Theories of Change and Good Practices in Sexual and Reproductive Health of Adolescents: A Reevaluation

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Abstract

This article analyzes practices intended to improve the sexual and reproductive health of adolescents through the systematization of a project promoting sexual and reproductive health and rights in rural and peri-urban areas in Peru, as well as ethnographic research with youth-promoters who participated in this project. The study discusses the theories of change underlying these practices, their conditions of possibility, potentialities, and limitations. Using an approach based on the social determinants of health in the daily life of adolescents, a reevaluation is proposed of participative approaches and the state-civil society relationship with respect to the responsibility and implementation of so-called good practices in sexual and reproductive health.

Keywords: Adolescents; sexuality; reproductive health; sex education; public policies; Peru.

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Acronyms

DEMUNA	Municipal Advocate's Office for the Defense of Children and Adolescents (Defensoría Municipal del Niño, Niña y Adolescente)
GTZ	German Technical Cooperation Agency
HIV	Human immunodeficiency virus
CDJ	Youth Development Center (Centro de Desarrollo Juvenil)
MINEDU	Ministry of Education (Ministerio de Educación)
MINSA	Ministry of Health (Ministerio de Salud)
MMR	Movimiento Manuela Ramos
NGO	Non-governmental organization
ReproSalud	Reproductive Health in the Community (Salud Reproductiva en la Comunidad)
SRH	Sexual and reproductive health
UGEL	Local School District Administration (Unidad de Gestión Educativa Local)
UNFPA	United Nations Population Fund
VRAEM	Valley of the Apurimac, Ene, and Mantaro Rivers (Valle de los Ríos Apurímac, Ene y Mantaro)
WHO	World Health Organization

INTRODUCTION

The Commission on Social Determinants of Health of the World Health Organization (WHO 2008) draws attention to the continuing contradiction between an awareness of the structural causes of health problems and the decision to implement policies or programs that ultimately address these causes in only the most superficial of ways. This observation is a useful point of departure for a critical analysis of sexual and reproductive health (SRH) interventions among adolescents in Peru, as I will attempt to show in this article. Through the analysis of an SRH and rights project with Peruvian adolescents, I will seek to demonstrate that even good or best practices in SRH have gradually become what the Commission on Social Determinants of Health calls "usual practices," those that continue to be viewed as the most feasible and realistic, but which ultimately result in very limited change.

Tackling the social determinants of SRH requires not only improvements in the health and education systems, but also social and institutional transformations outside these spaces. Different local studies suggest that, although access to information and SRH services is essential, this may be insufficient to prevent sexual risks due to situations of sexual or structural violence, as well as the existence of gender norms and other sociocultural structures that foster discrimination and risk or hinder negotiation and the rejection of unwanted sexual practices (Quintana and Vásquez 1997; Yon 1998; Cáceres 1999; Pérez et al. 2003; Ramos 2006; Salazar *et al.* 2005, 2006; Girón 2009; Sandoval 2009; Mujica *et al.* 2013). Likewise, there is sufficient evidence in the international literature to demonstrate that SRH is associated with social inequalities related to economic income, access to educational and employment opportunities, gender violence, ethnic and sexual discrimination, and sexual abuse and exploitation, among other social determinants (Farmer 1992; Farmer *et al.* 1996; Parker *et al.* 2000; Parker and Aggleton 2012; Aggleton *et al.* 2004; Pantélides 2004; Flórez 2005; WHO 2008; PAHO 2010a, 2010b).

I maintain that in the Peruvian case, good practices require the systematic incorporation of the different social determinants of adolescent SRH and dictate that it is the state's concrete responsibility to work on this task in the medium- and long-term. Otherwise, as this article will show, strategies for empowerment and rights-, gender-, or interculturality-based approaches do not have much chance for sustainability and impact. Nevertheless, undeniable potential gains and symbolic achievements — such as the public track record of certain health promoters or adolescent leaders — must be recognized. This article does not seek to discourage currently recognized good practices, but rather to contribute to a critical and contextualized reading of the impacts of strategies that may be considered positive, but which are shown here to have a limited scope in the context of adolescents' daily lives unless they are associated with social policies on health, education, and other

areas that increase opportunities and improve the living conditions of this neglected sector of the population.

WHY STUDY GOOD PRACTICES IN SEXUAL AND REPRODUCTIVE HEALTH?

Generally speaking, the notion of good practices seeks to recover experiences that are deemed beneficial, whether because of their positive results in a given context or because they reflect principles and methodologies considered appropriate according to approaches or parameters determined by consensus (Proinapsa 2007). Given that they serve as valuable reference points for other, similar interventions, it becomes necessary to analyze such practices, paying particular attention to their medium- and long-term potentialities and limitations in order to obtain a realistic idea regarding their sustainability, impact, and implications for the actors involved, whether they are from civil society or the state.

Between 2008 and 2009, teams from Minsa and Unfpa selected four good practices for pregnancy prevention among adolescents in Peru. The selection criteria were those proposed by Family Care International[1] for identifying good practices in this area: relevance; innovation; positive results or impact; sustainability; incorporation of human rights-, gender-, and social inclusion-based approaches; and partnerships with different actors or sectors (Minsa and Unfpa 2010: 19-21). These initiatives are illustrative of the good practices that have been implemented up to now in Peru in the field of adolescent SRH, an area in which the Peruvian state has done very little or has shown a consistently hesitant attitude despite the concerning indicators regarding adolescent SRH (see Mendoza and Subiría 2013; Minsa 2013).[2]

These interventions are seed projects, financed by international cooperation, and therefore they are usually limited in their coverage and scope. Although the emphases vary, they are pilot projects that share the goal of seeking better conditions for adolescents to exercise their sexual and reproductive rights (as such, they do not focus only on unwanted pregnancies), including the assurance of an adequate supply of health services. Two such projects were the "Peer Education System in Pucallpa" ("Sistema de educación de pares en Pucallpa") and "Youth Development Centers (CDJs): An Integrated Healthcare Model

1. For more details, see: Family Care International (2011).
2. One example is adolescent pregnancies. Nationwide, they has increased from 11.4% in 1991-1992 to 13.9% in 2013. In 2013, just 33% of adolescent mothers stated that they wanted the pregnancy at the time. The national average conceals major inequities. The percentage of adolescents who are already mothers or who are pregnant is higher among women with primary education (36%), those situated in the lowest quintile of wealth (24%), those who live in the departments of Peru located in the jungle (24%), and those residing in rural areas (20%) (INEI 2014).

for Adolescents – The Adolescent-Friendly CDJ (CDJ Faucett)" ("Centros de desarrollo juvenil (CDJ): modelo de atención integral de salud para adolescentes. El CDJ Amigo de los Adolescentes (CDJ Faucett)"), projects undertaken by MINSA in alliance with the education sector and with the support of the German Technical Cooperation Agency (GTZ). The third project was "Improving Access to Sexual and Reproductive Health for Adolescents between the Ages of Ten and Nineteen in Lima, Peru" ("Mejorar el acceso a la salud sexual y reproductiva para los adolescentes de 10 a 19 años en Lima-Perú"), implemented by Médicos del Mundo (France), which also sought to achieve changes in health services, raising awareness and providing training for professional teams, promoting the installation of differentiated healthcare spaces for adolescents in health establishments, and legitimatizing the adolescent centers. The fourth project selected was "SserR Jóvenes: Helping to Improve the Sexual and Reproductive Health of Adolescents and Youths from Rural and Peri-Urban Areas of Peru" ("SserR Jóvenes. Ayudando a mejorar la salud sexual y reproductiva de las y los adolescentes y jóvenes de sectores rurales y periurbanos del Perú"), carried out by the Movimiento Manuela Ramos (MMR) in Ayacucho, Huancavelica, Lima, and Ucayali (Minsa and Unfpa 2010: 14-15).

In this article, I will focus on one of these examples of good practices – the Sser Jóvenes project (2007-2009) – given the quantity and variety of information available on the project, including my previous studies (Yon 2010, 2014. Analysis of this project is useful in illustrating the complexities of the institutional and social contexts in which such initiatives for adolescent SRH in Peru are implemented and how their results are shaped. A critical review of these kinds of experiences – looking beyond the particularities of each case – is especially relevant following the approval of the Multi-Sectoral Plan for the Prevention of Pregnancy in Adolescents 2013-2021, which involves a series of commitments by state institutions for the implementation of this plan, as well as the application of approaches and strategies implemented in the aforementioned good practices and in the international literature (Minsa 2013).

Below, I will present a brief overview of the conceptual framework of the ethnographic study[3] that I conducted in Ayacucho (one of the four areas of intervention of the SserR Jóvenes project), emphasizing the contributions of medical anthropology so as not to lose sight of the multiple aspects involved in adolescent SRH, including the study of social structures that hinder the possibilities of applying new lessons learned in regard to rights and SRH. I will then go on to discuss the methodology employed in this study, highlighting the contributions of ethnography in raising the visibility of the specific ways in which structural factors operate in the daily lives of adolescents. Subsequently,

3. This study was part of my Ph.D. thesis at Columbia University, New York.

in light of the approaches described, I will reflect on the model of change proposed by the project analyzed here, taking into account the potentialities and limitations of two of its main approaches: participative strategies and adolescent empowerment strategies. I will complement this reflection with some of the results of the systematization of the project in its four areas of intervention, together with the ethnographic study carried out in Ayacucho. Finally, I will conclude with some reflections on how to go beyond so-called good practices in adolescent SRH.

THE SOCIAL PRODUCTION OF THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS

My approach to adolescent SRH and good practices in this field combines interpretative approaches with those of critical medical anthropology. This perspective enables the recovery of the subjectivity and agency of adolescents, as well as seeking to understand the broader social and cultural contexts that shape and limit their sexual experience, and their possibilities of negotiation in sexual interactions.

The interpretative and phenomenological perspective of medical anthropology (Kleinman 1980, 1988; Good 1994) contributes to a better understanding of health that questions a medico-centric and ethnocentric vision of this issue, working on the basis of the subjects' daily experiences, which are analyzed by taking into account their historical, social, and cultural contexts. This approach aids our insight into the different life experiences and interpretative frameworks of adolescents with regard to their sexuality and SRH, including their different sources of knowledge on the body and health and their notions of risk and prevention, as well as the hierarchies, forms of prestige, and gender identity that may be at play in the construction of meanings regarding their sexual practices. The critical perspective of medical anthropology, on the other hand, seeks to analyze the structural forces that condition the population's state of wellbeing and the asymmetrical relations of power in the construction of knowledge on health (Baer et al. 2003). This approach to the sexual health of adolescents aims to set aside the emphasis on individual risk behaviors in favor of a focus on the social and cultural contexts and the political economy that generate individual and group vulnerability to falling ill or being unprotected from sexual risks (Parker 2001; Parker and Aggleton 2012).

The aforementioned contributions dialogue with the concept of social determinants of health developed in the field of public health – which refers to the conditions in which people are born, grow up, live, work, and grow old – and to the structural factors that shape these conditions – that is, the distribution of power, money, and resources (WHO 2008). The concept of «determinants» is rooted, in part, in the socioecological perspective, which

holds that people are situated in interdependent and interactive environments or systems in which it is possible to identify determinants that are closer or more distant (Bronfenbrenner 1993). This conceptual approximation, like that of critical medical anthropology, allows for an understanding of the sexual conduct of adolescents that takes into account the various levels at which different influences operate (e.g., macrosocial structure, intermediary factors, and the social position of the individual).

It should be noted that, rather than proposing an analysis of cause-and-effect between social structures and people's sexual health and rights, the objective here is a complex reading of the role of the so-called determinants or conditioning factors of health. For this reason, it is necessary to take into account the multiple relations between culture and power, as well as between the agency of the subjects and the range of social processes linked to social inequalities, discrimination, and violence.

INVESTIGATING MEANINGS AND PRACTICES IN CONTEXT

This article is based on an ethnographic study with adolescents who took part in an SRH project over the course of eighteen months in marginal neighborhoods of Ayacucho, the period during which I conducted my fieldwork. This experience allowed me to gain in-depth knowledge of these adolescents' real possibilities of putting into practice in their lives what they had learned in regard to their sexual and reproductive health and rights. This research also allowed me to complement and undertake a critical analysis of the results of a systematization that I had previously performed on this same project, in its four areas of intervention (rural and peri-urban areas of Ayacucho, Huancavelica, Ucayali, and Lima).

Despite ethnography's notable advantages for studying the impact of social interventions on participants' lives, it has rarely been used as a methodology for the assessment of policies or programs.[4] This methodological proposal goes beyond the "before and after photograph" of the intervention or the "rapid" application of qualitative techniques. Ethnography requires the intensive use of participant observation and other methods by trained researchers, as part of a process of immersion in the social and cultural world of

4. One exception is the interim ethnographic assessment of the "Reproductive Health in the Community" ("Salud reproductiva en la comunidad, ReproSalud") project, carried out by Jeanine Anderson in 2002 (unpublished). Other examples include the qualitative studies on the implementation and effects of the Juntos conditional transfer program. These include research Norma Correa and Terry Roopnaraine (*Pueblos indígenas y programas de transferencias condicionadas* [2014]) and by Ludwig Huber, Patricia Zárate, and colleagues (*Certezas y malentendidos en torno a las transferencias condicionadas.* Estudio de caso de seis distritos rurales del Perú [2009]), among others.

the study's participants. The objective behind this is to understand what these people deem significant and to contextualize their practices in the framework of their daily experiences. This type of approach to reality provides considerable advantages for the study of local and transnational cultures or power structures based on their concrete manifestations in specific places, discourses, and practices (Burawoy et al. 2000). Additionally, it allows for the examination of complex interactions among certain social conditioning factors related to SRH (such as social inequity or poverty) and cultural meanings (for example, with regard to male or female sexuality) that play a part in both the experience and exercise of adolescent sexuality and the design and implementation of SRH policies and programs aimed at these adolescents.

This study employed a range of ethnographic methods, including: participant observation, in-depth interviews, and interviews with key informants, as well as archival research. Participant observation was carried out in public spaces in which adolescents interact (for example, in the street or at parties, bars, and other sites of entertainment or leisure), but also in schools and other spaces to which it was possible to gain access. Observation also included coordination meetings, class sessions, theater rehearsals, preparations for parades, and other program activities in which the adolescents took part. In the context of this participant observation, numerous informal conversations took place with both individuals and groups. Participant observation made it possible to learn about contextualized and specific practices through which discourses on adolescents' sexuality and rights are materialized, questioned, or negotiated by the different participants involved in the program, including adolescents. I also interviewed key informants (teachers, parents, healthcare providers, NGO promoters, and the head of the Municipal Advocate's Office for the Defense of Children and Adolescents (DEMUNA), among others) and forty adolescents between the ages of fifteen and nineteen (twenty women and twenty men), including youth promoters and participants in activities on SRH organized by these promoters. The names of the interviewees and other information that might be used to identify them have been changed or omitted in order to ensure confidentiality. The first twelve months of fieldwork overlapped with the implementation of the SRH program studied, while the remaining period was subsequent to the intervention.

Ethnography made it possible to shed light on different situations of social and sexual vulnerability among adolescents in areas of their lives that went relatively unaddressed by the project, such as those that occurred at their jobs and prohibited spaces of entertainment. Both the participatory diagnosis (self-diagnosis) and the other methodologies used with adolescents sought to bring out their own viewpoints and to address the real difficulties they faced in preventing risks and sexual abuse. However, types of sexual relationships (for example, casual relationships, such as "hookups" or "one-night

stands"[5]), spaces, and dynamics that are hidden from adults (such as "spin the bottle," dive bars, or brothels-cum-bars) were less frequently mentioned or were absent in the diagnoses and community intervention activities. This may be because although there is greater horizontality in relations with the NGO, the relationship was still between adults and adolescents in which the adolescents censored or protected themselves, divulging only what they considered "normal" or "permissible" in the adult world. Likewise, sexual abuse at the hands of family members and other adults, mentioned in the self-diagnoses and training workshops as a problem suffered by other adolescents, was found in the ethnography to be a serious problem in the life paths of some of the female participants.

THEORIES OF CHANGE AND GOOD PRACTICES[6]

The purpose of the project analyzed here was for adolescents from areas stricken by poverty and social exclusion "to exercise their sexual and reproductive rights as part of their citizenship."[7] The strategies for achieving this objective were aimed at not only expanding the individual and collective capacities of adolescents, but at fostering institutional, political, and cultural contexts for the exercise of these rights in order to help improve the sustainability of the project's interventions. Inspired by the MMR's previous experience with women from rural and peri-urban areas, the project sought to bolster the demand and improve the supply of SRH services based on the needs and perspectives of the adolescents themselves. The new challenge was to construct an intervention strategy that respected specific cultural contents while giving male and female adolescents a leading role in issues that continue to be considered taboo in their surroundings, such as sexuality and the rights of adolescents to information and services related to SRH.

The project's core component was «participative community intervention,» with adolescents as its main focus. Youth promoters and leaders were trained and support was provided for community actions in SRH, which sought to contribute to adolescents' empowerment and transform them into agents of change. As noted in the project's formulation document: "The goal is to recover and value the different views and needs expressed by adolescents and youths themselves, as well as their ability to change and effect change in their peers; and to turn them into mobilizers and managers of local initiatives (sub-projects) for the promotion of and attention to sexual and reproductive health"[8] (MMR 2006: 5).

5. Referred to in local Spanish as: "agarres" or "vacilones."
6. Part of the contents of this section, specifically those on the strategies and results of the SserR Jóvenes project, were prepared through a systematization performed by the author for the Movimiento Manuela Ramos (Yon 2010).
7. Translation by *Apuntes*.
8. Translation by *Apuntes*.

The project sought to empower adolescents, providing them with resources and opportunities to broaden their knowledge of and approaches to their sexuality and rights, as well as to have their voice and their protagonism recognized. Specifically, they were offered spaces for reflection and the presentation of their own proposals; new knowledge and techniques; and the economic resources and professional advice necessary to carry out their projects (e.g., radio programs made by and for adolescents). The training of youth promoters was implemented together with a collective process for the diagnosis, formulation, implementation, and assessment of community projects. Once the project for the intervention ("sub-project") had been drafted, a management committee was formed, consisting of representatives of the youth promoters and one member each from the health and education sectors, who were also invited to take part. To complement these actions, a strategy was proposed for the improvement of SRH services through coordinated actions (alliances), as well as monitoring activities spearheaded by civil society.

A second component of the project was aimed at providing adolescents and youths with services adapted to their needs and perspectives, as well as contributing to the sustainability of these services. With this goal in mind, it was proposed that the capacities of healthcare providers and teachers from educational institutions be built, and that differentiated services for adolescents and youths in SRH be promoted. Workshops were held to raise awareness and train teachers and healthcare providers from the districts where the intervention was being carried out. In addition, support was provided for the creation of differentiated services for adolescents.

The third component of the intervention sought to create auspicious political and cultural conditions for the incorporation of SRH into the discussion and political decision-making agenda, as well as for the participation of adolescents and youths as active citizens of the community. To achieve this, workshops were held to raise awareness among parents and local leaders and authorities. Local and regional communication and education campaigns aimed at adolescents and youths were also organized, in order to foster positive opinions on sexual and reproductive rights at the local level and broaden the audience for the educational messages aimed primarily at adolescents. Meetings were also held between youth leaders and the highest health and education authorities so that adolescents and youths could present their demands. Additionally, efforts were made to create intergenerational alliances between youth leaders, authorities, and social leaders in order to promote advocacy and monitoring in favor of the sexual and reproductive health and rights of adolescents and youths.

These intervention strategies and the actors involved were not prioritized equally in the project and did not receive the same allocation of resources. The differentiated emphasis

on the project's various components was due not only to its focuses and logic (which emphasized community projects spearheaded by adolescents, as agents of change), but also was based on those components that were realistically predicted to yield greater gains during the intervention with the resources available. It was most likely decided ahead of time that the project's three year time-frame would not be enough to transform public health and education services or ensure large-scale political and cultural changes in state and civil society institutions, while the work with adolescents was considered an investment with better short- and medium-term prospects.

Thus, while the theory of change underlying the project proposed transformations in the supply and demand of SRH services for adolescents, it was decided from the very outset to provide greater support for one of the components. In practice, this meant that most of the effort was placed on demand, which was seen not only as a group of users, but as active citizens with their own voices and agendas. In other words, higher expectations were invested in a change rooted primarily in the transformations that the project might achieve in adolescents and the changes that these adolescents could effect in their peers, although with the supplementary aid of any achievements reached by the project's other two components, i.e., changes in the supply of health and sexual education services, and in other, broader public policies.

Below, I would like to evaluate the benefits and costs or limitations of this intervention strategy in achieving the purpose set forth: to help adolescents and youths affected by poverty and social exclusion to exercise their sexual and reproductive rights. With this purpose in mind, I will look at two interrelated aspects that underlie the project's formulation and which condition its results , as is the case with other similar projects implemented in Peru. The first aspect is the lack of implementation of public policies and sustained programs to improve the SRH of adolescents, especially of those who live in situations of poverty and social exclusion. The second is the emphasis on the participation (tied to empowerment) of adolescents as a primary mechanism in the search for equity or inclusion in health and the strengthening of adolescents' citizenship in the area of SRH.

NGOS CANNOT REPLACE PUBLIC POLICIES (OR, WHEN THE STATE IS ABSENT)

The MMR carried out its work in favor of the sexual and reproductive rights of adolescents practically in isolation, "against the tide," in those places where the SserR Jóvenes project was implemented. The project was recognized by the teachers and adolescents interviewed as the main reference point for training and orientation on these matters. This situation played out within a legal and institutional framework that could be labeled as adverse to sexual and reproductive rights. First, the "Sexual Indemnity Law" ("Ley de

Indemnidad Sexual," now repealed), which was still in force at the time, called into question adolescents' ability and right to make decisions on their sex lives. In addition, there was a lack of mechanisms and resources for the implementation of sex education programs and for differentiated SRH resources for adolescents, despite the formal recognition of these programs in Peruvian legislation and public policies.[9]

During the period in which the intervention was carried out (2006-2009) and this study was conducted (July 2008 to January 2010), both MINEDU and MINSA included gender- and human rights-based approaches in their policy guidelines on the adolescent SRH,[10] despite repeated flip-flopping on issues in response to interventions by high-ranking officials of the Catholic Church (Arias and Bazán 2006; Chávez and Cisneros 2004). However, the existence of these guidelines did not mean that they were being implemented and monitored, especially in the case of the education sector. Consequently, much of what teachers said or did was based on their own personal criteria or those of the director or principal of each educational institution.

In a diagnosis performed by Minedu in 2006 (Gutiérrez 2007), it was found that 60% of teachers felt unqualified to address sex education content, having stated that they felt uncomfortable talking about the subject, they did not know how to deal with students of different ages, or they felt embarrassed or insecure. Similarly, over 50% of teachers said they had neither the support materials nor enough time to hold mentoring classes that covered sex education topics (Minedu 2008: 16). At the time my fieldwork was conducted (August 2008 to January 2010), the majority of teachers in Ayacucho's schools

9. This recognition was influenced by the resolutions of the Fourth International Conference on Population and Development, held in Cairo in 1994, where a positive correlation of forces was achieved in favor of reproductive rights, enabling feminist NGOs, women's movements, and other civil society organizations to add several points of interest to the agenda on the health and rights of adolescents at the conference (Chávez and Cisneros 2004; Petchesky 2003).
10. In 2005, MINEDU approved the inclusion of sex education as a topic in the Psychopedagogical Prevention Area within the Advisory and Educational Guidance (Tutoría y Orientación Educativa) and as part of the basic contents of various curricular areas. Then, in 2006, an integrated sex education pilot program was begun in 68 primary and secondary educational institutions in five cities around the country. In April 2008, the Office of Advisory Education and Educational Guidance approved the *Educational Guidelines and Teachers' Orientation for Integrated Sex Education (Lineamientos educativos y orientaciones pedagógicas para la educación sexual integral),* which suggested that sex education should be based on a focus on human rights, gender equity, and interculturality (MINEDU 2008). MINSA, for its part, approved *Adolescent Health Policy Guidelines* (*Lineamientos de política de salud de los adolescentes*) in 2005. The first guideline states that: "[The] universal access of adolescents to integrated and differentiated care in public and private health services; with an emphasis on mental health, sexual and reproductive health, prevention and attention to gender-based, domestic, sexual, and social violence, and that related to the consequences of political violence" (MINSA 2005: 42); translation by *Apuntes*.

were unaware of the Minedu-approved guidelines for integrated sex education (2008). The same held true for schools in Huancavelica and Ucayali. Sex education was viewed as something that belonged outside educational institutions, and was primarily associated with the agenda of the NGO advocating its implementation in public schools. Many of the teachers found out about the existence of these guidelines through the awareness and training workshops held by the NGO, which were organized in coordination with the Local School District Administrations (UGELs). Moreover, the NGO's proposal to provide comprehensive information on the prevention of unwanted pregnancies and the human immunodeficiency virus (HIV) met with resistance from principals and teachers, with some exceptions. They cited the need for an "education based on values" (associated with religious values and the control of sexuality) and the promotion of abstinence as the main forms of preventing pregnancies in adolescents. The highest level of opposition was raised against addressing subjects such as the use of condoms and contraceptive methods. The teachers' main argument was that providing such content to adolescents would entail the risk of fostering promiscuity and sexual initiation. At the same time, it became evident that part of the resistance to working with the NGO stemmed from several of the teachers' embarrassment and discomfort over talking about issues of sexuality.

In contrast to experiences in the education sector, health sector professionals had a clearer idea of their competence and responsibility regarding adolescent SRH. Some officials in regional offices and staff responsible for services even had a discourse that favored gender- and rights-based approaches. Nevertheless, many health services in the four areas of intervention did not provide attention with a human rights orientation, as established in the *Adolescent Health Policy Guidelines.* Instead, cases of mistreatment were reported involving girls who sought attention after becoming pregnant, and of reluctance to provide condoms and other contraceptive methods to adolescents on the premise that they should not yet be sexually active. The limitations detected in the training and development of competences among health staff were compounded by other limitations related to regional health plans and the resources allocated for work on adolescent and youth SRH. Several health promoters stated that they faced various difficulties in performing preventive work given that the SRH of this age group was not a priority and their health center lacked the necessary staff and budget; in addition, shortages in supplies of contraceptives were at a critical point. It should be noted here that unlike the Regional Government of Ucayali, the regional governments of Ayacucho and Huancavelica did not include the sexual health of adolescents among their priorities, instead focusing primarily on child malnutrition and maternal mortality.

CONSEQUENCES OF THE (REAL) ABSENCE OF PUBLIC POLICIES AND SERVICES RELATED TO SEXUAL EDUCATION AND HEALTH FOR ADOLESCENTS

The failure to implement health and education policies aimed at improving adolescent SRH had significant consequences on the NGO's work, both in terms of the achievements ultimately attained with teachers and healthcare providers and in the work done with adolescents, as discussed below.

Fragility of the Achievements with Public Institutions

Despite everything, the NGO succeeded in finding key allies in educational institutions and health services, which demonstrated a vision and attitude toward the sexuality of adolescents that gradually changed or, in some cases, was more positive from the outset. Favorable conditions were observed in Ucayali, where the number of cases of persons living with HIV and ongoing work being done by civil society, with the support of development agencies, appeared to contribute to the inclusion of SRH on the regional government's agenda of priorities. In Ayacucho, Huancavelica, and Lima, achievements in public institutions depended primarily on the individual commitment of particular people, thus contributing to their fragility. The few teachers who proved committed to a scientific approach to sexuality found themselves in an isolated, vulnerable position, largely dependent on the continuing support of directors or principals of the educational institutions and susceptible to high turnover in the teaching staffs. The teachers, like the officials of the UGELs, agreed that it was necessary to continue receiving support from entities such as this NGO in order to raise awareness and train all their colleagues. Although they recognized that this task was the state's responsibility, they expressed little hope of anything materializing, given the complete lack of action on the matter up to that point. With regard to the health sector, the functioning of the various services was affected by a shortage of specialized staff exclusively dedicated to working with adolescents, as a result of the lack of a budget allocated for work on adolescent health.

The Empowerment of Citizens through Public Policies

From a methodological standpoint, the peer education strategy, including the necessary training and ongoing monitoring, has proven effective (Sánchez et al. 2003; Pérez and Rodríguez 1996). Furthermore, it has resulted in appreciable benefits as a means of learning and developing social skills, leadership abilities, and forms of social recognition (La Porta et al. 2000; Romero 2004). In regard to this strategy, the youth promoters interviewed highlighted not only new knowledge and skills they acquired for interaction with the public, but also greater social recognition from their peers and some adults. Multiple promoters viewed this as a kind of leadership training, while others saw it as a way to gain experience for future jobs or political opportunities.

However, a three-way partnership between the state, civil society, and international cooperation for the application of public policies may be not only inequitable, but inefficient, when most of the weight for the implementation of these policies is shouldered by the NGO and the volunteer work done by adolescents in their role as SRH promoters. The projects prepared and implemented by the adolescents were formally carried out in alliance with the health and education sectors. This articulation was promoted by the NGO to ensure compliance with the guidelines approved on matters of sexual health and education of adolescents, and to lay the foundations for the sustainability of the promoters' work. Nevertheless, with a few notable exceptions, these agreements involved no further commitment on the part of state institutions beyond limited support for certain activities coordinated with their sectors. In practice, this involved the continuation of a working model in which the responsibility for community and educational work fell to the NGO and the youth promoters, a situation that not only proved to be unsustainable, but also problematic in terms of understanding citizen participation and the state's responsibilities with regard to the issue of adolescent SRH are to be understood.

Dynamics of Empowerment and Disempowerment of Adolescents

Given that the issue of adolescent sexuality continues to be an area of prohibitions and controversies, the lack of effective institutional commitments and changes in the health and education sectors contributed to a paradoxical dynamic marked by the simultaneous creation of opportunities for improvement and, at the same time, continued situations of vulnerability for adolescents.

As I noted in the systematization of the SserR Jóvenes project, this expanded the cultural and political agency of the adolescents, achieved by giving them the opportunity to take part in the creation of meanings on adolescent sexuality, as well as fostering spaces and providing support for male and female adolescents to question discourses and social relations that refuse to recognize their ability to decide and propose. As part of the community initiatives (sub-projects), the adolescents expressed themselves through forms and languages of their own choosing, such as games, characters, symbols of youth cultures, local cultural expressions, and the mass media. They also publicly questioned myths and taboos that affect the way they experience their sexuality (for example, those concerning masturbation, virginity, or the use of condoms) and introduced meanings and images that promoted the exercise of their sexual and reproductive rights. On the other hand, many youth promoters were the target of criticism and sanctions because of their new ideas and knowledge, both at school and at home. The promotion of the use of condoms for twofold protection – from unwanted pregnancy and from sexually transmitted diseases – as well as the demonstration of the correct use thereof by youth promoters was met with rejection and controversy, associated as it was with the promotion of sexual relations. Several of

the adolescents had to deal with multiple obstacles when trying to obtain a condom at the health services center, where the main purpose of this interaction was to convince the youths not to engage in sexual sanctions.

A relational approach to agency, in its dynamic interdependence on social structures (Ortner 1996), helps provide us with a more realistic perspective of what youth promoters might achieve in the short term, under adverse circumstances, with these new skills and knowledge. This approach also raises the visibility of the serious consequences in store if the state and entities dedicated to training professionals do not assume responsibility for the crucial changes which neither the NGO nor the youth promoters were able to achieve, such as the training of education and health professionals on issues of the sexuality and adolescent SRH. Lastly, it is helpful to recall the distinction made by Muller (1983) between the two ways of understanding participation in health, a differentiation that facilitates a critical view of the connections between community participation and empowerment. This author distinguishes between direct participation, understood as the mobilization of community resources (human, financial, and material resources, as well as creative abilities), in order to carry out health programs; and social participation, which he defines as the increase in people's control over the determinants of health. The ultimate goal thus should be social participation, while direct participation should only be a strategy that allows for greater social participation (Reyes 1989: 8-9). The (direct) participation of youth promoters would become social through an increase in their power to participate in the design and evaluation of SRH policies, and to ensure that they are taken into account in the broader agenda of social policies that have an impact on their living conditions and the exercise of their rights.

KNOWLEDGE AND RIGHTS IN SITUATIONS OF SOCIAL VULNERABILITY: WHY IT IS ESSENTIAL TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

The majority of youth promoters became peer educators and defenders of sexual and reproductive rights in contexts of social vulnerability and the repression of adolescent sexuality, in both urban and rural areas, albeit with their own particularities and variations. These scenarios are shaped by the limited educational and job opportunities to which these adolescents and their families have access as a result of relations of power and social inequalities (for example, between adults and adolescents, teachers and students, men and women, etc.), as well as the influence of the churches (Catholic or evangelical) in relation to to sex education by families and educational institutions.

Male and female adolescents stated that this was the first time that they had obtained complete scientific information on contraceptive methods, the morning-after pill, and

condoms. Using their own language, these adolescents promoted gender equity and sexual and reproductive rights through educational workshops with their peers, a radio program, and posters and pamphlets that they handed out at dance festivals and recreational events. Some of them were even able to offer solid arguments during debates with their teachers. The adolescents also recognized a series of advantages and lessons that the project had given them in their daily lives, especially adolescent females, who had more difficulty than males in dealing with the issue of shame when talking about subjects considered taboo or dirty due to the greater social control over and sanctions on female sexuality. For several of these women, the process was indeed liberating. In the words of one of them, a woman named Dulia:

> I didn't know anything, since no one ever talks to me about romance... and we talked about women, their bodies, getting to know our own bodies. That was the first time I'd done that. And so then... how embarrassing! They talked to us about the vagina. It was so embarrassing! There were men there. But I think it was a nice experience, because it changed a lot of things about my life... Oh, you have no idea! Now I can even look at my whole body and I don't feel ashamed![11]

The concept of machismo, which was in use prior to the project, judging by the participative diagnoses, became a kind of tool that was legitimated by the NGO in order to criticize situations of inequality and injustice between men and women, as well as men's privileges or supposed superiority over women. During community project activities, I observed that this concept was used to draw men's and women's attention to the way in which the organizational and logistical tasks were divided up, as well as pointing out the perpetuation of gender stereotypes through nicknames or jokes that the promoters shared among themselves. "Knowing" or "knowing more" about gender and sexuality issues, or contraceptives, has better positioned some female promoters in relation to their partner, provided they were able to manage the initial conflict or mistrust.

These are just some expressions of a complex process of empowerment of adolescent women in matters of SRH, which is related to what they think and know, as well as their social relationships and the forms of negotiation available to them. The application of new knowledge by female promoters and other female participants has faced its greatest challenges in situations of social vulnerability that are part of their daily lives, thus increasing the likelihood of sexual abuse and the risk of unwanted pregnancies or the acquisition of a sexually transmitted disease. Under these circumstances, the new

11. Translation by *Apuntes*.

knowledge, approaches, and access to health and other institutions were severely curtailed, if not closed off, as real resources or options for the prevention of sexual abuse and risks.

Over the course of my fieldwork, I was able to discern at least three types of critical situations in which social vulnerability augments the sexual vulnerability of adolescents; these are covered in greater depth in Yon (2014). Firstly, there are situations of sexual abuse in the home at the hands of family members, which are shaped and concealed by power relations organized around gender and age. These power relations not only limit adolescents' decision-making ability, but also feed their fears and restrict mothers' ability to support their daughters or safeguard them against abuse by the mothers' partners. As such, the adolescent women interviewed were well aware of how and where to denounce sexual aggressors, because of their participation in the NGO's workshops and the information they received at school, in some cases, but this was not considered a real "option." Among the primary reasons for not filing a report was the fear of losing one of the few sources of support or social assets that these young women and their families had for accessing the material resources they need on a daily basis, and which constitute forms of protection from external threats or support in case of emergencies. These young women also fear being stigmatized and shamed after reporting sexual abuse.

Secondly, situations of social vulnerability were also observed in the workplace, in relation to sexual and other risks: domestic services in the case of adolescent women, and temporary employment farming coca leaf crops in the case of adolescent men. Where the adolescent women were concerned, there were situations of sexual harassment and abuse facilitated by the precarious working conditions in which domestic services are provided, as well as the inequalities that are socially "justified" by ethnic discrimination against those people who engage in such work and the low status ascribed to it. Females working in domestic services were also aware of how and where to file reports, but they rejected this possibility out of the belief that such actions would not yield results because of their subordinate position in the hierarchies of ethnicity and social class, and that they might end up being further humiliated for having done so. Nevertheless, they were ultimately able to denounce their sexual aggressors to their female employers (although not through legal channels) and permanently removed themselves from these situations. Unlike the situations observed in cases of sexual abuse in the home, these girls were able to speak out about the aggression they had suffered with less fear and shame. This may be associated with less stigmatization of abuse committed by a stranger, under the circumstances of a less dependent relationship - both economically and emotionally speaking - with the aggressor, since they viewed their jobs as something temporary that they could leave behind to escape sexual abuse. Adolescent males, on the other hand, faced sexual risks (due to the inconsistent use of condoms) tied to the growing (and increasingly organized) sale

of alcohol and sexual commerce in the coca producing areas located in the Valley of the Apurímac, Ene, and Mantaro rivers (Vraem). Work is done in these areas by local children, adolescents, and youths, but also by seasonal migrants from marginal neighborhoods of Ayacucho and other neighboring towns and cities (see Unicef 2006; García *et al.* 2008). For the interviewees, going to the bar-cum-brothel each week was something that was seen as practically "inevitable" when they were in the Vraem. They mentioned the lack of options for relaxing and blowing off steam after the workweek, being far from their families and friends, the greater availability of money, the supply of sex workers in the bars that they frequent, peer pressure, and what they refer to as "a man's nature," associated with a greater difficulty in restraining sexual desire. As a manifestation of gender inequalities in the area of sexuality, in contrast to situations of abuse that mostly affect adolescent women at home and in the workplace, situations of sexual vulnerability for males in the coca production areas involve the exercise of their sexual agency. Although peer pressure occurs, due to hegemonic patterns of masculinity, male adolescents play an active part in their own decisions (they see it as a sexual opportunity) and have a wider margin of action in order to escape unwanted sexual relations or to make use of condoms, if they so wish.

Thirdly, there are situations of sexual vulnerability at sites of entertainment or meeting places with peers. These are derived from the dynamics existing in such social spaces (for example, the excessive consumption of alcohol), but also from parental gender norms that define the scope of social risk for adolescents (being discovered, judged, and sanctioned), and that paradoxically tend to overshadow risks of other kinds, such as sexual and safety risks. Thus, the gender inequities that shape the division of permitted/prohibited social spaces for adolescents and the social norms related to their sexuality serve to increase vulnerability to social and sexual risks on the part of young women; this is true of even the most informed, such as female youth promoters, who are also subject to the instructions and sanctions from their family members-even if they think these are machistas.

The notion of rights is absent from the lives of these adolescents, aside from what they learned in the project and the use of this language in public or educational activities. Generally speaking, their opportunities and resources have not been realized (or even viewed) as rights, but rather the result of personal or family risks or sacrifices. Several situations of sexual vulnerability faced by adolescents in the workplace and places of leisure occur as part of paradoxical processes in which there exists a tension between seeking to increase assets or exercise agency — and sometimes succeeding in doing so – and running significant risks that are directly or indirectly associated with these opportunities. This tension brings about variable results, including consequences for their sexual and reproductive health and rights. Furthermore, situations of social and sexual vulnerability may be rendered invisible, accepted, or never confronted because of the assumption that these are the

only opportunities to achieve greater autonomy, to be recognized as equals, or to fulfill aspirations rooted in globalized stereotypes of gender and citizenship. These "modern" or prestigious forms of being adolescent include investing in certain presentations of the body and obtaining goods that lend it value, prestige, and identity, such as stylish clothes, electronic devices, motorcycles, and other objects that symbolize different youth cultures to which the adolescent has been exposed through peers or the internet (Yon 2014).

Implementing the discourse of sexual and reproductive rights in the situations of vulnerability described above would involve a level of autonomy, individual agency, and social and institutional support that adolescents truly do not have. Thus, just as important as working on processes of individual empowerment, which even involved questioning relations of gender and intergenerational inequity, is to directly confront the social determining factors that shape adolescents' opportunities and risks and influence their choices and forms of prevention or confrontation. Otherwise, the limits of these interventions may be predicted from the very start.

BY WAY OF CONCLUSION: GOING BEYOND (CURRENT) GOOD PRACTICES

This article demonstrates the potentialities and limitations of an SRH project that is generally aligned with MINSA criteria (2013) and the international literature on good practices. The project discussed here tackled the challenge of advocating for the exercise of the sexual and reproductive rights of low-income adolescents in rural and urban areas, taking into account intergenerational and gender inequalities, using a gender equity- and interculturality-based approach. As in other similar Latin American experiences (Romero 2004), the aim was not only to raise awareness, but also to promote the exercise of democratic values, respect for the other, and gender and intergenerational equity. In other words, a proposal was set forth for a change in the interpretative framework of sexuality and interpersonal relations. At the same time, emphasis was placed on matters such as the development of competencies or capacities to put into practice a new way of seeing one's own body, decision-making, and sexual interactions. Finally, an effort was made to foster processes of empowerment and recognition of the voice and agendas of adolescents through community projects. Despite the costs to the participants of limited support from adults close to them (parents, teachers, and healthcare providers), they managed to develop forms of agency that allowed a group of adolescents to look at their bodies without shame, speak publicly about sexuality, and demand sex education and access to contraceptive methods, as well as question gender and age hierarchies that cut across the whole of society. This certainly lends more nuance or complexity to the hypothesis maintained by several development anthropologists who argue that development categories and strategies that appear to be liberating, such as empowerment and social participation, may ultimately

tend to sidestep the power structures operative at the macro level by concentrating on the micro level of participative democracy (Porter 1997; Cooke and Kothari 2001; Edelman and Haugerud 2005).

However, the intervention strategies implemented (participative community projects, training and awareness workshops for health and education operators, strategic intergenerational alliances, and meetings with decision-makers) had a limited impact, given the inability to transform institutional and social contexts that were relatively unfavorable or downright adverse to the rights and SRH of adolescents. Predictably, the three-year long intervention by one NGO could not achieve these changes in the political context and structural determinants of health. Nevertheless, it is still necessary to design empowerment strategies that extend beyond subjective aspects and the development of adolescents' social skills. Such strategies should also take into consideration the proven ties between SRH and the lack of opportunities for adolescents in situations of considerable social inequalities, especially those affecting adolescent women. From this standpoint, state policies and programs have been highlighted that demonstrate the positive effect of prolonging adolescents' time at school on the postponement of pregnancy (World Bank 2012; Mendoza and Subiría 2013), namely, the Educational Subsidy (Subsidio Educativo) conditional government transfer program in Colombia (Cortés *et al.* 2011) and the national education reform that extended school hours in Chile (Berthelon and Kruger 2011). Additionally, high-quality education is needed, especially in areas with higher poverty, that can legitimately motivate adolescents and become part of their life plans (Näslund-Hadley and Manzano 2011).

This paper is not intended as a critical assessment of a good practice per se, but rather an analysis of the conditions that determine whether or not it is possible for this and other similar initiatives to achieve the expected results and attain sustainability in the Peruvian context, particularly in the rural and peri-urban areas of the country, where the project analyzed here was carried out. Two aspects that clearly shaped the process and the results of this intervention were the adolescents' situations of social vulnerability and the absence of public policies. Such policies, as the WHO (2008) notes, are a means of confronting the social determinants of health that must be taken up by governments, foregoing short-term interventions that fail to scratch the surface of the problems being addressed.

The acceptance of the Catholic Church's influence over public policies by our political leaders and government officials (at different levels of the public sector) may be one of the reasons for the Peruvian state's flip-flopping – and oftentimes, inaction—in regard to the issue of the adolescent SRH (Chávez and Cisneros 2004). The truth is that there has been no observable political will to guarantee the training of public sector authorities and workers on this issue, nor has an adequate budget been allocated for the implementation,

monitoring, and assessment of the sex education program and differentiated health services. Fortunately, several of these determinants are included in the *Multi-Sector Plan for the Prevention of Pregnancy in Adolescents 2013-2021*, spearheaded by the Minsa and drafted with the support of the Unfpa.

From this point of view, the main problem does not currently seem to lie in the identification and testing of good practices or successful forms of intervention, but rather in the state's compliance with international agreements on the promotion of the sexual and reproductive health and rights of adolescents, such as those reached at the Conference on Population and Development in Cairo (1994), the Millennium Development Goals (2000), and the Ordinary Meeting of Ministers of Health of the Andean Area (2010). As correctly recognized (Minsa 2013), the response capacity of governmental institutions is itself also a determinant of health (McLeroy *et al.* 1988). More specifically, this means that the Peruvian state needs to take responsibility for the implementation of policies that facilitate access to scientific sex education and SRH services for adolescents, as well as multi-sectoral policies aimed at diminishing poverty and gender inequities in access to education and a higher income, putting a stop to abusive or violent intergenerational relationships between parents and children – and, in general, between adults and minors – homophobia, and gender violence in its different manifestations, along with forced labor and sexual exploitation of adolescents. The projects undertaken by community organizations, NGOs, and international cooperation cannot serve as a stand-in for public policies, but they can help foster compliance with these policies, as well as improving their design, implementation, and assessment as part of a multi-sectoral approach based on expertise and lessons learned with regard to the problems at hand. It is also necessary to strengthen the network of organizations and youth and adult leaders interested in the health and rights of adolescents,[12] so that, as a group, they can act as a counterbalance to conservative positions and form part of a citizenry that is active and vigilant with regard to these issues.

12. One example is: the ¡Sí podemos! Alliance for Comprehensive Sex Education.

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