# Adolescent Pregnancy in Costa Rica

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Costa Rica: adolescent national policies · Adolescent pregnancy · Abortion · Condom use · Poverty · Sexuality and reproductive health · Sexual education · Sexual initiation · Sexually transmitted infections · Teenage fertility

## Introduction

Costa Rica is a small country in Central America known as a peaceful, democratic, and prosperous nation with high achievements in the health care and education of its people. The country, however, is facing questions regarding adolescent pregnancy and the education of children and youth in areas of sexual and reproductive health. Coming from a long Catholic tradition and patriarchal views concerning gender and family, Costa Rica is making important decisions that could have a transformative impact on not only adolescents' pregnancy, health, and education, but also on the areas of human rights, gender equity, and economic prosperity that are at the heart of its democratic identity.

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## A Contextual Background

Costa Rica is one of the oldest democracies in the region. After the arrival of the Spaniards in the 1500s, Costa Rica declared itself a sovereign nation in 1838, and general elections began in 1889. The 1949 ruling constitution of Costa Rica abolished the army permanently and guaranteed free elections and peaceful succession of power (Aguilar Bulgarelli and Fallas Monge 1977), and for the last 60 years, the electoral process and succession of power in the government have been peaceful despite Costa Rica's geographical proximity to conflict-affected countries such as Nicaragua, Salvador, and Guatemala. The government of Costa Rica is a democratic republic with national presidential elections every 4 years and a cabinet of 57 Legislative Assembly deputies. In 2010, Costa Rica elected its first female president.

### Population

Since the 1970s, Costa Rica has experienced a steady national population increase. The

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population in 2009 exceeded 4.5 million individuals with 49.3 % of those being women (INEC 2009). This sharply compares to the 1.8 million inhabitants of Costa Rica in 1973 (Aguilar Bulgarelli and Fallas Monge 1977). Reflecting a heavy European influence, Costa Rica's population is primarily made up of mestizos or people of mixed European and indigenous descent (94 %) (U.S. Department of State 2011). Indian people comprise 1.7 % of the national population, and Blacks comprise 3 % of the population (Political Risk Services 2010; U.S. Department of State 2011). Other important groups include Nicaraguan documented and undocumented immigrants and refugees who account for no less than 10 % of the population. Nicaraguans, primarily young people 20–39 years of age, 50.9 % of whom were women, began to immigrate to Costa Rica in significant numbers at the end of the twentieth century seeking peace and options for prosperity. They make up the most relevant immigrant group in Costa Rica (Fondo de Población 2009; INAMU 2008).

## Religion and Contemporaneous Influences

Conquered by the Spaniards, Costa Rica has a Catholic religious tradition, which is stated in the national constitution. Article 75 of the constitution indicates that the Roman Catholic Apostolic Church is the religion of the state (as amended with regard to its number by Article 1, Law No. 5703, June 6, 1975). Today, 76 % of the population in Costa Rica is Roman Catholic. However, Evangelical Protestant religious groups have been emerging and growing in the country, with 13 % of the current population as followers (Pearson 2010; U.S. Department of State 2011). The remaining 10 % of the population reports practicing other religions (6 %) or not practicing any religion (3 %). As the primary religion practiced in the country, Catholicism is influential in matters of the state. Its position regarding issues of human sexuality, reproductive health, and birth control is central to the topic of adolescent pregnancy and has contributed to the current national debate on women's and children's rights, gender equity, sexuality, and reproductive health education.

Congruent with a tradition of the Roman Catholic Apostolic Church, the views of the church follow traditional hierarchical and patriarchal definitions of the family, gender relations and roles, and sexuality. For example, regarding single motherhood, Budowski (as cited in Chant 2002) reported that, according to the Catholic Church in Costa Rica, single motherhood is the result of sinful behavior and as such is a threat to the moral and social order of the country. Chastity, celibacy, and virginity are considered cardinal values for the Catholic Church, so sexual abstinence until marriage is favored. Sexuality or physical intimacy is to occur between a married man and woman, and it is within this union that children are to be born. Marriage, sexuality, and procreation are inseparable in Catholic teachings (Pontifical Council 1995; Trujillo 2003). The Catholic Church also is clear on its position regarding human sexuality education for children and adolescents, which is considered to be the parent's right and first duty. Sexuality education in other institutions is perceived as discouraging parents from performing their duties and roles.

Regarding birth control and barriers to sexually transmitted infections (STIs), the Catholic Church has been critical of programs endorsing condom use as a safe alternative for preventing HIV\AIDS and other sexually transmitted illnesses. Aside from the moral reasons, the Church is concerned that young people may be misled to assume that condoms provide total protection against STIs. Instead, promotion of abstinence before marriage and fidelity to one's spouse are the Catholic Church's alternatives for 100 % prevention of STIs (Pontifical Council 1995; Trujillo 2003).

The Catholic Church recognizes the value of human life from conception and consequently opposes abortion (Barrantes Freer et al. 2003). Perceived as offending the religious code, a

woman who has an abortion can be excommunicated from the Catholic Church.

Besides the traditional religious influences, Costa Rica has not escaped the impact of globalization, market-driven economy, scientific advances in birth control, the pandemic of HIV\AIDS, the absorption of women into the work force, the feminist movement, and the ascent of women to important leadership positions (Chant 2002) that paved the way to increased recognition of women's and adolescents' rights, and have fueled the changes in the structure and composition of Costa Rica's families since the 1970s.

The provision of birth control by the Caja Costarricense del Seguro Social (CCSS) (Costarican Social Security) in the decade of the mid-1960s to mid-1970s was a salient factor in the decline in Costa Rica's fertility rate because it made birth control available to all women across the national territory (Carranza 2009; Rosero-Bixby 1984). Concurrently, the impact of feminist thinkers since the 1970s led to important achievements in the advancement of women's rights and gender equity legislation, and the creation of key institutions such as the Instituto Nacional de las Mujeres (INAMU) (National Institute of Women) (Chant 2002). Chant (2002) points to the rise of and advocacy for women, not only in political and leadership positions but also in professional fields traditionally occupied by men, which resulted in significant legislation and programs on behalf of women, such as the Law for Social Equality for Women (No. 7142), and the Law for the Protection of Adolescent Mothers (Law no. 7739).

In addition, since the early 1980s, global economic pressures have pushed women to enter the work force and be subjected to global and national economic trends (Martinez Franzoni et al. 2009; Milosavjevic 2007; Rosero-Bixby et al. 2009). All of these issues came together to significantly influence the composition and structure of Costa Rica's families, evidenced by a decline in marriages, an increase in divorces, cohabitating couples, and a drastic increment in mono-parental families headed by women (Barquero Barquero and Trejos Solórzano 2004; Chant 2002; Milosavjevic 2007). For example, Costa Rica has experienced an increase in the number of children born out of wedlock, with 23 % in 1960 compared to 49 % in 1998 (Budowski and Rosero-Bixby 2003). Also, the marriage rate for every 1,000 people in Costa Rica declined from 7.71 in 1989 to 5.30 in 2009 (INEC 2009). Families headed by women make up a large proportion of Costa Rica's households and families living in poverty (Chant 2008). In addition, the HIV\AIDS epidemic has presented society with diversity in sexual expression and the need for prevention of STIs. These variations and needs are dissonant with the patriarchal heterosexual concept of a nuclear family, and they challenge traditional religious views of the family, which has ignited the involvement of the Catholic Church in the debate about sexuality and reproductive health education for children and adolescents.

It is among these forces—traditional patriarchal and religious family views, global and economic trends, scientific advances in birth control, poverty, diverse family configurations, awareness of diverse sexual expressions, women's achievements, and the advancement of a feminist ideology for increased women's rights and gender equity—that the debate regarding adolescent sexuality and pregnancy is situated today in Costa Rica's society.

## Children and Adolescents in Costa Rica

The age of adulthood in Costa Rica is 18 years. In 2005, the number of children younger than 18 in Costa Rica was approximately 1.5 million or a little more than a one-third of the total population. However, it is important to observe that the number of children in Costa Rica has been in decline for several decades due to a reduced national fertility rate. In 2005, there were 8,500 fewer children born in Costa Rica than in the year 2000 (UNICEF 2005). In 1988, children 15 or younger represented 37 % of the national population. For 2009, the same age group represented 25 % of the total population, marking a 12 % decline (INEC 2005, 2009, 2011). National 2009

estimates indicate that teens age 13–17 represent 9.4 % of the population. Including youth 13–19, estimates for 2010 show a total of 591,222 individuals (INEC 2008, 2011).

## Adolescent Sexuality and Pregnancy

*Sex initiation and practices:* The onset of intercourse and sexual experience for people in Costa Rica has been changing, with a trend toward early intercourse initiation. However, gender differences in sexual practices continue to prevail, with men initiating sexual intercourse at a younger age than females do. For example, adult men 61–80 years old reported having their first intercourse experience at age 17.8; the women in the same age group reported their first experience with intercourse at age 20. In addition, 80 % of men 65–69 years old reported having at least one masturbation experience in their lives compared to 7.65 % of women. Among those reporting experiences with masturbation, the first masturbation was reported to have occurred around 13.5 years of age for males and 22 years for females (Ministerio de Salud 2011b).

In terms of premarital intercourse experiences, Morris (1988) documented that 18 % of Costa Rican women aged 15–19 said they had premarital sexual intercourse; the mean age for the first premarital intercourse experience was reported to be 17. Interestingly, the women participating in this study reported that their first sexual partner was 6 years older than they. In 1991, Rosero-Bixby noted that 23 % of Costa Rica's women reported engaging in premarital sex before age 18; by age 19, the rate increased to 30.6 %. Ten years later, in 2001, the Programa de Atención Integral a la Adolescencia (Program of Integral Care for adolescents), sponsored by the CCSS (2002), reported that 20 % of adolescent women and 31 % of adolescent men aged 13–17 had been sexually active. Sexual intercourse was initiated between 14 and 15 years of age, with the highest number at age 15.

Regarding abstinence, in a study conducted by Gutiérrez Fernández et al. (2010), 82 % of teens aged 10–19 reported abstaining from sex. Again, important variations across gender were noted, with 72 % of the men relative to 92 % of the women reporting sexual abstinence.

Recently, the latest national report on sexual and reproductive health by the Ministerio de Salud (2010) (Health Ministry) corroborated an early onset of sexual intercourse for adolescents in Costa Rica. Sexual intercourse was reported to begin between ages 15 and 16, with adolescent men initiating sexual intercourse a year earlier than adolescent women. First sexual intercourse was reported by 68 % of men and 51.4 % of women to have occurred before age 18 overall (Ministerio de Salud 2011b). The first sexual partners for teens were again reported to be older than the adolescent; 5 years older than the adolescent girls and 2 years older than the teen boys (Ministerio de Salud 2010, 2011b). Among 15- to 44-year-olds, 22 % of males and 11.2 % of females reported having their first sexual intercourse before age 15. Regarding masturbation, 86.7 % of men reported having masturbated at least once in their lives, while only 23.4 % of women in that age group reported the same (Ministerio de Salud 2010). For immigrant groups, 59.5 % of youths 14–17 from Nicaragua reported intercourse initiation, which is higher than the 52.3 % of Costa Rican youths in the same age group (Fondo de Población 2009).

On the number of sexual partners, 60.7 % of women 15–17 reported having only one partner compared to 38.3 % of adolescent men. The adolescent men reported female sexual partners in the same age group as themselves or younger, but adolescent women reported male sexual partners older than themselves. For 1.6 % of adolescent women 15–17 and 3.8 % of young women 18–24, male partners were 40 years old or older (Fondo de Población 2009). According to Costa Rica's penal code, some of these relations may be unlawful, but besides the legality of the relationship is the issue of the impact of these relationships on adolescent women's identity and autonomy development.

A number of factors influenced teens in their decisions about whether or not to engage in sexual intercourse. However, for all young people 15–35, love for their partner was identified as the primary reason to engage in sexual intercourse (Fondo de Población 2009).

*Fertility rate:* Now, in contrast with the steady national population increase, the national fertility rate in Costa Rica has been in decline for the last 40 years. In the last decade, the fertility rate declined from 2.39 children per woman in 2000 to 1.82 in 2010, which is one of the lowest fertility rates in Latin America (Carranza 2009; INEC 2010). However, it is important to clarify that the fertility rate for teens 19 and younger has shown smaller rates of decrease (INEC 2010; Ministerio de Salud 2011c).

The highest fertility and birth rates for Costa Rica are reported for women aged 20–29. This age group of women contributed more than 55 % of the national births for the year 2009. The median age in 2009 for Costa Rica's first-time mothers was reported to be 25.2 years (INEC 2009). In the same year, teen mothers 15–19 contributed close to 19 % of the national births (INEC 2009; Ministerio de Salud 2011b). For 2008, the fertility rate for women 15–19 was 20.18 % (INEC 2008). There were also in 2008 a total of 15,217 births for mothers 11–19 years of age (Ministerio de Salud 2011c) and a total of 1,633 births for mothers younger than 15, representing 2.2 % of the national births for 2008 (Ministerio de Salud 2011b). In 2004, mothers younger than 19 gave birth to a total of 27,877 children in Costa Rica, equivalent to 19.9 % of the national births; also, a total of 455 mothers were younger than 15 years of age (Naciones Unidas et al. 2010; UNICEF 2005). For teens 18 and younger, the percentage of births was 14.09 % in 2005 (INEC 2005).

In contrast to the overall fertility rate for Costa Rican women, the number of births for immigrant women in Costa Rica has increased. In 2005, 18 % of the national births were to immigrant women, which compares to 15.5 % in 2000 (INEC 2010; UNICEF 2005). For Nicaraguan women, Camacho and Rosero-Bixby (2001) reported that in 1998, the overall fertility rate for Nicaraguan immigrant women was 40 % higher than the fertility rate for Costa Rica's women.

Within the national territory, the rate of adolescent fertility and births for indigenous groups is 40 %. This is alarming as many indigenous adolescent mothers are as young as 11 and 12 years of age, and the infant mortality rate was reported to be double for areas with indigenous populations, such as Talamanca (18.4 %), Coto Brus (16.9 %), Corredores (15.2 %), and Buenos Aires (13.9 %) (República de Costa Rica 2008a).

Among adolescents and young women, many pregnancies are unintended. Morris (1988) reported that 28 % of women 15–24 conceived or became pregnant before entry into a union or marriage. More than half of the births in 1986 that occurred during the first 7 months of union or marriage were the result of premarital or preunion conceptions. Among single mothers (not married or in a union) aged 15–24, 53 % reported that their first pregnancy was unintended, and 59 % reported that their most recent pregnancy was also unintended.

## Health

In areas of health, Costa Rica has a socialized health care system. The main public health institution in Costa Rica is El Ministerio de Salud Pública (Ministry of Public Heath), which guides the nation on health policies, epidemiological controls, and health programming. The CCSS is the primary organization in charge of implementing and providing health programs and direct health services to the population. Public expenditures on health approach 7 % of the national GDP (Political Risk Services 2010). Children covered in 2005 by the national health care system were proportionally 90 % of infants (children less than a year old), 80 % of children 7–12, 50 % of children 1–6, and 30 % of adolescents aged twelve and older. Regarding child immunizations, in 2004–2005, 90 % of all children were covered. However, it is important to note that this is less than the 97 % immunization

coverage achieved in 1997 (UNICEF 2005). Costa Rica's infant mortality has continued to decline from 10.21 infant deaths for every 1,000 births in the year 2000 to 8.84 in 2010 (INEC 2010). The average life expectancy for Costa Ricans is 77 years of age.

## Adolescent Pregnancy Health Concerns

Health risks for pregnant teens and mothers increase as the age of the adolescent decreases and relates to the level of poverty and deprivation in their living conditions (Barrantes Freer et al. 2003). In Costa Rica, health and medical concerns related to teen sexuality, pregnancy, and delivery include lack of routine gynecological exams, lack of early detection of STIs, unplanned pregnancies, pregnancy complications, anemia, spontaneous abortions, late prenatal care, malnutrition, low birth weight and premature births, and increased risk for maternal and infant deaths (Barrantes Freer et al. 2003; Núñez Rivas and Rojas Chavarria 1998). Based on these concerns, health care services are available to all pregnant teen women independently of health insurance (República de Costa Rica 2008a, b).

For 2008, the total of maternal deaths in Costa Rica was 25; six of those were adolescents mothers, including one death of a mother younger than 15 (Ministerio de Salud 2011c). In general, maternal deaths in Costa Rica decreased from 3.58 deaths for every 10,000 births to 2.11 from 2000 to 2010. In 2010, there were a total of 15 maternal deaths, which included women's deaths during pregnancy or delivery, or due to postnatal complications. Two additional deaths were reported due to abortion complications during the same year (INEC 2010). In 2004, only 30.44 % of adolescents 12 years or older were covered by the national health care system (República de Costa Rica 2008a). This statistic is important since in 2003, the CCSS reported that a total of 5,646 adolescents 17 or younger were treated and released from national hospitals due to complications during or after the births of their babies. Including the number of teens that were treated due to pregnancies ending in abortions, the number increased to 6,410 teens. Overall, 6.71 % of all births in the country were reported to present with low birth weights in 2004. However, the low birth weight prevalence for teen mothers aged 15–19 was 7.84 %, and for those aged 10–14, the number reached 10.14 %. These numbers are significant, as low birth weight is associated with increased risk for later health complications and even death for both the teen and the baby. For 2004, the number of deaths for neonatal babies (less than a month old) and postnatal infants (1–11 months old) reached 508 (UNICEF 2005).

Regarding prenatal education, 39.9 % of teens 15–17 and 49.4 % of young women 18–24 reported receiving prenatal education during pregnancy (Fondo de Población 2009). In 1998, 97 % of births to pregnant teens were reported to occur in hospitals (Núñez Rivas and Rojas Chavarria 1998). For all women in 2002, 99.4 % of deliveries were reported to occur in hospitals (Organización Panamericana 2007).

There is also a concern for the mental health of pregnant teens and mothers due to the impact of sexual violence and trauma in some cases, but also because of the growing awareness of the impact of early intercourse initiation and pregnancy on young women's identity, self-definition, sense of power, and autonomy. This is a major concern as many adolescent women have male sexual partners much older than themselves, which may challenge their ability to navigate these relationships (Fondo de Población 2009; Ministerio de Salud 2010, 2011b). In regard to this, Law no. 7739, Code on Childhood and Adolescence, Article 44, point G, determines that services provided to pregnant teens and mothers need to involve a team of professionals with expertise in adolescent pregnancy and early motherhood, including a physician, a social worker, and a psychologist.

## Pregnancy Prevention and Condom Use

In 2007, the Fondo de Población de las Naciones Unidas (2009) reported on the use of methods of birth control and infection prevention barriers: 54 % of women 15–24 reported using condoms, 33 % reported using birth control pills, 3 % turned to surgical interventions, 1 % trusted natural methods, and 14 % reported using some other method. For the men, 48 % reported using condoms, 39 % relied on the use of pills by their partners, 1.8 % turned to surgical interventions, 0.7 % trusted natural methods, and 13.5 % used other methods. A recent national report on the use of contraceptive methods indicates that the prevalence of birth control in Costa Rica is 82 %. The methods more frequently used include female sterilization (30 %), oral birth control (21 %), injections (9.3 %), male condoms (8.9), male sterilization (5.8 %), and IUDs (3.3 %) (Fondo de Población 2011).

It is interesting to observe the low proportion of vasectomies, the high number of women using surgical sterilizations for birth control, and the decline in condom use from 16 % in 1992 to 9 % in 2010, which poses increased risk for STIs, including HIV. On women's surgical sterilization, Carranza (2007) points out that even though therapeutic sterilization is a procedure legally restricted by the penal code to be used only when the mother's health and/or life is at risk, it has been generalized as a contraceptive method. Even though frequently used as birth control, sterilization is not an alternative for women seeking only temporary prevention of conception, such as those women in their adolescent years.

On the use of condoms among individuals aged 15–49, women reported fewer incidents of condom usage during their last sexual intercourse experience relative to the men. The same pattern was observed with teens 15–19, with only 44 % of women compared to 66 % of men reporting the use of condoms during the last intercourse experience (Ministerio de Salud 2011b).

Concerns about effective family planning and contraceptive options for Costa Rica's women have been raised. In Re: Supplementary Information on Costa Rica, which is a letter responding to reports submitted by Costa Rica, the Joint NGO Commission (2011) denounces the CCSS for not making available newer and safer contraceptives appropriate for women and teens (e.g., vaginal rings, hormonal IUDs like Mirena, and progestin-only based pills).

Specific to teens, the value placed on female virginity and avoidance of intercourse until marriage, versus the acceptance and value of men's sexual experimentation, was reported to have an impact on the use of birth control by teens (Núñez Rivas and Rojas Chavarria 1998). Fear of being discovered often discourages adolescent girls from accessing birth control and barriers for disease prevention, while adolescent males are not often encouraged to take a proactive role in and responsibility for pregnancy and disease prevention. Soper and Tristan (2004) observed that teens are misinformed about STIs and birth control, and Molina Chavez and Leiva Diaz (2010) also noted that even when teens know about birth control, many fail to act on their knowledge, as the low usage of condoms shows. Consistent use of condoms is more likely by older teens but not younger adolescents (Gutierrez Fernandez et al. 2010). The INAMU report based on a national survey of perceptions of women's rights specified that almost 69 % of the responders support the use of contraceptives by adolescents, while 21.3 % do not. The large majority of responders in favor of birth control for adolescents, however, contrast with public policies that do not support the distribution of birth control to teens (INAMU 2008). This is puzzling as intercourse initiation has been documented to occur several years before age 18 (age of adulthood in Costa Rica), and teens as young as 15 can get married with parental consent. On this issue, Carranza (2009) notes that the lack of clear policies by the CCSS regarding the provision of contraceptive services to teens impacts the standardization of services

adolescents receive across the national territory, often leaving the decision on which services to provide to the attending professionals. Also, (a) short consultation time available for women and physicians to truly discuss contraception methods and recommendations, (b) changes in attending physicians, which limits the continuity of care and follow-up, and (c) a reduced variety of contraceptives available to women that use the CCSS are some of the concerns about birth control in Costa Rica (Carranza 2009; Chen Mok et al. 2001).

Regarding emergency contraception, decisions about the approval of use and distribution have been pending since 2007 (Joint NGO Commission 2011). Even though the Ministerio de Salud (Health Ministry), the Panamerican Health Organization, and the International Federation of Gynecology and Obstetrics have determined that emergency contraception pills are not abortive, legislators have not acted on the issue for years (Joint NGO Commission 2011; The Morning After Pill 2009; Fondo de Población 2005). While the use of emergency contraception is not criminalized in Costa Rica, the CCSS does not distribute the emergency contraception nor has the medication in its pharmacies or hospitals. This limits the ability of women, including those victims of sexual violence, to secure the medication. The lack of emergency contraception for Costa Rican women has been denounced as a violation of women's rights (Joint NGO Commission 2011).

## Sexually Transmitted Infections

In Costa Rica, 87.4 % of teens 15–17 and 83.1 % of young adults 18–24 reported receiving information on STIs. Across all age groups, the proportion of women (84.4 %) that received information on STIs was higher than the proportion (82.5 %) of men (Fondo de Población 2009). There were 125 cases of STIs in children up to 17 years of age treated in the hospitals of the CCSS in 2003. The majority of those (99) were cases of congenital syphilis, emphasizing the importance of preventive and opportune maternal health education and care (UNICEF 2005).

A total of three cases of teens 13–17 were reported to have been treated and released from the hospital due to HIV in 2003. The total number of HIV cases for all youths younger than 18 was 36. The majority of those cases (33) were children nine or younger and were probably due to maternal infection. It is important to note that in 2002, the total number of children treated and released from the hospital due to HIV infections was 16, and three of those were teens aged 17 (UNICEF 2005).

In 2004, HIV\AIDS was reported to have affected a total of 314 women, which is 12.8 % of all reported cases. The highest risk for HIV infection for Costa Rican women is for those 20–49 years of age. Women aged 30–39 are at the highest risk for presenting with AIDS symptoms (Fondo de Población 2009). In the year 2008, there were 263 reported cases of HIV. Men were primarily affected; so, for each 4.5 cases of infected men, there is one infected woman in Costa Rica. No cases of HIV were reported for children 0–14. After age 15, the number of cases increased to reach a peak in those aged 20–34. There were no documented cases of AIDS for youths younger than 19 in 2008. However, the total number of cases increased in people aged 20–49, with the highest number of cases in the group of 40- to 44-year-olds. A total of 81.82 % of registered AIDS cases affected men (Fondo de Población 2009).

## Abortion

Costa Rica's penal code establishes that abortion is illegal except when the life or health of the mother is at risk (articles 118–121). As such, abortion in Costa Rica has legal implications for those who perform them and those who have them. This has an impact on the accuracy of the reporting of abortions.

In cases in which the pregnancy poses a risk to the mother's life or health or is the result of

rape or incest, or when there are serious physical and mental deficiencies or malformations affecting the product of the pregnancy, therapeutic abortions have been allowed under the nation's laws since 1971. Therapeutic abortions require the woman's consent; teens younger than 18 cannot consent (Barrantes Freer et al. 2003; Joint NGO Commission 2011).

Chen Mok et al. (2001) reported that 55 % of women ages 15–49 opposed abortion, and only 37 % approved of the procedure for cases presenting health risks for the mother or in cases of incest. Therapeutic abortions, however, are rarely performed in Costa Rica, which is surprising due to the health risks and complications associated with pregnancy during teen years. In its Re: Supplementary Information on Costa Rica (2011), the Joint NGO Commission points to the lack of equipment, professional expertise, and clear abortion guidelines for health care professionals to deliver services in optimum conditions and without fear of legal repercussions. Professional medical guidelines for conducting legal abortions have been pending approval by the government since 2009. The lack of action places women's lives and well-being at risk, especially those with high-risk pregnancies like young adolescents or those pregnant as a result of sexual violence. Lack of abortion services may encourage women to seek abortion services outside the public health system. Carranza (2007) reported that only seven therapeutic abortions were documented or performed by the CCSS between 1984 and 2003. Nevertheless, the CCSS reported a total of 764 pregnancies that ended in abortions for teens 17 or younger, including 215 from girls 13–15 years old in 2003 (UNICEF 2005). The number increases to 8,038 for all women treated and released from hospitals run by the CCSS due to abortions in the same year. However, it was not clear whether any of these were induced or elective abortions (Fondo de Población 2005). In the case of elective abortions, it is very likely that they are underreported because the illegality of the practice in Costa Rica limits and obscures its study. However, 6,500–8,500 therapeutic abortions were calculated to have occurred among women 15–49 from 1988 to 1991 (Brenes Varela as cited in Carranza 2007). The Joint NGO Commission (2011) points to a yearly average of five legal abortions performed by the CCSS, contrasting with at least 10,000 abortions outside the public health care system. The number 10,000 represents women seeking postabortion health care services in public health organizations, signaling a larger number of abortions occurring every year outside the public health system in clandestine facilities.

## Adolescent Pregnancy Social and Economic Concerns

The links between adolescent pregnancy, education, and poverty are some of the main social concerns regarding teen pregnancy. Early pregnancy and motherhood have an impact on teens' ability to continue their education and, consequently, on the opportunities to get out of poverty, which often affects the well-being of both mother and child.

### Poverty Structural Factors

Adolescent pregnancy is not a homogenous phenomenon. The fertility of Costa Rican teens is linked to socioeconomic conditions and determinants that do not favor women. Poverty, few opportunities for comprehensive health care, lower educational options and attainment, lower wages and work options, lack of consistent and integrated sexual and reproductive health education, and reduced opportunities for single-women families and women heads of households are some of the related factors in adolescent pregnancy in Costa Rica (Barquero Barquero and Trejos Solórzano 2004; Collado Chaves 2003; Fondo de Población 2005; Gutierrez Fernandez et al. 2010; Mainiero 2010; Núñez Rivas and Rojas Chavarria 1998; Soper and Tristan 2004).

From the 1960s to the 1990s, Costa Rica achieved important reductions in the nation's poverty rate. The poverty rate decreased from 51 % of households in poverty in 1961 to a low

of 20 % in 1994. However, since the 1990s, significant reductions in the poverty rate have not been observed, especially for families headed by women (Barquero Barquero and Trejos Solórzano 2004; Chant 2008). In 2005, poverty was estimated to affect 20 % of the people in Costa Rica, which marks an increase in the poverty rate reported for 2000 of 17 % for urban areas and 25.4 % for rural areas. Unemployment increased from 5.25 % in 2000 to 6.6 % in 2005. It is relevant to observe that unemployment among men was 5 %, while unemployment for women was almost double that at 9.6 %. In 2002, one-third (32.1 %) of the nation's poor families were composed of one-parent households with a women as the head of the family. This number is significant as families headed by women almost tripled between 1990 and 2005 (Chant 2008).

Aggravating the situation is that households headed by women comprise a large proportion of Costa Rica's families in extreme poverty. In 2005, extreme poverty affected 5.6 % of all Costa Rica's families. Across gender, 4.3 % of families headed by men were affected by extreme poverty, while more than double that number, 8.9 %, of families headed by woman were living in extreme poverty in 2005, signaling a persistent gender differential in the nation's poor (Chant 2008). Teen pregnancy has increased across the national territory, but it is overrepresented in the coastal provinces, regions with indigenous populations, or in urban areas with high levels of poverty and limitations to education, and in families with a women as the head of the household (Barquero Barquero and Trejos Solórzano 2004; Collado Chaves 2003; Fondo de Población 2005; Organization Panamericana de la Salud 2008; Slon Montero and Zúñiga Rojas 2005). Following this, the women-headed household's family structure is an important risk factor for poverty and extreme poverty (Chant 2008; Organización Panamericana 2007) and consequently for adolescent pregnancy. For girls younger than 18, the probability of adolescent pregnancy was reported to be four times higher among the poorest third of the population relative to the wealthiest third (Rodrigues Vignoli 2004). Areas affected by social disadvantage also present high adolescent fertility rates; Collado Chaves (2003) documented a link between metropolitan poor areas and areas with the highest teen fertility.

Another concern regarding adolescent single mothers is that many of their children do not have legally identified fathers on the national registers. In 2000, two-thirds of births to teens under 19 had unidentified fathers, and 33 % of the children born to adolescent mothers 15–17 also had unidentified fathers (INAMU 2001; INEC 2001). Reforms to the Family Code in 2001 include the current Law for Responsible Paternity (Law No. 8101[2001]), intended to increase the number of identified fathers of children born out of wedlock or unions and their responsibility in the parenting and care of their children.

Teen pregnancy is salient among Nicaraguan immigrant women. The main discrepancies in the fertility rates between immigrant Nicaraguan and Costa Rican women were observed in the younger age groups, with a 55 % increase in the fertility rate for Nicaraguan immigrant teens 15–19 relative to Costa Rica teens and 25 % higher than Nicaraguan teens in their home country. This compares to the fertility rate of Nicaraguan immigrant women aged 40–44, which is very similar to that of Costa Rican women in that age group. High teen fertility rates and motherhood also occur in impoverished metro areas of San Jose, where a higher concentration (42 %) of immigrant Nicaraguan women reside, compared to the 27 % concentration of Costa Rican women. Overall, it was estimated that the fertility rate for single 25-year-old Nicaraguan immigrant women is 40 % higher than for Costa Rican women, but for those unmarried Nicaraguan immigrants living in San Jose, the fertility rate is 121 % higher than for Costa Rican women with the same characteristics (Camacho and Rosero-Bixby 2001). This is significant as prenatal care was also reported to be lower for Nicaraguan immigrant women, especially for those in the metro

area of San Jose (León Solís and Rosero-Bixby 2001).

A high rate of adolescent pregnancy is also reported in indigenous populations, which are also affected by isolation, high rates of poverty and unemployment, poor health care access, and low levels of education. Cultural factors are believed to relate to the early intercourse and high fertility rates among young Indian girls (Fondo de Población 2005; República de Costa Rica 2008a). However, the strength of association between cultural factors and early intercourse and motherhood for 10- to 12-year-old girls is puzzling, particularly when considering the salient unfavorable socioeconomic factors that affect them. This high rate of pregnancy is striking, as infant mortality doubles for regions such as Talamanca, with 18.4 % infant mortality; Coto Brus, with 16.9 %; Corredores, with 15.2 %; and Buenos Aires, with 13.9 % (República de Costa Rica 2008a). Compounding the situation, some regions with high indigenous concentrations, such as Cabecar de Chirripo, are reported to have a high proportion of deliveries not occurring in hospitals or medical facilities, increasing the health risk for mother and child (República de Costa Rica 2008a).

## Education

Education in Costa Rica began since the 1880's (Quesada Camacho 2005), and the Ministerio de Education (MEP) (Education Ministry) is the organization in charge of the nation's education. Education in Costa Rica is free and compulsory until age 15, requiring 6 years of primary and 3 years of secondary schooling. Costa Rica annually allocates 6 % of its GDP to education, and the overall literacy rate is 95.2 % (Political Risk Services 2010; República de Costa Rica 2008a). Overall, 75.5 % of youths 15–17 were attending school in 2009 (Fondo de Población 2009). However, since 1990, a small decline in school enrollment by boys has been observed, and in 2004, the dropout rate at any school level was higher for boys than girls (INAMU 2009a). For youths 15–17, 20 % were reported not attending school in urban areas and 30 % in rural areas (Fondo de Población 2009). At the university level, 60 % of graduates were women (INAMU 2009a).

Increased education is associated with increased economic opportunities and a reduction in poverty, so adolescent sexuality, pregnancy, and motherhood relate to education (Fondo de Población 2005; Slon Montero and Zúñiga Rojas 2005). Early pregnancies are related to the discontinuation of education, while educational achievements are associated with a delay in sexual initiation and first pregnancy (Rosero-Bixby et al. 2009). The link between education and sexuality in Costa Rica has been documented for several decades. Rosero-Bixby (1991), in a national study, observed a negative association between education and premarital sex activity. The proportion of college-educated women who reported premarital sexual experiences was half the proportion reported by women with an elementary-school education (17–34 %). Of the women with secondary-school levels of education, 25 % reported having premarital sex. Again, this is important for Nicaraguan immigrant women, as 44 % have not completed a primary-school education, a figure that is much higher than the 13 % of Costa Rican women living in the same conditions (León Solís and Rosero-Bixby 2001).

The relationship of school absenteeism to high fertility was documented by Collado Chaves (2003), who reported that 47 % of the conglomerates with high fertility in the metro area of Costa Rica have youth populations between 13 to 17 years old who are not attending school, suggesting a link between school nonattendance and teen fertility. Pregnancy was identified as a reason for dropping out of school for 11.3 % of adolescent women aged 15–17. However, differences were observed between teens in the same age group residing in rural and urban areas. For adolescent women 15–17 in urban areas, pregnancy was reported as a reason for dropping out of school for 9.5 %, but the percentage was 12.7 % for those in rural areas. It

is also important to note that many teens experience pregnancy after they have abandoned or dropped out of school, and school desertion is a risk factor for teen pregnancy (Molina Chaves and Leiva Díaz 2010). Living with a partner as a couple was a reason for dropping out of school for 24.8 % of teens in urban settings and for 7.5 % of teens in rural areas. Having to work was a reason for 20.7 % of teens in urban areas (Fondo de Población 2009).

In Costa Rica, the number of pregnant teens attending school is rising. The Ministerio de Educación reported that in 2009, a total of 1,434 pregnant teens younger than 18 were attending school; this number marks an increase in 578 pregnant teens from 2004. In 2004, there were 2.2/1,000 pregnant students attending school; for the year 2009, the number increased to 3.6/1,000. Of the pregnant teens attending school in 2004, 86 were in primary school. Of these teens, 72.9 % were 13–15 years old, and 43 of them were attending the sixth grade; there were 11 pregnant children ages 11–12 in third, fourth, and sixth grade. Eight pregnant teens 17 or older were also attending primary school. In addition, there were 2,099 teens attending secondary school (seventh to twelfth grade). A total of 167 were 14 or younger, and 1,286 were 15–17. There were 746 teens aged 18 and older attending secondary school, with 50 % in the tenth and eleventh grades (Ministerio de Educación 2011).

## Adolescent Labor

Early pregnancy and motherhood increase social exclusion for adolescents during their pregnancies and after the births of their children, which has an impact on their work opportunities and economic conditions (Arroyo 1997). The relationship between unemployment, underemployment, and teen fertility was noted by Collado Chaves (2003). In the metropolitan areas of Costa Rica, 54 % of the zones with high unemployment also present high poverty and teen fertility. Fondo de Población de las Naciones Unidas (2009) reported that in 2007, 18 % of teens 15–17 and 47.8 % of those aged 18–24 were working. Women 15–35 reported not working because they were taking care of the family (47.4 %) or going to school (24.8 %). For men in the same age group, reasons for not working were going to school (60 %) and difficulties having access to work (12.1 %).

Costa Rica's labor laws prohibit work for children younger than 15 and regulate the work activities of those teens under age 18. However, a total of 11.4 % of children and teens as young as 5–17 were reported to be economically active in 2003. Work activities for children and adolescents vary by gender, with construction predominantly absorbing adolescent men, and childcare and domestic work absorbing adolescent women or girls. The proportion reported of boys working, 16 %, was more than double the proportion of girls, which was 6.7 % (INAMU 2009a). Domestic work has been plagued with low salaries and low enforcement of labor laws regarding working hours and worker rights (Martinez Franzoni et al. 2009). This situation is relevant for unskilled pregnant teens and young adolescent mothers, who often seek domestic work to support themselves and their children, which again restricts their ability to pursue opportunities for social advancement and break the cycle of poverty. It is important to note that according to the recent 2009 reforms to the Labor Laws [Article 108], no adolescent younger than 15 can be contracted as a domestic worker in Costa Rica. Those 15–17 who are hired as domestic workers are under special provisions and protections, according to the Código de los Derechos de la Niñez y la Adolescencia (Code of Children and Adolescent Rights) and the laws for the protection of young people (No. 8261). It is important to add that 40 % of women working as domestics are heads of their households in mono-parental families, and 87 % have children under their care. Their salaries are 78 % of what men employed in domestic work receives (Martinez Franzoni et al. 2009).

## Legal Issues

The legal age for marriage in Costa Rica is 18 (Law 8517, Family Code article 14), but with parental authorization youths can marry as early as age 15 [Sistema Costarricense de Información Jurídica (SCIJ), Código Penal n.d.]. Carranza (2009) observes that this poses interesting dilemmas for health care providers working with young adolescents because under the same Costa Rican Penal Law, providing contraceptive services is restricted to teens 15 and younger.

Costa Rica Penal Code (Sección 1 Articulo 156, 157, 159, 161) (SCIJ, Codigo Penal Título III n.d.) clarifies that any sexual activity with a youth under the age of 13 is a crime. For all youths under 18, any sexual activity that takes advantage of the youth's age is also a crime even when the youth consents. Higher penalties apply to those who engage in sexual relationships that take advantage of teens 13–15 (Ministerio de Salud 2009; SCIJ n.d.; UNICEF 2005).

However, national reports and studies consistently document sexual partners for teens, especially for young women, much older than themselves (Fondo de Población 2009, 2011; Morris 1988). The reported number of pregnancies and births in adolescent girls 14 or younger can signal illicit sexual violence and exploitation that needs to be investigated (Carranza 2009; Ministerio de Salud 2009, 2010). This is particularly troublesome in light of the number of young girls delivering babies. In 2008, there were 15 children 11 years or younger who had babies, and in 2009, there were eight. Girls 12–14 years of age delivered 669 babies in 2008 and 697 in 2009. Minors 15–17 had 7,242 babies in 2008 and 7,084 in 2009 (Naciones Unidas et al. 2011). It is very likely that the number of young girls and children having intercourse in Costa Rica is larger, as the reported numbers do not include abortions or miscarriages, which can be assumed to occur among such young girls.

On other types of maltreatment, youths 15–17 residing in urban regions reported being the victims of insults, screams, and threats from their families (12.5 % for adolescent girls and 12.9 % for adolescent boys). Physical violence was reported by 5.4 % of adolescent girls and 4.5 % of adolescent boys in the same age group (Fondo de Población 2009). The Patronato Nacional de la Infancia (PANI) is the leading child protection agency in Costa Rica. In 1999, PANI attended 115 cases of child sexual exploitation (UNICEF 2005). The National Children's Hospital in Costa Rica reported 331 children seen at the hospital in 2002; more than half (53.5 %) were victims of sexual abuse and more than one quarter (25.5 %) of physical abuse. In 2005, PANI provided services to 7,621 children (younger than 18); half (49.5 %) were physically abused, 34 % were victims of sexual abuse, and 16.7 % were emotionally abused (Organización Panamericana 2007). In March of 2008, PANI had under its protection, a total of 3,755 children and adolescents (Naciones Unidas et al. 2010). Bolaños Salvatierra (1989) documented a total of 113 adolescent admissions during a 6 month period (1986–1987) to the National Psychiatric Hospital in San Jose, Costa Rica. Of those admissions, 17.7 % reported experiences of incest, pointing to some of the detrimental consequences of child abuse and maltreatment. Claramunt (2002) reported that sexual exploitation primarily affects teens 12–18 years of age. In 2009, Fondo de Población de las Naciones Unidas (2009) indicated a total of 0.8 % of all adolescents 15–17 reported experiences of sexual abuse, and of those, 1.7 % were adolescent women.

In areas of intervention and treatment, the Ministerio de Salud published the 2009 Manual for the Attention of Children and Adolescent Victims of Commercial Sexual Exploitation. The manual provides specific guidelines for the detection, treatment, and reporting of child and adolescent victims of sexual exploitation to attending health care professionals. The guidelines are intended to facilitate the delivery and standardization of quality health care services to child and adolescent victims of sexual exploitation across the national territory and to ensure the fulfillment of legal responsibilities to report

such crimes according to the stipulations of the Penal Code.

## Adolescent Pregnancy Public Policy

Costa Rica has assumed significant responsibilities in accordance with international agreements for the advancement of human rights, social justice, and gender equity, with particular relevance to the phenomenon of adolescent pregnancy in the country. Among those, the U.N. Convention on Children Rights was ratified in 1990 (Law no. 7184) and the Optional Protocol to the U.N. Convention on the Elimination of All Forms of Discrimination Against Women was approved in 2001 (Law no. 8089) (República de Costa Rica 2008a).

To fulfill these commitments, the country has embarked on vigorous revision and creation of legislation to establish and signal to national entities the allocation of resources, the enactment of guiding policies, and the creation of responsive programming for the advancement of and adherence to these agreements. The work has been massive, including significant revisions and planning at all levels of the public sector in accordance with the rights of children and adolescents and equity among genders. Costa Rica has submitted its fourth report for the 2002–2007 periods to the Convention on Children and Adolescent Rights and has received further recommendations (Naciones Unidas et al. 2010, 2011; República de Costa Rica 2008a). PANI, as the main child protection entity, is designated on the reports as the leading institution to oversee the efforts toward the protection and enforcement of child and adolescent rights. This includes matters related to pregnant adolescents. PANI is undergoing significant restructuring to be able to serve in such a role. Also, almost all public institutions have specialized teams on children and adolescents, called to coordinate and integrate programs and services for this population (República de Costa Rica 2008a).

Regarding national legislation, Costa Rica has been able to advance significantly in the creation of important national legislation on the rights of women, children, and adolescents; safety and protection relevant to the issue of adolescent pregnancy and motherhood. Some examples include:

Law no. 7142, Promoting Social Equity of Women, approved in 1990;

Law no. 7769, Act on Women Living in Poverty, approved in 1998;

Law no. 8261, Young Persons, approved in 2002;

Law no. 8539 on penal consequences of violence toward women;

Law no. 8590, against the Sexual Exploitation of Children and Adolescents.

Specific to adolescent pregnancy and early motherhood, two laws are salient: Law no. 7739, Code on Childhood and Adolescence, approved in 1998 and Law no. 8312, general act on the Protection of Adolescent Mothers Reform, approved in 2002.

**Law no. 7739, Code on Childhood and Adolescence**: This law, approved in 1998, appoints the Ministerio de Salud under its Article 44, Point C, to guarantee the development of preventive programs and services to all children and youth, including sexual education and reproductive health.

Specific to pregnant adolescents, Point G establishes the creation by the Ministerio de Salud of comprehensive integrated health programs and services for teens, including social and psychological programs and services, during all stages of pregnancy. Focusing on integrative and holistic services, Article 50 adds that all public health centers must give pregnant children and adolescent maternal-infant information and services. Besides medical care, supplemental food during the pregnancy and breast-feeding period is to be provided if needed.

For pregnant teens or mothers living in poverty, Article 51 emphasizes the right of teens to receive comprehensive services, including economic assistance, while attending training

programs aimed to support their continued personal and social development, according to the Instituto Nacional de Ayuda Mixta (IMAS) guidelines; the IMAS is the main national welfare organization.

Article 52 mandates all employers to provide adequate conditions for breast feeding for teen mothers. Article 70 prohibits all public and private institutions from imposing corrective or disciplinary measures or penalties on students due to pregnancy; it also adds that the MEP must develop a system that supports the continuity of education for pregnant children and adolescents.

**Law no. 7735 and Law no. 8312**: Law no. 7735, for the Protection of Adolescent Mothers, was approved in 1997 and later revised in 2002 to become the current Law no. 8312, general act on the Protection of Adolescent Mothers Reform. Under this law, the Inter-Institutional Council for the Attention of Adolescent Mothers was established. Adjoined to the Ministerio de Salud, representatives from the main public organizations form the Council. The responsibility of the Inter-Institutional Council is to coordinate integrative prevention, education, and intervention programming on behalf of pregnant teens and adolescent mothers. It designs an annual strategic plan to guide, coordinate, and support the programs and actions of both public and private organizations for pregnant teens and mothers. Following this, the responsibilities of the different public institutions concerning the provision and coordination of services are delineated by the law and overseen by the Inter-Institutional Council. For example, the health centers and clinics of the CCSS are charged with the provision of free prenatal and postnatal services; the MEP is to provide prevention, education, and training programs regarding the implications of pregnancy during adolescence for secondary students and their families; the IMAS is to secure resources for adolescent mothers to allow them to raise and educate their children adequately.

## National Policies

Among the most relevant national policies concerning adolescent sexuality and pregnancy are the National Health Polices on Sexuality and Reproductive Health 2010–2021, the Children and Adolescent National Policies 2009–2021 (PNNA), and the Policy for the Young Person 2010–2013.

### National Health Policies on Sexuality and Reproductive Health

The Ministerio de Salud of Costa Rica recently published the national sexuality policies for 2010–2021 (2011a, b). The document includes nine main areas for policy development and corresponding strategies. Departing from a definition of sexuality as a human right that includes the right to a safe, informed, coresponsible, and satisfying sexual life for both genders, the first section (e.g., Policy 1.1) focuses on communication, capacity building, awareness, and promotion. Section Population is about strengthening the notion of sexuality as both an individual and social right, so it proposes strategies for setting norms, rules, and protocols according to judicial mandates. It also sets strategies for the involvement of people and organizations in monitoring for compliance in order to safeguard the sexual rights of all people.

Most relevant to this chapter is section Adolescent Pregnancy Health Concerns on service integration. It guarantees to everyone in the national territory access to sexuality and reproductive health education that is scientifically based and current, inclusive, diverse, and congruent with the stages of human development across the life span. The section recognizes that education and services on human sexuality and reproductive health must be embedded in both formal education and health systems and aims to integrate sexuality education and reproductive

health across all service areas. The following section, Policy 4.1, focuses on guaranteeing equitable access to quality services. The policies also address strategies for prevention and intervention regarding sexual violence (e.g., Policy 5.1). On the same line, section Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities) is about increasing knowledge and research about the scientific-technological as well as the psychosocial aspects of human sexuality that can feed intervention programs. The last section of the national sexuality polices (e.g., Policy 9.1) is about the coordination and integration of services across different national institutions and international organizations.

Even though the policies are comprehensive, detailed information about specific provisions on adolescent sexuality, adolescent gender relations, adolescent reproductive health, and adolescent pregnancy is not clearly defined or articulated.

*Child and adolescent national policies:* According to the convention of children's rights, La Política Nacional Para la Niñez y la Adolescencia Costa Rica 2009–2021 (PANI-UNICEF 2009) delineates the national laws concerning children and adolescents until 2021. The document includes important legislation on a variety of topics concerning the rights of children and adolescents.

Pertinent to adolescent pregnancy and motherhood, the document recognizes that sexuality constitutes an integral part of human development. As such, children and adolescents have the right to be educated and receive scientific information on human sexuality and reproductive health that is appropriate to their stage of development and conducive to thoughtful decision making.

Following this, it identifies the Ministerio de Educación (MEP) as the responsible entity for delivering sexuality and reproductive health education programs to children and adolescents in the national education system and across the school curriculum. Specific learning opportunities and activities are to be designed and made accessible to all children and youth, including those with special needs and those outside the formal school system. The document also clarifies that the state must guarantee the preparation and training of teachers in human sexuality and reproductive health to implement the curriculum. Law No. 7739 adds that a monitoring office is to be created within the MEP to safeguard the rights of children and adolescents.

*Public Policy for the Young Person 2010–2013:* This Public Policy for the Young Person was created after the ratification of the Ibero-american Convention for the Rights of Young Persons in 2007 and was approved to be enacted from 2010 to 2013 (Consejo Nacional de la Política Pública de la Persona Joven 2010). The main goal of the policy is to secure within a context of human rights that the rights young people, which includes those ages 12–35, are represented and respected. The policy addresses (a) the civil and political and (b) the socioeconomic and cultural rights of young people. Relevant to this paper, the policy clearly establishes (a) the right of young people to have sexual education that is responsible and based on human sexual and reproductive rights, and (b) the formulation and application of sexuality education across all school levels that is developmentally congruent and oriented toward the full development of individuals, including acceptance of one's identity; responsibility in the expression of one's sexuality and reproductive rights; respect for sexual diversity; responsibility in the prevention of violence, sexual abuse, and STIs, including HIV/AIDS; and unplanned pregnancies. And, (c) the policy includes the development of inter-institutional assertive actions geared to orient and inform families on human sexual development and reproductive health. The effort aims to equip families with adequate knowledge and tools on human sexuality and reproductive health, so they can fulfill their responsibility in the sexual education of their children (Consejo Nacional 2010).

## Programs

### Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities)

Among the programs that have been developed in Costa Rica, according to the legislative mandates and policies for prevention and intervention regarding at-risk, pregnant adolescents, or teen mothers, two are salient: Amor Joven (Young Love) and Construyendo Oportunidades (Building Opportunities).

From 1998 to 2002, a joint effort was undertaken by the Inter-institutional Council for the Attention of Adolescent Mothers, INAMU, and the MEP, to address adolescent sexuality, reproductive health, and pregnancy. Endorsed by the first lady, these efforts were guided by a holistic view of human rights, gender equity, and social justice in relation to the needs of children and adolescents. The programs aim to provide integrated and comprehensive services to at-risk, pregnant, or adolescent mothers and their families across the different public institutions, and to facilitate the delivery of services. This is how Amor Joven and Construyendo Oportunidades emerged.

Araya Umaña writes that Amor Joven was a teen pregnancy prevention program that promoted education and thoughtful decision making in youths regarding sexuality and reproductive health, not only as a sexuality-based education program but within the context of women's rights and gender equity. Amor Joven was designed to integrate sexuality and reproductive health education by the MEP in the school system and across the entire school curriculum. It included the training of teachers specializing in the teaching of human sexuality and reproductive health to deliver the formal curriculum. The program was also to disseminate information in communities and reach youth out of the school system. The program design was completed in 1999, but during initial stages of implementation, the ecclesiastical authorities and the OPUS DEI reacted against the program (Araya Umaña 2003). A joint commission of church and government representatives was convened to no avail (Faerrón as cited in Araya Umaña 2003). In 2002, the church withdrew its members from the joint commission and undertook a media campaign to disseminate the rationale of its decision and concerns against Amor Joven. The Catholic Church then published its own sexuality education guides and presented its unanimous decision to break any collaboration with the government in the implementation of Amor Joven (Araya Umaña 2003). The program disappeared in 2002 during the transition to a new presidential administration (República de Costa Rica 2008a).

Construyendo Oportunidades was also established in 1998 and supported by Laws No. 7739 and No. 7735. It was designed as an intervention program to guarantee comprehensive services to at-risk, pregnant, and adolescent mothers in support of their personal and social growth toward independence by providing family planning, health, educational, vocational, economic, and employment assistance. The program facilitates adolescent reintegration into school and vocational centers, intending to increase economic options and disrupt the cycle of poverty for the well-being of both mother and child (INAMU 2004; República de Costa Rica 2008a). However, the program was not funded as initially planned. Currently, the program continues to exist on paper, but there is no planned implementation. Instead, PANI is operating a free national telephone hotline attended by professional psychologists and lawyers. The hotline program began in 2007 and focuses on assisting adolescent mothers with issues of sexuality, substance abuse, maltreatment, and the legal procedures often related to establishing paternity for their children. There is an emphasis on supporting adolescent mothers in continuing their education in order to break the cycle of poverty. Consequently, the program offers scholarship funds to adolescent mothers, including monthly monetary resources while they attend school. To date, there are a total of 500 adolescent mothers who have benefited from the program (República de Costa Rica 2008a).

## Avancemos (Advancing)

Another relevant program is Avancemos, or Advancing, created in 2006. This program targets adolescents, establishing monthly funds for teens living in poverty to help them stay in school; however, this is not a program exclusive to pregnant adolescents in poverty. Also, the Program for Integrative Attention to Adolescents (PAIA) from the Ministry of Health and the CCSS has been able to create a network of adolescent groups across the national territory. The focus of the program is to train adolescents in communities to provide and coordinate health preventive activities, including sexuality and reproductive health education.

## Education Programs on Human Sexuality and Reproductive Health

The trajectory of the implementation of educational programs in human sexuality and reproductive health in the school system in Costa Rica has been arduous. Since the 1960s, efforts have been undertaken by the MEP and other organizations toward the implementation of sexuality and reproductive health education in accordance with national policies, but to no avail.

Prior to the attempts with Amor Joven from 1998 to 2002, several efforts were made that were partially achieved, archived after completion, or simply discontinued. Some examples include La Asesoría y Supervisión General de Planificación Familiar y Educación (the Advisory and Supervisory Board for Family Planning and Education), formed in 1969 to create policies and implementation plans for the education of human sexuality for children and youth. The department included the Programa de Adiestramiento en Educación Sexual, which was a program aimed to train the trainers on human sexuality (Araya Umaña 2003). However, the program was only partially completed or implemented (Faerron as cited in Araya Umaña 2003).

In 1985, the MEP charged the Proyectos Especiales del Centro Nacional de Didáctica (Special Projects Unit) to develop specific actions to promote education on human sexuality. Educational materials, supporting activities for students, and training for teachers were created (Arias Guzmán 2006). However, there is no clarity concerning the whereabouts of these efforts.

Later, from 1990 to 1994, a joint effort between the MEP and the Conferencia Episcopal (Episcopal Conference) produced a series of curricular guides for education on human sexuality to high-school students or those in diversified alternative schools, but they were not used (Araya Umaña 2003).

During 2000–2001, the MEP establishes El Departamento de Educación Integral de Sexualidad Humana (Department for the Integrative Education of Human Sexuality), in charge of implementing the integration of human sexuality and reproductive health education across all education levels. Concurrently, the Plan de Capacitación en la Educación de la Sexualidad del Programa Amor Joven (Plan for the Training and Education of Sexuality in the Program Young Love) was undertaken, resulting in 2001 in public disapproval by the Conferencia Episcopal and the Catholic Church, as noted earlier (Araya Umaña 2003; Arias Guzmán 2006).

The latest report to the Children and Adolescent Rights convention (República de Costa Rica 2008a) indicates that as part of the restructuring of the MEP during the transition to a new presidential administration, the Departamento de Educación Integral de la Sexualidad Humana (Department for Integrative Education of Human Sexuality) became a new department, this time called the Departamento de Promoción del Desarrollo Humano y Educación para la Salud (Department for the Promotion of Human Development and Health Education). With this new department, which focuses on all areas of health, the specific delivery of the controversial sexuality and reproductive health education curriculum becomes less salient and perhaps diluted.

Among the specific actions regarding sexuality and reproductive health education achieved since 2004 by the MEP, the República de Costa Rica (2008a) report to the Convention on Children and Adolescent Rights for the period 2004–2007 notes that a budget was established for the selection of teachers, and educational support was provided to organizations dealing with substance abuse.

Lately, INAMU (2009b) reports that to date, there is no permanent program on human sexuality and reproductive health across the nation's education system. It adds that the MEP and the National University (UNA) are jointly in the initial planning stages of working on the diagnostic tools, methodology, and materials for a sexuality and reproductive health education program. The latest report by Costa Rica to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) indicates that the MEP is having difficulties regarding the provision of human sexuality and reproductive health education. It adds that the policy in place lacks clarity, so consequently each education center has to make its own decisions on how to approach the topic of human sexuality and reproductive health education (República de Costa Rica 2008b). It is important to add that the Joint Nongovernment Organizations (NGO) Report (2011) denounces the lack of follow-up from Costa Rica regarding sexuality and reproductive health education as a violation of its commitments to CEDAW.

Recently, el Ministerio de Salud, in the National Sexuality Policies for 2010–2021 (2011a), reiterated the right of children and adolescents to received sexuality and reproductive health education. However, specifications about implementation were not identified. The role of the MEP is still not clear regarding the implementation of a comprehensive and holistic scientifically based and developmentally appropriate human sexuality and reproductive health curriculum for all children and youth. Compounding the situation, it appears that programs such as Construyendo Oportunidades are not funded, rendering them ineffective. Instead of responding to the state's or country's clear needs, programs appear to change based on the priorities of whatever government administration is in power, which challenges the evaluation of their impact.

## Conclusions

Costa Rica is a small country with a long history of peace that takes pride in its democratic system. One of the challenges it faces is that adolescent pregnancy has been on the rise even though the national fertility rate has been in decline for several decades. Teen pregnancy and motherhood is multicausal and relates to poverty, low education, isolation, and lack of preventive consistent sexuality and reproductive health education. Facing international commitments regarding human rights, Costa Rica has embarked during the last decades on legislative revisions, policy changes, and program restructuring, hoping to improve the living conditions of its people. All the compromises that Costa Rica has undertaken with international entities have spurred the country to research and document the status of those on the margins of its society. The association between a woman's identity, sexuality, and maternity has been overemphasized in the patriarchal culture of Costa Rica, confining both males and females to rigid stances on gender roles and values that mask the oppression of women. These rigid stances are woven together with religiosity and political postures that cloud the advancement toward an inclusive, progressive society.

Costa Rica has a rich legislative, organizational, public policy, and programmatic base for advancement in the areas of prevention and effective intervention regarding adolescent pregnancy and maternity. This progress is huge and clearly identifies the resolve of its people not only to address issues of adolescent sexuality and pregnancy, but of the complexity of the cultural, social, economic, and human rights matters these issues encompass. On one hand, Costa Rican laws, public policies, and programs on teen pregnancy are the result of a process of social transformation that permeates every layer

of the culture. On the other hand, it is now that the challenging phase of implementation, application, and change must go forward with relentless resolve.

The phenomenon of adolescent pregnancy provides Costa Ricans with a platform to move beyond religious and political discourses to actions and true reforms congruent with human rights and an authentic democracy as stipulated in many national documents. Costa Rica is a country that takes pride in its trajectory of democratic and peaceful history, and the decisions regarding adolescent sexuality and pregnancy are providing the nation with an opportunity to live up to democratic standards. As such, the need for clear boundaries between state and church is obvious, and the needs of people prior to any party/political agenda must be valued. Clear boundaries between state and church ensure inclusivity and freedom for the expression of every perspective, which is the hallmark of a democratic society. However, those outcomes are hard to achieve if there is no firm planning and continuity regarding the nation's priorities across government cycles.

As the nation moves forward in this transformative experience, it is important to continue to gather more information on adolescent fatherhood and on the socialization of the genders. Congruent with human rights and systemic thinking, the voices of young men need to be included, so their needs can be addressed.

Costa Rica is a country with much strength, including institutions of higher learning that provide a research infrastructure and places where intellectuals can engage in critical thinking, civil debate, and thoughtful decision making. This important work will need continued support as the country faces changes in the priorities of governments and in international pressures and influences.

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