

Chapter 1

Preparing the Twenty-First Century's First Generation of Adults: Policy and Program Perspectives

Judith Bruce, Population Council

Rationales for Investing in Adolescents

There are over one billion adolescents between the ages of 10 and 19, accounting for about 20 percent of the world's total population. More than 85 percent of these young people live in the developing world. In 1998 the Population Council published *The Uncharted Passage* (Mensch, Bruce and Greene, 1998), an inquiry into adolescents' experience in the developing world, with an emphasis on adolescent girls. We opened that monograph with the following observation:

What happens between the ages of 10 and 19, whether for good or ill, shapes how girls and boys live out their lives as women and men—not only in the reproductive arena, but in the social and economic realm as well. Yet, despite its impact on human development, adolescence has been sidelined as a research and policy subject in developing countries. As a result, we know little about young people's lives in these societies.

Happily, over the last three years, there has been impressive intensification of policy and programmatic efforts focusing on adolescents. The objects of these interventions are variously referred to as “teenagers,” “youth,” “young people,” and “adolescents.” The age span considered similarly varies.

This document will give most of its emphasis to policies and programs affecting those between the ages of 10 and 19 (in keeping with the WHO definition of adolescence as the second decade of life). We underscore, however, that what happens in the 5–9 and 20–24-year age periods is also enormously important to understand and observe.

Over the last decade, support has grown at national and international levels for strengthening gender equity, improving reproductive health, and protecting the rights of all people—including adolescents—to make informed decisions regarding reproductive matters and other important aspects of their lives. The Convention on the Rights of the Child (CRC), which defines childhood as ending at age 18, and the Convention to End All Forms of Discrimination Against Women (CEDAW) jointly provide a comprehensive foundation for efforts to define and respect the rights of adolescents. Both documents acknowledge the close relationship between human rights and human development. Both understand the necessary relationship between rights and capabilities: without social and economic capabilities, adolescents will be unable to make choices, access services, and have productive lives. Finally, both recognize the impossibility of protecting human rights without promoting gender equality.

The broad foundations provided by the CRC and CEDAW were further refined in the historic accord signed in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The ICPD Programme of Action gave special attention to the condition of adolescents, and the gender equity dimension of reproductive health and rights. The Cairo vision was further affirmed at the Beijing International Conference on Women in 1995, and re-affirmed and broadened later at the conferences ICPD+5 and Beijing+5.

The documents that emerged from these international conferences include formal recommendations to governments and monitoring committees to give close attention to the protection of adolescents' reproductive and sexual rights. They highlight the special stake of young people in development processes and the general relationship between health and development.

This document focuses on programmatic issues, and is built upon the international agreements cited above. Before turning to the programmatic discussion, it is useful to review some of the key, internationally recognized rationales for investments in adolescents.

Investments in adolescents are vital for:

1. Implementing the United Nations Convention on the Rights of the Child;
2. Defending girls' rights to later, informed, and voluntary marriage;
3. Protecting reproductive health and establishing positive health habits;
4. Realizing investments in human capital, including health investments made in early childhood, which are undermined without attention to adolescent development and observance of adolescents' rights;
5. Intervening at a crucial point to reduce gender disparities in health, social, and economic resources (adolescence is often the last period in which many processes deleterious to the health, welfare, and social development of girls and boys may be reversed);
6. Building an effective economic base in poorer economies (adolescence is the period in which most males and females begin their economic life, however properly or ill prepared they are for it); and
7. Increasing the span between generations and reducing rapid population growth.

1. Implementing the United Nations Convention on the Rights of the Child

This convention, ratified by all of the members of the United Nations except the United States and Somalia (which have signed but not ratified it), provides the broadest possible foundation for cross-cultural concern for those in late childhood; ages 10-18 as defined by the Convention. It acknowledges the special capacities of young people in this age group and identifies their rights, while also urging continuing protections of them so that they may safely develop their capabilities.

Children aged 10–18 may be at greater risk than younger children of having their rights contravened. In the case of girls, the arrival of puberty brings the threat of forced departure from school, economic and sexual exploitation, involuntary removal from the home for unchosen marriage, imminent childbearing, fostering (i.e., being sent to live in another household), migration for work, and increasing limitations placed on their participation in public and civic life. For boys, particularly in the lower income classes, there is also the possibility of being withdrawn from school under pressure to provide income for their families, as well as the risk in some settings of being drawn into armed conflicts as soldiers.

2. Defending girls' rights to later, informed, and voluntary marriage

Perhaps the most widespread human rights violation of children in the adolescent age group is early, often unchosen, marriage. If present conditions prevail, *82 million of the girls currently aged 10–17 in the developing world will be married while still officially “children.”* The passage to marriage is often a significantly negative experience for girls because of their loss of mobility, and access to schooling; limited legal rights (a married girl may require her husband's legal consent to travel or work); removal from supportive family and social networks; and subjugation to uninformed, obligatory sexual activity, albeit with a nominal husband, who is often considerably older and a relative stranger.

The health threats associated with early marriage were in past decades largely confined to early childbearing, but have in the last few decades grown to include exposure to increasingly dangerous sexually transmitted infections (STIs), including HIV infection/AIDS. Rates of HIV infection among girls aged 15–19 are rapidly accelerating

(see Chapter 10). It is past time to defend girls' right to wait until they are adults to marry voluntarily partners of their own choosing.

3. Protecting reproductive health and establishing positive health habits

HIV/AIDS

Tragically, recent surveillance data provide a picture of rapid increases in HIV among 15–24-year-olds, especially girls. This requires an immediate response. Of the more than 60 million people who have been infected with HIV in the past 20 years, about half have become infected between the ages of 15 and 24. Today, nearly 12 million young people are living with HIV/AIDS. In 20 African countries, 5 or more percent of females aged 15–24 are infected with HIV (UNAIDS 2001); ratios of male-to-female infection among those aged 15–19 are as high as 1:6 in some areas (UNAIDS 2000). In the age of HIV, unprotected sexual relations for girls—always a rights and safety issue—are directly life-threatening.

Unmarried adolescent girls and boys are clearly at risk of severe reproductive health problems and need continuing support to assist them in adopting safe, voluntary behaviors. Married adolescent girls, often under pressure to become pregnant, have virtually no strategies articulated at this point to protect themselves. *Delaying age at marriage to at least 18 and offering frank and comprehensive information and services to adolescents about their sexual health is a vital strategy to undercut the AIDS epidemic.*

Health risks of adolescent childbearing

Adolescent childbearing has always carried special risks — some founded on clinical factors (most of these operating in girls 15 and under) and others on closely related social and economic factors. Demographic shifts such as declining fertility and

later-parity births (at one time as risky as first births) are actually increasing the relative risks of morbidity and mortality associated with the first pregnancy and delivery. Thus efforts to make motherhood safer must give special attention to first-time mothers in the developing world, half of whom are adolescent girls. Two strategies are needed; increasing the age of first birth, so that the young mother has more physical and social capabilities, and designing pregnancy support services with the needs of the youngest mothers more in mind (see Chapter 9).

Substance abuse

Extremely harmful habits are established in adolescence—including cigarette, alcohol, and other drug use. The use and abuse of these substances not only absorbs vital cash resources, it also does immeasurable and devastating harm to adolescent and adult health. Health behaviors established in adolescence, for good or ill, are hard to break.

4. Realizing investments in human capital, including health investments made in early childhood, which are undermined without attention to adolescent development and observance of adolescents' rights

The needs of children under the age of 5 in particular, and even up to the age of 10, have been better understood and more subject to technological innovations (e.g., vaccines, oral rehydration therapy, and so forth) than have the less well defined, less well understood, and frankly less appealing needs of those aged 10–19. But the child survival revolution begs a key question: Survival for what? Girls' and boys' survival rates are improved and relatively equal after the age of 5. What entitlements and social processes ensure that these children in which we have invested so much will realize their development potential and make productive contributions to society? Adolescent policy must be seen as bringing to fruition decades of effective investments in early childhood.

5. Intervening at a crucial point to reduce gender disparities in health, social, and economic resources (adolescence is often the last period in which many processes deleterious to the health, welfare, and social development of girls and boys may be reversed)

Though the ground is prepared in early childhood for gender disparities and confining gender roles, their consequences are not fully yielded until adolescence. At puberty, girls' mobility in the public sphere and access to schooling are often dramatically curtailed. Beginning at this stage, girls' sexuality and fertility are defined in increasingly narrow terms. Boys may take on behaviors destructive to themselves and to society as part of misguided masculine identity development. Gender-sensitive adolescent programs and policies are a key means by which society can both describe and directly address gender disparities and disabling gender norms.

6. Building an effective economic base in poorer economies (adolescence is the period in which most males and females begin their economic life, however properly or ill prepared they are for it)

According to the International Labour Organization (ILO), the minimum age for relatively full-time employment and wage work "shall not be less than the age of completion of compulsory schooling and, in any case, shall not be less than 15 years." (ILO 1973) While adolescents may work legally at age 15, they may not necessarily have the skills—or access to skill-building resources—needed to enter the modern economy, or the negotiating power or legal authority to control and direct their earnings and other assets. (For example, in many countries the youngest age at which one is allowed to have a bank account is 18.)

Young people aged 15–24 (especially girls) are the new torchbearers of globalization, though they are rarely perceived as such. Many debates proceed as if the

workers being pitted against each other are mainly men in their thirties supporting families, when in fact the face of the worker is often a young, unmarried girl. For example, of the 1.9 million workers in Bangladesh's garment industry (the leading segment of the country's export industries), 90 percent are female, and the vast majority of these are unmarried girls aged 15–24 (Amin 1997). Defining safe, appropriate livelihoods, and mechanisms to allow young workers to control their income, is vital not only to their well-being at the individual level, but to overall national productivity, savings levels, and economic stability.

7. Increasing the span between generations and reducing rapid population growth

Finally, and not fully appreciated in recent years (as reproductive health concerns have dominated the discourse within the population community), is the demographic impact that would be achieved by deferring first births, which take place primarily within marriage in developing countries. In less developed countries, half of all future population growth is attributable to population momentum—the tendency of populations to keep growing, even after fertility rates fall, in societies with a young age structure (i.e., many young people in or entering their childbearing years). In the countries with the highest fertility rates and lowest average age at marriage (concentrated in South Asia and sub-Saharan Africa), a sizeable proportion of future population growth can be addressed by delaying marriage and closely associated childbearing. For example, *if the mean age of childbearing in Bangladesh were to rise by 5 years—from 18 to 23 years—approximately 36 percent of future population growth would be averted* (Bongaarts

1998).¹ Similar effects of delayed childbearing (raising the age of first birth by five years) would reduce population growth in countries such as Egypt, India, and Mexico (where fertility rates have substantially declined and population momentum is now the primary cause of demographic growth) by 25–40 percent.

A Proposed Strategic Approach to Adolescent Programming: Evidence-Based Planning, Clear Objectives, Flexible Resources, and a Realistic Time Frame

Among population organizations, adolescent programs were founded substantially on what had been learned over previous decades in providing family planning services to adults. It was the activist family planning community that was the first to champion an adolescent agenda per se. The strength of the community's contribution was the depth of its commitment, its network of activists on the ground who were accustomed to dealing with controversial subjects, and its genuine concern with the well-being of young people. The weaknesses of the family planning/population base as a springboard for adolescent policy and programming are the narrow confinement of its concepts and action plans to the health sector, an insufficient capacity to deal with the structural determinates of key gender issues that emerge in adolescence, and an overemphasis on the Western construction of adolescence.

Early, and indeed some current, program documents conceive of adolescents as comprising a relatively homogeneous and autonomous group. They define their objectives in terms of helping adolescents to “reduce risky behavior” and “make better choices.” The vision of adolescent life on which much youth programming in developing countries has been founded often reflects a Western perspective. For example, efforts to

¹ In the Bangladesh case, 80 percent of future growth will come from population momentum, and 40 percent of that would be averted with an upward shift in females' age at first birth.

address adolescent fertility have centered attention on unwanted pregnancy in unmarried girls. Initiatives to reduce unsafe sexual activity typically have been directed to the unmarried, based on the inaccurate assumption that sexual activity among the unmarried is voluntary. Almost no mention is made about the safety or voluntarism of sexual relations among married adolescents. While there has been a concern that health providers are not sufficiently youth-friendly, the scope of their responsibilities toward youth is often seen as being limited to offering information and contraceptive services to unmarried, often school-going youth. The situation of married adolescent girls—arguably the largest group of adolescents at high, immediate risk of poor reproductive health outcomes (e.g., maternal mortality and morbidity)—has rarely been considered.

Over the last three years, there has been a welcome broadening of interest in adolescents. A broad, development-based approach has been endorsed by UNFPA, WHO, UNICEF, and many private foundations. Diversification of adolescent program content, however, has followed more slowly, and has often been incremental. A few experimental efforts have initiated their contacts with remote and vulnerable subsets of young people through non-health interventions (e.g., creating new/different livelihoods opportunities for trafficked girls).

Desired outcomes have similarly been too confined by family planning/population program antecedents. Some programs may still have the goals of increasing contraceptive use and promoting abstinence; however, both of these objectives, though potentially beneficial, may not be achievable over the short term—and may not even be salient concerns.

Perhaps the greatest programmatic failing has been the homogenization of adolescents into one mass called “youth.” Without disaggregated data and methodologies

to generate these data, adolescent reproductive health programs may be simultaneously responsible for reaching the in-school, unmarried, 10-year-old girl, the school-going boy of 17, the out-of-school employed boy of 14, and the married 16-year-old girl.

In short, the adolescent field is groping toward a broadening of its mission; a repositioning of the loci of its activities from one to a number of sectors; the close identification of subgroups of adolescents needing special attention of one kind or another; and, finally, a realistic set of short-term and intermediate goals, often of a social nature (attitude change, greater ability to move around the community, better negotiating skills, and so forth), that are connected (though not necessarily closely) with reproductive health benchmarks. Adolescent programs may yield any number of short-term and intrinsically good outcomes for young people in a one-to-two-year time frame. Yet, one of the great challenges of adolescent programming is that the most beneficial outcomes we can hope for will not necessarily be viewable within the framework of most projects unless they extend five to eight years. We need flexibility both in our time frames for and in our expectations of programs targeting adolescents.

We recommend designing interventions for adolescents based on international agreements regarding adolescents' rights and capacities; generating more context-specific information about adolescents; articulating program objectives that recognize the links between social, economic, and health factors; and employing more flexible sets of progress benchmarks that are achievable over the short term with adolescents—a highly dynamic, unique, and diverse client group. Therefore we offer the following strategic prescriptions:

1. Base programs on development-oriented, rights-affirming principles.

2. Recognize the close links—particularly determinate for girls—between social and economic opportunities and reproductive health benchmarks.
3. Acknowledge the striking diversity among adolescents and design strategies to reach subsets of adolescents differentiated by age, gender, marital and schooling status, social and economic class, and residence (urban/rural).
4. Be willing to critique and learn from the failings and successes of currently popular programmatic approaches.
5. Include adolescents—particularly those in the targeted group or subset of special interest—in the development of programs as information/perspective providers and, when appropriate, in program implementation and leadership.
6. Engage gatekeepers (e.g., parents, parents-in-law, employers) as constructively as possible while being ready to thwart them when necessary in order to defend young people, especially girls.
7. Plan and provide for a diagnostic phase and keep budgets flexible until this phase is completed.
8. Pursue alliances with organizations that have expertise in working with youth and working outside the health sector.

1. Base programs on development-oriented, rights-affirming principles.

From a policy perspective, the identification of young people as a resource, and the acknowledgement of their rights, is key for an effective, long-term, cross-cultural strategy to improve adolescents' well-being. Demonizing young people or a particular behavior of young people is not a fair or constructive foundation for policy or programs. A rights- and development-based approach to policy and programs for adolescents has many points of departure—the Convention on the Rights of the Child (CRC) being premier among them. A number of regional and national consortiums (such as the recent Organization of African Unity meetings) have similarly affirmed the broad spectrum of rights acknowledged in the CRC.

2. Recognize the close links—particularly determinate for girls—between social and economic opportunities and reproductive health benchmarks.

An evolved strategy for adolescent work must at the very least acknowledge social, economic, and health links. Ideally it would develop approaches to deal (however modestly) with a few of the most critical factors impinging upon reproductive health outcomes of interest. For example, livelihood activities may be especially important in areas where girls are under economic pressure and must exchange sex for income or other valued resources in the absence of wage-earning work opportunities (see Chapter 8).

An example from Bangladesh also illustrates this point. A recent study revealed a four-year age gap between married adolescent girls' ideal and actual age at marriage: the girls identified 19 as the ideal age at which to marry, yet their age at marriage averaged 15. The researchers concluded that Bangladeshi girls needed to be informed about reproductive processes, sexual intercourse, the consequences of unsafe sex, early marriage, and early childbirth—reflecting the conventional view that reproductive knowledge is the key to changing girls' reproductive behavior. If, in fact, a program seeks to improve the reproductive health of girls in Bangladesh, it must go beyond delivering health information to those relatively privileged unmarried girls in secondary school, and also provide social and economic opportunities that offer in- and out-of-school girls bargaining power with parents and other family members who may otherwise compel them into early, potentially involuntary marriages followed hard on the heels by childbirth.

3. Acknowledge the striking diversity among adolescents and design strategies to reach subsets of adolescents differentiated by age, gender, marital and schooling status, social and economic class, and residence (urban/rural).

Much adolescent programming is designed to help “youth” (with no further specification) to achieve some very generalized goals such as “better reproductive health.” While adolescent national policies may highlight the interests of youth in contrast to those of adults, the acknowledgement of that distinction is not sufficient. *Effective policies and programs must acknowledge the high degree to which the adolescent population is segmented* in its life experiences and responsiveness to interventions.

South Africa’s national adolescent policy is of interest because it simultaneously promotes inclusiveness while underscoring the distinctions between males and females, different age groups, and different ethnic groups. It even acknowledges the unique situation of young people whose schooling was disrupted because of the national struggle for independence.

At a practical level, this programmatic prescription requires developing a fuller and more descriptive base of information about adolescents, diversified by age, gender, schooling, and working and marital status. Such a base will identify and honor important distinctions among subgroups, a vital step in developing programs that will work (see Chapter 3).

4. Be willing to critique and learn from the failings and successes of currently popular programmatic approaches.

Resources for adolescents have been concentrated in the health sector and invested primarily in four basic types of interventions: youth centers, peer education, school-based programs, and “youth-friendly” contraceptive services; some programs

combine these different strategies. But the potential efficacy of these strategies has infrequently been projected before they were begun, and their current effectiveness vis-à-vis the needs of different subgroups of adolescents has not been much analyzed. It is time to learn whether these programs are well utilized, whom they serve and do not serve, and whether they are, in fact, effective (see Chapter 5, which contains analyses of youth centers from four countries and investigate schooling factors related to reproductive health).

5. Include adolescents—particularly those in the targeted group or subset of special interest—in the development of programs as information/perspective providers and, when appropriate, in program implementation and leadership.

There are great differences among adolescents with respect to the time and freedom they have to participate in programs and with respect to the nature of the contribution they can make to implementation. While tapping the views, preferences, and realities of young people, it is important to ensure that plans to include the adolescent perspective in the program development phase do not exceed what they can contribute. Further, the costs to adolescents and to the program of their participation must be carefully examined. Often, including adolescents in programs has amounted to using (often poor) young people as volunteers in programs that they may not understand well and cannot remain closely involved with (see Chapter 5).

6. Engage gatekeepers (e.g., parents, parents-in-law, employers) as constructively as possible while being ready to thwart them when necessary in order to defend young people, especially girls.

Research projects and programs targeting adolescents must realistically involve adolescents' "gatekeepers"—parents, in-laws, community officials, service providers,

and so forth—in gathering information, perspectives, and support, where possible. At the same time, researchers and program staff must keep the interests of adolescents front and center. This will often mean confronting practices that undermine the attainment of adolescent rights and development and the individuals who promote these practices.

Recent literature on adolescents discusses “connectedness” as a positive element in adolescents’ lives—a contention that needs some cross-cultural testing. Connectedness with parents can be a very positive feature in the life of a child in the Western hemisphere, where detachment from family and social support has measurable links to risky behaviors. Connectedness in highly traditional societies, unless redefined, could equally mean being subject to the will of parents whose wishes for their adolescent offspring are not necessarily in the adolescent’s best interest—such as migration to unsafe areas for work, early marriage, or sexual liaisons that might confer economic benefit on the family (see Chapter 7 for some discussion of working with parents of adolescents).

There is a particular challenge in dealing with the employers of young people, including those who employ the vast army of girls currently in domestic service. These girls are effectively emancipated, living away from parents, often without protection. Efforts to promote the rights of the youngest workers may sometimes require gaining access to them through gatekeepers (parents, foster families, and employers). While it is essential to negotiate with such authorities, it is equally essential that adolescent workers are able to express themselves freely and safely, and to participate in social, health, and economic programs (see Chapter 8).

7. Plan and provide for a diagnostic phase and keep budgets flexible until this phase is completed.

A true diagnostic phase, however honored in the literature, is poorly observed in practice. The failure to have a diagnostic phase is problematic for all development efforts, but will be particularly negative for adolescent programs, given the weakness of available data and the few long-term, well-evaluated adolescent interventions. The diagnostic phase is also a dialogue phase, which can engage gatekeepers, including community and family members and other potential supporters of young people.

Some program processes allow for a planning grant, which supports a diagnostic phase before elaborating a full intervention program. In other cases, budgets are allocated for a general plan, which is to be refined during a diagnostic phase. For work on adolescents, particularly work on new subjects or in communities where work has not been done before, a diagnostic phase of not less than six months is necessary to gather information, make a more refined selection of adolescents to be served, engage partners, and float intervention ideas. Keeping the plans and budget flexible until the diagnostic phase is completed is essential, as much in adolescent programming cannot be anticipated.

It is strongly suggested that when program plans are drawn, budgets are similarly kept flexible regarding sectoral allocations. It may be reasonable to anticipate that a responsive adolescent program may spend 20 or even 50 percent of its budget outside the initiating sector or the central interests of the initiating donor. For example, an initiative planned as a reproductive health program may discover after the diagnostic phase that the best way to engage girls in highly traditional societies is to offer them some economic literacy or livelihoods skills. Reproductive health information may then be offered in the

context of savings groups for girls—not the usual direction of expenditures in conventional reproductive health programs.

There is an interesting example of how cross-sectoral investment emerged in the context of a large-scale reproductive health program in Peru. A women's organization seeking to reach women in rural zones with family planning and other reproductive health services conducted diagnostic exercises with women in the community. They learned that in order to engage and sustain women's participation, they needed to create some social and economic supports for them. Anticipating a diversification of spending, but being unable to foresee exactly in which sectors, the overall program budget reserved 16 percent of funds to be appropriated for non-health interventions—banks for women, functional literacy, and other activities promoting social mobility.²

8. Pursue alliances with organizations that have expertise in working with youth and working outside the health sector.

Programs developed to respond to adolescent needs will generally have mixed content and reach adolescents through a variety of entry points (see previous point). Even the smallest-scale, community-based adolescent program may require inputs from a number of “sectors”. Often the initiating organization may not have the expertise necessary to pursue new programmatic avenues, whether it be the introduction of sports, a savings scheme, or functional literacy. Therefore, it is essential that sponsoring organizations and their donors look for strong and possibly unfamiliar partner organizations that have expertise in key areas outside the conventional population and health agenda. This is a matter of simple practicality. Family planning organizations are

² For a more in-depth discussion of this, see Rogow and Bruce 2000.

not very good at offering livelihood activities, and livelihood organizations may not understand the social context and information-dissemination strategies necessary to foster reproductive health.

Such partnerships may result not only in mixed-content programs, but also in diversification of program evaluation criteria. Programs must be evaluated not only in terms of their feasibility and acceptability, but also in terms of their internal effectiveness from the point of view of the originating sector (if a program offers health or economic services, for example, are these services of good quality?). Creative partnerships will result in asking not only standard questions regarding, for example, levels of service utilization and changes in reproductive health knowledge, but also questions regarding how many participants took loans, learned to read, and so forth.

Conclusion

Operationalizing these principles requires both art and science — imagination and use of data. The following chapters provide more in-depth discussions, programmatic dilemmas, and guidance on the day-to-day process of programming.

References

Amin, Sajeda. 1997. “The poverty-purdah trap in rural Bangladesh: Implications for women’s roles in the family,” *Development and Change* 28(2): 213-233.

Bongaarts, John. 1998. Personal communication.

International Labour Organisation. 1973. Minimum Age Convention, No. 138. Geneva: ILO.

Mensch, Barbara S., Judith Bruce, and Margaret Greene. 1998. *The Uncharted Passage: Girls’ Adolescence in the Developing World*. New York: Population Council.

Rogow, Debbie and Judith Bruce. 2000. "Alone you are nobody, together we float: The Manuela Ramos Movement," *Quality/Calidad/Qualite*, no.10. New York: Population Council.

UNICEF. 1989. *Convention on the Rights of the Child*. New York: United Nations.

United Nations. 1979. *Convention to End All Forms of Discrimination Against Women*. New York: United Nations.

UNAIDS. 2000. *Epidemic Update*. June.

_____. 2001. *Epidemic Update*. December.