

Regulation of domestic partnerships

In all nine countries, couples frequently live together and raise families as if they were married. These situations are known as *uniones de hecho* or domestic partnerships in some countries and "concubinage" in others. However, not all countries recognize that such unions generate legal rights and obligations. In the countries that regulate domestic partnerships, laws are generally nondiscriminatory. The regional trend is toward increasing recognition of rights of these couples and their children and granting rights similar to those that exist within a legal marriage. Although laws generally confer upon women in domestic partnerships fewer rights than those conferred upon married women, the existence of legal standards in this regard benefit women. It is women who usually need to claim their property rights vis-a-vis their male partners and apply for social security benefits for themselves and their children when such benefits are provided only by their partner's employment.

Seven countries — Bolivia, Brazil, Colombia, El Salvador, Guatemala, Mexico, and Peru — regulate domestic partnerships. Of these nations, El Salvador, Guatemala, and Peru regulate domestic partnerships at the constitutional level. In El Salvador, the absence of a legal marriage does not affect the enjoyment of rights established in favor of families. In Guatemala, domestic partnerships are considered legal by the Constitution, and these unions have legal effect so long as the interested parties declare to a local authority. In Peru, the Constitution defines and guarantees domestic partnerships in a manner similar to that of legal marriages and the Civil Code regulates such unions. Bolivian law also protects domestic partnerships or "free marital unions" as well as other forms of premarital unions such as "*tatancú*" and "*sirvinacuy*." The latter exist in Andean and other communities and enjoy legal effects similar to those of legal marriage. Moreover, in Brazil, Colombia and Peru, laws establish minimum periods of stable cohabitation for the domestic partnership to be legally recognized. In Brazil, this period is five years; in Colombia and Peru, it is two years. In Brazil, in sharp contrast to laws that govern legal marriages, laws that govern domestic partnerships respect the principle of equality and nondiscrimination against women. In Colombia, a couple in domestic partnership has equal rights. In 1992, the Constitutional Court in Colombia set a relevant precedent at the regional level by recognizing the value of domestic work as a contribution to the property jointly held in domestic partnerships. In Mexico, each state regulates domestic partnerships within its territory.

Argentina and Jamaica are the only countries in which domestic partnerships or situations of cohabitation are not regulated. However, in both countries, children born out of wedlock are entitled to the same rights as children born within a

marriage. In Argentina, there is only one example of a law — a labor law that recognizes the right of a cohabiting partner to receive a pension when the other dies — that confers rights to women (called concubines) in these unions. The law confers this right to a pension only if the couple have lived together for at least five years before the death in question, or if they had acknowledged their children, or if the deceased did not have other legal ties. In Jamaica, there exist many "visiting unions" and "common-law unions." Couples sometimes raise children together before entering a legal union. However, these unions are not legally recognized and this situation often leads to lack of legal protection for women and their children.

Divorce and custody law

All nine countries permit divorce. In all of them, except El Salvador, there is a predivorce stage called separation in which jointly held property is liquidated and the marriage is not dissolved. Civil laws that regulate divorce do not establish, as a rule, discriminatory provisions against women. They are, generally speaking, egalitarian when regulating the requirements, procedures, and effects of divorce and separation.

In Argentina, Guatemala, Jamaica, and Peru, there are gender distinctions in the law regarding child custody and maintenance. In Argentina, the law grants women custody of children under the age of 5. In Peru, parents are under an obligation to support their single daughters over the age of 18 but not their sons. In addition, except when the judge decides otherwise, a mother assumes the custody of daughters and sons under the age of 7 when both spouses are deemed "guilty" — or at least at fault in — the divorce. In Jamaica, the husband is not under any obligation to support his wife if she is "guilty" of "adultery" or "desertion." The wife is only under an obligation to support her husband if he is destitute and she has property. A man is also required to maintain his children and any of his wife's minor children or the children of any woman with whom he lives. In Guatemala, maintenance/alimony is granted to a woman who has obtained a separation or divorce when the husband is "guilty" only if she "behaves well" and does not marry again.

B. ECONOMIC AND SOCIAL RIGHTS

Property rights

In all nine Latin American and Caribbean countries profiled herein, a woman is equal before the law with regards to the right to property. But this does not mean that she has equal opportunities to access it. The following examples indicate practical limitations on property rights. In Bolivia, women in rural communities where customary norms prevail are subject to restrictions related to the acquisition or maintenance of land if there is no male in the home who can ensure its productive use. In that country, a peasant woman is also unable to inherit land when there are living male relatives. In Colombia, only 37.5% of women who are heads of household are proprietors, as opposed to 53% of the homes in which a man is head of household. In El Salvador, only 10% of rural property is registered in the name of women, even though 26.23% of heads of households are women. In Brazil and Guatemala, existing discriminatory provisions in their civil laws that grant the administration of joint property to men constitutes an infringement of married women's right to property. In addition, in Brazil, the Civil Code permits a person to draft a will that disinherits a "dishonest" daughter living in the paternal house. In this case, the term "dishonesty" refers to sexual conduct.

Labor rights

Seven countries — Argentina, Brazil, Colombia, El Salvador, Guatemala, Mexico, and Peru — have laws to protect women's labor rights. The law in these countries forbids discrimination in employment, establishes the principle of equal pay for equal work and, by granting a minimum of seventy-five days of paid maternity leave, protects pregnant women and mothers. In El Salvador, pregnant women only receive 75% of their wages during maternity leave. Several countries also require employees to grant breaks so that female employees can breastfeed their children. Moreover, it is illegal to dismiss women on the grounds of pregnancy. In addition, in Brazil and Colombia, there are laws that protect the reproductive rights of women workers. Since 1994, it has been illegal in Colombia to require pregnancy certificates before hiring a female employee unless the job entails a high health risk. In 1995, Brazil enacted a law that forbids employers to request pregnancy or sterilization certificates when hiring women.

Bolivia and Jamaica are the exceptions to the regional trend toward protecting women's labor rights. In Bolivia, laws protect only pregnant employees. Bolivian law does not protect women against discrimination at work. In Jamaica, the Constitution does not forbid discrimination based on gender and does not forbid employment discrimination against women. The Jamaican Women's Labor Act provides that no woman shall be employed in night work and that women may not exceed a total number of ten hours of work per twenty-four hours, except in certain professions. Among other protective measures, the Ministry of Labor may limit or forbid the employment of women in industrial undertakings. However, a 1970 Jamaican law establishes criminal liabilities for an employer that pays employees differently for the same work.

Access to credit

Although none of the nine Latin American and Caribbean countries discussed in this report has laws that directly regulate

or limit women's access to credit, it is evident that men and women often do not have equal access to credit. In some nations, such as Brazil and Guatemala, marriage laws that either restrict the administration of joint property by women or their access to inheritances also limit their access to credit. In rural areas, the unequal distribution of property between men and women also limits women's access to credit. In addition, it is a common practice among banking institutions in some countries to request the husband's signature when granting credit to a married woman even when she has the resources necessary to obtain such credit. In Jamaica and Peru, banking institutions retain practices that discriminate against women. In Jamaica, a married woman who requests a loan is required to obtain written confirmation from a lawyer that she has received necessary legal advice even when a husband and wife apply together for such a loan.

Some nations — Argentina, Colombia, El Salvador, and Mexico — have implemented governmental policies to solve the difficulties associated with women's access to credit. In Argentina, the government is developing training programs for women involved in small businesses. The Colombian government has enacted legislation to support access to credit by women who are heads of family. In El Salvador, in 1990, the government created communal banks and small businesses to address women's credit needs. In 1994, these institutions granted loans to 6,372 women. The Mexican government has enacted legislation to support rural women's access to credit by establishing industrial agricultural units for women in agriculture and providing aid to rural women's income-generation projects.

Access to education

None of the nine Latin American and Caribbean nations profiled herein restricts women's access to education. The general trend is for Constitutions and other laws to include the universal right to education and to establish that it is the government's duty to provide such education. Although all nine countries have instituted the right to free basic education for all, some – Colombia, El Salvador, Guatemala, Mexico, and Peru – specifically provide for it. For example, in Jamaica, education is free, although the cost recovery program, recently introduced, allows the government to recover only a little over 5% of its budget from fees paid by students.

Many countries also provide policies and programs to ensure education under equal conditions. In general, government education policies in all nine countries focus on girls and young women and not on the adult population. However, most illiterate women in these countries tend to be adult women, particularly those in rural areas. In Mexico, despite the fact that access to education is not restricted and that enrollment rates have increased, two out of three illiterate adults are women, and women in rural areas have the lowest educational levels in the country. In Argentina, Bolivia, Colombia, El Salvador, Guatemala, and Peru, illiteracy primarily affects women and rural people. Some governments are undertaking plans and programs to address this situation. For example, Argentina is developing a national-level equal-opportunity program for women in education. This first stage of this program focuses on the elimination of discriminatory stereotypes in educational materials and on the institutionalization of nonsexist language in the Federal Education Act. There is also a department for women in the Argentinian Ministry of Education that seeks to ensure and strengthen gender equity.

Women's bureaus

Although governmental offices entrusted with the promotion of women's rights exist in all nine Latin American and Caribbean countries, their powers vary considerably. Peru is the only nation where the main government institution for women is of ministerial rank. In Argentina, Bolivia, Brazil, Colombia, and El Salvador, these institutions have their own budgets and decision-making powers. In Jamaica and Mexico, these bureaus have less power. In Guatemala, this division's budget is limited and dependent on a ministry, so it is not regarded as significant. The regional trend is toward the creation and strengthening of these kinds of institutions. Most women's bureaus are independent from ministries but depend upon the executive branch.

As stated above, Peru is the only nation of the nine described in this report that has a ministry focused on women. In Peru, the Ministry for the Promotion of Women and Human Development, created in 1996, is the main bureau for women. Its mission is to promote the development of women, family, and population and to ensure priority attention for minors at risk. The other important institutions for the promotion and defense of women's rights in Peru are the Women's Commission in the Parliament and an Ombudsman for Women's Rights in the national Ombudsman's Bureau.

In five nations, women's bureaus have their own budgets and exercise considerable decision-making powers. In 1992, Argentina created the National Council for Women, which seeks to implement the Convention for the Elimination of All Forms of Discrimination Against Women within the nation. In Argentina, this convention's legal status is equivalent to that of the Constitution. This bureau has its own budget and also seeks to achieve the maximum participation of women at all levels. In sixteen Argentine provinces, there are women's bureaus that aim to develop public policies that address women's problems. Since 1991, Bolivia has attempted to

implement a gender perspective in public policies. The Women's National Program, the key instrument for such social policies, is enforced by the National Solidarity Board, which is dependent on the National Secretary for Ethnic, Gender, and Generational Affairs. Furthermore, the Gender Affairs Undersecretary is responsible for institutionalizing a gender perspective in development policies. Brazil's National Women's Rights Council is responsible for formulating national-level policies and programs related to women's rights. In 1995, Colombia created the National Office for Women's Equality in the interest of promoting women's equality and participation. This institution is the main women's bureau responsible for national policy coordination. It is associated with the presidency and has its own economic resources. In El Salvador, the Salvadoran Institute for the Development of Women aims to design public policies to improve women's status and to establish gender equality. It was created in 1996 as an autonomous body with legal status and its own economic resources.

Women's bureaus in Jamaica and Mexico have limited status. In 1975, in Jamaica, the Bureau for Women's Affairs was created as a bureau of the Ministry of Labor, Social Security, and Sports. Its main function is to educate, train, and raise the national awareness of women's affairs and to promote women's integration into national development plans. In Mexico, a Women's National Program is enforced by a secretary of the government, which develops policies that seek to eliminate discrimination against women.

Of all nations described in this report, Guatemala has the weakest women's bureau. In Guatemala, the Women's National Bureau, which is part of the Labor Ministry, is the governmental institution responsible for designing policies for the promotion of women. Because its budget is scant and it has a low administrative rank, this institution is prevented from adequately achieving its aims. Other specialized women's institutions are the Women's Commission in the Human Rights Office and the Women's Attorney General. A proposal to create another institution awaits approval in Congress.

C. RIGHT TO PHYSICAL INTEGRITY

The available statistics on violence against women indicate the importance of this problem for many countries in the region. For instance, in Brazil, 70% of all the reported incidents of violence occurred at home. In almost every case, the abuser was the woman's spouse or partner. In Colombia, violent death is the main cause of death for women aged between 15 and 24; 5.3% of women of reproductive age have declared that they had been forced to have sex, and in 80% of the cases, the abusers were acquaintances or relatives. In Mexico City, 87% of the victims of all crimes reported to the Attorney General's Office were women. In Peru, rapes constitute 48.6% of all "crimes against freedom." In 1996, domestic violence increased by 50.53% compared with the previous year.

Rape

All nine Latin American and Caribbean countries described herein define rape as a crime against sexual freedom, honesty, or respectability. The most common legal description of rape includes vaginal, anal, or oral penetration and penetration with objects. Except for Guatemala and Jamaica, the laws of the remaining nations do not differentiate between male and female victims of this crime.

In Guatemala and Jamaica, the crime is defined as occurring only when the victim is a woman. Moreover, in Jamaica, rape is also defined as including only vaginal intercourse.

Penalties for the crime of rape vary by country. In general, penalties are aggravated in the following circumstances: the number of people committing the crime; the extent of injuries suffered by the victim; pregnancy and death resulting from rape; the relationship between the abuser and the victim; and when the victim is defenseless. Guatemala and Jamaica have the toughest penalties for rape. In Guatemala, punishment for rape varies from six to twelve years of imprisonment. If the victim is under the age of 10, the crime is punishable with the death penalty. If the victim dies as a result of the crime, the punishment ranges from twenty to fifty years. In Jamaica, the penalty for rape is life imprisonment. Bolivia, Mexico, and Peru impose the most lenient penalties for rape. For example, Bolivian law punishes rape with a prison term ranging from four to ten years. In Peru, rape results in a penalty that ranges from four to eight years. If the crime is aggravated, the penalty ranges from twenty to twenty-five years. In addition to prison sentences, some countries establish other punitive measures. In Peru, the perpetrator must also undergo therapeutic treatment and must support the children born as a result of the crime. This provision does not specify whether it is necessary to obtain the victim's consent to the perpetrator's role in supporting the child. Finally, three countries maintain legislative provisions that exempt abusers from punishment if the victim marries the rapist. In Argentina, Bolivia, and Guatemala, there is no penal punishment if the victim willingly agrees to marry the perpetrator of the crime. In Bolivia, Brazil, Guatemala, and Mexico, "abduction for a sexual purposes" is a specific crime that it is not punished if the victim and the abuser marry.

A regional model of legal protection from marital rape exists in Colombia. In all nations, except Colombia, marital rape is not regarded as a crime. In Colombia, the penalty for marital rape varies from six months to one year. Jamaica presents another example of a nation making an effort to

criminalize marital rape. In this country, common law protects women separated from their husbands by recognizing that a wife is not deemed to having consented to sexual intercourse with her husband when she is threatened with violence; her husband suffers from a sexually transmissible infection; or the couple is separated. Moreover, there is a bill pending that seeks to enable a woman to charge her husband with marital rape. As opposed to this trend, a regrettable precedent was set in Mexico in June 1997 by its Supreme Court of Justice. This decision established that coercive sexual intercourse between spouses does not constitute a crime. Rather, it is to be considered the "wrongful exercise of a right" by the husband. Given that, in 1995, a Mexican state (Queretaro) considered marital rape as a crime, this judicial opinion may represent a regressive trend toward protecting women against violence in the home.

Domestic violence

Between 1993 and 1996, seven out of nine countries described in this report enacted, for the first time, laws and policies against domestic violence. These laws seek to establish legal protections, to develop preventive measures for victims of domestic violence, and to eradicate such violence. They also establish provisional measures and punishment for abusers through penalties like fines, restraining orders, and exclusion of the abuser from the family home. Depending upon the degree of violence, abusers may also be imprisoned. The legal proceedings in these nations involve the police, prosecutors, and civil, penal, and family judges. Examples of these laws include those in Colombia, Peru, and Argentina. In Colombia, a 1996 law declares domestic violence to be a crime and establishes temporary and permanent protective measures for victims of such violence. Victims can turn to a unit of the police dedicated to domestic matters, the public prosecutor, or the police generally. However, when domestic violence results in physical injuries, criminal laws are applicable. In Peru, the 1993 Domestic Violence Act aims to eradicate domestic violence, establish legal proceedings for victims, provide police offices with specialized personnel, promote the establishment of temporary shelters, and create institutions to treat abusers. In such proceedings, complaints are brought either to the police or a prosecutor to undertake preliminary inquiries; their report is then sent to a justice of the peace or a prosecutor-in-charge to issue a series of immediate punitive measures that range from expelling the abuser from the home to the imposition of civil fines. If a crime has been committed, the inquiry is extended. In Argentina, the 1994 National Act for the Protection Against Domestic Violence allows the victim to request protective measures from a judge. However, the law forces the victim and the abuser to participate in a mediation hearing. The regulations implementing this law create information centers and counseling in cases of physical and psychological violence.

In two of the countries studied, domestic violence falls within the scope of two laws. In Jamaica, two statutes are applicable — the Domestic Violence Act and the Matrimonial Causes Act. The latter is applicable only to married couples while the former also protects those who live in common-law unions or other nonmarital unions. Recently, Jamaica created special units within the police force to address domestic violence. In El Salvador, both the Domestic Violence Act and the Penal Code regulate violence. These laws specify three types of violence: psychological, physical, and sexual. Since the Penal Code also establishes sanctions for domestic violence, it falls within the scope of both the penal and civil systems. There is a special division of the National Civil Police to investigate and undertake the necessary procedures.

The domestic violence laws of Bolivia and Guatemala enable a variety of entities to enforce the law. Bolivian laws provide an interesting mechanism for the eradication of domestic violence in indigenous and rural communities. In Bolivia, the Domestic Violence Act is similar to those in other nations, except that it establishes an important mechanism to make protection against violence more accessible to indigenous and rural women. Authorities of native and rural communities are deemed competent to resolve cases of domestic violence in accordance with their usage and custom, provided such regulations and procedures are not contrary to the Constitution or the spirit of the national law relating to domestic violence. In Guatemala, the Act for the Prevention, Punishment and Eradication of Domestic Violence establishes that a victim's relatives and doctors, as well as any witness to the attack, may request protective measures. National police and justices of the peace take part in the proceedings.

Brazil and Mexico do not have specific national-level laws that address domestic violence. In Mexico, there is no federal legislation that specifically criminalizes domestic violence. In 1996, the Federal District enacted a law — the Act for the Assistance and Prevention of Domestic Violence — to establish nonjudicial procedures for the protection of victims. Some states consider violence against spouses or domestic partners only as an aggravating circumstance in certain cases. In Brazil, the Constitution ensures protection against domestic violence. However, there are no laws regarding domestic violence. There are draft bills that have encountered great resistance from jurists who declare that penal laws already protect individuals from crimes against personal safety. In Brazil, police offices focused on the defense of women encourage women to report cases of domestic violence to them. There is no legal basis at

the federal level for the creation of such offices. Rather, they have been established at the state level.

Sexual harassment

Only four of the nine Latin American and Caribbean countries profiled in this report — Argentina, El Salvador, Mexico, and Peru — have laws or regulations regarding sexual harassment. El Salvador and Mexico deem sexual harassment a crime. In El Salvador, it is defined to include unwanted and unmistakable sexual acts such as "touching." Sexual harassment is punishable by six months to one year of imprisonment; additional fines may be imposed if the harasser is exploiting his supervisory authority. In Mexico, only some states view sexual harassment as a crime. In the Federal District, if the harasser is a civil servant, the penalty is a fine and loss of job. However, in order for a crime to be punishable, the victim must be injured and must file a complaint against the harasser. In Peru, sexual harassment is defined as an act of "hostility" by an employer that is, in accordance with labor laws, equivalent to dismissal without cause. Within thirty days of the incident involving sexual harassment, the victim may either take action to limit the hostility or terminate her contract and request compensation. In Argentina, the sole regulation relating to sexual harassment deals with situations in which a superior induces another person to agree to his sexual request. The scope of this law is also rather limited since it does not cover most civil servants.

In Guatemala, Brazil, and Peru, legislatures are considering draft bills to regulate sexual harassment. The regional trend is to continue to restrict punishment of sexual harassment in the workplace, except for in Guatemala and some bills pending in Brazil, where protection measures against harassment in educational facilities are also being considered. In general, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women is the regional instrument that provides the best framework for protection against harassment. It considers sexual harassment an act of violence against women that occurs within the community and that may be perpetrated by anyone in educational institutions, health establishments, places of work, and in other places. All nine Latin American and Caribbean countries analyzed in this report have either signed or ratified this convention.

IV. Focusing on the Rights of a Special Group: Adolescents

Minors and adolescents account for almost half the population of each of the nine Latin American and Caribbean countries discussed in this publication. However, not all laws and policies define the term "adolescent." Only the national laws of Brazil and Peru define adolescents as persons between the ages of 12 and 18. Although Colombia has constitutional provisions that establish rights for young people and children, it does not establish any specific age limits. Generally, legislation in the remaining countries distinguishes minors from adults only in the context of marriage and sexual crimes. Even those countries that formulate policies addressing the reproductive health of adolescents do not define the term "adolescent." However, most demographic statistics refer to an "adolescent" as a person between the ages of 15 and 19. For the purposes of this report, whenever national-level laws and policies do not provide definitions, we follow the definition contained within Article 1 of the Convention of Children's Rights, which defines as a child anyone under the age of 18.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

Reproductive health statistics are not equally available among all the nine countries analyzed in this report. In several countries in the region, such as Colombia and El Salvador, international cooperation and NGOs have promoted the collection of demographic information and reproductive health indicators from all members of the population, including adolescents. The governments of Mexico and Peru have taken more initiatives in this area, unlike Argentina, which possesses limited general demographic information, particularly on adolescents.

Teenage pregnancy is a problem in every country profiled in this publication. In all nine countries, policies and laws that promote reproductive health among adolescents are very scarce. In these countries, higher rates of adolescent maternity correspond to lower rates of contraceptive usage. El Salvador and Bolivia have the highest rates of teenage pregnancy in Latin America — 20% and 18%, respectively, of all pregnancies. In these countries as well as in Jamaica, adolescent access to contraceptives is extremely limited. Hence these countries experience the highest rates of teenage pregnancy. In Jamaica, a third of all mothers who give birth are adolescent. Although this rate is very high when compared with that of other Latin American nations, it does not appear to be so in terms of the Caribbean region. In Peru, pregnancy among adolescent girls accounts for 15% of maternal deaths. The Ministry of Health has pointed out that a great number of adolescent pregnancies result in abortions because such pregnancies are unwanted. Mexico also provides a good example of the effect of contraceptive access on adolescent maternity. Statistics indicate that the use of contraceptives among adolescents during 1976 to 1992 has increased, and teenage pregnancy for the same period has decreased from 132 to 78 births for every 1,000 women. However, Mexico faces other challenges in the field of adolescent reproductive rights;

between 1990 and 1993, STIs among adolescents increased by 14%, and the maternal mortality rate of women under 20 is still 6% higher than that of older women.

Among the nations discussed in this report, there are only a few that utilize laws to promote adolescents' reproductive health. In four of them — Argentina, Bolivia, El Salvador, and Jamaica — there are no public policies or national programs to meet the reproductive needs of adolescents. In Argentina, very few provinces have initiated programs focused on the care of low-income teenage mothers. In Jamaica, the private sector assists with health needs and seeks to facilitate the return to school of adolescent parents. In the remaining six countries, there are some policies that address reproductive health and the family planning needs of adolescents. The common objectives of these policies include the prevention of unintended pregnancies and abortions among adolescents; the prevention of HIV/AIDS and STIs; the provision of information on family planning; and the eradication of sexual violence against minors. In these six countries, the trend is to formulate specific goals regarding adolescent reproductive health as part of either their general policies on these matters or of broader policies that relate to all adolescents. Peru, for instance, has a specific integrated health care program for adolescents; one of its components is reproductive health. One of the most important aims of the National STI/AIDS Program in Brazil is to fight child prostitution.

Although all countries except Argentina and Jamaica are characterized by common policy goals for adolescent reproductive health, they differ in terms of the strategies and activities undertaken to implement them. In Colombia, Mexico, and Peru, the main strategy to reduce unwanted pregnancies and abortions has been to initiate activities to provide family planning information. In Guatemala, educational campaigns on HIV/AIDS have focused on promoting chastity among young people. In Colombia, the national public policy on equality for women has as one of its goals the prevention of abortions and unwanted pregnancies, through the design and implementation of family planning activities that facilitate adolescent access to contraceptives. Mexico has opened special reproductive health units for adolescents in 102 health establishments across all thirty-two states. In Peru, the Comprehensive Health Program for Schoolchildren and Adolescents also services adolescents' reproductive health problems. It covers 40% of the adolescent population and, for the period from 1996 to 2000, has established a goal of achieving a contraceptive coverage rate for adolescents living with partners at not less than 60%.

National laws vary in terms of the legal protection they afford adolescent health. Where legal protection of adolescents exists, it is does not always cover their reproductive health. In some cases, instead of protecting adolescent health, the law seems to affect it negatively. For example in Mexico, the Federal Constitution establishes that parents have the obligation to preserve the physical and mental health of their children, and children are legally protected from violence in many states. However, these states also have obsolete norms in their penal laws, which grant parents the right to inflict corporal punishment on their children. On the other hand, in Bolivia, Brazil, and Peru, special national laws that regulate the rights of children and adolescents also guarantee certain reproductive rights. In Brazil, the Single Health System covers pregnant adolescents. In Peru, the state must provide special care for adolescents during pregnancy, birth, and subsequently, and adolescents also have the right to receive sex education and family planning information. The Bolivian Code for Minors establishes the state's obligation to provide specialized care to pregnant minors before and after birth.

Current laws do not take into consideration the rights of adolescents as users of health services. Some regulations that apply exclusively to professional health care providers contain special rules regarding the care of adolescent patients. For example, in Guatemala, the Medical Council's Ethics Code requires the presence of parents or guardians when a gynecological examination is performed on a minor, unless there is a gynecological/obstetric emergency or it is ordered by a court. This norm also establishes that patient confidentiality on pregnancy diagnosis or assistance at childbirth is not mandatory when the patients are minors.

Although the provisions contained in the legal codes of Bolivia, Brazil, and Peru that establish reproductive rights for children and adolescents are very limited, they are the best regional examples of such laws. In fact, Peru is the only country that has legally recognized the reproductive right of adolescents to sex education and family planning in its Minor and Adolescent Code. In addition, the situation in Guatemala serves to illustrate the role that ethical codes of health care providers could play in the regulation of adolescent rights as users of reproductive health care services.

B. MARRIAGE AND ADOLESCENTS

In the nine countries described herein, the average age of first marriage ranges from 18.5 to 23, with the lowest age prevailing in El Salvador and Mexico and the highest in Argentina. Civil laws in these countries establish the age when people may marry without obtaining authorization from a third party and the special circumstances under which minors may obtain judicial authorization to marry. In Argentina and Brazil, individuals can get married without authorization at the age of 21, while in the other seven nations, this age is 18. In Jamaica, the

minimum legal age of first marriage is 16; unlike other countries, there are no exceptions to this rule, and all marriages of persons under 16 are invalid. In El Salvador, parents, guardians, or judges can deny authorization to marry to individuals under 18 on grounds related to their behavior and their inability to support a family. In El Salvador, as in Colombia, if a minor has a child or is pregnant, she may be eligible to marry at below the minimum legal age of first marriage.

In seven Latin American countries, except El Salvador, national laws establish different minimum ages of first marriage for women and men who seek to marry without authorization from parents, guardians, or judges. However, the law does not provide a reason for this difference. Minimum ages of first marriage for women vary among 12, 14, and 16; for men, the corresponding ages are usually two years older.

C. SEXUAL OFFENSES AGAINST ADOLESCENTS AND MINORS

Although available only in a few nations, statistics regarding sexual violence against adolescents and minors indicate that this issue is a cause for great concern. Although all nine Latin American and Caribbean countries described herein punish such offenses severely and penalties may include life imprisonment, this legal harshness contrasts sharply with the lack of policies or programs directed at eradicating sexual violence both at home and in the streets. In Mexico, it is estimated that half of all rapes and other sexual crimes are committed against girls and adolescents; in 60% of the reported cases, the aggressors were relatives of the victim, including her parents. In Colombia, the average age for adolescent rape is 14, which represents 3.1% of all reported rapes. A similar pattern occurs in Mexico, where 39% of all aggressors were boyfriends, friends, or neighbors and 26% were relatives.

Penal laws that punish sexual crimes against minors and adolescents are similar in all nine nations profiled in this report. Legal protection extends to children between the ages of 7 and 18, and the range of crimes covered is broad. The most common crimes are rape (intercourse using physical violence); statutory rape (sexual acts using deceit); incest; abusive sexual acts (any sexual acts other than intercourse); abduction with sexual intentions; "corruption" of minors; encouragement of child prostitution or pornography; and sexual harassment of children and adolescents. The penalty for each of these crimes depends upon the age of the victim and increases in severity as the age of the minor decreases. The aggressor's relationship with the victim is the most important aggravating circumstance in these kinds of crimes; the closer the relationship with the victim, the more serious the crime.

In some of the countries studied, there are obsolete and discriminatory provisions against adolescents. For example, in Argentina, Bolivia, Guatemala, and several Mexican states, statutory rape is punished only when the adolescent victim is viewed as "honest." In Argentinian jurisprudence, the term "honesty" is synonymous with virginity. In other countries, "honesty" requires that the adolescent meet several criteria of good behavior. In certain countries, perpetrators of rape are exempted from any punishment if they marry the victim after committing the crime. Although Colombia, Mexico, and Peru have recently abolished such provisions, Bolivia and Peru have maintained them in cases of statutory rape and "seduction."

D. SEX EDUCATION

Sex education programs that are integrated into formal education are scarce in the region. In four of the nine Latin American and Caribbean countries analyzed herein, there are no sex education programs. In Jamaica, a program that has not yet been formalized is being implemented in schools. Bolivia, Colombia, and Peru have legislation and educational programs directed at students. In Bolivia, programs also train teachers and produce material regarding sex education that varies depending upon the age of the target audience. At the primary education level, the content of sex education is focused mainly on the development of sexuality and family life; at the secondary level, educational material is concerned with developing a responsible sexual life, HIV/AIDS prevention, and family planning. Colombia's national sex education plan seeks to change sex roles, make family relationships more egalitarian, and increase the knowledge of adolescents of their sexual and reproductive rights.