STOLEN LIVES

A Multi-Country Study on the Health Effects of Forced Motherhood on Girls 9–14 Years Old

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Ximena Casas Isaza
Oscar Cabrera
Rebecca Reingold
Daniel Grossman

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Since 1971, **Planned Parenthood Federation of America** (PPFA) has worked through its international division, Planned Parenthood Global, to ensure the reproductive health and rights of women in the neediest parts of the world. We are proud of the work we do to globalize the mission of Planned Parenthood through support to partner organizations that share our goals. The efforts of Planned Parenthood Global are grounded in a philosophy of collaborative work and strategic alliances between partners in the region and the legal and health community to position the agenda of sexual and reproductive rights. Planned Parenthood Global's priority areas are:

- Access to high-quality sexual and reproductive health services and education.
- Access for marginalized adolescents, low-income women and other populations whose reproductive health needs are not met.
- Improve the social, legal, and policy environment in favor of sexual and reproductive health environments.
- Promote the exchange of experiences and learning to improve programs and services.

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Executive Summary

In Latin America, pregnancy among girls under 15 is both a major public health and a human rights problem. The risk of maternal death in mothers under 15 in low- and middle-income countries is twice that of older women. There is ample evidence in scientific literature that pregnant minors have worse maternal and neonatal outcomes compared to women 20–24 years old.

Pregnancy in children and adolescents also results in risks to their mental and social health. Many pregnancies in adolescents younger than 15 are the product of rape, a phenomenon that in addition to having special social relevance is also a crime.

Often, under these circumstances, pregnant adolescents under 15 face an unplanned motherhood because in many countries of the region, abortion is heavily penalized[1] and access to comprehensive sexual and reproductive health is poor.

This report documents the impact on the overall health of pregnancies in girls under age 15 and outlines: 1) the consequences of the lack of access to comprehensive sexual and reproductive health faced by victims of sexual violence; 2) the criminalization of abortion on the grounds of rape in Guatemala and Peru, the total criminalization of abortion in Nicaragua and the partial decriminalization of abortion for rape in Ecuador, where only mentally disabled women have access; and 3) the biomedical focus on the physical health of girls and adolescents facing unwanted pregnancies, particularly as a result of rape, ignoring the impact on mental and social health.

Planned Parenthood Global (PP Global) worked with two regional consultants: Dr. Dan Grossman, former vice president of Ibis Reproductive Health and Oscar Cabrera, Director of the O'Neill Institute of Georgetown University, to create the methodology of this study. The methodology was applied in the four focus countries of PP Global (Ecuador, Guatemala, Nicaragua and Peru). In each of these countries, researchers and PP Global partner organizations conducted research and produced a national report for each country. Additionally, a compilation of the common results of these four reports was completed, incorporating a health and legal analysis, and is presented in this report.

The **FIRST PART** of the report assesses the impact of pregnancies in girls 9–14 years old and the consequences of sexual violence on their overall health and life plans. Despite the small sample size of each study, adverse results were found that were later backed up by the published literature. These findings are summarized below.

Physical Health

In the majority of the studies, a large percentage of the participants suffered some type of complications with their pregnancy, among which the most common were anemia, nausea/vomiting, or urinary or vaginal infections. However, several cases of more severe complications, including preeclampsia-eclampsia, membrane rupture, and premature delivery were observed. It's important to note that for the study in Peru and Guatemala girls in the study had given birth in hospitals or had accessed prenatal care and, therefore, had received medical care throughout pregnancy. Very young adolescents who attended fewer prenatal visits, or who did not attend any visits, are likely to have worse outcomes. Despite the relatively small size of the studies conducted for this report, neonatal and perinatal deaths were noted.

There were several other notable adverse outcomes around the time of delivery. In the study conducted in Peru, 24% of girls had complications around the time of delivery, including postpartum hemorrhage and infection. There were two cases of hemorrhage and a case of mastitis among girls under 15 in Nicaragua. In Guatemala and Nicaragua, approximately half of the girls had a cesarean delivery. The prevalence of cesarean delivery among girls aged 14 or younger in Peru was slightly lower (34%) compared with the other three countries. It's worth noting the way cesareans affect girls at this early age: serious risk immediately after surgery, later complications (including the formation of adhesions and risks during subsequent surgery), and a high probability of cesarean delivery with future pregnancies.

Mental Health

In each of the four country studies, a significant proportion of children and adolescents who had given birth reported symptoms of depression, anxiety, and (particularly for those who had been sexually assaulted) post-traumatic stress. In both Peru and Nicaragua, 7–14% of the participants reported having contemplated suicide during their pregnancy.

Social Health

In each country, pregnant adolescents came from poor and extremely poor families who often lived on the outskirts of cities or in rural or semi-rural areas. These girls had low educational levels and a large proportion of them had not returned to school at the time of the follow-up interview (although in most countries this interview took place several months after delivery).

The **SECOND PART** shares the stories of five girls aged 9–14 forced into motherhood.

S, age 14 years, Ecuador:

A story of sexual and obstetric violence

S[2] got pregnant when she was 13 years old after being raped by her father, who had systematically raped her since she was around 12, threatening to kill her brother if she protested. When S became pregnant at age 13, she did not even realize it because she was completely unaware of what it meant to be pregnant. Her family also suffered an economic burden as a result of her pregnancy, for which they were not prepared. S, at an early age, not only had to deal with the violent situation with her father and the effects of abandonment produced by a dysfunctional family, but also experienced obstetric violence as she was denied access to comprehensive and specialized sexual and reproductive health services. She had to suffer through comments and attitudes from medical staff that did not consider her situation as a victim of sexual violence and her social environment.

Juana, age 14 years, Guatemala:

A story about the effect on Juana's[3] mental health

Juana, an Indigenous girl, was the victim of sexual violence by her half-brother at age 12. At age 13 she got pregnant and was treated at a municipality health center. Juana's family

is extremely poor. Following the protocol for victims of sexual violence, Juana was sent to a home for young mothers. Here she spent two months during which due process protection (except for criminal proceedings against the rapist) was given to her. Then Juana, seven months pregnant, was transferred to another shelter, where she remained for 20 days; this situation removed her from the place where the criminal proceedings were taking place and away from her family. For Juana, the time at this shelter represented great social and cultural change. At 39 weeks, Juana said she felt uncertain about her future and that did not know what would become of her life. Her mental health was at risk and she showed signs of depression.

Ana, age 12 years, Guatemala:

A story of re-victimization, the shortcomings resulting from the lack of a comprehensive response to victims of sexual violence and the impact of forced motherhood

Ana[4] is an indigenous girl in Guatemala who like Juana does not speak Spanish. Ana was raped by her stepfather when she was 12. During efforts to seek care, the system meant to protect her from her victimizer, re-victimizes her as she is transferred by police patrol, among people she did not know. Likewise, no consideration was taken for the obstetric risk and the possible complications Ana could face during transfer from one department to another, nor of the fact that it was a new cultural context for Ana. Since she was under 14, Ana was taken to the community health center when the nurse filed the complaint with the Public Ministry. However, no investigation was initiated. Given the inaction of the authorities, the community health center staff called a meeting to clarify the case. With input from local indigenous organizations, the community came to an agreement based on the Mayan legal system, "*The girl's stepfather will be responsible for expenses during pregnancy and delivery, and the upbringing of the baby.*"[5] The Attorney General's Office[6] told the Directorate General of the National Civil Police to immediately rescue the child. When they picked her up, Ana was eight months pregnant. She was moved from her home to the police station. That same day, she was transferred to another department, and after being passed from one patrol to another, then to a secure home in Guatemala City.[7] When Ana was in her last month of pregnancy, they moved her again and placed her in the care of a foster family provided by the Welfare Ministry. Ana had a cesarean delivery and the newborn was hospitalized for five days for perinatal asphyxia, Apgar 5 and 7. Ana was readmitted and then hospitalized for 10 days due to medical complications.

Diana, age 14 years, Nicaragua:
A story of multiple forms of violence

Diana[8] was a victim of prolonged violence. From age nine, Diana suffered harassment and violent sexual assaults by her 58-year-old grandfather. Throughout her childhood, Diana had to deal with the power dynamics generated by her grandfather, who told her that she belonged to him. Repeatedly, her maternal grandfather sexually abused Diana under threat of further violence. The attacker psychologically abused Diana, controlling all her activities and refusing to allow her to interact with anybody else. After her youngest son was born – she was still less than fourteen – the assailant searched and threatened people at gunpoint to find where she and the child were. Diana explained that when she was nine, her grandfather raped her when she brought him food on the mountain where he worked. From that day on, he repeatedly raped her, holding scissors to her neck and threatening to stick them in her chest if she screamed. He also threatened to cut off her head and give it to the dogs, and to kill her grandmother if Diana told anyone what he did to her.

Marta, age 14 years, Guatemala:
A story of early marriage, domestic violence and a lack of a gender perspective in the judicial system

Marta[9] and her current husband started dating when she was 12 years old. One day, Marta's brothers discovered them having sex in her house. Marta's mother confronted the boy, demanding that he marry and take care of Marta. The young man refused, so Marta's mother went to court and filed a complaint, demanding that the young man marry his daughter. The judges told the young man to marry Marta, or if not, he would go to jail. Since their marriage, Marta has suffered physical and psychological violence. Her husband does not allow her to see her family. Her husband attacked Marta four weeks after delivery, trying to choke her. The judge's response to her request for help was, "*These are matters for the couple, leave them alone and tell her to behave so her husband doesn't have a reason to hit her.*" During her pregnancy, Marta had frequent urinary tract infections and her baby was breech so she had to have a cesarean delivery. Marta had postoperative complications and had to stay five days in the hospital. Her child only weighed 5 pounds at birth.

The **THIRD PART** of the document discusses the regulatory frameworks of Ecuador, Guatemala, Nicaragua and Peru on violence against women, sexual and reproductive health, and the responses of the respective state systems to adolescent victims of sexual violence.

The **FOURTH PART** considers the intersectional nature of violence and discrimination caused by forced maternity in adolescents between 9–14 years old, emphasizing how their human rights are violated under these circumstances. The report analyzes the responsibility of the State, which has a responsibility not only to prevent harm, but also to respond properly when girls and adolescents experience violence, particularly when they become pregnant as a result of sexual violence. Violence is a phenomenon that affects everyone. However, norms, beliefs, prejudices and negative gender stereotypes that prevail in society tend to subordinate and devalue women and girls, resulting in emotional, economic, or social dependency, and thus, making them more vulnerable. Violence against women constitutes a form of discrimination. International human rights law recognizes that people can belong to different protected categories at once and, therefore, face multiple forms of discrimination. As a result, the discrimination experienced by women often requires an intersectional analysis, a great theoretical, conceptual and policy tool used to address the multiplicity and simultaneity of the oppression of women.

FINALLY, the report offers some conclusions and recommendations to key decision makers on how they can address this serious problem.

Introduction

The Problem

In Latin America, pregnancy in girls under 15 is a serious problem. In Ecuador, according to census data, it has increased by 74% in the last decade. This means approximately 4,000 adolescents[1] are pregnant or mothers in Ecuador.[2] In Nicaragua, the number of pregnant women between 10 and 14 years old increased 47% over 9 years, from 1,066 women in the year 2000 to 1,577 women in 2009.[3] In Guatemala, there were 5,100 deliveries reported to girls between 10 and 14 years old.[4] And in Peru, about 50,000 births a year are to mothers under 20 years old. According to 2013 statistics from the Ministry of Health, more than 1,100 births are to mothers only 12 and 13 years old. In other words, three or four girls between 12 and 13 become mothers ever day in Peru.[5]

Pregnancy in girls and adolescents[6] is considered one of the most important public health problems affecting women.[7] The risk of maternal death in mothers under 15 in low- and middle-income countries is twice that of older women. The aforementioned younger group also suffers significantly higher rates of obstetric fistula than older women. There is ample evidence within the scientific literature that pregnant minors have worse maternal and neonatal outcomes than women 20–24 years old. The risks associated with adolescent pregnancy – especially for pregnant women 15 years or younger – include increased risk of maternal death, infections, eclampsia, premature delivery and neonatal mortality and morbidity.

Pregnancy in adolescence also increases risks to the mental and social health of the expectant mother. In the area of mental health, the high rates of depression in adolescents during pregnancy and the postpartum period are generally higher than those of adults.[8] When an adolescent under 15 years of age becomes pregnant, her present and future change radically, and never for the good. Her educational cycle ends abruptly. She faces serious health problems, including death. Her job prospects fade and her vulnerability is multiplied by factors of poverty, exclusion, violence and dependency. However, few studies have documented the mental health and social impact of early pregnancy, particularly in children between 9–14 years old.

Many pregnancies in adolescents younger than 15 are the result of rape, a phenomenon that in addition to having special social notoriety, is also a crime.[9] Up to 90% of pregnancies

in girls under 14 are the product of rape.[10] Peru is the country with the largest number of sexual violence complaints in South America, 63,524. Four out of five complaints in this nation were among minors.[11] Also in this country, 90 out of every 100 pregnancies among girls under 15 were due to incest.[12] And, 34 of every 100 who became pregnant were between 10–19 years old.[13] As for the aggressors, we know that in 76 of every 100 cases involved men who have direct relationships with the victim (father, stepfather, guardian, teacher, adult caring for the child).[14] As a result, in Peru there are 3,500 pregnancies due to rape every year.[15] It should also be noted that 29 out of every 100 maternal deaths in adolescents are related to unsafe abortion.[16]

In Nicaragua, almost half of women reported that their first experience of sexual abuse occurred before they were 15 (49%), while a quarter of women who experienced forced sex reported the forced sex happened to them at the same age (26%).[17] In 2014, 5,100 births to girls between 10 and 14 years were reported in Guatemala.[18] In Ecuador, pregnancy in girls under 14 has become a serious public health problem in the last decade. According to census data, the rate has increased by 74%, which means that approximately 4,000 adolescent minors are pregnant or are mothers.[19]

Rape of girls and adolescents deeply affects their lives. Sexual coercion exists as a continuum, extending from forcible rape to include other pressures that push children and adolescents to have sex against their will.[20] "Perhaps the child or adolescent affected does not register an act as rape, even if it was a situation against her will, but was "accepted" since she didn't oppose. These situations are very common in sexual initiation when there is a significant age difference between the male and the girl/adolescent."[21]

Often, under these circumstances, pregnant adolescents under 15 are forced to face an unplanned motherhood because in many countries of the region, abortion is heavily penalized[22] and access to comprehensive sexual and reproductive health services, such as emergency contraception,[23] is absent or deficient. In Peru[24] and Guatemala[25] abortion on the grounds of rape is criminalized. In Ecuador, abortion is only allowed when a woman has a mental disability.[26] However, in these three countries, therapeutic abortion is permitted, i.e., legal only when the life and/or health of the woman are at risk.[27] In Nicaragua, abortion is totally criminalized. In spite of this, the administrative norms regulating the former Article 165 of the Criminal Code of Nicaragua,[28] included rape as grounds for therapeutic abortion.[29]

Peru, Ecuador, Guatemala and Nicaragua have taken active steps to address gender-based violence. Nonetheless, continuing to criminalize abortion for rape victims hinders the ability

of these states to effectively address the high rates of violence against women, particularly against girls and adolescents. Forcing adolescents under age 15 to carry an unplanned and unwanted pregnancy to term, particularly a pregnancy as result of rape, is a violation of their human rights[30] and torture.[31]

Justification

For this reason, Planned Parenthood Global and its partner organizations[32] conducted research in Peru, Ecuador, Guatemala and Nicaragua to assess the impact of pregnancies on the overall health of girls 9–14 years old. This report, **"Stolen Lives"**, encompasses the common factors found in the national research led by our in country partners[33] in order to comprehensively demonstrate the effects that early pregnancy has on all dimensions of health (physical, mental and social) and on the human rights of girls 9–14 years old.

The overall goal of this qualitative and quantitative analysis is to raise awareness about violence against girls at national and regional level. Particularly we aim:

- To initiate a dialogue with decision makers on the need for public policies and concrete actions to end the pandemic of sexual violence against girls and adolescents.

- To provide tools for discussing relevant aspects of guaranteed access to comprehensive sexual and reproductive health services for victims of sexual violence, including emergency contraception, sexuality education and information on sexual and reproductive rights, and legal abortion services.

- To enrich the body of knowledge on the impact of an unplanned pregnancy on the overall health of girls aged 9–14.

- Promote change by encouraging decision-makers and public service providers to design and implement evidence-based strategies for prevention and response to violence against girls and adolescents in Latin America and the Caribbean.

The first part of the report assesses the impact of pregnancies on the health of girls 9–14 years old and the consequences of sexual violence on their health and life plans. The second part presents the stories of girls 9–14 years old that have been forced into motherhood, sharing the testimonies of five girls. The third part of the document discusses the regulatory

frameworks of Ecuador, Guatemala, Nicaragua and Peru on violence against women and sexual and reproductive health, and the responses of the respective state systems to adolescent victims of sexual violence. The fourth part considers the intersectional nature of violence and discrimination caused by forced motherhood among adolescents between 9–14 years old with an emphasis on human rights violated under these circumstances. Finally, the report offers some conclusions and recommendations to key decision makers on how they can address this serious problem.

Methodology

Study design and sample

This study included three general components, but not all components were implemented in each country. These components included qualitative interviews, a review of the clinical history of participants – pregnant or post-partum adolescents and girls – and the collection and analysis of aggregate hospital statistics on births in children and adolescents. We conducted in-depth interviews with young women under 18, including some under age 15, who had given birth in the past two years or were currently pregnant. We also conducted in-depth interviews with parents or guardians of young women who were pregnant, and hospital staff (doctors and social workers) who attended the pregnant adolescents.

In the cases of girls recruited during pregnancy, we also attempted to conduct a follow-up interview within three months after the birth. In the cases of young women who had recently been pregnant, we also asked permission to review their medical records related to pregnancy and childbirth. In each country, we interviewed up to 20 people for each of these categories (a total of 60 participants in each country). In addition, researchers reviewed anonymous statistics in each country from large hospitals to identify the proportion of all births that occurred in children and adolescents, the caesarean section rate of young women compared with older women, and the rates of perinatal complications.

Study population, criteria for inclusion/exclusion

Women eligible to participate in the study were under 18 years old and were pregnant or had given birth in the previous two years. The participants, mostly, were also able to communicate in Spanish. There were some indigenous communities, however, who did not speak Spanish and translation was requested. In addition, we interviewed parents and guardians of young pregnant women, as well as doctors and social workers attending to pregnant adolescents in public hospitals in each of the countries.

Recruitment

Young women who were pregnant or had recently given birth in public sector clinics or hospitals were recruited. Clinical staff identified potential participants and research staff approached them and asked some preliminary questions to confirm patient interest and eligibility. Parents and guardians were approached through the young women. If the young woman was under 18 years of age, the parent or guardian's consent was obtained. Members of the hospital staff in public sector hospitals in each of the countries were approached and recruited.

Data collection

In each of the countries, hospital staff (doctors and social workers) that took care of pregnant adolescents in public sector hospitals was invited to participate in an interview. The interview was conducted in the health facility at a time convenient for the interviewee. The interview focused on the interviewee's training and their perceptions of the extent of the problem of adolescent pregnancy in their establishment, including common medical problems and use of contraceptives.

Young women and their parents or guardians were invited to participate in an interview at a time and place convenient for them. Parents or guardians of minor participants were present during the interview if the minor agreed. The interview focused: on the circumstances surrounding the pregnancy; on whether the participant had any physical or mental health complications during pregnancy or childbirth; and, on details of the health of the child. A participant may have been interviewed more than once if a physical or mental health problem was being treated. The adolescents who were pregnant at the time of enrollment were interviewed about three months after birth. If participants were interviewed in early pregnancy, additional interviews were requested during later stages of pregnancy.

Also, researchers requested permission from pregnant or recently pregnant adolescent girls to review their medical records. The purpose of this review was to identify any physical or mental health complications that might have developed during pregnancy and any complications related to childbirth and newborn health. Participants received no reimbursement for their participation.

Analysis

Descriptive statistics were used to present the majority of the variables. In the case of Peru, chi-square tests and T-tests were used to identify differences between younger and older adolescents. A qualitative analysis of the answers to open questions was also performed.

Ethical Questions

Informed consent

Written informed consent was obtained for all the study participants. Participants received a copy of the informed consent form which described the research and a contact person to answer questions. If the participant was under 18 years of age, both the consent of the parent or legal guardian and of the participant was obtained.

We obtained a waiver of informed consent to collect anonymous data from hospitals on adolescent birth statistics. The study received ethical approval from the Institutional Review Board of Allendale.

Part 1

Public Health Impact of Forced Motherhood

Common results

Summary of the research

- In Peru, the study included 58 pregnant adolescents between 12 and 14 years old and 81 between 15 and 17 years old for a total of 139 adolescents. All participants had given birth in a public hospital in Lima-Callao, Sullana or Pucallpa, Ucayali. The study consisted of interviews with the adolescents and their parents or relatives, and a review of their medical history.

- In Guatemala, the study included 20 pregnant adolescents between 12 and 14 years old receiving prenatal care in public services. The study consisted of interviews with the adolescents and their parents or relatives, and a review of the adolescents' medical histories.

- In Ecuador, the study included 15 pregnant adolescents under 14 years, eight semi-structured interviews with professionals, and one interview with an expert on sexual violence against children. There was also a review of 139 medical records of mothers under 14 years.

- In Nicaragua, the study included 14 pregnant adolescents between 12 and 14 years old and 16 pregnant adolescents aged 15 to 19 years, all victims of rape and statutory rape.

Social Environment: Poverty and Vulnerability

- In Peru, the adolescents in the study came from working class, poor and also extremely poor areas. The adolescents were living in marginal urban or rural areas and came from disrupted or dysfunctional families according to information collected by the interviewers. The vast majority of adolescents identified as mostly as housewives (84%), some as students (14%) and fewer with other occupations.

- In Peru, the vast majority of adolescents (43.9%) in the study said they had not yet finished high school. In Guatemala, three girls had not attended school, 14 had attended primary school, and three were in high school. 70% lived in rural areas of Guatemala, and

40% were indigenous (Maya). 90% of study participants were adolescents from poor or extremely poor families.

- In Ecuador, from the review of medical records, 33% of adolescents had attended primary school, but not all had completed it. Some had not attended any school.

- In Nicaragua, 64% were in primary school and 14% were in high school, one adolescent (7%) had never attended school. The lowest level of education completed was first year of grade school and highest grade was the fourth year of high school.

Delivery Method: Prevalence of cesarean

- In Peru, adolescents had vaginal delivery in 73.4% of cases, although more frequently in the group of 15 to 17-year-olds (78.3%). Cesarean section was performed in 26.8% of adolescents with 33.9% of those under 15 years and 21.7% in adolescents aged 15 to 17 years. Adolescents under 15 experienced more problems during labor.

- In Guatemala, 55% of the participants had cesarean sections.

- In Nicaragua, of the ten teens under age 15 who had given birth, half had cesarean sections.

Attempts to abort

- In Peru, 19 adolescents (14%) said they tried to terminate the pregnancy. However, here we may be facing a sample bias, since the study only incorporated pregnant adolescents who delivered; we don't know what happened to pregnant teens who made the decision to voluntarily terminate their pregnancy.

- In Nicaragua, of the 14 pregnant girls under 15 years, seven tried to terminate the pregnancy. One said she was going to drink poison. Another hit herself forcefully in the abdomen to try to end the pregnancy.

Suicide attempt or thoughts upon learning of the pregnancy

- In Peru, nine adolescents (7%) had at some point intended to commit suicide by swallowing rat poison or insecticides, or cutting their skin to reach their veins.[1]
- In Nicaragua, of the 14 teens under age 15, two had thoughts of suicide.

Physical Health Complications (9–14 years old)

- In Peru, 63% of the girls had complications during pregnancy. In general these were minor problems such as urinary tract infections (16%), nausea/vomiting (11%), vaginal infections (6%) and anemia (6%). But there are other more serious complications: 9% were hypertensive disorders such as preeclampsia-eclampsia; 6% involved premature rupture of membranes; and 5% involved preterm labor. In interviews, health professionals in Peru said that there are often complications with adolescent pregnancy, childbirth and postpartum. The most frequent complications are reportedly hypertensive disease related to pregnancy, preterm labor and hyperemesis gravidarum.

- In Guatemala, of the 20 participants, four had some form of complications. The following complications were detected during prenatal care: two girls with urinary infections, one with severe preeclampsia (she was referred to the regional hospital), and another with preterm birth. One 12-year-old participant had a cesarean complicated by a dehiscence wound and endometritis by placental remains, so she was hospitalized for 10 days.

- In Ecuador, according to a review of medical records, 71% of the cases had complications in pregnancy, due mainly to anemia and urinary tract infections.

- In Nicaragua, of the 14 teens under age 15, there was one case of urinary tract infection, 3 cases of anemia, and one case of preeclampsia; another was hospitalized for four days.

Mental health repercussions in girls and adolescents (9–14 years old)

- In Peru, despite the fact that 45% of the girls reported feeling well during pregnancy, the remaining 55% reported some sort of emotional issues, including feeling fear/scared and

worry/anxiety. At the time of the interview, most of the participants said they felt peaceful and healthy; however almost 35% had symptoms that are likely related to depression.

- In Peru, in terms of the infant, a quarter of the adolescents felt that they should take care of their infant. Almost another 25% said they felt happy and content and 36% had feelings of love for the child. Also, 15% experienced either minimal feelings of affection, did not accept the child or very reluctantly accepted it.

- In Guatemala, the psychological evaluation after delivery showed that 12 of the adolescents had signs of emotional harm such as fear, restlessness, low energy and crying.

- In Ecuador, the participants expressed a range of emotions such as fear, anger, neglect, terror, rage, shame, nerves, pain, guilt, outrage, stress, sadness, offense, annoyance, shock, despair, frustration, anxiety, depression, and exasperation. 91% of the cases reviewed in the medical records reflect "depressive symptoms" and "adjustment disorder".

> "I was scared, because gosh…now what do I do, me with a kid. [I cried] because when I was pregnant I didn't know what do and I said gosh… what do I do."
>
> D, 14 years old, Ecuador.

- In Nicaragua, all adolescents under 15 said that during pregnancy they experienced all sorts of feelings: grief, sadness, crying, suffering, nightmares, sorrow, fear, laziness, weakness, isolation. In one adolescent, the psychological assessment details the presence of symptoms of post-traumatic stress syndrome. At the time of the interview, only two participants said they were healthy. Three (22%) described themselves as healthy although they added feelings of sadness and moodiness. And 7% described themselves as sick. 57% described feelings of anxiety, exhaustion, sadness, fear, frustration, insomnia, nervousness, worry, irritability, anger, headache, hopelessness, overtiredness, nightmares, and pain while breastfeeding. The participants felt as if they were in a state of dependency in which they are unable to make decisions. They also reported feelings of worthlessness, living a life without hope and wanting to kill themselves.

Social health repercussions in girls and adolescents (9–14 years old)

- In Peru, 77% of girls dropped out of school as a result of pregnancy and child care. However, 94% do not work or stopped working. 75% receive financial support from the father of the child, which is often scarce. The family of the adolescent or her partner provides resources or housing for her and the child (94%), and eventually the couple. Social institutions supported only 6% of the participants. Over 60% of teens expect to continue their studies, and even have a technical or professional career. And, 17% want to work.

- In Guatemala, of the 17 girls who were in school, only two continued their studies. The other 15 girls dropped out when they found out they were pregnant. After pregnancy and childbirth, only four adolescents said they are building a life plan and striving to achieve it (two of them were victims of sexual violence by family members, and are receiving psychological care). The other 16 girls did not share any plans. At the time of the postpartum interview, 12 did not have any economic activity, and eight were homemakers or had another economic activity.

- In Nicaragua, 85.7% of adolescents do not receive financial support from the father of the newborn, 78.6% received family support, and 28.6% support of an institution.

Components of prenatal care

- In Peru, 89% of pregnant adolescents received institutionalized prenatal care with a median of six consultations. 79% said they received education, 78% received nutrition counseling, and 86% said they received counseling on contraception.

- In Guatemala, due to the design of the study, all participants received prenatal care.

- In Nicaragua, 29% of adolescents under age 15 did not receive prenatal care. 64% received prenatal care from early on, such as 7 weeks and one at 24 weeks, with an average of four visits. 79% received no counseling on sexual education, and 43% received no nutritional guidance counseling.

Postpartum complications

- In Peru, 24% of adolescents had a postpartum complication. Postpartum hemorrhages were the most frequent (9%), followed by infections (9%).

- In Nicaragua, of the adolescents under 15 years, there were two cases of hemorrhage and one case of mastitis.

Postpartum contraception

- In Peru, only 58% of adolescents received some form of contraception at the time of discharge, with the three-month injectable the most commonly provided. But, at the time of the interview, only 39% were using some method of contraception.

- In Nicaragua, only four adolescents under 15 years received a contraceptive method after childbirth or abortion.

State of the child at birth

- In Peru, 83% of infants born to adolescents had no complications. However 17% of the infants did suffer complications. The most frequent of the complications were prematurity (6.5%) and intrauterine growth retardation (3%). One child was stillborn and one premature child with very low birth weight died in the neonatal period. In addition to these deaths, at the time of the interview, 7% of children were sick.

- In Ecuador, of the 14 young women interviewed, two had lost their babies. And according to medical records, 27% of newborns present different types of problems ranging from jaundice to malformations.

Perceived stigma by the girls and adolescents (9–14 years old)

- In Peru, adolescents under 15 felt some sort of stigma from health services staff (28%). The frequency of stigma experience was slightly higher in the family environment (38%) and in the social environment (33%) for this group.

- In Nicaragua, 64% said they felt stigma from health personnel.

  > One patient said, "Because the doctor said I was really very young to be pregnant; that made me feel badly."[2]

- 36% felt stigma from family and 86% felt stigma in their social environment.

  > A patient said, "People criticize me and say that it's my fault that I'm pregnant because I got to him and now the poor teacher is a prisoner."[3]

Forced and unwanted sexual initiation occurs at an early age

- It is remarkable that in Peru, 80% of girls said their pregnancy was the result of consensual sex, but 80% of the pregnancies were unwanted. In Guatemala and Nicaragua, none of pregnancies in women under 15 years were desired.

- In Ecuador, one of the girls was raped by her father for years under the threat of harm to her brother if she were to tell anyone. According to a review of the medical records, 82% of the pregnancies were unwanted/unplanned.

The aggressor is usually somebody close to the girls

- Among the participants under 15 in Peru, 83% said they got pregnant with their partner; however four girls said they got pregnant with their cousin,[4] one with her brother-in-law, and two with a neighbor.

- In Guatemala, most of the attackers were between 17 and 20 years old, two were 22 to 24 years and one was 42 years old. In two cases the perpetrator was a stepbrother or stepfather.

- In Ecuador, 12% of medical records reviewed indicated fathers of the newborns as aggressors. Within this portion of the records, 44% of the aggressions were sexual abuses or violations committed by relatives.

- In Nicaragua, there was only one case among the girls under 15 years old where the (two) rapists were strangers to the victim. In 93% of the cases, the attackers had some sort of relationship with the adolescent (either familial, emotional, spiritual, and/or educational ties) or was a neighbor. In two cases, the attacker was the biological father of the adolescent. In other cases, the attacker(s) turned out to be a maternal grandfather, stepfather, uncle, cousin, religious pastor, principal or neighbor. The age range of the attackers was 18 to 60, with two adolescents, two youth, five adults, and a senior.

Impact on the overall health of pregnancies in girls and adolescents (9–14 years old)

This study of adolescent pregnancy – particularly pregnancy among 12–14-year-olds – identified important impacts on the physical, mental and social health of these girls. Despite the small sample size in each of the studies, adverse outcomes were identified that are further substantiated in the published literature. Below is a summary of these findings.

Physical health

In most of the studies, the majority of participants had some complication of pregnancy, with the most common being problems such as anemia, nausea/vomiting, or urinary tract or vaginal infections. However, several cases of more severe complications were noted, including preeclampsia-eclampsia, rupture of membranes and preterm birth. It is important to note that the study conducted in Peru and Guatemala recruited young girls who gave birth at hospitals or who presented for prenatal care—and, therefore, received medical attention throughout their pregnancy. Outcomes for very young teens are likely worse among those who have fewer or no prenatal care visits. In terms of neonatal outcomes, it is notable that even in the relatively small studies conducted for this report, cases of neonatal death and prematurity were noted.

Several other adverse outcomes were experienced around the time of delivery. In the Peru study, 24% of the patients had a complication around the time of delivery, including postpartum hemorrhage and infections. There were two cases of hemorrhage among girls younger than age 15 in the Nicaragua study, as well as one case of mastitis. In Guatemala and Nicaragua, about half of young girls had a cesarean section delivery, although this may have been related to policies encouraging cesarean delivery for pregnant women at this age. One girl in Guatemala had a postoperative complication after her cesarean.

The prevalence of cesarean delivery among girls age 14 or younger in Peru was a bit lower (34%) compared to the other three countries. It is important to note how these girls are affected by having a cesarean delivery at such a young age, including the higher immediate risks of the surgery, delayed complications (including the formation of adhesions and risks during subsequent surgery), and the high probability of having a repeat cesarean for future deliveries.

The outcomes observed in these small studies are substantiated in the literature—particularly the literature from Latin America, which suggests that pregnancy and birth carry higher health risks for the youngest adolescents, even for outcomes where older adolescents may not differ significantly from adult women. A review of public health data from 2000–2008 from several Latin American countries found that maternal mortality rates for 10–14 year olds are 2 to 3 times that of 15–19 year-olds[5]. These rates were highly variable due to the small number of observations, but the authors note that in contrast with overall maternal mortality in Latin America, there was no apparent decline among the youngest girls. Similarly, rates of infant and neonatal mortality and small for gestational age were 25% to 70% higher among girls under age 15 compared to 15–19 year olds. In addition, a higher proportion of hospitalizations during pregnancy were due to abortion among girls under age 15 compared to older adolescents[6].

Conde-Agudelo et al. (2005) analyzed the Perinatal Information System data from Latin America during the period 1983 to 2003, and controlled for 16 health and socio-demographic confounders in their analysis, also finding that the youngest mothers fared worst. Compared to women aged 20–24, girls aged 15 and under had 4 times greater odds of maternal death. They also had 4 times higher odds of puerperal endometritis, 60% higher odds of eclampsia (but not significantly so) and postpartum hemorrhage, and 40% higher odds of anemia. Compared with infants of mothers aged 20–24 years, those born to girls aged 15 and under had more than 60% higher odds of low birth weight and preterm delivery, and 50% higher adjusted odds of small for gestational age and early neonatal death.

Another study[7] investigated the risk of adverse pregnancy outcomes in 29 countries in Africa, Latin America, Asia, and the Middle East. Nicaragua and Ecuador had the highest adolescent birth rates and the highest birth rates specifically to girls 15 years old and under. Overall, the prevalence of eclampsia among girls aged 15 years and younger was more than twice that of women aged 20–24 (75% of those with several maternal outcomes versus 34%).

Though the multivariate results were qualitatively consistent with Conde-Agudelo et al., the significance and magnitude of effect for each outcome varied. Compared with mothers aged 20–24 years, adolescent mothers 15 years old and younger had 5 times the odds of puerperal endometritis, 3 times higher odds of eclampsia, nearly twice the odds of systemic infections, nearly 70% higher odds of preterm delivery, 57% higher odds of neonatal mortality, and 75% higher odds of several neonatal conditions. The odds of severe maternal outcomes, including maternal death, was 20% higher among those under 16, but it was not significant.

Mental health

In each of the four country studies, a significant proportion of young adolescents who had given birth reported symptoms of depression, anxiety and, particularly for those who had been sexually assaulted, post-traumatic stress. In both Peru and Nicaragua, 7–14% of participants reported considering suicide during their pregnancy.

There is very little published evidence specifically about mental health outcomes for girls aged 14 or younger who give birth. A recent review of the literature on mental health outcomes among adolescents aged 21 or younger found that rates of depression in pregnant and postpartum adolescents vary widely across studies, with estimates between 8%[8] and 47%[9]. Findings from the articles reviewed suggest that the rates of depressive symptoms in pregnant and postpartum adolescents are comparable to non-pregnant adolescents, but higher than those reported in samples of pregnant adults. The only study of anxiety in pregnant adolescents indicated that rates might be higher than in non-pregnant adolescents. One study found that depression in the second and third trimesters in adolescent mothers was associated with both small for gestational age infants and preterm deliveries[10].

One study from the United States used data from the nationally representative 1988 National Maternal and Infant Health Survey to compare depressive symptoms among adolescents to

adult mothers. They found high rates of depressive symptoms among adolescent first-time mothers more than a year after delivery. These rates, ranging from 37% to 48% among Black teenagers and from 28% to 33% among Whites, were substantially higher than rates among adult women. The highest rates of depression (48%) were found among Black mothers age 15–17. The high rates of depressive symptoms associated with adolescent motherhood may be primarily social in origin, since they moderated considerably with adjustment for adverse socioeconomic circumstances and unmarried status[11].

Similar results were found in a study from Portugal, which found that adolescent mothers aged 14–18 were at higher risk for depression during and after pregnancy compared to adult women, even after controlling for other socio-demographic factors[12].

Another study from the United States used data from a 17-year longitudinal cohort study of 173 women who were unmarried, pregnant adolescents between June 1988 and January 1990. The researchers found that the prevalence of elevated depressive symptoms in adolescent mothers significantly increased over the 17 years of the study from 19.8% to 35.2%. In adjusted analyses, antenatal depressive symptoms were positively and significantly associated with elevated depressive symptoms at every developmental period[13].

Social health

In each of the country studies, pregnant adolescents came from poor and extremely poor families, which often lived in peripheral areas of cities or in semi-rural or rural areas. The interviewers who performed home visits as part of the study noted that the adolescents' families appeared to be dysfunctional. These young girls had low levels of education, and a large proportion of them had not returned to school at the time of the follow-up interview, although in most of the countries this was only several months after delivery.

These findings are consistent with the published literature, which indicates that there appear to be negative socio-economic consequences associated with teen pregnancy[14]. When compared to women who delay childbearing past the teen years, women who become teen mothers are less likely to complete high school, more likely to work at low-income jobs and experience longer periods of unemployment, more likely to receive welfare benefits during the years following birth and more likely to experience single parenthood and higher levels of poverty. However, when racial and economic variables are factored in to the analysis, the negative consequences of teen pregnancy are shown to be largely dependent on race,

ethnic background, family background, neighborhood background, and income level rather than on maternal age at birth[15].

One published report of studies from Barbados, Chile, Guatemala and Mexico explored the relationship between adolescent pregnancy and mothers' economic and social opportunities, as well as the well-being of their first-born children. The studies include a comparison group of adult mothers to account for the effects of background factors (e.g. poverty) and the timing of observations. Findings from the four country studies suggest that adolescent pregnancy is associated with negative economic rather than social outcomes, occurring for poor rather than for all mothers. Among the poor, adolescent childbearing is associated with lower monthly earnings for mothers and lower child nutritional status[16]. The four studies show evidence that adolescent motherhood is associated with adverse socioeconomic conditions and poor earning opportunities for the teenage mother.

After controlling for the mother's schooling and her economic status as a child, both the Guatemala and the Mexico studies found that adolescent childbearing was positively associated with multiple poverty indicators[17]. In the Mexico sample, 26% of the adolescent mothers surveyed lived in conditions of poverty, compared with only 4% of the adult mothers[18]. The Chile study suggests that early childbearing and closely associated factors can have important economic costs, in terms of lower monthly earnings, especially for poor mothers. For poor women, adolescent motherhood is associated with lower earnings, even after controlling for mothers' education level. The monthly earnings of adolescent mothers are about 90% lower than those of adult mothers[19].

Data from other countries also support these findings. One longitudinal study of 819 teen mothers in Nova Scotia, Canada found that 32.8% of mothers lived in poverty, a rate twice the provincial rate[20]. Hotz, McElroy, and Sanders (1997) examined the socio-economic costs of teen pregnancy in the United States for women who had their first child before 18 years, and used a sample of teenage women who miscarried as a control group. The data indicated that 61% of the teen mother group completed high school as compared to 90% of women in the delayed childbearing group. By the age of 30, teen mothers earned 58% of what those who delayed childbearing earned and received more than four times the amount of public assistance benefits than did non-teen mothers. These results, however, are not adjusted for socio-economic variables such as parental income and education level or receipt of welfare as a child. Examination of these variables showed prominent differences between the groups, with teen moms being more likely to have lived in families that received welfare benefits. Thus, one should be cautious when drawing conclusions from these findings[21].

Another study reviewed the literature on teen pregnancy in the United Kingdom[22]. One study on mothers of twins in the UK showed that compared with adult mothers, teenage mothers experienced more mental health problems and had lower levels of educational attainment, and more emotional and behavioral problems[23]. Other recent studies found that teenage mothers are less likely to complete their education and training and, therefore, face restricted job opportunities, potentially reinforcing the cycle of deprivation and teenage pregnancy[24].

Part 2

Stories of stolen lives: The story of one, the story of many

Through the narration of these five stories told by the girls themselves and their families, we hope to make visible the different forms of violence and discrimination girls suffer when they are robbed of their childhood, when their life plans are cut short, and the role of unplanned motherhood is thrust upon them. Their voices should get attention, particularly from the State and different organizations that work towards the protection of human rights. These aforementioned entities, who through guidelines, public policy and proper implementation of these tools, have a responsibility to curb high rates of sexual violence, reduce pregnancies at an early age and ensure comprehensive sexual and reproductive health services (i.e. access to accurate information, sexuality education, emergency contraception and legal abortion services).

S, 14 years old[1], Ecuador:

A story of sexual and obstetric violence

S[2], a girl from the province of Pichincha (Chespí) in Ecuador, got pregnant when she was 13 after being raped by her father. S has two brothers and a sister. During her short childhood, she was taken to live in different places with different family members, until she ended up at a shelter,[3] where she had been since she had her first child, a product of rape.

> "They took me to INFA,[4] they took me to where my aunt [P] that lives by Pomasqui, I didn't learn, I got sick, and then those from INFA[5] were taken to where my cousin was, the one who had been abused by my dad. From there they took me to Pacto where my mom and stepfather were, that's where my other sister lived. My stepfather had abused my sister. She got pregnant. She was thirteen. My mom didn't say anything… [Then] they took me to live with my brother and my dad … From there my dad and my mom fought because he hit my mom a lot because she said that she was always with other men; one time he almost killed her… My dad continued hitting my mom, and she found another man."

S, since around the age of 12, was repeatedly raped by her father, who threatened to kill her brother if she protested. When S became pregnant at age 13, she did not even realize she was because she was completely unaware of what it meant to be pregnant. Her testimony shows how this unwanted and forced pregnancy brought an additional economic burden, for which neither S nor her family were prepared.

> "I never imagined that my father would abuse me. I was asleep and he began to fondle me, dreamily, as if he was dreaming. Time passed. Another time he wanted to abuse me, I said no, he said if I didn't let him he would hurt my brother, I was afraid that he would do something to my brother so I permitted it because I was scared, he continued, I didn't want it so he did it by force… He knew to tell me that if I didn't let him, he would kill my brother and himself… Time passed, I was twelve at that point, at thirteen I got pregnant and at fourteen I gave birth… My brother filed the complaint. My aunt said not to because it was her brother in law. My brother filed the complaint against my father. I think the police went to get him, but he had already left… Then DINAPEN[6] came and they said to my uncle, "we are going to bring your wife so she signs and so they can do a medical check to see if it as rape or because she wanted it." But there they said not, that it had been rape… My aunt and the police said I couldn't go to the mountain again because my dad was there, so I stayed here with my aunt who took care of me."

> "I was only in third grade when I got pregnant… I got pregnant, I knew where to go because my sister was abused, she lived with her husband, I said I would go live with her and she said no; so I left crying… I didn't know [that I was pregnant], I just felt that my belly was growing, people went around saying I was pregnant… [I didn't know that your period went away when you were pregnant]. I think that once [I menstruated] … Sometimes my brothers give me money, sometimes I buy diapers or my aunt helps me."

S, at an early age, not only had to deal with the violent situation with her father and the effects of abandonment produced by a dysfunctional family, but also obstetric violence from being denied access to comprehensive and specialized sexual and reproductive health services. She had to suffer through comments and treatment from medical staff that did not consider her situation as a victim of sexual violence and her social environment.

> "I couldn't give birth normally, because I had been violated repeatedly and I didn't want anybody to even touch me, it scared me, they did a caesarian… I didn't let them [examine] me because I just cried, my vagina hurt, it felt awful when the doctor did the exam. The doctor said, "Then, Miss, go to another hospital," because I wouldn't let her examine me."

Juana, 14 years old, Guatemala:
A story about the effect on her mental health

Juana,[7] a 14 year old indigenous girl from Alta Verapaz in Guatemala, was the victim of sexual violence by her half-brother at age 12. At age 13, she became pregnant and was treated at a municipality health center. Juana's family is extremely poor. The health center staff reported the rape to the competent authorities, according to the protocols for sexual violence. The record went to the Attorney General's Office and the Public Ministry. In his statement, the father, amidst the confusion and in an effort to make his son look less guilty, blamed the girl for being provocative. Juana confirms she was subjected to the abuse for two years. Following the protocol of care for victims of sexual violence, Juana was sent to a Maternal House "Dulce Espera" in Salama as a measure of protection and security. Here she spent two months. During this time due process protection was given, but there were no criminal proceedings against the rapist.

Then Juana, at seven months of pregnancy, was transferred to another shelter, where she remained for 20 days; this action removed her from the place – Alta Verapaz – where the criminal proceedings were taking place and away from her family. For Juana, the time at this shelter represented great social and cultural change. The intervention from the Reproductive Health Observatory[8] allowed Juana to be moved to a sexual violence (SVET)[9] shelter in Alta Verapaz, where it was easier for her family to visit her.

At 39 weeks, Juana went into labour in the morning and was taken to the emergency hospital at 6:30 a.m. It was a very fast labour, and at 7:40 a.m., the child was born. It was a vaginal birth that gave her first-degree tears. The baby weighed 6 pounds and had a severe dermatological infection due to a vaginal infection that was not treated during pregnancy. While the State did intervene to protect Juana, she expressed uncertainty about her future; she did not know what would become of her life. Her mental health was at risk, and she showed signs of depression.

> "I am 14 years old, and I live with my son in a government shelter. My parents visit me once a month, they said I will get out of here when I'm of age. I haven't been able to continue studying here; I wanted to finish primary school. But they help us to practice what we studied before and I have won a prize for being well behaved and responsible. I lost all of last year (2014) and this year (2015) I didn't enroll anywhere… I'm here, because when I was 13 and in fifth grade, I got pregnant from my older brother, that's just my dad's son. He raped me starting when I was 11 years old, he did it when my mom and dad weren't home. He told me not to tell anyone what he did to me or he would kill my mom, so that's why I kept quiet. One day my mom realized I hadn't gotten my period and she took me to a health center where they told my mom I was pregnant. Since I was 13 years old, they filed a complaint with the authorities. Afterwards they called my mom and my dad to tell them what had happened. My dad said that it was me that started it all with his son …that I teased him. So they sent me to a center for girls… I'm thankful for what they give me at the shelter, but I want to leave because I feel trapped here and I can't go outside… **I don't know what's going on with me but I want to die, my heart is not happy like before.**"

Ana, 12 years old, Guatemala:

A story of re-victimization, the lack of a comprehensive response to victims of sexual violence and the impact of forced motherhood

Ana,[10] an indigenous girl from Alta Verapaz in Guatemala who like Juana, does not speak Spanish, was raped by her stepfather when she was 12 years old. During her efforts to seek care, the system meant to protect her from her victimizer, re-victimizes her as she was placed (by police patrol) among people she did not know. Likewise, no account was taken of the obstetric risk and the possible complications that Ana could face being transferred from one department to another, or of the fact that it was a new cultural context for Ana.

When Ana was brought to the community health center, the nurse filed a complaint with the Public Ministry because Ana was under 14. However, no investigation was initiated because supposedly there was an unmet condition: the victim or her family needed to be there to ratify the complaint.[11] Despite the risk to Ana's two sisters, who were five and three, there was no arrest warrant put out for the perpetrator. Given the inaction of the authorities, the community health center staff called a meeting to clarify the case on May 16, 2014. With input from local indigenous organizations, the community came to an agreement based on the Mayan legal system, "*The girl's stepfather will be responsible for expenses during pregnancy and delivery, and the upbringing of the baby*".[12]

Despite this resolution, in the Magistrates Court in Chisec, Alta Verapaz on May 22, 2014, a complaint was filed by women's organizations from Coban. As a result, the Attorney General's Office[13] becomes aware of the case and decides as a measure of protection, to "order the Directorate General of the National Civil Police (PNC)[14] to immediately rescue the child." The rescue was performed four days after the complaint. Ana was taken from the house despite the cries of Ana's mother and her sisters.

When Ana was rescued, she was eight months pregnant. She was taken from her house to the police station around eleven in the morning. At nine p.m. that same day she was brought to Atla Verapaz and later to a safe house in San José Pinula, in the capital of Guatemala City.[15] The move was done by passing her from one patrol to another. On July 8, 2014, when

Ana was in her last month of pregnancy, they moved her and placed her with a foster family provided by the Social Welfare Ministry in the city of Coban, department of Alta Verapaz.

On July 15, 2014 Ana went into labor and was taken to the public hospital in Coban. She delivered by cesarean. The newborn was hospitalized for five days for perinatal asphyxia, Apgar 5 and 7. Ana was discharged but she returned on July 22, 2014 to pick up the baby. Taking advantage of the visit, the surrogate family had Ana see a doctor because she complained of pain in the surgical wound. The doctor detected a dehiscence wound and endometritis by placental remains, so they hospitalized her for 10 days. The medical risk was very high. The baby was discharged and the foster family tried to enroll the child in the National Registry of Persons (RENAP)[16] so that both Ana and the baby would have the support provided by the Social Welfare Department (SWD) in these cases. However, there are many obstacles since Ana was not present for the registration. The Attorney General´s Office and the Social Welfare Department explained that the child/baby's mother was hospitalized and there was an urgency to enrolling in the program to ensure support, milk, clothes and medicines.

During the times Ana was visited, after leaving the hospital, she was found crying because Doña Lidia[17] (foster family) scolded her on the grounds that she was "*a bad mother, didn't want to care for her baby, didn't want to sleep with him ... I will give him to you so you learn to be responsible ...*". On the last visit to Ana in May 2015, thanks to the support offered by OSAR, Ana was living again at her home in Alta Verapaz with her mother, sister and son. The stepfather was no longer in the community, although he's still a fugitive from justice and the penal process continues.

> "I am 12 years old. My son is already 12 months. I was in third grade when my stepfather abused me. I dropped out of school because I didn't feel well and I didn't know why. My mom took me to the community health center and a nurse took care of me, and told my mom that I was already seven months pregnant…Sometimes I start to play and I laugh a lot, and then I remember that I left my baby on the bed and it could fall off…"

Diana, 14 years old, Nicaragua:
A story of multiple forms of violence

Diana,[18] a 14 year old girl from Waslala in Nicaragua, was a victim of prolonged violence. From the time she was nine years old, Diana suffered harassment and sexual assault from her 58 year old maternal grandfather. Throughout her childhood, Diana had to deal with the power dynamics generated by her grandfather, who manipulated her, abused her and told her that she belonged to him. Repeatedly, her maternal grandfather sexually abused Diana under threat. The grandfather psychologically abused Diana, controlling all her activities and refusing to allow her to interact with anybody else. Even after Diana's youngest son was born (when she was still less than fourteen years old), the assailant searched and threatened people at gunpoint to find out where she and the child were.

According to the criminal complaint record, Diana's mental health has deteriorated. Her life has been completely transformed. Realizing she became a mother too early, she suffers from depression and anger, passivity, insomnia and fear.[19]

At birth, Diana's biological mother sent her to live with her maternal grandmother. Diana grew up in the company of her biological grandfather, who became her rapist. In her testimony, Diana explained she was nine when he first raped her, during the occasion when she brought him food to the mountain where he worked. On that day, he began to fondle her so she ran. But the assailant chased her down and she fell, at which point the aggressor took advantage of the situation to force her to have sex with him. From that day on, he raped Diana repeatedly. While her grandmother slept, he woke the girl up and forced her to have sex with him, as he put scissors to her neck and threatened to stick them in her chest if she screamed. He also threatened to cut off her head and give it to the dogs and to kill her grandmother if she told anyone what he did to her. Diana, reported that her belly began to grow and she told the aggressor that she felt a ball. So, he answered, "it is not a ball, you are just fat". The assailant told Diana's grandmother there was a spell on the child and that was why her belly had grown. Until one day one of the sisters of the aggressor saw the child and the grandmother asked her to examine Diana's belly. The sister explained that this was not due to a spell, but that the child was pregnant. The grandmother replied that nobody else ever came around and that (pregnancy) was the result of her husband. The woman´s only choice was to stop eating to affect her health. The grandmother then asked permission from the attacker to leave the community to seek medical attention. The attacker told her to go

alone and insisted that Diana had to stay with him. Twelve days or so after the grandmother had gone, the assailant gave permission to Diana to go have the baby in Waslala. He took Diana to Waslala where her grandmother was, giving Diana just eight days to attend to her health. He said after those eight days he would be back and threatened them with death if they complained or went to another place. The next day Diana and her grandma went to the hospital and the hospital referred Diana to the Maternal House in Waslala, where the baby was born.

When Diana's youngest son, a product of being raped by her grandfather, was born to this fourteen year old minor, both Diana and her grandmother went to the Commissioner of Women in Waslala to denounce the aggressor. But, the staff refused to accept the complaint, claiming lack of jurisdiction; so, they were referred to a Waslala shelter. From there, Diana and the baby were transferred to the center, because of the danger of the aggressor. In the health center, Diana was treated and received the respective care. Additionally, the center processed the registration of the child in the Civil Registry of Persons of the city of Esteli.

Marta, 14 years old, Guatemala:

A story of early marriage, domestic violence and a lack of a gender perspective in the judicial system.

> "I am 14 years old; I don't know how to read or write as I never went to school. I'm married, my husband is 22; we got married in August 2014. I have a 3-month-old baby. I met my husband in my community."

Marta and her current husband started dating when she was 12 years old. One day, Marta's brothers discovered them having sex in her house. Marta's mother confronted the boy, demanding that he marry Marta and take care of her. The young man refused, so Marta's mother went to court and filed a complaint, demanding that the young man marry his daughter. The judges told the young man to marry her, or he would be put in jail.

First they were married in a civil ceremony and then by the Evangelical Church. Since they married, Marta has suffered physical and psychological violence. Her husband does not

allow her to see her family. In this situation, the mother of Marta, who is also a victim of violence by her husband, went to court to seek support for her daughter. Marta was attacked by her husband 4 weeks after delivery; during that incident he tried to choke her.

The judge's response to this request for help was, "*These are matters for the couple, leave them alone and tell her to behave so her husband doesn't have a reason to hit her.*"

During her pregnancy, Marta had frequent urinary tract infections, and her baby was breech so she had to have a cesarean delivery. Marta had postoperative complications, had to stay in the hospital for five days, and her child only weighed five pounds at birth.

Part 3

Response of the state system to victims of sexual violence

National Regulatory Framework

Ecuadorian legislation on violence against women and reproductive health, particularly minors

Ecuador has several laws, rules and policies that address violence against women and reproductive health, although they are not always consistently implemented.

- ***The Violence against Women and the Family Law (1995):*** The purpose of the so-called "Law 103" is to protect the physical and mental integrity and sexual freedom of women and members of her family. However, this law is incomplete, particularly regarding the State's obligation to prevent violence and comprehensive protection for victims.

- ***National Plan to Eradicate Gender-based violence against girls, adolescents and women (2007):***[1] The Ministries of Health, Education, Interior, Justice and Economic and Social Inclusion, and two National Councils are responsible for its implementation. However, the plan was gradually weakened as it obtained no resonance in society. On the other hand, several standards and protocols for comprehensive care of gender-based and domestic violence and sexual life cycles were created,[2] such as the Comprehensive National Plan to eradicate sexual offenses in the education system.[3]

- ***Constitution[4] (2008):*** The law prioritizes girls, pregnant women, as well as victims of domestic and sexual violence, and pledges to take protective action and care against all forms of violence, abuse, sexual exploitation or otherwise, and negligence causing such situations (articles 38 and 46). It also incorporates the right to physical, mental, moral and sexual integrity that includes a life free of violence in the public and private sectors (Article 66).

  The Constitution also protects the right to sexual and reproductive health, including the right to make free, informed, voluntary and responsible decisions about sexuality, reproduction, life and sexual orientation, such as when and how many children to have (paragraphs 9 and 10 of Article 66). It also ensures the health and lives of women during pregnancy, childbirth and postpartum (Articles 43 and 363), and requires the State to ensure that all educational institutions provide rights-based sexuality education (Article 347). Among other sexual and reproductive rights are the rights to confidentiality (Article 362),[5] access to services based on the principles of bioethics (that

respect intergenerational (Articles 37 and 39),[6] intercultural, and gender conditions, with efficiency, providing dignified, quality and warm treatment, (Article 32),[7] ensuring availability and access to medicines (Article 362),[8] and the allocation of resources to meet the health demands (Articles 264, 286 and 298).[9]

- ***National Plan for Quality Living (2013):*** This Plan aims to prevent and eradicate violence against women in all its forms between 2013 and 2017.[10] Policy 6.9 establishes a special goal to combat and eradicate violence and abuse against children and adolescents.

- ***Comprehensive Penal Code (2014):*** For the first time, this code introduces the crime of femicide into Ecuadorian legislation (Article 141) and criminalizes violence against women or members of her family, which was previously only recognized as a criminal violation (Articles 155–159).[11] It also recognizes that the pregnant woman can terminate her pregnancy when her life and sexual and reproductive health are at risk, and when a woman with a mental disability becomes pregnant as a result of rape (Article 150).

- ***Health Law (2006):*** The Health Law conceptualizes and protects the right to reproductive health (Article 20) and recognizes maternal mortality, adolescent pregnancy and unsafe abortion as public health problems (Article 22).[12] It also recognizes domestic violence as a public health problem and requires the State to provide comprehensive care to victims of domestic and sexual violence.[13] Among the health services that are required for survivors of domestic and sexual violence are the supply of emergency contraception and therapeutic procedures.

- ***Code on Children and Adolescents (2003):*** This code recognizes that people under 18 years of age also have sexual and reproductive rights, and establishes that "...children and adolescents are entitled to enjoy the highest level of physical, mental, psychological and sexual health "(Article 27).[14] By protecting the right to sexual and reproductive health, this code affirms that one must pay attention to the multiple features of all people, regardless of gender, age and social status, without discrimination and with respect to their autonomy.

Guatemalan legislation on violence against women and reproductive health, particularly minors

- ***Constitution (1985):*** This law protects people's right to life, liberty and security (Article 3) and guarantees comprehensive development (Article 2). It also protects the right

to health and the protection of health, so every human being can enjoy a biological and social balance that promotes a state of wellbeing in relation to the surrounding environment; this means being able to access to services that enable the maintenance or restoration of physical, mental and social wellbeing "(Article 93). Also, this regulation protects motherhood (Article 52).

- ***Social Development Act (2001):*** This regulation establishes the right to decide freely, responsibly and consciously about family and reproductive life, and the right to receive timely, accurate and complete information to exercise this freedom (Article 5). It defines reproductive health (Article 25)[15] and establishes that there must be coordination between the Ministry of Health and Welfare and the Ministry of Education to design, coordinate and implement the Reproductive Health Program. The program must include tailored and differentiated care for adolescents, including extensive information and counseling regarding human sexuality, responsible parenthood, prenatal care, delivery and postpartum care, birth spacing, and treatment of STIs and HIV and AIDS (Article 26).[16] It also includes provisions on programs and services for family planning and safe motherhood, emphasizing that the lives and health of mothers and children is a public good (Article 26).

- ***Safe Motherhood Act (2010):*** This regulation aims to create a legal framework to implement the necessary mechanisms to improve the health and quality of life of women and newborns and promote human development (Article 1). Its goals include reducing the rates of maternal and neonatal mortality and ensuring universal, timely, high quality access to maternal and neonatal services, including family planning and differentiated services for adolescent (Article 2).

- ***Comprehensive Protection Law for Children and Adolescents (2003):*** This law establishes the State's obligation to design and implement programs of sex education, prevention of sexually transmitted diseases, preparation for procreation and married life and development of responsible fatherhood and motherhood, when threat or violation of the rights of childhood and adolescence exist (Article 76).

- ***Law for Universal and Equitable Access to Family Planning Services (2005):*** In 2009, the CEDAW Committee recommended that the State more fully enforce the Law of Universal Access and its integration into the National Reproductive Health Program.

- ***Penal Code (1973):*** This code allows for therapeutic abortion (section 137). *"Abortion performed by a physician with the consent of the woman, following a favorable diagnosis of at least one other physician is not punishable; if performed without the intent to directly seek the death of the product of conception, but rather for the sole purpose of avoiding danger, duly established, to the life of the mother, after all other scientific and technical means have been exhausted."*

- ***Law Against Sexual Violence, Exploitation and Trafficking (2009):***[17] This law introduced amendments to the criminal code, including the use of the terms physical and/or psychiatric, distinguishing these as two different assumptions, which provides a more accurate standard regarding the concept of "enough violence". The new wording "better reflects the reality of many sexual assaults, where there is not necessarily physical force that leaves marks, but rather an intimidating environment, abuse of power or trust.[18]

- ***Law on Free Access to Public Information (2009):*** This establishes the obligation of all institutions to inform the public about statistics, among other things.

- ***Agreement (2010):*** This agreement established the Criminal Courts of First Instance and Courts for Sentencing Femicide Crimes and Other Forms of Violence against Women. These tribunals make the concept of gendered justice in some specific departments a reality. Its purpose is to understand crimes related to femicide, violence against women and economic violence (established in the Law against Femicide and Other Forms of Violence against Women, 2008).

- ***Agreement 12-2012(2012):*** This agreement created courts to deal with the same subject in other departments and expanded their role to also deal with crimes under the Law against Sexual Violence, Exploitation and Trafficking. It also created the Chamber of the Court of Appeals for Criminal Offences of Femicide and Other Forms of Violence against Women, with jurisdiction in the second instance of the crimes contained in the Law against Femicide and Other Forms of Violence against Women and the Law against Sexual Violence, Exploitation and Trafficking.

- ***Agreement 43-2012 (2012):*** This was established by the Courts to provide uninterrupted attention 24 hours a day on this issue. Currently, Guatemala has 11 specialized courts and tribunals to deal with cases of violence against women and femicide and rape cases, exploitation and trafficking competition.[19]

Nicaraguan law on violence against women and reproductive health, particularly minors

- ***Constitution (2007):*** It recognizes the right to life (article 23),[20] privacy (article 64) and health (article 59).[21] Also, secondary laws have developed these constitutional rights.

- ***Comprehensive Law Against Violence Against Women (hereinafter "Law 779") (2012):*** This law aims to protect the human rights of Nicaraguan women and guarantee a life free of violence (Article 1).[22] Similarly, it establishes the rights to a life free of violence in both the public and private sectors, to their freedom and sexual and reproductive integrity, "as well as the recognition, enjoyment, exercise and protection of all human rights and freedoms enshrined in the Constitution of the Republic of Nicaragua, in national law and international instruments on human rights "(Article 7).

  Since entering into force in June 2012, Law 779 involved the inclusion of various criminal offenses as femicide,[23] property crime,[24] workplace violence,[25] violence in the civil service.[26] It allows for precautionary measures,[27] creation of courts and criminal courts of appeal specialized in violence,[28] and the prohibition of mediation.[29] However, Law 779 was tied to the reform carried out in September 2013, in which the prohibition of mediation is excluded for all forms of violence against women with the exception of femicide. This undoubtedly puts the victim in an unequal position against her attacker; it ignores or trivializes violence against women..

- ***Regulation of Law 779 (2014):*** This gave a new twist to the law, giving the protection of the family a central place in the law,[30] and creating new institutions such as family counseling models that are intended "to strengthen values of respect, love, and solidarity within families and the community "(Article 8). The truth is that by encouraging a family-centered approach, this law could reinforce traditional gender stereotypes, which would maintain and preserve the family even when the life and health of women is in danger.

- ***Family Code (2014):***[31] The main objective of this code is to give legal status to the institution of the family and its members. It includes the "Cabinets of Family and Community Life,"[32] which promotes "values and family unity, self-esteem and esteem, rights and responsibility, communication, coexistence, understanding and community spirit to achieve coherence between what one is, what one thinks and what is done(Article 32)". Similarly, the code states that unborn babies are considered minors and may require maintenance payments (Article 316)[33] and it states that the defense and the right to life

of a child or adolescent "when hospitalization, treatment or surgery is essential to protect human life or health is necessary, "(Article 277). By interpreting the unborn as minors, this code could prioritize their treatment over the mother in case of risk. This code has been the target of various criticisms due to its failure to include international standards on human rights.[34]

- ***Penal Code (2007):*** In 2007, total criminalization of abortion was confirmed in the Penal Code. It currently stipulates deprivation of liberty for one to three years for anyone who performs an abortion with the knowledge of women, and if it's performed by a health professional, they will be disqualified from practicing medicine for two to five years (Article 143).[35] Also, the woman who intentionally causes her own abortion or consents to the practice will be punished by imprisonment of one to two years (Article 143).[36] In the case of an abortion without the consent of the mother, the penalty increases from three to six years; if it is done by a health professional, the period under which they can't practice goes from four to seven years (Article 144).[37] Finally, reckless abortion is defined in Nicaraguan law as one "whom through recklessness causes an abortion" and has a penalty from six months to one year in prison, and if the abortion was performed by a healthcare professional, they will be disqualified for one to four years (Article 145).[38]

  Several UN Human Rights committees expressed concern about such disadvantages,[39] including the Inter-American System.[40] Internally, various human rights and women's rights organization filed about 72 appeals of unconstitutionality before the reform of the Penal Code (34 appeals against Law 603 and 38 for unconstitutionality against the Penal Code) between 2007 and 2008. However to date there has been no resolution by the Supreme Court.

Peruvian legislation on violence against women and reproductive health, particularly minors

- ***Penal Code (1991):*** It states that therapeutic abortion to save the life and protect the health of the pregnant woman is not punishable (Article 119).[41] In 1989, an amendment was proposed to decriminalize abortion in cases of sexual violence, artificial insemination without consent and fetal abnormalities incompatible with life, but the form never took, nor was there the subsequent debate to replenish these exceptions.[42] In 2014, based on a Citizen's Initiative, organizations and women's groups in Peru, through the Let Her Decide Campaign ("Déjala Decidir"), advocated for a bill to decriminalize abortion for rape. However, the Commission of Justice and Human Rights of Congress archived it.[43]

- ***National Technical Guidelines for the decriminalization of therapeutic abortion in pregnancies less than 22 weeks (2013):***[44] According to the Minister of Health, who presented the National Technical Guidelines for the procedure, it will only apply when abortion is the only means to save the mother's life or to prevent serious and permanent damage to her health. Also, the pregnancy has to be less than 22 weeks of gestation and the pregnant woman or her legal representative must have given written consent after being fully informed about her diagnosis, prognosis and risks to their health and life.[45]

- ***Judgment EXP. No. 02005-2009-PA / TC of the Constitutional Court (2009):*** This banned the free distribution of emergency contraception (EC) by the Ministry of Health, leaving EC beyond the reach of low-income women and those in remote areas of the country with few and underserved pharmacies.

- ***Multisectoral Plan to Reduce Teen Pregnancy 2013–2021 (2014):*** This incorporates six sectors and other bodies convened with the goal of reducing by 20% the prevalence of adolescent pregnancy.[46] It is only one of several public policies adopted by the government to address the increasing percentage of children and adolescents who are mothers or pregnant.[47] However, a problem with the implementation of many of these policies has been the almost exclusive management by the Ministry of Health. The education sector has not participated (due to the unwillingness to implement sex education at all educational levels) or the working sector (due to not creating policies for skill development and labor inclusion), among other sectors.

Judicial response

Despite the formal and legal recognition of the Latin American states that violence against women is a priority challenge, there is a large gap between the incidence and severity of the problem, and the quality of the judicial response.[48] According to the IACHR, most cases of violence against women are never formally investigated, prosecuted and punished by the justice systems in the hemisphere.[49] Often women victims of violence do not receive expeditious, timely and effective access to judicial remedies when reporting the events.[50] It has generated a pattern of systematic impunity in the proceedings and in the prosecution of these cases in several countries.

In Ecuador, the percentage of prosecutions that are initiated in the criminal sphere is very low in relation to all complaints of violence against women. For example, in

Guayaquil, cases were initiated in only 12% of complaints in one year.[51] The percentage of cases of sexual crimes completed is also low, with 2% of cases coming to judgment.[52] In Guatemala, only 33% of sexual crimes cases went to trial.[53] Peru is the South American country with the highest number of complaints of rape (22.4 allegations of rape per 100,000 inhabitants),[54] for a total of 63,545.[55] In this regard, the Committee on the Elimination of All Forms of Discrimination (CEDAW) expressed concern about "the difficulties that women face when seeking redress in cases of violence, such as discrimination, prejudice and insensitivity to gender among the judiciary, prosecutors and police; the effects of these difficulties discourage women from seeking justice in such cases. The Committee warns, in particular, about the high level of impunity for perpetrators in cases of violence against women and the failure by the State to comply with its obligations under Article 2 of the Convention for the purposes of preventing, investigating, prosecuting and punishing acts of violence."[56]

A number of structural problems within the justice systems affect the prosecution of cases of violence against women. Among them are the lack of financial and human resources to carry out effective investigations and to prosecute and punish cases; the absence of outposts of the administration of justice in rural, poor and marginalized areas; the lack of lawyers for victims of violence who are without economic means; the weakness of government ministries, as well as the police authorities involved, in the investigation of crime; and lack of special units of police and prosecutors with the expertise required to address issues of violence.[57] In Guatemala, the authorities themselves confirmed that "they do not have the human resources, infrastructure, equipment or budgets to carry out their investigation and prosecution of the crime".[58]

The performance of officials at all levels of the judicial branch also contributes to the problem. According to the IACHR, as a result of discriminatory social and cultural patterns, the officials

"don't consider violence to be a priority and disqualify the victims, do not conduct tests that are key to clarifying who is responsible, attach exclusive emphasis to physical evidence and testimony, give little credence to the claims of victims and provide inadequate treatment to them and their families when they attempt to cooperate in the investigation of the facts."[59]

Research in Ecuador and Guatemala, for example, reveals that the reason the percentage of sexual offenses that reach trial are notoriously low is the ineffective investigations by the prosecution and the tendency to prosecute only those cases where it is considered that

there is enough evidence to get a conviction.[60] Other research carried out in Ecuador found that "judges do not consider crimes of sexual offenses or domestic crimes to be like any other ... they do not give them the importance of drug or murder cases, they do not give them equal treatment."[61]

Other factors limiting the correct application of the law by state authorities include "lack of regulations and clear procedures and training programs to encourage proper interpretation and application of laws in prosecuting cases of violence against women by public officials, the workload of the bodies responsible for implementing the law and ignorance of the law and how to interpret it by the general public."[62]

Likewise, a series of obstacles hinder the filing of complaints of violence. Among the reasons for this problem are 1) the secondary victimization that female victims experience when trying to denounce the acts perpetrated; 2) the lack of protection and judicial guarantees to protect the dignity and security of victims and witnesses during the process; the economic cost of judicial proceedings; and 3) the geographical location of the courts receiving the complaints.[63] For example, in Ecuador, an investigation found that many victims of sexual crimes and/or family violence feel abused by the system of administration of justice because to report the facts, they have to undergo more invasive testing and provide testimony many times.[64] In Guatemala, testimony received by the Special Rapporteur indicated that in many cases the authorities responsible for the investigation and prosecution of crimes of violence against women treated victims' relatives disrespectfully.[65]

Furthermore, violence, discrimination and difficulties in accessing justice differentially affect certain groups of women, including indigenous women and Afro-descendants. "*The obstacles they face to access suitable and effective judicial resources to remedy the violations suffered may be particularly critical because they suffer from multiple forms of discrimination, as women, because of their ethnic or racial origin and/or socio-economic status.*"[66] In many regions of Guatemala, according to the IACHR, indigenous women do not have the ability to be understood in their own language.[67]

Health System Response

The health sector is an important place where women can find support after experiencing sexual violence. People who work in health services and respond to the survivors can play a significant role in their recovery, or their continued victimization.[68] Health services must meet

the needs of female victims of sexual assault, and to do so, they should take into account the experiences, needs and demands of the survivors.[69]

Girls and adolescents face a series of injuries and diseases resulting from sexual violence and coercion. The data indicate that survivors of sexual violence can experience behavioral, social, and mental health consequences and implications. Data also shows survivors are vulnerable to sexual and reproductive health consequences such as unwanted pregnancies, unsafe abortions, and increased risk of contracting sexually transmitted infections, including HIV.[70] In this context, the provision of comprehensive health and medical-judicial services to victims of rape survivors, including adolescents under 15 years old, is fundamental. In addition to compassionate care, survivors need access to a number of specific health services provided by trained personnel: psychological support (and referrals to institutions for mental health care, if necessary); emergency contraception; treatment and prevention of sexually transmitted diseases; prophylaxis for HIV, where appropriate; and information about safe abortions.[71]

Multidisciplinary services to victims of sexual violence

However, the IACHR has noted a number of failures in the operation of government programs designed to provide multidisciplinary services to victims of violence in Latin America. Among the problems it highlighted "*the lack of coordination and cooperation between programs; deficiencies in the provision of interdisciplinary services required by victims; lack of resources to sustain programs; and limited geographical coverage, which particularly affects women living in marginalized, rural and poor areas.*"[72]

Mental health services for victims of sexual violence

Another major flaw is the failure to provide comprehensive mental health services to victims of sexual violence. Unfortunately, it is common for health care providers to overlook the mental health needs of victims of sexual violence. An investigation of the health services available in Guatemala found that female victims of violence would have liked psychologists to pay more attention to them.[73] In Nicaragua, research from the Association of Axayacatl Women (Asociación de Mujeres Axayacatl) revealed that 50% of girls felt stigma from health personnel.[74]

The protectionist attitude towards motherhood of some medical staff is another practice that prevents girls and adolescent victims of sexual violence from accessing mental health

services. In Ecuador, for example, research from the Fundación Desafío found that in 91% of the cases reviewed, girls had depressive symptoms and adaptive disorders. "*However, girls and pregnant adolescents did not receive mental and social health services from state institutions.*"[75] Instead, providers of health services focused attention on "maternalizing" them (i.e., they were taught to be mothers), "*ignoring the other areas of their lives, such as education, building their own dreams and understanding their own stories*".[76]

Rape affects all dimensions of health, including mental health. It is common for rape and forced pregnancy to generate emotional problems in women, which can result in suicidal thoughts or suicide, depression and post-traumatic stress, among others.[77] Given their age, girls and adolescents aged 9 to 14 years have a higher risk of a range of psychopathology after an incident of sexual assault, such as PTSD, depression, and dissociation and anxiety.[78] In addition, under these circumstances, forced pregnancy can result in a psychological impairment for victims, damaging their mental health. Mental health services are a key part of a "pathway of care"[79] for women, adolescents, and children in this situation; the failure to provide these services is a violation of the right to mental health.

Abortion services for victims of sexual violence

Girls who are victims of sexual violence also face significant barriers to accessing safe abortion, which should be a part of a comprehensive response to the needs of surviving victims. In Guatemala, Nicaragua and Peru, abortion on the grounds of rape is criminalized. And in Ecuador, it is only allowed when a woman has a mental disability. Preventing victims of sexual violence who decide to terminate a pregnancy from accessing an abortion condemns them to forced motherhood. It also results in the practice of illegal abortions in unsafe conditions, which put their lives at risk. Unfortunately, efforts to combat the high rates of maternal mortality among adolescents have had a protectionist attitude towards motherhood, violating the human rights of the victims.

Part 4

The responsibility of the State regarding human rights and adolescent victims of sexual violence

Sexual violence against girls and adolescents, in addition to yielding consequences for their physical, mental and social health, is a serious violation of their human rights. States have a responsibility not only to prevent this form of violence, but also to respond properly when girls and adolescents experience it, particularly when they become pregnant as a result. State responsibility for human rights in this context is characterized by two important principles: 1) violence against women and girls is addressed as a matter of equality and non-discrimination between women and men, and has an intersectional character; and, 2) as a result of the intersectional nature of violence and discrimination, human rights are violated multiple times and interdependently.

Intersectionality of violence and discrimination against girls

Violence is a phenomenon that affects everyone. However, women and girls can be more vulnerable to violence because of: devaluing and subjugating norms, beliefs, and prejudices; negative gender stereotypes; and emotional, economic, or social dependency. Consequently, violence against women constitutes a form of discrimination, as stated by the Inter-American Commission on Human Rights (hereinafter IACHR).[1]

The international regulatory framework on the principle of non-discrimination is based primarily on the protection against any distinction that is made based on a protected category (such as race, gender, sex, ethnic origin, nationality, religion, language, sexual orientation, disability, age, etc.). However, international human rights law also recognizes that people can belong to different protected categories at once and, therefore, face multiple forms of discrimination. And, the effect is different due to how these categories overlap. In other words, people do not experience discrimination in a vacuum, but in a particular social, economic and cultural context where privileges and disadvantages are constructed and reproduced.

As a result, the discrimination experienced by women often requires an intersectional analysis, which is a tool of great theoretical, conceptual and policy making utility in addressing the multiplicity and simultaneity of the oppression of women.[2] The analysis of the interaction and intersection of different protected categories against discrimination in the case of *Rosendo Cantu*[3] allowed the IACHR to identify the existence of a pattern of discrimination, present both in the facts of the rape and in the multiple barriers to accessing justice.[4] Also, the IACHR determined that multiple intersectional vulnerabilities and the risk of discrimination associated with her condition as a child, woman, person living in poverty

and person living with HIV in the *Gonzalez Lluy and others v Ecuador* converged.[5] Similarly, the European Court of Human Rights in the case of *BS v. Spain*,[6] applied an intersectionality analysis to the extreme vulnerability of BS, who suffered discrimination for gender, race, national origin, status of foreigner and prostitution.[7]

Motherhood in childhood and adolescence is an emerging public health problem that is often a result of violence against girls and adolescents and a form of discrimination. It affects thousands of children who are in a vulnerable state, characterized by: 1) not having access to education; 2) living in poverty, in rural areas or in poor urban areas; and, for some, 3) being a member of minority groups, such as indigenous girls, coupled with a culture and customs that promote early marriages, abduction or theft, the power of men over women, the naturalization of sexual violence, etc. Since the issue of motherhood during childhood and adolescence also crosses sectors such as education, health, justice, and the rights of children and women, it is considered as an indicator of development and social welfare, which, therefore, requires an intersectional analysis.

Interdependence of human rights violations

The international community has increasingly recognized violence against women not only as a public health problem, but also as a human rights violation. This section considers some of the human rights related to violence against women, and highlights the inalienable, integral and indivisible nature of them.

Right to a life free of violence

General Recommendation 19 of CEDAW states that "*Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.*"[8] It also broadens the interpretation of CEDAW 's definition of discrimination against women, to assert that this definition includes gender-based violence, i.e. "*violence that is directed against a woman because she is a woman or that affects women disproportionately.*"[9]

Within the inter-American protection system, the Convention of Belém do Pará[10] states that violence against women is a violation of human rights and fundamental freedoms, an offense to human dignity, and a manifestation of the historically unequal power relations between women and men that pervades every sector of society regardless of class, race or

ethnicity, income level, culture, education level, age or religion. The Convention recognizes, too, that the elimination of violence against women is essential for their individual and social development and their full and equal participation in all spheres of life.[11] Moreover, the right of every woman to a life free of violence[12] is linked directly to the general prohibition of discrimination in the Convention.[13]

The testimonies of the girls interviewed as part of the research revealed that States are failing to meet their obligations to respect, protect, and promote the right to freedom from violence of these girls.

> "[The father of my daughter] took me to a very ugly place and took away my daughter of three months and a bit. When my daughter was born, he knew that it was a girl, he told me to leave or my family would be dead…he took away my daughter of three months and trapped me in prostitution, passing me from one man to another…I said to myself that I had to escape for my daughter. "
>
> K, 17 years old, Ecuador.[14]

> "I didn't want to but he made me…he told me to have relations like that, like that, and I said no but in the end…well."
>
> R, 15 years old, Ecuador.

Similarly, it was found in many cases that there is emotional abuse by the perpetrator, such as intimidation or threats of harm. This abuse can also be a form of violence.

> "I tried to call my grandma, but she told me to not say anything, because they wouldn't believe me. I respected my uncle, I don't know why he came to my room, after he was done, he warned me not to say anything or he would hit me."
>
> Irene, 12 years old, Nicaragua.

Right to a life free of sexual violence

The Committee on the Rights of the Child, in its Recommendation No. 13 states that "all sexual activity imposed by an adult against a child is sexual abuse and the child is entitled to the protection of criminal law. Activities imposed by one child to another is also sexual abuse, if the first is significantly older than the victim or uses force, threats, and other means of pressure. Sexual activities between children are not considered sexual abuse once children outgrow the age limit for consensual relationships set by the State. "

> "…One night my uncle came to where I was sleeping, his wife was not at home and my three cousins sleep next to me, he told me to take off my clothes, and I told him no, he told me angrily that if I didn't' take them off, he would take them off, I took off my clothes, he covered my mouth with his hand, he got on top of me and pulled down his pants, I saw that he took something out that he had between his legs, but I don't know what it's called, he told me to open my legs, I didn't want to so I tried to keep them closed, but he opened them by force, he stuck his thing in my 'chunche ' (vagina) it hurt and burned a lot…my chunche hurt, I started crying, I couldn't' sleep, when I shut my eyes I could see what my uncle did to me, I didn't want to, I felt bad, the next day my uncle said that I did like what he had done, I told him no, that I didn't even want him to do it, he approached me and told me to go play in my room, he was going to do to me what he had done at night, I got away from him because I was scared of him, when my grandma sends me to herd the pigs, I went alone, he told me to go play in my room, or he was going to hit me…"
>
> Irene, 12 years old, Nicaragua.

Irene's harrowing story reflects the reality that 120 million girls (just over 1 in 10) around the world have experienced forced sex or other forced sexual contact at some point in their lives.[15] Planned Parenthood Global has found that of the 204 children and adolescents interviewed for this research, 23 of them were raped by a relative or somebody close to the minor.[16] According to a report by the Pan American Health Organization (hereinafter PAHO),

violence against women by an intimate partner is widespread in all the countries of Latin America and the Caribbean.[17]

"My stepfather wanted to abuse me, one night when my mom was out, she left me alone with [him]…he grabbed my parts and I tried to avoid him."

D, 14 years old, Ecuador.

"My stepfather raped me when I was eight."

K, 17 years old, Ecuador.[18]

"My uncle was 74, he abused me [I was] 11."

Y, 13 years old, Ecuador.

"When I was little, my uncle…was too affectionate with me, he would have been 14 and I was 5 or 6…he grabbed me and touched my butt cheeks."

A, 15 years old, Ecuador.

"… [the aggressor] was a neighbor, he was around 55."

Claudia's mother, 13 years old, Nicaragua.

Right to Freedom from Structural violence

Structural violence includes physical and psychological harm to persons as a result of structurally inadequate conditions in institutions and public systems.[19] Institutional violence can also be generated by laws, policies or practices that restrict the exercise of reproductive rights. Laws that criminalize abortion completely,[20] 1) perpetuate cultural patterns of stigma and discrimination; 2) create barriers to access to basic health services for women; 3) create barriers to access to justice for women; and 4) disproportionately affect specific groups of women.

"In the hospital, they looked down on me, the obstetricians told me to go play with dolls because I was just a girl."

Ana, 16 years old, Peru.

The prohibition of abortion for victims of sexual violence in countries such as Ecuador, Peru, Nicaragua and Guatemala is structural violence. Also, the institutional denial of access to public health services required by these victims translates into a violation of their right to be free from structural violence.

Right to Health

Reproductive health is defined as "*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*".[21] Moreover, sexual and reproductive health implies that "*people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.*"[22] Abuse and sexual violence are reproductive health problems that affect the quality of life, generate emotional and behavioral problems, and complicate both pregnancy and childbirth.[23]

In countries of the region that do not allow access to abortion in cases of rape and/or that have a restrictive interpretation of therapeutic abortion, children and adolescents are forced to carry a pregnancy resulting from criminal acts to full term. This situation may expose the girl or adolescent to risks to her physical health, such as sterilization and infection. Children under 16 who become pregnant within two years after menarche (when first menstruation occurs), or when their pelvis and birth canal are still growing, are more likely to have health problems than an older woman. Moreover, "*in Latin America, the risk of maternal death is four times higher among adolescents under 16 years.*"[24]

In addition, this can produce psychological effects in the victim that can result in suicidal tendencies or suicide, and mental health problems, such as depression and post-traumatic stress. In Ecuador, for example, suicide is the second leading cause of death in adolescents.[25]

> "… I couldn't sleep dreaming of my stepfather there abusing me, imagining him in my dreams, my son calling me mom, and me hitting him felt terrible, I couldn't' sleep, so I used to get up and walk."
>
> K, 17 years old, Ecuador.

The continuation of unwanted pregnancy, as in the case of rape or incest, severely limits a pregnant woman's life plans. For example, it can hinder the educational training process and access to decent work, as well as their success in these activities.[26]

"I didn't feel like I was a young girl anymore. Because I had a baby in my arms, I had given birth, it changed my body…[When I knew I was pregnant I felt] terrible. At the beginning, because I couldn't' study any more, people were calling me out, they were saying…that girl…having kids. I was 13."

R, 15 years old. Ecuador.

"I learned to bathe her because I couldn't bathe her and my mom became her mom, my mom bathed her, changed her, bonded with her. The first year was as if I wasn't the mom, but my mom became a mom again."

A, 15 years old, Ecuador.

"I'm thankful for what the shelter gave me, but I wanted to leave because I felt trapped and I couldn't go out."

Juana, 14 years old, Guatemala.

The right to health has as its counterpart a state obligation to ensure access to a full range of services, including sexual and reproductive health services. The results of this study affirm that none of these girls who were victims of sexual violence had access to emergency contraception (EC), and legal abortion was not presented to them as an option. The lack of access to comprehensive sexual and reproductive health services imposed an unwanted and unplanned motherhood on these children and adolescents, forcing them to assume a role as mothers and leave behind a childhood that they will never get back.

"When I was ten [I got pregnant] from my stepfather…I didn't want to have it because it was a result of rape and I wasn't going to have it…I see that to be a mother, you have to have patience because they can take away my kid if I'm not treating her well…my daughter was hospitalized because she had pneumonia."

K, 17 years old, Ecuador.[27]

The right not to be subjected to torture or to cruel, inhuman or degrading treatment

International law recognizes the right of women to be free from torture and cruel, inhuman or degrading treatment.[28] Cruel, inhuman or degrading treatment is not limited to acts that cause physical pain, but also extends to acts that cause mental suffering.[29] In fact, States have an obligation to prevent acts that seriously impair the physical and mental health of women and that constitute cruel and inhuman acts.[30]

The mental suffering experienced by a child or adolescent who is forced to carry a pregnancy resulting from rape can be considered torture, shaming and/or cruel, inhuman and degrading treatment.[31] According to the Committee against Torture, forcing a woman to carry a pregnancy to term constitutes "*a constant exposure to the violations committed against them, ... and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression.*"[32]

Right to a life free of discrimination

The right to equality and freedom from discrimination is a basic and general principle, relating to the protection of other human rights guaranteed by the free and full exercise of those rights without distinction of race, color, sex, language, religion, political or other opinion, national or social origin, property, and birth or other status.[33] The Convention of Belem do Para explicitly establishes the right of women to be free from all forms of discrimination.[34]

Lack of access to comprehensive sexual and reproductive health services, including emergency contraception and abortion, and the absence of effective measures to prevent violence against girls, may be considered discrimination. Emergency contraception and abortion are health services that only women, adolescents and girls require. Denial of access infringes upon the right to be free from gender discrimination because a ban *only prevents women and girls* from accessing services upon which their life and health depend.

The right to non-discrimination also encompasses the right to be free of stereotypes of behavior and social and cultural practices based on concepts of inferiority or subordination. For *L.C. v. Peru*,[35] for example, the CEDAW Committee stated that the prohibition or limitation of reproductive health services, including abortion services, is closely related to the stereotypical view of the reproductive function of women.[36] The Committee also recognized the need to decriminalize abortion in cases of sexual violence, based on the argument that limiting abortion in these cases reinforces the gender stereotype according

to which women are recognized as sexual objects and reproductive vehicles whose rights are not effectively recognized. The Committee also recognized the obligation of States to ensure women's access to health without any discrimination in order to ensure equal access for men and women.[37]

In the context of the provision of health services, "*it cannot be considered that those patients who have not been taken into account individually, but have been treated according to impersonal, degrading, or simplistic stereotypes by their health suppliers, have received a benefit to their mental or social well-being or, therefore, their health.*"[38]

> "…I felt guilty when the little girl died, because at the beginning the doctor, when I went to the children's hospital, said that I smothered her. I always had this guilt, even now..."
>
> R, 15 years old, Ecuador.

Many girls and adolescent victims of sexual violence also experience other forms of discrimination as they are part of other marginalized groups. According to PAHO, in many countries, the prevalence of physical or sexual violence by an intimate partner is significantly higher with lower levels of education and economic resources compared to the rate among the highest level of education and economic resources.[39] Likewise, Planned Parenthood Global, in the results of interviews with 204 children and adolescents in Peru, Ecuador, Guatemala, and Nicaragua, found that all the participants lived in marginal urban areas or in rural areas, and were economically disadvantaged.

> "I lived with both, with my mom and dad, until I was 5. When I was five, there was violence in my house between my mom and my dad and they filed complaints and all that, so then in protest I decided to leave and go with my mom…my house burned down…I was living with my sisters…the gas cylinder exploded and we were left [without a house]. My mom was both mom and dad for us [that's why she wasn't home], she was working in the banana fields/I was terrible in school, I hit everybody."
>
> K, 17 years old, Ecuador.

> "My aunt, me, my other aunt, my sister and my godfather, we all slept in one room, yes, 5, half were adults and half were children. My godfather was my aunt's husband. He sold hens, at 4 in the morning [we all fought]."
>
> D, 14 years old, Ecuador.

Unfortunately the context and social environment of K and D are not isolated. This is the harsh reality that millions of girls face in Latin America.

Right to Information

Article 13 of the American Convention on Human Rights establishes that States Parties have the obligation to effectively provide the most complete, clear, accessible, and updated information on at least: "*... information that is required to the exercise of other rights-for example, regards the satisfaction of social rights such as pension rights, health or education.*"[40] Also, the right to health has as one of its essential components, the accessibility, manifested among other dimensions, access to information.[41]

The human right to information includes the right of the recipient to receive timely, complete, quality,[42] truthful, and impartial information[43] that is clearly distinguished from opinions.[44] This way people can make informed and truly free decisions. The IACHR has protected within the scope of the rights of privacy, liberty and personal integrity both the aspect of making decisions, and the access to health services which actualizes decisions on sexuality and reproduction.[45]

However, the Commission has expressed its concern over the misrepresentation of information on reproductive matters by public officials with dissuasive motives in the region.[46] Part of the stigma, violence, and discrimination suffered by girls and adolescents who are part of this Planned Parenthood Global research stems from the lack of clear, comprehensive, accessible, and updated information on violence against women. There is the State's obligation on the one hand, to have disaggregated data to promote appropriate public policies. And, on the other hand, there is the State's obligation to provide girls and adolescents and their families clear, complete, and accurate information about their reproductive rights.

While all women in the Americas have difficulty accessing sexual and reproductive health information, women who have been marginalized historically because of race, ethnicity, economic status and/or age face additional barriers. Girls and adolescent victims of sexual violence are often part of these marginalized groups, and they experience additional discrimination for having experienced sexual violence.

We believe that the right to information establishes the States' obligation to ensure that girls and adolescent victims of violence have access to counseling about sexual and reproductive health, pregnancy information, and medical information on treatment options and ways to prevent pregnancy, such as emergency contraception or abortion. This obligation is reinforced by the absence or inadequacy of information facilitates and discrimination and stigmatization of girls and adolescents who are victims of violence, particularly sexual violence.

Right to a Dignified Life

The Commission has said the right to life includes the right to a decent life; therefore, violations to the right to life are not deemed to be limited to cases where there are deaths.[47] To this end, the Commission ordered the State to provide structural conditions for a dignified life: food, water, sanitation, and adequate medical care.

Colombia's Constitutional Court indicates that human dignity is particularly important in the development of the principle of the effectiveness of fundamental rights and the attainment of the objectives and values of the Constitution. In fact, Judgment T-881 of 2002 interprets human dignity in three areas:

"*i) autonomy to build a life plan and choose its characteristics (living as you will), ii) access to certain material conditions of existence (living well) and iii) the intangibility of non-capital assets, physical and moral integrity (live without humiliation)* ".[48]

This line of case law has resulted in a number of important rulings on sexual and reproductive health, based on fundamental rights such as autonomy and human dignity.[49]

The research results indicate that the rights to autonomy and dignity of these children and adolescents have been extensively violated. First, their right to live as they want has been violated because they have been denied the right to design and implement a life plan of their choice.

"A life plan expresses the dignity of human beings and is an end in itself. That is why it is so vital that the laws on self-determination must protect the life plans as it is of utmost moral and legal relevance, in general, and for reproductive rights in particular."[50]

Unwanted pregnancy implies the imposition of motherhood, destroying life plans.

> "I don't know what will happen with my life and with my son."
>
> Ana, 16 years old, Peru.

And secondly, the right to live well is violated by a pregnancy that imposes unwanted or unplanned motherhood, and maintains cycles of poverty. Poverty influences the probability of minors becoming pregnant and entering into a vicious cycle because early motherhood often compromises their academic performance and economic potential.[51] The results of the investigation indicated the vast majority of girls and adolescents interviewed dropped out of school when they got pregnant.

> "I dropped out of school because I started to feel sick and I didn't know why."
>
> Ana, 12 years old, Guatemala.

Conclusions

From the results obtained in this study, the following conclusions can be made:

- **Intersectional Problem:** Motherhood in childhood is a crosscutting, emerging problem that includes sectors such as education, health, justice, and the rights of children and women; therefore, it is regarded as an indicator for development and social welfare. The intersectional analysis shows the true extent of the violations of human rights and enables the adoption of suitable measures to address the situation.

- **Comprehensive Health:** Forcing children and adolescents to carry to term a pregnancy that is the result of criminal acts seriously damages the patients' physical, psychological and emotional health. Moreover, the continuation of the pregnancy may be incompatible with life plans of the pregnant woman. The access to comprehensive sexual and reproductive health, including emergency contraception, and the option to choose a safe and legal abortion, would contribute to the welfare of children and adolescents under these circumstances.

- **Criminalization of abortion:** The absolute criminalization of abortion on the grounds of rape by Ecuador, Guatemala, Nicaragua and Peru results is a serious violation of human rights, including the right to health. These restrictions interfere in decisions related to health and access to health services, education, and information; therefore, States should eliminate these restrictions.[1]

- **Biomedical Focus:** A biomedical focus that ignores the effect of unwanted pregnancies on mental and social health, particularly those resulting from rape, persists. This focus reflects a narrow interpretation of the right to health that does not address minors' health in a comprehensive manner, and results in more violence and discrimination.

- **Cycle of Poverty:** Pregnancies in girls and adolescents living in poverty or extreme poverty reinforces the cycles of poverty. Likewise, poverty affects the probability of becoming pregnant and entering into a vicious cycle because early motherhood often compromises academic performance and economic potential of the young women.

- **Access to Information:** States where research was conducted are not fulfilling their obligation to efficiently generate sufficient and complete information about violence against girls and adolescents and the impact on their sexual and reproductive health. This is an important barrier to developing public policies that address the human rights violations resulting from pregnancy among girls and adolescents.

Recommendations

To the Inter-American Commission on Human Rights

- Adopt the concept of the right to health care (physical, mental, and social health) as part of the framework of economic, social, and cultural rights of the Inter-American Commission on Human Rights.

- Raise the issue of forced motherhood and unplanned pregnancy in the agenda of the Unit on Economic, Social and Cultural Rights, in addition to the agenda of the Special Rapporteur on the Rights of Women and the Special Rapporteur on the Rights of the Child.

- Recommend that States decriminalize abortion in cases of sexual violence and have a broader interpretation of the right to health (according to international standards) so that girls and adolescents have the option to legally terminate pregnancy in these cases.

- During on-site visits to these countries, monitor the situation, including meetings with civil society organizations, such as PROMSEX-Peru,[1] Women Transforming the World-Guatemala,[2] Fundación Desafío-Ecuador,[3] and Axayacatl-Nicaragua,[4] as well as the different State entities.

To the Pan American Health Organization

- Continue to provide technical support and collaborate with the Inter-American Commission on Human Rights on respect, protection and promotion of the right to health.

- Monitor the impact of forced motherhood on adolescent victims of sexual violence on public health and human rights at the regional level.

To the States: Government of Ecuador, Guatemala, Nicaragua and Peru

- Provide comprehensive health care to girls and adolescent victims of sexual violence, taking into account the effects that pregnancy may have on their physical, mental and social health. This should include access to emergency contraception and legal abortion when a woman's life and/or health is at risk, early access to prenatal care services to detect early complications, and prenatal family planning counseling.

- Adopt a broader interpretation of the right to health to include the physical, mental and social components in the context of abortion because current interpretations are limited to physical health.

- Decriminalize abortion in cases of rape.

- Ensure the implementation of comprehensive sexuality education in all areas to broaden the horizons of girls and adolescents—especially education that empowers girls and increases their knowledge and management of sexual and reproductive rights.

- Construct and promote a path to legal care for girls and adolescent victims of sexual violence that is consistent with national law and international human rights standards.

- Train state agents both in the judicial sector and the medical sector in comprehensive care, with a focus on gender and human right perspectives for victims of sexual violence.

Country Executive Summaries

Ecuador

Background

In Ecuador, pregnancy among girls under 14 years old is a serious public health problem. The trend in the percentage of births among girls aged 10–14 has increased approximately 78.1% from 2002 to 2010 (INEC, 2010). Thousands of Ecuadorian girls under 14 are already mothers, in most cases as a result of rape. In 2010, a total of 3,864 girls under 14 years old became mothers due to sexual violence (INEC, 2010).

This research aims at studying, analyzing, and, above all, increasing awareness of a reality that the State seems to ignore. This study from Fundación Desafío [Challenge Foundation] highlights the major limitations this group of girls has to face: part of their lives have been robbed, and a different life has been imposed upon them—one they often cannot bear.

Objective

To identify in adolescent women under 14 years old the impact of pregnancy and maternity resulting from rape on the three dimensions of their health (physical, mental and social) and on the exercise of their human rights.

Methodology

This research was mainly approached from a qualitative perspective, emphasizing the experiences and feelings of girls/adolescent women, in order to understand more fully the effects on their overall health. The research was conducted in the city of Quito in 2014, gathering information through: 15 in-depth interviews with 14 year-olds; 8 semi-structured interviews with professionals from a public hospital and a care center: and, one in-depth interview with a psychologist who is an expert in sexual violence committed against minors. In addition, 139 medical records from mothers younger than 14 years old found in a public hospital's archive were reviewed.

Main Results

General Data

- According to clinical records reviewed, in 51% of the cases the fathers of the newborns were over 18.
- According to clinical records reviewed, 12% of adolescent women reported that their pregnancies were the product of sexual violence, of which 44% were the result of sexual abuse or rape committed by relatives.
- According to clinical records reviewed, 82% were unwanted/unplanned pregnancies.

Physical Health

- According to testimonies and clinical records reviewed, 71% of patients had pregnancy complications mainly related to anemia and urinary tract infections.
- A physician from the public hospital said that more than 80% of these births are resolved with C-sections.
- According to clinical records reviewed, 11.5% of newborns showed complications that also compromise their overall health.
- According to clinical records reviewed, 53% of patients were discharged with a subdermal implant in place.

Mental Health

- According to clinical records reviewed, 91.4% of cases reflected "symptoms of depression" and "adjustment disorder."
- According to testimonies, girls expressed feelings of fright, annoyance, fear, anger, horror, nervousness, pain, guilt, rage, stress, sadness, irritation, nuisance, trepidation, despair, frustration, anxiety, and depression and/or exasperation in relation to pregnancy, childbirth and maternity.

Social Health

- According to clinical records reviewed, 47% of girls reported they were dedicated to housework.
- According to clinical records reviewed, 33% of adolescent women only attended primary school.

12% of adolescent women reported that their pregnancies were the product of sexual violence.

Conclusions

This study offers a brief look at a very serious situation: pregnancy as the result of rape among girls under 14 years old. This situation has not received sufficient attention in terms of proposed interventions. It is clear that the effect on the overall health of these raped and impregnated girls is total. Although their mental health and social health are the most affected, their physical health is also threatened by the risks of pregnancy at such a young age and by complications that usually occur in greater proportion.

Forced motherhood among young adolescent women is also an issue of social justice. It is essential to emphasize that girls who face pregnancies at such an early age are those who live in situations of marginalization and vulnerability, given their age, class and gender. In addition, violence against them does not stop with motherhood; and, in some cases, it reappears in the form of another pregnancy, or inability to study. These situations force the women to live in a social limbo which they fail to leave, as this reality is inherent to the poverty in which they live.

Guatemala

Background

Sexual violence and pregnancy among girls is a growing problem in Guatemala. According to data from the Health Management Information System of the Guatemalan Ministry of Public Health and Social Assistance, there were 3,100 pregnancies among 10–14 year-old girls in 2012 only. This number rose to 4,220 among 10–14 year-old girls in 2013. And, in 2014 this number reached 5,100. For only the first 6 months of 2015, 2,953 cases were reported.

From 2012, there has been progress in identifying and reporting cases of rape among girls in the country. So far, the State's efforts have concentrated on criminal prosecution. This research study on the consequences of pregnancy among these young adolescent women aims at bringing efforts and providing evidence about the urgent need to ensure a comprehensive response of the State to sexual violence among girls.

Objective

To identify the impact of pregnancy on the physical, mental, and social health of pregnant girls aged 10–14 years.

Methodology

The prospective qualitative and quantitative study of the Observatory on Sexual and Reproductive Health (OSAR for its Spanish acronym), included research that followed 20 pregnant girls between the ages of 10–14 years from different areas of the country. The research methodology included: clinical follow-ups through prenatal visits, home visits, various interviews, and support given to girls and their families. In order to gain insight into the health impact of pregnancies among girls, cases where pregnancy resulted in death were also included in this research. The cases were documented by OSAR as part of its work.

Main Results

General Data

- More than 55% of the girls became pregnant at age 13.
- 65% of the girls were living with their partners. One of them was married.
- None of their partners were facing criminal proceedings.

Physical Health

- The impact on their physical health included preeclampsia, anemia, urinary tract infection, childbirth complications, intrauterine growth problems, premature birth and/or underweight newborns.
- 50% of the girls were less than 1.50 meters in height (5 inches), and, in 60% of these cases, weighed less than 45 kilograms (100 pounds) before pregnancy; both of these indicators are considered risk factors that may result in underweight babies.
- In 25% of the cases, newborns had low birth weight, which carries a risk of infant death during the first year of life, up to 14 times more than normal-weight newborns.

50% of girls were less than 1.50 meters in height.

Mental Health

- Sexual violence and pregnancy generated symptoms of depression, fear, sadness, anger, guilt, recurrent thoughts about the situation experienced, restlessness, fright, and shame.
- After the pregnancy, 100% of the girls were victims of violence, mainly psychological. However, they were also victims of physical, sexual and economic violence.
- 25% of the girls said that their parents had threatened to sexually abuse them in the past, or that they were previously abused by other men.

Social Health

- 15% of the girls have never attended school.
- Of all the girls who were at school, 88% left school after the pregnancy. Dropping out of school reduces employment opportunities, leaving the girls with the only choice—both present and future—of fulfilling the traditional roles of mother and housewife, and thus maintaining the poverty cycle.
- Only 25% of the girls had a steady job and earned the minimum wage.
- 90% of the girls were doing housework at the time of the interview.

Conclusions

For adolescent women under 15 years old included in the study, pregnancy was not the result of a deliberate decision. On the contrary, pregnancy in this group tended to be the result of the absence of adolescents' power to make decisions and of circumstances that are beyond their control. Early pregnancy reflects the erosion of power, poverty and pressure from family, peers and communities. And in these cases, it is the result of sexual violence. Girls have little autonomy—particularly those who are forced into marriage— and little power to make decisions about their future, their body and reproduction.

Many biological, economic and cultural factors (e.g., poverty, malnutrition, sexual violence, child marriage and gender inequalities) condition the life of a teenager through a pregnancy, putting her health, her personal fulfillment, and her life at risk. In contrast to general concerns related to sexual violence, the main problem among the group of adolescent women included in this study lies in the conceptualization of unions and early childbearing (specifically, early unions and the naturalization of violence by communities and families).

Nicaragua

Background

The women association AXAYACATL considers this situation a painful tragedy that affects not only the reproductive health and well-being of girls and adolescents, but also the internal dynamics of their families. Additionally, the situation has an undeniable impact on the pace and direction of the country's development as it prolongs cycles of poverty, social exclusion and inequality. Pregnancy in this age group is a public health problem because of its high frequency and serious consequences, and because it can be addressed with applicable preventive measures.

Objective

To identify the impact that pregnancy as a result of rape and statutory rape has on the three dimensions of health—physical, mental and social—and the lives of girls and adolescent women.

Methodology

This research has a mixed approach; it is a retrospective cohort epidemiological study. Data were collected from primary sources, such as interviews with 30 girls and adolescent women (aged 12–19 years from seven departments throughout the country), and secondary sources, such as personal documents containing medical information.

Main Results

General Data

- 93% of teen pregnancies were the result of rape and 7% of statutory rape.
- The rapists were identified only in one case (7%). In 92% of the cases, the person responsible for the pregnancy had some sort of relationship with the girl or adolescent woman: family, sentimental, spiritual guidance, educational guidance, neighbor, friendship or work.
- In 100% of the cases the pregnancy was unwanted. 50% tried to terminate the pregnancy.

Physical Health

- The adolescent women had complications during pregnancy, childbirth and postpartum: abortion, threatened abortion, anemia, gestational hypertensive syndrome, low maternal weight, emesis and hyperemesis gravidarum, urinary tract infection, postpartum hemorrhage and/or mastitis.
- Newborns had strabismus, neonatal hypocalcemia, and physiological jaundice and/or were in an incubator for 7 days.
- Of the 10 adolescent women who gave birth, 50% needed a c-section.
- 57% of the young women received counseling on contraception and 28.57% were given a contraceptive method before leaving the health facility (barrier methods and Depo-Provera).
- At the time of the interview, 90% of babies were found healthy.
- 79% did not receive sex education counseling and 43% did not receive nutritional guidance counseling.

Mental Health

- In 100% of the cases, participants reported having adverse feelings during pregnancy, including grief, sadness, crying, suffering, nightmares, sorrow, fear, laziness, weakness and/or isolation. In one of the cases, the psychological assessment details the presence of post-traumatic stress symptoms.
- 14% had suicidal thoughts.
- At the time of the interview, 7% reported being healthy and calm; 7% reported being healthy; 22% reported being healthy although they added feelings of sadness and moodiness; and 7% reported feeling ill.

93% of teen pregnancies were the result of rape.

- At the time of the interview, 57% reported having adverse feelings (i.e., distress, exhaustion, sadness, fear, frustration, insomnia, nervousness, worry, irritability, anger, headaches, hopelessness, oversleeping, nightmares, pain while breastfeeding, a state of dependency in which they are unable to make decisions, feelings of worthlessness and living a life without hope, and/or wanting to kill themselves).
- 35.71% said they got used to their new situation. 35.7% refers to feelings of love.
- One of the respondents (7.1%) gave the baby up for adoption. Another one (7.1%) said the newborn annoys her.

Social Health

- At the time of the crime, 64% of the respondents were in primary school and 14% were in high school.
- After the crime, 64% were neither studying nor working. Only 28.57% were studying and 7.1% were working.
- 50% referred to experiencing a worsening of their economic reality due to the situation.
- 85.7% receive no financial support from the father of the newborn.
- 78.57% receive support from their family, and 28.5% receive assistance from an institution.
- 78% of adolescent women have expectations regarding their future in the direction of self-improvement through study and work.
- 86% felt the stigma from their social environment.
- 100% of respondents are not pregnant again.
- 85.7% of cases are in some stage of court proceedings.
- In 14 cases, once the initial crime and the pregnancy have passed, violence continues in all its manifestations and severity, also including severe collateral damages that deepen the level of drama and tragedy.

85.7% receive no financial support from the father of the newborn.

Conclusions

On the one hand, the lives of these girls and adolescent women suffered a serious impact on the three dimensions of their health—physical, mental and social—making them victims of discrimination and torture. On the other hand, in most cases, neither the girls/adolescents nor their families had the minimum conditions for raising a child that is the product of rape; therefore their households became even more impoverished.

Experiencing rape and/or statutory rape, confirming a pregnancy, and giving birth to a child that is the product of the aforementioned violent acts constitute a succession of traumatic experiences for girls and adolescent women. Years after the event, they still show signs of post-traumatic stress syndrome. Once the crime and pregnancy have passed, and even if the victim is married to her abuser, the violence continues in all its manifestations and severity. There are also severe collateral damages that deepen the level of drama and tragedy.

There are subtle differences between victims of rape and statutory rape within this context, and these differences are based on whether the adolescent women could give their consent to sexual relations. Modern contraceptive methods that favor long-term adherence and prevent a second pregnancy are not offered. The lives of girls and adolescent women who are victims of sexual violence will never be the same, even if they go through a process of emotional recovery. These are, in fact, Stolen Lives.

Peru

Background

Teenage pregnancy is considered one of the most prevalent and important public health problems affecting Peruvian women. It mainly affects young people from segments of poverty and extreme poverty, especially from dysfunctional families. The Peruvian jungle is a particular case where the teen pregnancy rate is the highest and the number of pregnant women overall is comparatively higher than in other regions.

Objective

To analyze the impact that teen pregnancy has on the physical, psychological and social health of women younger than 18 years old.

Methodology

This qualitative and quantitative retrospective study had three stages: 1) interviews with 20 adolescent women under 15 years old and 20 adolescent women between the ages of 15 and 17 in 4 health facilities (General Maria Auxiliadora Hospital in Lima, National Hospital Daniel A Carrion in Callao, Support Hospital II in Piura, and Amazonian Hospital in Ucayali); 2) a review of clinical records; and 3) interviews with 21 health professionals who provide services to adolescents.

Main Results

General Data

- 87.8% of the adolescent women got pregnant as the result of voluntary sex, in most cases, with her partner or boyfriend (84.9%).
- 12% said the pregnancy was the result of rape; however, this situation was slightly more frequent among the 15–17 year-old group.
- 80% of adolescent women said their pregnancy was unplanned or unwanted. They were probably exposed to sex without using a contraceptive method; the method failed; they failed to maintain contraception continuity; or they were biased in relation to method use.
- Only 13.7% of adolescent women who became pregnant tried to terminate the pregnancy. However, most of them accepted the situation.

Physical Health

- 89% of pregnant adolescents received institutionalized prenatal care.
- 63.31% had complications, mainly urinary tract infections, hypertensive disorders related to pregnancy, nauseas and vomiting, vaginal infections, anemia and premature rupture of membranes.
- Only 57.55% received some form of contraception at the time of hospital discharge with the quarterly injection being the method that was most often delivered (almost 30% of this group).
- Of the 139 adolescents interviewed, 17 were pregnant again (12.2%).

Mental Health

- 55% reported having some form of emotional distress (fright, fear, worry or anxiety). At the time of the interview, the majority said they felt calm and healthy, but 35% of the young women continued to experience some form of depression, perhaps because the support they were receiving was not enough to cope with such a demanding situation.

Of the 139 adolescents interviewed, 12.2% were pregnant again.

- Just over 6% of adolescent women tried to commit suicide at some time by taking rodenticides, insecticides or inflicting cuts on their body. This situation expresses an extreme form of depression.

- One-fourth of adolescent women feel they should take care of the infant; another 25% said they feel happy and content; 36% have feelings of love for the child, and 15% experience feelings of little affection, do not accept, or very reluctantly the child.

Social Health

- Most children born from the adolescent women (62%) lived with the family of the mother, father or other relatives.

- 75% receive financial support from the father of the child, which is often scarce. The family of the adolescent woman or of her partner (93.53%) provides resources and/or hosts her and the child.

- A high proportion of these adolescent women (43.9%) have not completed secondary school.

- 78% left school due to the pregnancy and 94% do not work outside their house, because they are engaged in housework. These results, in conjunction with the restricted financial support given by their family or their partner, greatly limit the development of a life project in these young women, and prolongs the poverty circle in which they live.

- More than 60% of adolescent women have expectations of continuing their studies (and even having a technical or professional career) and 17% want to work.

- Adolescent women said they felt stigmatized due to their pregnancies: 25% felt the stigma coming from health personnel, 24% from relatives and 27% from their social environment.

- 66% of interviewed health professionals said that health personnel hold prejudices or stigmatize pregnant adolescents, and 58% said that family members stigmatize or have prejudices against these adolescents.

Adolescent women said they felt stigmatized due to their pregnancies.

Conclusions

While the study focused on three regions of Peru, data collected therein facilitate understanding of the impact on adolescent women's health beyond the specific geography; the pattern of many adolescent women is the same at a national scale in terms of socio economic level, education, and vulnerability in relation to violence. Pregnant teenagers come mostly from popular classes, where poverty and extreme poverty prevail.

There is still a very large importance given to biomedical diagnostic that focuses on physical health, leaving aside the mental and social components. Additionally, there is little recognition of adolescents' human rights. Broad sectors of society continue to think that early pregnancy is not their concern.

It is essential to move towards developing standards that surpass the biomedical approach and reach beyond maternal mortality in order to make way for a better understanding of the mental and social health and human rights of adolescents; unfortunately, these aspects are still far from the commitments of those who have obligations and hold guarantees.

Endnotes

Executive Summary

1 Center for Reproductive Rights. Leyes sobre aborto en el mundo de 2014 (2014, September 18). Retrieved from ***http://www.reproductiverights.org/es/document/leyes-sobre-aborto-en-el-mundo-de-2014***

2 Name changed to protect the identity of the victim and her family.

3 Name changed to protect the identity of the victim and her family.

4 Name changed to protect the identity of the victim and her family.

5 Taken from the Stolen Lives in Guatemala research results.

6 The Obudsman Office of Guatemala is a public institution created by constitutional mandate, dedicated to advising and consulting State entities that, through the Attorney General's Office, are in charge of the legal representation of the State of Guatemala, minors and people deemed legally incompetent, with strict adherence to the law and due process.

7 Guatemala City is approximately 8 hours from Ana's home.

8 Name changed to protect the identity of the victim and her family.

9 Name changed to protect the identity of the victim and her family.

Introduction

1 Throughout the study, we use the term "adolescent minors" when referring to adolescents under the age of 15.

2 Ecuador Estadístico Instituto Nacional de Estadística y Censos (INEC). (2012). Retrieved from ***http://www.inec.gob.ec/estadisticas/***

3 UNFPA. SI Mujer, Cairo+20 – Nicaragua National Diagnosis 1994-2012.

4 Data from the health information management system (SIGSA) of the Guatemalan Ministry of Public Health and Social Services (MSPAS) shows that in 2012 alone, 3,100 pregnancies were reported in girls 10 to 14 years old. This number continued to increase, with 4,220 births reported in 2013, and 5,100 reported in 2014. See: Monitoring report conducted by the OSAR national network, March 2015 ***www.osarguatemala.orghttp://www.osarguatemala.org***

5 For more information, see data from ENDES ***https://dhsprogram.com/pubs/pdf/FR299/FR299.pdf*** and corresponding press release from Peru21, *Mil niñas de 12 y 13 años se convierten en madres cada año en el Perú*, 26 September 2015. ***http://peru21.pe/actualidad/cada-ano-mil-ninas-12-y-13-anos-se-convierten-madres-2228392***

6 According to the World Health Organization (WHO), adolescence is defined as the life stage of an individual between 10 and 19 years old. In some cases, adolescence is interrupted when a youth becomes pregnant. One in five women worldwide will have a child before turning 18 years old, and 16 million births to adolescent mothers happen every year.

7 Leppälahti, S., Gissler, M., Mentula, M., & Heikinheimo, O. (2013). Is teenage pregnancy an obstetric risk in a welfare society? A population-based study in Finland, from 2006 to 2011. BMJ open, 3(8), e003225. See also:, Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., ... & Vogel, J. P. (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study.

8 Global Doctors for Choice/Colombia. (2012). El embarazo adolescente: Afectación de la salud y garantía de los derechos. Documento de posición. [Online]. ***http://www.clacaidigital.info:8080/xmlui/bitstream/handle/123456789/442/Adolescentes.pdf?sequence=1&isAllowed=y***

9 Decree number 09-2009 of the Congress of the Republic of Guatemala, Law against sexual violence, exploitation, and human trafficking, reformed the Penal Code, Decree number 17-73 of the Congress of the Republic of

Guatemala, Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 173 Bis was added to this legal text, establishing that: "…the crime of rape is always committed if the victim is a person under fourteen years of age". Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 173 of the Penal Code of Peru states: "Sexual violation of a minor under fourteen: he who has vaginal, anal, or oral sexual relations, or other analogue acts, including inserting foreign objects or body parts vaginally or anally, with a minor under the age of fourteen will be subject to the following penalties…" Available at: ***http://perso.unifr.ch/derechopenal/assets/files/legislacion/l_20130308_04.pdf***. In Nicaragua, sexual relations with a minor under the age of fourteen constitutes statutory rape. Art. 168 of the Penal Code of Nicaragua states, "Rape of minors under the age of fourteen. Whomsoever has sexual relations with or makes available for such relations a person under the age of fourteen, or whomsoever introduces or obligates them to introduce finger, object, or instrument vaginally, anally, or orally, with or without the minor's consent, will be sanctioned with a penalty of twelve-fifteen years in prison". In Ecuador, sexual relations with a minor under the age of fourteen is considered sexual abuse. Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 171 of the Penal Code of Ecuador states, "The person that, against the will of the other, forces themselves upon them or obligates them to realize, with themselves or another person, a sexual act, without the necessity of penetration or sexual intercourse, will be punished and deprived of their liberty for three to five years. When the victim is a minor under the age of fourteen…"

10 Gómez, P. I., Molina, R., & Zamberlin, N. (2011). Factores relacionados con el embarazo y la maternidad en menores de 15 años en América Latina y el Caribe. T. O. Távara (Ed.). Promsex.

11 *Violaciones sexuales en el Perú 2000-2009* (Infographic Déjala Decidir)

12 García-Suarez, 2006; Rico, 1996 (Infographic Déjala Decidir)

13 Ministry of Women´s Affairs Peru (Infographic Déjala Decidir)

14 *Supra note* 4

15 Apuntes para la acción: El derecho de las mujeres a un aborto legal, 2007 (Infographic Déjala Decidir)

16 Ministry of Women´s Affairs Peru (Infographic Déjala Decidir)

17 UNFPA

18 Data from the health information management system (SIGSA) of the Guatemalan Ministry of Public Health and Social Services (MSPAS) shows that in 2012 alone, 3,100 pregnancies were reported in girls between 10 and 14 years old. This number continued to increase, with 4,220 births reported in 2013, and 5,100 reported in 2014. See: Monitoring report conducted by the OSAR national network, March 2015 ***www.osarguatemala.org***

19 Ecuador Estadístico Instituto Nacional de Estadística y Censos (INEC). (2012). [Online] ***http://www.inec.gob.ec/estadisticas/***

20 Gómez, P. I., Molina, R., & Zamberlin, N. (2011). Factores relacionados con el embarazo y la maternidad en menores de 15 años en América Latina y el Caribe. T. O. Távara (Ed.). Promsex.

21 Gómez, P. I., Molina, R., & Zamberlin, N. (2011). Factores relacionados con el embarazo y la maternidad en menores de 15 años en América Latina y el Caribe. T. O. Távara (Ed.). Promsex.

22 Center for Reproductive Rights. Leyes sobre aborto en el mundo de 2014 (2014, September 18)[Online]. ***http://www.reproductiverights.org/es/document/leyes-sobre-aborto-en-el-mundo-de-2014***

23 For example, in 2009, following a lawsuit filed by a religious organization, the Peruvian constitutional court changed its position on emergency contraception pills (EC), prohibiting the free distribution of Levonorgestrel–one of the components of the emergency contraception pills- within public health services, while continuing to allow its sale in pharmacies. This left emergency contraception out of reach for low income women and women living in areas of the country where pharmacies are scarce and often under-stocked.

24 Penal Code Art. 120. (Peru) "The abortion will be punished with imprisonment of not more than three months: 1. When the pregnancy was the result of rape that occurred outside of marriage or of non-consensual artificial insemination that occurred outside of marriage, provided that the facts have been reported or investigated, at minimum by the police; or 2. When it is likely that the fetus in formation will be born with serious physical or mental defects, only after fully proven via a medical diagnosis".

25 Center for Reproductive Rights. Leyes sobre aborto en el mundo de 2014 (2014, September 18). Retrieved from ***http://www.reproductiverights.org/es/document/leyes-sobre-aborto-en-el-mundo-de-2014***

26 Ecuador Organic Penal Code (COIP). Art. 150: "Law violence against women and law reform N. 641, "Penal Code" (Law 779) states "Legal abortion: Abortion realized by a doctor or other trained medical professional with the full consent of the pregnant woman or, if she is unable to grant consent, her spouse, partner, next of kin, or legal representative, will not be penalized in the following cases: …2. If the pregnancy is the result of the rape of a woman with mental disabilities".

27 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 119 of the Peruvian Penal Code: "An abortion realized by a doctor with the full consent of the pregnant woman will not be penalized if it is the only way to save the life of the woman or to avoid serious and permanent damage". Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 137 of the Guatemalan Penal Code: "An abortion will not be penalized if it is realized by a doctor with the full consent of the pregnant woman, and with the favorable opinion of at least one additional physician; if it was realized without the direct intention of the death of the product of conception and with the only intention being to avoid danger, previously established, to the life of the mother after all other options have been exhausted. Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012. 150 of the Ecuadorean Organic Penal Code (COIP): "Legal abortion. - Abortion realized by a doctor or other trained medical professional with the full consent of the pregnant woman or, if she is unable to grant consent, her spouse, partner, next of kin, or legal representative, will not be penalized in the following cases: 1. If there is danger to the life of the pregnant woman and if this danger cannot be resolved by other methods. 2. If the pregnancy is the result of the rape of a woman with mental disabilities".

28 Penal Code Art ?? (Nicaragua) "For legal purposes, therapeutic abortions will be determined scientifically, with the involvement of at least three physicians, and the consent of the spouse or next of kin". Available at: ***http://cyber.law.harvard.edu/population/abortion/Nicaragua.abo.htm***

29 Nicaraguan Society of Gynecology and Obstetrics (SONIGOB), defines therapeutic abortion as "the termination of a pregnancy when the physician's criteria have been met and at least one of the following conditions are present: 1. If the life or health of the woman is compromised; 2. If the fetus presents physical or mental malformations incompatible with life; 3. In cases of rape, incest, or statutory rape".

30 Paola Bergallo y Ana Cristina González Vélez. *Interrupción legal del embarazo por la causal violación: enfoques de salud y jurídico*, 2012

31 Committee against Torture, *Concluding Observations: Nicaragua*, paragraph. 16, UN Document CAT/C/NIC/CO/1 (2009). See also: *Informe del Relator Especial sobre la tortura y otros tratos o penas crueles, inhumanos o degradantes*, Juan E. Méndez, 1st of February, 2013. Available on: ***http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A-HRC-22-53_sp.pdf***

32 Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos, PROMSEX-Peru, Fundación Desafío-Ecuador, AXAYACATL-Nicaragua y OSAR-Guatemala

33 Dr. Luis Távara (PROMSEX); Dr. Héctor Fung (OSAR); Dra. Ligia Altamirano (AXAYACATL); Paula Castello y Virginia Gómez de la Torre (Fundación Desafío)

Part 1

1 "As a mother, I did try to get her to abort, because she's still so young. She tried to kill herself because of her lover. She swallowed rat poison." Testimony of the mother of Mafalda, 14 years old, Sullana, Peru.

2 Testimony obtained via the research of Stolen Lives in Nicaragua, 2015.

3 Testimony obtained via the research of Stolen Lives in Nicaragua, 2015.

4 "My daughter's sexual relations were not consensual. You see, she was raped by a cousin of mine. I told her to get rid of the pregnancy, because he's locked away in prison. I reprimanded her, I asked her why did she let it happen, why didn't she defend herself instead of letting herself be raped". Testimony of the godmother of a minor under the age of fourteen in Sullana, Peru. Taken from the research of Stolen Lives in Peru, 2015.

5 Gómez PI, Molina R, Zamberlin N, & Távara L. (2011). Factores relacionados con el embarazo y la mortalidad en menores de 15 años en América Latina y El Caribe. Lima: Federación Latinoamericana de Sociedades de Obstetricia y Ginecología, 86.

6 Conde-Agudelo, A., Belizán, J. M., & Lammers, C. (2005). Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. American Journal of Obstetrics and Gynecology, 192(2), 342-349.

7 Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., . . . Mori, R. (2014). Pregnancy and childbirth outcomes among adolescent mothers: A World Health Organization multicountry study. *BJOG: An International Journal of Obstetrics & Gynaecology BJOG: Int J Obstet Gy*, 121, 40-48.

8 Beck, A. T., Steer, R. A., & Brown, G. K. (1993). *Beck Depression Inventory: Manual*. San Antonio, TX: Psychological.

9 Ginsburg, G., Baker, E., Mulaney, B., Barlow, A., Goklish, N., Hastings, R., . . . Walkup, J. (2008). Depressive symptoms among reservation-based pregnant American Indian adolescents. *Maternal and Child Health Journal*, 12(Suppl 1). Siegel, R. S., & Brandon, A. R. (2014). Adolescents, Pregnancy, and Mental Health. *Journal of Pediatric and Adolescent Gynecology*, 27(3), 138-150.

10 Kabir, K., Sheeder, J., & Stevens-Simon, C. (2008). Depression, Weight Gain, and Low Birth Weight Adolescent Delivery: Do Somatic Symptoms Strengthen Or Weaken the Relationship? *Journal of Pediatric and Adolescent Gynecology*, 21(6), 335-342.

11 Deal, L. W., & Holt, V. L. (1998). Young maternal age and depressive symptoms: Results from the 1988 National Maternal and Infant Health Survey. *Am J Public Health American Journal of Public Health*, 88(2), 266-270.

12 Figueiredo, B., Pacheco, A., & Costa, R. (2007). Depression during pregnancy and the postpartum period in adolescent and adult Portuguese mothers. *Archives of Women's Mental Health Arch Womens Ment Health*, 10(3), 103-109.

13 Gavin, A. R., Lindhorst, T., & Lohr, M. J. (2011). The Prevalence and Correlates of Depressive Symptoms Among Adolescent Mothers: Results from a 17-Year Longitudinal Study. *Women & Health*, 51(6), 525-545.

14 Bissell, M. (2000). Socio-economic outcomes of teen pregnancy and parenthood: A review of the literature. *Canadian Journal of Human Sexuality*, 9(3), 191-204.

15 Byrne, D. M., Myers, S. C., & King, R. H. (1991). Short term labour market consequences of teenage pregnancy. *Applied Economics*, 23(12), 1819-1827. Corcoran, J. (1998). Consequences of Adolescent Pregnancy/ Parenting. *Social Work in Health Care*, 27(2), 49-67.

16 Buvinić, M. (1997). Women in Poverty: A New Global Underclass. *Foreign Policy*, (108), 38.

17 Engle, P. L., & Smidt, R. (1996). Consequences of women's family status for mothers and daughters in Guatemala. Technical Report, Population Council, New York/International Center for Research on Women Series.

18 Rico, J. & Atkin L. (1995). De abuela a madre, de madre a hijos: Repetición intergeneracional del embarazo adolescente y la pobreza. Report prepared under the Population Council/ICRW joint program, "Family Structure, Female Headship and Maintenance of Families and Poverty." New York and Washington, D.C.: The Population Council and ICRW.

19 Buvinić, M. (1997). Women in Poverty: A New Global Underclass. *Foreign Policy*, (108), 38.

20 Nova Scotia, Department of Community Services. (1991). Mothers and Children: One Decade Later. A Follow-up Study to Vulnerable Mothers, Vulnerable Children. Halifax: Department of Government Services.

21 Hotz, V.J., McElroy, S.W., & Sanders, S.G. (1997). The costs and consequences of teenage childbearing for the mothers and the government. In: Maynard, R.A. (ed.). Kids Having Kids. Washington, DC: The Urban Institute Press: 55-94.

22 Paranjothy, S., Broughton, H., Adappa, R., & Fone, D. (2009). Teenage pregnancy: Who suffers? Archives of Disease in Childhood, 94(3), 239-245.

23 Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002). Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. *Develop. Psychopathol. Development and Psychopathology*, 14(1), 179-207.

24 Bradshaw, J. (2005) Child poverty and deprivation, in J.Bradshaw, and E. Mayhew (eds.) The well-being of children in the United Kingdom, London: Save the Children.; Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002). Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. Develop. Psychopathol. Development and Psychopathology, 14(1), 179-207.

Part 2

1 S was 14 years old when she gave birth, 13 years old when she became pregnant, and 15 years old when we conducted the interview.

2 Name changed to protect the identity of the victim and her family.

3 The information of the shelter has been omitted to protect the privacy of the minor and her surroundings.

4 National Child and Family Institute (INFA), part of the Ministry of Economic and Social Inclusion (MIES) of Ecuador ***http://www.inclusion.gob.ec/***

5 Ibid.

6 The National Specialized Police Directorate for Children and Adolescents (DINAPEN) is a program of the National Police of Ecuador focused on developing plans, programs, and projects for prevention, intervention, and training to benefit children and adolescents. ***http://www.policiaecuador.gob.ec/dinapen/***

7 Name changed to protect the identity of the victim and her family.

8 The Congress of the Republic of Guatemala, in accordance with its monitoring duties, and in partnership with the Faculty of Medicine at the Universidad de San Carlos de Guatemala, the Health and Medical Faculty of the Universidad Mariano Gálvez, the Instituto Universitario de la Mujer of USAC, the Instancia por la Salud y el Desarrollo de las Mujeres, the Colegio de Médicos y Cirujanos, the Association of Women Doctors (AGMM) and the Guatemalan Association of Gynecology and Obstetrics (AGOG) promoted the creation of a reproductive health observatory (OSAR), with the purpose of monitoring and overseeing the implementation of public policies related to reproductive health. OSAR bases its work on a foundation of systematic follow-up, and the application of toolkits to create a set of indicators and collect data that facilitates the production of timely and quality information on the advances and challenges of the policy implementation processes.

9 Secretary against Sexual Violence, Human Trafficking and Exploitation (SVET), an entity connected to the Vice-Presidency of the Republic of Guatemala whose objective is to eradicate sexual violence, human trafficking and exploitation, and mistreatment of minors, as well as the impunity commonly associated with these issues, with the timely and efficient intervention of public institutions. ***http://svet.vicepresidencia.gob.gt/***

10 Name changed to protect the identity of the victim and her family.

11 This statement was taken during the Stolen Lives research in Guatemala, and was given by the assistant prosecutor of Chisec, who stated that an investigation is not begun until the family and the victim arrive in person to file a complaint.

12 Taken from the research results of Stolen Lives in Guatemala.

13 The Obudmsan Office of Guatemala is the public institution created by constitutional mandate and dedicated to the assessment and advising of state-level organizations and entities, and that legally represents the State of Guatemala, as well as underage minors and handicapped individuals as defined by the law, via the Attorney General, with strict adherence to legal issues and due process. ***http://www.pgn.gob.gt/***

14 Leadership of the National Civil Police of Guatemala (Dirección General de la Policía Nacional Civil) ***http://www.pnc.gob.gt/***

15 Taken from the Stolen Lives in Guatemala research results.

16 For more information, visit: ***https://www.renap.gob.gt/***

17 Name changed to protect the identity of the victim and her family.

18 Name changed to protect the identity of the victim and her family.

19 Taken from the research conducted by Stolen Lives in Nicaragua. Due to privacy concerns, we have omitted the case reference number, as the case is still under investigation.

Part 3

1 Presidential Decree No. 620, National Plan to Eradicate Gender based Violence among Children, Adolescents and Women (2007).

2 Ministry of Public Health of Ecuador, Norms and Protocols to Provide Comprehensive Care for Victims of Gender-based domestic and sexual violence during the life cycle.

3 Ministry of Education Ecuador, Agreement N. 340-11 (2008)

4 Constitution of the Republic of Ecuador, Official Registry # 449 (2008)

5 Constitution of the Republic of Ecuador, Art. 362

6 Constitution of the Republic of Ecuador, 37 & 39

7 Constitution of the Republic of Ecuador, Art. 32

8 Constitution of the Republic of Ecuador, Art.362

9 Constitution of the Republic of Ecuador, Art. 264, 286 & 298

10 National Secretariat for Planning and Development, National Plan of Well-being, 2013-201. Objective 6, Policy 6.7., ***http://documentos.senplades.gob.ec/Plan%20Nacional%20Buen%20Vivir%202013-2017.pdf***

11 Comprehensive Organic Penal Code, Official Registry No. 180. Second Chapter. Crimes Relating to the Re Right to Freedoms. Second Section. First Paragraph. Crimes relating to violence against women or family members, Arts. 155-159

12 Organic Health Law, Law 67, Supplement Official Registry 423 (2006), Art. 21

13 Organic Health Law, Law 67, Supplement Official Registry 423 (2006), Art. 32

14 Children and Adolescents Code. Law 100. Official Registry 737 (2003), Art. 27

15 The Social Development Law defines reproductive health as "a general state of physical, psychological, personal, and social well-being in all aspects related to human sexuality, with the functions and processes of the reproductive system, with a sexual life of personal dignity, and the personal life choices that lead to the enjoyment of a pleasurable and risk free sex life, as well as the decision to procreate or not and to decide when and how often, in a responsible manner".

16 Plan. (2012). *Study Regarding International and National Norms in Favor of Girls and Adolescents* (p. 91). [Online]. ***http://bibliotecaplan.org/wp-content/uploads/2013/12/Normativa-a-favor-de-las-ni%C3%B1as.pdf***

17 This is an indicator system for civil society to evaluate the State's compliance with the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women "Convention of Belém do Pará" (SIBDP).

18 CF. Chejter, Silvia, et a. (1999). *Law 25.087, Reform Penal Code Regarding Crimes Against Sexual Integrity* (pg. 8). Centro de Encuentros Cultura y Mujer y del Centro Municipal de la Mujer del Municipio de Vicente López.

19 Third Report of the Criminal Courts in crimes of Femicide and other Forms of Violence against Women, Sexual Violence, Exploitation and Trafficking in Persons, 18 -19 (June 2013- June 2014)

20 Constitution of Nicaragua, Art. 23. [Inviolability of the right to life] The right to life is inviolable and inherent to each human being. The death penalty does not exist in Nicaragua.

21 Constitution of Nicaragua, Art. 59. [Right to health] Nicaraguan citizens all have an equal right to health. The State will establish basic conditions for the promotion, protection, recuperation, and rehabilitation of health. It is the State's responsibility to direct and organize the programs, services, and actions necessary for health, and to promote popular participation in the defense of the same. Citizens have the obligation to comply with the health measures put in place.

22 Violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 1

23 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 2

24 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 12

25 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 15

26 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 16

27 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 24

28 Title V: Responsible Organizations in the Area of Violence against Women. Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012

29 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 46

30 Law violence against women and law reform N. 641, "Penal Code" (Law 779). 26th of January 2012, Art. 4

31 Family Code. Law 870. Approved on 24 June 2014 Published in La Gaceta No. 190 8 October 2014

32 Family Code. Law 870. Approved on 24 June 2014 Published in La Gaceta No. 190 8 October 2014, Art. 32

33 Family Code. Law 870. Approved on 24 June 2014 Published in La Gaceta No. 190 8 October 2014, Art. 316

34 Family Code. Law 870. Approved on 24 June 2014 Published in La Gaceta No. 190 8 October 2014, Art. 53 cited as an example, defining marriage as the "voluntary union between a man and a woman".

35 Penal Code of Nicaragua. Law 641. Article 143. Approved on 16 November, 2007.

36 Penal Code of Nicaragua. Law 641. Article 143. Approved on 16 November, 2007.

37 Penal Code of Nicaragua. Law 641. Article 143. Approved on 16 November, 2007.

38 Penal Code of Nicaragua. Law 641. Article 143. Approved on 16 November, 2007.Law 641.

39 Committee on Civil and Political Rights (94th session. CCPR/C/NIC/CO/3); Committee on Economic, Social, and Cultural Rights (41st session. E/C.12/NIC/CO/4); Committee against Torture (42nd session. CAT/NIC/CO/1); Committee on the Elimination of Discrimination against Women (CEDAW) (37th session. CEDAW/C/NIC/CO/6); Committee on the Rights of the Child (55th session. CRC/C/NIC/CO/4).

40 Letter dated 10 November 2006, from Victor Abramovich and Santiago A. Canton to Norman Calderas Cardenal, Nicaraguan Foreign Minister.

41 Peruvian Penal Code, Legislative Decree N° 635, signed on 3 April 1991 and enacted on 8 April 1991.

42 Peruvian Penal Code. Art. 120, paragraph. 2.

43 (2015, May 29). Dejala Decidir - aborto en el Perú. Articulacion Femenista Marcosur. Retrieved from ***http://www.mujeresdelsur-afm.org.uy/105-uncategorised/381-dejala-decidir-aborto-en-peru***

44 This guide was published on 28 June 2014 in the official newspaper El Peruano and went into effect on 29 June 2014.

45 (2014, June 27). Minsa presento guia tecnica para aplicar aborto terapeutico. El Comercio. Retrieved from ***http://elcomercio.pe/lima/sucesos/minsa-presento-guia-tecnica-aplicar-aborto-terapeutico-noticia-1739222***

46 National Secretariat for Planning and Development, National Plan of Well-being,9-1. Objective 6, Policy 6.7., ***http://documentos.senplades.gob.ec/Plan%20Nacional%20Buen%20Vivir%202013-2017.pdf***

47 Instituto Nacional de Estadistica e Informatica. (2014). *Encuesta Demográfica y de Salud Familiar – ENDES*. Retrieved from ***http://proyectos.inei.gob.pe/endes/***

48 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica.[Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

49 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica (pg.6).[Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

50 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica (pg.1).[Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

51 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica (pg.17).[Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

52 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica (pg.18).[Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

53 IACHR, Access to Justice for Women Victims of Sexual Violence in the Americas, 18.

54 Mujica, J.(2011). *Violaciones sexuales en Perú 2000 – 2009. Un informe sobre el estado de la Situación*.

55 Mujica, J.(2011). *Violaciones sexuales en Perú 2000 – 2009. Un informe sobre el estado de la Situación*.

56 Committee on the Elimination of Discrimination against Women, Concluding observations on the combined seventh and eighth periodic reports of Peru, CEDAW/C/PER/CO/7-8. 24 July 2014.

57 IACHR. (2011). Access to Justice for Women Victims of Sexual Violence in Mesoamerica.the Americas, 8, 10.

58 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica., Access to Justice for Women Victims of Sexual Violence in the Americas, 185.

59 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica. [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

60 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica. [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

61 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica. [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

62 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica. [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

63 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica(pg.142). [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

64 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica(pg.143). [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

65 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica(pg.176). [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

66 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica(pg.14). [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

67 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica(pg.205). [Online]. ***https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf***

68 Ipas Centroamerica. (2011). Mujeres víctimas-sobrevivientes de violencia sexual y sus experiencias con los servicios de salud disponibles en Guatemala.

69 Ipas Centroamerica. (2011). Mujeres víctimas-sobrevivientes de violencia sexual y sus experiencias con los servicios de salud disponibles en Guatemala.

70 PAHO Understanding and addressing violence against women. [Online].***http://www.paho.org/hq/index.php?option=com_content&view=article&id=8165%3A2013-understanding-addressing-violence-against-women&catid=1505%3Aabout-us&lang=en***

71 PAHO.(2014).Understanding and addressing violence against women. [Online].***http://www.paho.org/hq/index.php?option=com_content&view=article&id=8165%3A2013-understanding-addressing-violence-against-women&catid=1505%3Aabout-us&lang=en***

72 IACHR. (2011)., Access to Justice for Women Victims of Sexual Violence in Mesoamerica

73 Ipas Centroamerica. (2011). Mujeres víctimas-sobrevivientes de violencia sexual y sus experiencias con los servicios de salud disponibles en Guatemala.

74 Stolen Lives, Research Report Nicaragua.

75 Stolen Lives, Final Report , Ecuador.

76 Stolen Lives, Final Report , Ecuador.

77 Bergallo, Paola, & Ana Cristina González Vélez. *Interrupción legal del embarazo por la causal violación: enfoques de salud y jurídico*. 2012

78 Maniglio, R. (2009). "The Impact of Child Sexual Abuse on Health: A Systematic Review of Reviews Sexual Violence Research Initiative". *Clinical Psychology Review*, 29, 647-657. [Online]. ***http://www.svri.org/MentalHealthResponse.pdf***

79 World Health Organization. (2002). *World Report on Violence and Health*. [Online]. ***http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf***

Part 4

1 IACHR - Inter-American Commission on Human Rights, (201l). *Acceso a la justicia para las mujeres víctimas de violencia sexual: la educación y la salud* [Online]. ***http://www.oas.org/es/cidh/mujeres/docs/pdf/VIOLENCIASEXUALEducySalud.pdf***

2 Cabrera Muñoz, Patricia (2011).*Intersecting Violence: A Review of Feminist Theories and Debates on Violence Against Women in Latin America*. CAWN.

3 Rosendo Cantú et al v. Mexico, Inter-American Court of Human Rights. (2010), August 31.]. ***http://www.corteidh.or.cr/docs/casos/articulos/seriec_216_esp.pdf***

4 Women's Link Worldwide Gender Justice Observatory. [Online]. ***http://www.womenslinkworldwide.org/wlw/new.php?modo=observatorio&id_decision=358***

5 Inter American Human RIghts Court. (18 September 2015) *Sentencing in the Case of Girl with HIV from Sexual Assault* [Online]: ***http://www.corteidh.or.cr/docs/comunicados/cp_32_15.pdf***

6 Women's Link Worldwide Gender Justice Observatory. *Caso B.S. v. España [B.S. v. Spain]*, Judgment 24 July 2012. [Online]: ***http://www.womenslinkworldwide.org/wlw/new.php?modo=observatorio&id_decision=445***

7 Women's Link Worldwide Gender Justice Observatory. [Online]: ***http://www.womenslinkworldwide.org/wlw/new.php?modo=observatorio&id_decision=445***

8 CEDAW Committee (1992, 29 of January). *General Recommendation Nº 19: Violence against women. 11º session, A/47/38, paragraph 1*. [Online]: ***www.amdh.org.mx/mujeres3/CEDAW/docs/Recom_grales/19.pdf***

9 CEDAW Committee (1992, 29 of January). *General Recommendation Nº 19: Violence against women. 11º session, A/47/38, paragraph 6*. [Online]: ***www.amdh.org.mx/mujeres3/CEDAW/docs/Recom_grales/19.pdf***

10 Organization of American States. (5 March 1995). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women*. [Online]: ***http://www.oas.org/juridico/spanish/tratados/a-61.html***

11 Organization of American States. (5 March 1995). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women*. [Online]: ***http://www.oas.org/juridico/spanish/tratados/a-61.html***

12 Organization of American States. (5 March 1995). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women*. [Online]: ***http://www.oas.org/juridico/spanish/tratados/a-61.html***

13 Organization of American States. (5 March 1995). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women*. [Online]: ***http://www.oas.org/juridico/spanish/tratados/a-61.html***

14 K was a victim of sexual violence beginning at the age of 8, and she gave birth at 14. Planned Parenthood Global met her in a shelter and took her testimony. Although retrospective, it is very helpful in understanding the impact that her pregnancy at 14 has had on K, now 17 years old.

15 UNICEF. (2014). *Hidden in Plain Sight: A Statistical Analysis of Violence against Children*. [Online]. ***http://www.unicef.org/publications/files/Hidden_in_plain_sight_statistical_analysis_Summary_EN_2_Sept_2014.pdf***

16 4 in Peru, 2 in Guatemala, 4 in Ecuador, and 13 in Nicaragua

17 Pan American Health Organization. (2013). *Violence Against Women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries* (pg. 6).

18 K was a victim of sexual violence beginning at the age of 8, and she gave birth at 14. Planned Parenthood Global met her in a shelter and took her testimony. Although retrospective, it is very helpful in understanding the impact that her pregnancy at 14 has had on K, now 17 years old.

19 Ipas. (2003). *Violence, Pregnancy, and Abortion: Women's Rights and Public Health Issues*.

20 The Center for Reproductive Rights is a United States based organization dedicated to the defense and promotion of reproductive rights worldwide. ***http://www.reproductiverights.org/es***

21 United Nations Population Fund. (1994). *International Conference on Population and Development. Programme of Action*. [Online]: ***http://www.unfpa.org/publications/international-conference-population-and-development-programme-action***

22 PanAmerican Health Organization (2007). *Health in the Americas 2007* (Volume I, pg. 143). Washington, DC: PanAmerican Health Organization.

23 PanAmerican Health Organization (2007). *Health in the Americas 2007* (Volume I, pg. 143). Washington, DC: PanAmerican Health Organization.

24 BBC World. (2005), The Tragedy of Pregnant Girls from Sexual Assault [*La tragedia de las niñas embarazadas por violaciones en América Latina*]. [Online]. ***http://www.bbc.com/mundo/noticias/2015/05/150512_america_latina_embarazos_ninas_violadas_vs***

25 National Statistics and Census Institute (INEC) of Ecuador. (2011). *National Survey of Familial Relationships and Gender Based Violence 2011*.[Online]. ***http://anda.inec.gob.ec/anda/index.php/catalog/94***

26 Gonzalez, Ana Cristina. (2008). *Casual Health: Legal Interruption of Pregnancy, Ethics, and Human Rights. Causal Salud: Interrupción Legal del Embarazo, Ética y Derechos Humanos*. [Online]. ***http://cotidianomujer.org.uy/pub_casos_causal11.pdf***

27 *Supra*, note 41

28 Organization of American States. (1966). *American Convention on Human Rights*.

29 United Nations Human Rights Committee. (1992). General Comment No. 20, UN Doc. HRI/GEN/1/Rev.7.

30 Committee against Torture. (2006) *Concluding Observations: Peru* (Paragraph. 23).

31 Bergallo, Paola, et al. (2011). *Legal Interruption of Pregnancy from Sexual Assault: Health and Legal Issues*. [Online]. ***http://www.ossyr.org.ar/pdf/bibliografia/244.pdf***

32 *Supra note*, 40

33 Organization of American States. (1969). *American Convention on Human Rights* (Art. 1).

34 Organization of American States. (5 March 1995). *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women* (Art. 6) . [Online]: ***http://www.oas.org/juridico/spanish/tratados/a-61.html***.

35 L.C. became pregnant when she was 13 years old as a result of being repeatedly raped by an older man. L.C. tried to commit suicide by jumping from a neighbor's roof, and suffered a spinal cord injury. Transported to a public hospital, doctors recommended an urgent surgical intervention to minimize additional damage caused by the fall. The surgery was put on hold when she was confirmed pregnant. Despite seeking formal permission from hospital leadership for a therapeutic abortion, she was denied the procedure. It was only after L.C. miscarried, almost three months after the initial spinal cord injury, that she was able to receive the operation. It was unsuccessful, and she remained a quadriplegic.

36 United Nations. (2011). *The Convention on the Elimination of all Forms of Discrimination Against Women*. [Online]. ***http://www.cladem.org/cladem/L.C.-vs-Per%C3%BA-%28Dictamen%29.pdf***. See also, Center for Reproductive Rights: ***http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/28JAN15%20GLP_LAC_LCvPeru_Factsheet%20AS%20FILED.pdf***

37 Center for Reproductive Rights. *L.C. vs Peru: the Right to Abortion in Cases of Rape*. [Online]. ***http://www.reproductiverights.orghttp://www.reproductiverights.org***

38 Cook R., Cusack, S., et al (2010). *Unethical Stereotyping of Women's Reproductive Health* [La Estereotipación Poco Ética de la Mujer en la Salud Reproductiva], International Journal of Gynecology and Obstetrics, 109, 255-258. [Online]. ***http://www.law.utoronto.ca/documents/reprohealth/SP23rev-Stereotyping-IJGO.pdf***

39 Cook R., Cusack, S., et al (2010). *Unethical Stereotyping of Women's Reproductive Health* [La Estereotipación Poco Ética de la Mujer en la Salud Reproductiva], International Journal of Gynecology and Obstetrics, 109, 7. [Online]. ***http://www.law.utoronto.ca/documents/reprohealth/SP23rev-Stereotyping-IJGO.pdf***

40 Inter-American Commission on Human Rights: Special Rapporteurship for Freedom of Expression (2010). *The Inter-American Legal Framework regarding the Right to Access to Information* [El Derecho al Acceso a la Información en el Marco Jurídico Interamericano] (paragraph 32). [Online]. ***https://www.oas.org/en/iachr/expression/docs/publications/2012%2009%2027%20ACCESS%20TO%20INFORMATION%202012%20edits.pdf***

41 Committee on Economic, Social, and Cultural Rights (2000). General Comment No. 14, E/C.12/2000/4, paragraph 12.

42 Inter-American Commission on Human Rights: Special Rapporteurship for Freedom of Expression (2010). *The Inter-American Legal Framework regarding the Right to Access to Information* [El Derecho al Acceso a la Información en el Marco Jurídico Interamericano] (paragraph 67). [Online]. ***https://www.oas.org/en/iachr/expression/docs/publications/2012%2009%2027%20ACCESS%20TO%20INFORMATION%202012%20edits.pdf***

43 Constitutional Court Colombia. Judgments C-488 from 1993, T-074 from 1995, T-472 from 1996, T-066 from 1998, T- 626 from 2007, T – 263 from 2010, and T - 627 (2012)

44 Constitutional Court Colombia, Judgment T – 627 from 2012.T – 627 (2012).

45 Inter-American Court of Human Rights. (2012). Case of Artavia Murillo et al. ("In vitro fertilization") v. Costa Rica: Preliminary Objections, Merits, Reparations and Costs (paragraphs 142 - 147).

46 Inter-American Commission on Human Rights. Special Rapporteurship for Freedom of Expression, Op. Cit., (paragraph 67).

47 Inter-American Court of Human Rights. (1999). *Case of the "Street Children" (Villagrán-Morales et al.) v. Guatemala*. [Online]. ***http://www.corteidh.or.cr/docs/casos/articulos/Seriec_63_esp.pdf***

48 Inter-American Commission on Human Rights: Special Rapporteurship for Freedom of Expression (2010). *The Inter-American Legal Framework regarding the Right to Access to Information* [El Derecho al Acceso a la Información en el Marco Jurídico Interamericano] (paragraph 67). [Online]. ***https://www.oas.org/en/iachr/expression/docs/publications/2012%2009%2027%20ACCESS%20TO%20INFORMATION%202012%20edits.pdf***

49 Bohórquez, V., et al. (2010). "The Tensions of Human Dignity: Conceptualization and Application of Human Rights in International Law". *Revista Sur Internacional de Derechos Humanos*, 11. Constitutional Court Colombia, Judgment C – 355, 2006.

50 Tealdi, 2011:2

51 World Health Organization. (2009). "Adolescent Pregnancy: A Cu lturally Complex Issue", 87 (2009). [Online]. ***http://www.who.int/bulletin/volumes/87/6/09-020609/es/***

Conclusions

1 Grover, Anand. (2011). *Special Rapporteur of the Human Rights Council's Interim Report on the Right of Every Person to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. [Online]. ***http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254&referer=/english/&Lang=S***

Recommendations

1 PROMSEX is a feminist non-governmental organization, made up of men and women, professionals and activists, which seeks to contribute to the effectiveness of the integrity and dignity of access to sexual health and reproductive justice and human security through advocacy, knowledge generation, and coordination with other civil society organizations. ***www.promsex.org***

2 Mujeres Transformando el Mundo is a Guatemalan organization focused on providing support in situations of sexual violence, discrimination, femicide, and human trafficking. ***http://www.mujerestransformandoelmundo.org/es***

3 Fundación Desafío is a private development organization that promotes equality via the full exercise of sexual and reproductive rights, strengthening and facilitating free and responsible decision making in regards to sexuality and reproduction, with a particular emphasis on women and adolescents. ***http://www.fundaciondesafio-ec.org/***

4 La Asociación de Mujeres de Axayacatl is a non-profit organization whose principal objective is the promotion and defense of women's rights.

Country Executive Summaries

1 Monitoring reports conducted by the OSAR national network, March 2015, ***www.osarguatemala.org***