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The Health Status, Concerns, and Reform in Uruguay with an Emphasis on Health Promotion Programs Geared towards the Care and Development of the Country's Children and Adolescents

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Para los niños, niñas y adolescentes
y para los maestros y todos los que guían a los jóvenes

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Abstract

This study was conducted in Montevideo, Uruguay, where I examined the actions that the country and society as a whole, its various communities, the Uruguayan government, and the people take in order to prevent disease and promote a healthy society. An ethnographic experiential and evidence-based approach, including personal experience, interviews, and official government documents, was used to fully describe the way the system operates. Due to Uruguay's demographic characteristics, particular attention was paid to children and adolescents. For this thesis, Uruguay is described in terms of its history, physical and mental health issues, society's shared health concerns, and its vulnerable groups, which include mothers, children, and the disabled. Underlying factors that contribute to health concerns are also described, including behavior, infection, geography, environment, access to medical care, and socio-economic-cultural factors. Population interventions involve both preventative and curative efforts, with specific programs designed for nutrition and vaccinations. A specific example is Uruguay's intervention of dengue, a mosquito-borne infectious disease. While its neighboring country of Argentina is greatly affected by dengue, Uruguay's interventions against the fever have resulted in virtually no cases of dengue. The approaches that are thoroughly examined are the country's health care, delivery of services, and their traditional public health approach, which involves target communities/populations, disease control, food and drug safety, nutrition, and social policy. This thesis attempts to show that, contrary to popular belief, social policy is strongly related to health. Areas of social policy that are examined include the promotion of social justice and happiness, increasing convenience, economic growth, services for the poor, and education. For Uruguay, the *Programa de Educación Sexual* is a program that aims to ensure healthy child development. This is part of the government's effort against youth emigration. Despite the fact that Uruguay is a small country, it is viewed globally as an important model country due to its reform in the health care system and the many programs and interventions that the government and private organizations have launched for the care and progress of the people of Uruguay.

Introduction

I chose to conduct my investigation in Uruguay after being informed about its unique policies and concentration on children and adolescents. Also, it is shocking to most, including myself, to learn about a sexual education program that is integrated into the educational system starting at age three. I wanted to know what it was about this small country (the second smallest in Latin America) that gave the government the initiative to take action through organized policy, not only those focusing on children and adolescent health, but also why and how the country decided to entirely change its health care system in 2005 (*Desarrollo Saludable de los y las Adolescentes en Montevideo,* 11-17*)*. Through visits to organizations, personal interviews, lectures, and case studies, I was able to answer these questions, determine the advantages and disadvantages of the system, and observe how effective certain health policies are.

As it turns out, the country's history impacted the current government and its health policies. This is explained in chapter one. In order to improve past and present health concerns, the health care system needed a new focus on health prevention and promotion, and it needed to be implemented by law in an effort to guarantee certain services as obligations. The country is taking action for the sake of its future as well. Uruguay is a country with one of the lowest percentages of young people in Latin America (*Desarrollo Saludable*, 11). In the second chapter, the current health situation is analyzed with specific attention to the integration of the universal health care system. The last chapter continues to focus on health policy, but specifically on children and adolescents. It is in the county's best interest to place significant efforts on their younger population, since this population represents the future of the country. These policies focus mainly on education and health, but other programs with objectives aimed towards the protection of children and adolescents are also explained. In addition, two case studies are outlined: the first, a visit to a city right outside of Montevideo, and the second, a visit to a school in Montevideo.

By examining the history of the country, I hope to give a background to the country that would help to describe its culture and society, and how these factors influence the recent reforms. By outlining the reforms in health care and education, I also hope to show Uruguay's capacity to generate new policies for the sake of its citizens, and show how it is a model country for the process of creation, implementation, and action of health policies.

CHAPTER ONE
The Historical Development of the country of Uruguay

Early History of the Land of No Advantage

During a history lecture with Laura Ibarlucea, a professor at CLAEH, it was emphasized that Uruguay does not have a profound pre-Colombian history or a heavy indigenous history compared to other Latin American countries. When the territory was being explored by Spaniards during the 16th Century, the zone of Uruguay was known as *La Banda Oriental*. There was a fountain of wealth after an enormous amount of silver was discovered in Bolivia. The Spaniards set out to find more silver in Latin America. One saying from that time was "If a bridge could be made out of silver, it would reach Spain; if a bridge could be made out of the people who died trying to find the silver, two bridges could be built." Uruguay's neighboring country, Argentina, was even named after the Latin word for silver, *argentum*. Unfortunately for the Spaniards, there was virtually no silver in either Argentina or Uruguay. In fact, the territory of Uruguay, which is currently *La República Oriental de Uruguay*, was renamed *tierra de ningún provecho*, or useless land.

This uselessness was the first perception of the territory that is now Uruguay; however this reputation did not persist for long. By the beginning of the 17th Century, there was renewed interest in it. At the time, governor Hernandarias deduced that the land was perfect for *pradera*, or a meadow that has the ideal natural conditions that are favorable for *ganados*, the term used for old world animals such as pigs, cows and sheep. The water availability and pastures would allow *ganados* to grow and develop well. This introduced a new lifestyle and "character" to South America: *el gaucho*. The gaucho is known for throwing his *boleadora*, a tool that wraps around the animals feet, and a *dejaretador* to cut the tendons of the legs so that the animal could fall. From these animals, the gauchos obtained leather. The meat was of bad quality and there were no means to preserve it. Thus developed a new economic market in Uruguay due to its open fields filled with *ganados*. There were even restrictions on exportation of the animals to other neighboring countries: it was legal for Argentina and other countries, with the exception of Brazil because it was a Portuguese territory; however, this did not stop contraband.

By the end of the 19th century, salt houses were introduced in Uruguay, which further expanded Uruguay's market because the meat from the *ganados* could now be

preserved. The salted meat was exported throughout the Americas for slave diets, and the leather was exported to Europe where it was in high demand because of its fine quality.

Uruguay is a country that contained frontiers and ports, which is why both the Portuguese and the Spanish attempted to claim this territory. It was easy for Brazil to use its rivers to move into the interior of the land, but with this, Brazil tried to own the territory, only to finally fall into the hands of the Spanish. The first city that was officially founded was Colonia del Sacramento in 1680. The Portuguese founded this city for its close proximity to Buenos Aires for commercial reasons. In 1742, the capital of Montevideo was founded. Then, it was known as San Felipe y Santiago de Montevideo. It was, and to some extent still is, considered the best port of the Río de la Plata. It was a very accessible port, which worried Buenos Aires. The Spaniards founded Montevideo, and the organization of the city into city blocks is very characteristic of Spanish founded cities, like that of Buenos Aires. Colonia differs in organization.

The 19th Century is characterized as a century of revolutions in Latin America. In May 1810, General Artigas led the revolution because he wanted to form the largest federation in Latin America that included the Argentine provinces of Entre Ríos, Corrientes, and Misiones, and the Uruguayan departments of Córdoba and Santa Fe. His effort did not succeed. In addition, the Brazilians tried to make Uruguay their province, but not without a fight with Argentina. In the end, there were two options: to have two large countries, with Uruguay belonging to either Argentina or Brazil, or create a new country. The idea for a new country came from the English, who wanted to stop the fighting and continue to sell goods and make a profit from South America. This is why the English are known in Uruguay as their "godfathers of independence" (Ibarlucea, 2010).

Modernization of Uruguay

What is known as Modernization and Discipline in Uruguay occurred around 1855. Modernization is known to be associated with the history of the United States, specifically the civil war. The south was producing less cotton and the north blocked trade to Europe. Europe still wanted textiles, so they turned to other countries, such as Egypt and Uruguay. In Uruguay, the price of wool skyrocketed, and became a great business, so a new *ganado* was introduced in great numbers: sheep. There was a shift in the market economy in Uruguay, where there was much more wool than leather, and the

wool was being exported to France, England and Belgium. The market was still centered on the *gaucho* industry, but there was a new upper class: the capitalists, who produced what the capitalist world wanted. The demand for quality meat rose, especially with the invention of the steamboat that allowed better passage to Europe.

Due to this drastic change in the economy, the *gaucho*, who had been the prototype of the pampas of South America, would soon become extinct. There was no longer a need to capture animals or worry about *gauchos* stealing other people's cows because there were now fences delimiting territory that also separated breeding animals and prevented animals from running away. In addition, the English invested in the building of railroads in South America, many of which fed into the port of Montevideo.

With a rising population and the disappearance of the *gaucho,* Uruguay started to implement change for the betterment of society. Efforts were made to convert from a culture that "fooled around too much" to one that was well disciplined. It was important to discipline the population by means of educating. Institutions such as schools were an important link to discipline, since schools are where values can be inculcated starting at a young age. These values and reforms were to form a new type of society, especially with the mix of population that resulted from waves of immigrants that began in the 20th century, especially from Spain and Italy.

Uruguay went from being known as a useless piece of territory, to a country of great splendor. It still holds the nickname of "the Switzerland of South America" due to its richness and economic prosperity. Uruguay was also known for being an innovator in terms of bettering the situation of women and workers. It was the first country in Latin America, and one of the first in the world, to allow divorce. Uruguay had laws mandating eight-hour working days, prohibiting child exploitation in occupations, and implementing a 45-day maternity leave. In 1930, to celebrate the one-hundredth anniversary of the constitution, Uruguay hosted the first World Cup in soccer, and won the championship that year.

Even World War I was a time of prosperity in Latin America. Uruguay was in a great economic situation and joined forces with the British to provide boots, leather and wool blankets and corned beef for the soldiers. The times of prosperity soon ended, however, in coup d'état and dictatorship. What was Peronismo in Argentina was Neobatllismo in Uruguay. The crisis of 1958 caused inflation and an uprising among the people. The new government's response was

to use violence and repression to stop the unrest.

The dictatorship of 1973 was characterized by terror in the country. This dictatorship happened simultaneously with that of Argentina, and followed the *plan corrido* of Augusto Pinochet, the dictator of Chile. There were approximately 30,000 people in Argentina, 3,000 in Uruguay, and 600 in Chile who disappeared. The disappearances to this day still affect these societies, because many people still do not know the whereabouts of their loved ones or what happened to them. Many students were affected, many of whom disappeared because they were known as "subversives" who were against the military *junta*. It was known as The Dirty War in Argentina, and there were many silent marches in Uruguay to protest the disappearances. Another form of protest way was the *caseroleos*, where people protested by banging on pots in the middle of the night. The year 1984 marked the return to democracy; however the results of the dictatorship and terror still remain in today's society with hundreds of people who still remain disappeared (Ibarlucea, 2010).

Societal Consequences of the Crisis of 2002

An historical event that led to an economic and social change in Uruguay was the crisis of 2002. As a result of the crisis, poverty increased as many people lost all of their savings and were left without jobs. Three of Uruguay's largest banks closed, and the ones that did not, such as *Banco República*, did not disperse any funds in order to avoid bankruptcy. The help of the American Treasury was part of the solution that helped Uruguayans overcome this crisis; people are still recovering their earnings and reconstructing savings today. Despite the fact that the crisis of 2002 was the biggest crisis that has occurred in Uruguay, it was not nearly as acute as the crisis in Argentina that occurring during this same year. In fact, the crisis in Uruguay is a result of the Argentina crisis of 2002 and shows Argentina's influence on Uruguay.

The crisis was no doubt a turn for the worse for Uruguay. The country was introduced to a new kind of poverty. Before, the typical poverty of Latin America was not characteristic of that of Uruguay, but this poverty, where children were in the streets begging, was a known reality in 2002. From 2003 to 2004, the infant mortality rates increased. In 2005, the situation began to change for the better, primarily due to the fact that the leftist party won the elections for

that year. Many people favored the government of Tabaré Vázquez, and Uruguayans felt, with an exceptional approval rate of fifty-six percent, that he took the right actions. The government organized and implemented social programs to try to recover from the damage. There were emergency plans and cash transfers for families that were most affected.

The crisis of 2002 led young adults to leave the country in search of better opportunities. In addition, during the military dictatorship, young adults were leaving the country, and those who were involved with the leftist party were exiled. The people who were left in the country included a large population of the elderly and small families consisting of parents and few children (approximately 2 per family). This demographic characteristic is still present in Uruguay today. It leads to many challenges that the country deals with today, such as how to pay for retirements when there are so many elderly. Extremely high taxes remain the solution.

The current president, who was elected in 2010, is José Mujica. He is considered a proud figure of the country. It is surprising that he was elected president, especially after the fact that he has spent fourteen years in jail. After the military coup in the 1970s, he was placed in jail, and this included spending more than two years in the bottom of a well. Despite the fact that he had previously faced jail time, Mujica remains a very well respected man by those who elected him, and he continues to live in a humble home in Uruguay. He was elected by the people out of confidence and the hope that he understood the people themselves and wanted to improve the current situation of the nation.

Another historical event, directly relating to the health politics of the country dealt with the interventions against tobacco. Prior to the Vázquez presidency, former president Jorge Luis Batlle Ibáñez made Uruguay one of the first countries in the world to ratify the global anti-tobacco treaty in 2006/7. As an oncologist, Vázquez made the WHO treaty a priority on his agenda. By signing this treaty, smoking is completely prohibited in all enclosed public areas. This includes not being able to smoke in front of buildings such as clinics and schools. One must go outside onto the streets or to an appropriate distance away from the building in order to smoke a cigarette. Uruguay used to be like Argentina, which still allows all areas as smoking areas. It is quite extraordinary to "cross the puddle" from Argentina in a three-hour ferry ride, and go from a country where people can smoke freely, to a country that is "100% sin humo",

or without smoke. Uruguay was once like Argentina, yet surprisingly, such drastic changes in the smoking culture led mostly to a positive reaction from the people. This is due to the fact that the campaign against tobacco was based on messages to invoke terror. Cancer is directly associated with the principal cause of death among smokers, but non-smokers can suffer the same consequences as a result of other people's decisions and actions (Ibarlucea, 2010).

CHAPTER TWO
The New Government and its Concerns and Reforms

Case Study: The Western Zone of Montevideo

In Uruguay, the government has the responsibility for guaranteeing health for the people. Many of the social programs that were observed during this study are organized and implemented in the capital of Montevideo. For example, Uruguay is divided into 19 departments, and there exist 19 *intendencias,* or administrative divisions of health. The capital of Montevideo is considered a department, and it is the smallest and most populated department/city of the nation. These *intendencias* do not form part of the *Ministerio de Salud* (Health ministry), but function as a part of a departmental government (Etchebarne, 2010).

Picture of Montevideo taken from a hill during my visit to El Cerro.

Picture of the Plaza de Independencia in Montevideo, a central plaza. The PES building is located right off this plaza.

The level of work at the departmental level was observed on a city tour of the western zone of Montevideo with nurse Margarita Ecuay on June 16, 2010. The rural zones 12, 17, and 18 were observed. The focus of Margarita's work is to examine health needs, especially those of infants, and also on drug prevention and addiction. Other health concerns that are extremely prevalent are the social impact of alcohol and the addiction of a derivative of cocaine, known as *la base de cocaína*.

In the west of Montevideo, there are eight *policlínicas*, or public clinics. The organization and infrastructure of two clinics, *La Paloma* and *La Teja*, were visited. *La Paloma* is a very small clinic located in a region known as *El Cerro*, which is very poor. This part of Montevideo is known as one of the most dangerous. Nurse Margarita even admits that she will not go alone or

without a car to visit the clinic.

Picture of La Paloma in El Cerro during my visit

The clinic is located here because the services need to be located where the people are. It is open 24 hours a day, seven days a week, and many people who arrive are victims of gunshots and stabbings. Inside the clinic, there is one organized medicine cabinet and bookshelves with patient histories. There was no mid-wife at this clinic, but there were a few medical students who saw patients as part of a one-year requirement for a medical degree, as well as some doctors and nurses. The clinic is very run down; however, it just underwent an expansion and new windows were going to be installed. Part of the expansion included a room for educational activities for children. For example, activities that promoted dental health were carried out in this room. There is also a television, but it has to remain locked up when it is not in use. The front desk just received a new computer as well, but a doctor and a few nurses were conversing about security and having to have the system locked up. Everyone, even the host family with whom I lived talked about security problems. The threat for robbery is high, and no one should ever go around with too much money.

In front of the clinic is what Margarita describes as once being *una boca*. This was the term used for a place where people knew to purchase *la base de cocaína*. It is a very clean plot of land, with a ground of firm dirt and a small playground.

Picture of the former "boca".

It used to be a dumpster, but the people of the area were fed up and tore it down for something better. Even Margarita said, "We'll see how long it will last". There is a new place where the cocaine derivative is sold, and the people know, they just will not say anything to authorities. This drug is very cheap, and very addictive. The reason for the many thefts in the area is to support continued consumption of the drug. The effect of this drug is evident even in the center of Montevideo, where many young people are homeless and sleeping on the

streets. I was surprised to be informed by one of the locals that the reason for this is not because they come from poor families, but most likely because their families kick them out of their houses due to their addiction.

It is also evident that there is great truth in the expression "where there is a will, there's a way"; even if that way is a danger to society. For example, one of Margarita's friends is a psychologist who is working with a young patient from a very poor neighborhood. The patient mentioned that a neighbor obtained a grenade to use for assault, possibly of a person or an entire building. The question of how this person obtained such a dangerous and illegal weapon seems obvious to Margarita. It could be from the military directly, from the police, or from a family connection. People in these occupations do not receive great pay, so it is probable that these weapons are sold for money.

Driving back from *La Paloma* into the central city of Montevideo, the driver mentioned that an 18 and 29 year old died in a bicycle accident. The 18 year old died on his mother's birthday. Transit accidents are a big concern in Uruguay. There is an extremely high rate of these accidents every year, and there is a big initiative to reduce those rates. For instance, there are heavy fines for not wearing a seatbelt; yet, Margarita admits, it does not do much (Ecuay, 2010).

A zone right next to *El Cerro* is called *El Prado*, which one must drive through in order to get back to the city. It is incredible how a zone that is so close to one of poorest zones completely contrasts it. There are beautiful big parks with lots of fresh air due to the number of eucalyptus trees. It is easy to know where you are just from the odor of the air. For example, the shopping district of *Portones* is characterized by the smell of *torta frita*, or fried dough. In *El Cerro*, there is a foul smell in the air due to the amount of trash that is all over the ground and pouring out of dumpsters. A pregnant woman was spotted digging through the trash, something that one has to see to believe.

The Health Concerns and Approach to Promotion and Prevention in Uruguay

In a meeting with Mario González from the Pan-American Health Organization, I was informed that after the crisis of 2002, the first reform that the government installed was the *Sistema Nacional Integrada de Salud* (SNIS). This is the universal healthcare system of Uruguay that is available to everyone. Since the epidemiological profile of the country has a lot to do with the increased aging of the population,

preventative efforts are a priority. Infectious diseases such as yellow fever, although they exist, are not a major cause for the morbidity or mortality of Uruguay. There is a great immunization system in Uruguay that prevents most infectious diseases. Preventative efforts have also eliminated high rates of illnesses. For example, there is an epidemic of dengue in the southern cone. In Argentina, rates of dengue are rapidly increasing, and there are posters everywhere to warn people of symptoms and what action to take if one has those symptoms. The dengue mosquito exists in Uruguay; however, the illness is controlled. Beaches are kept clean, and bottles are closed when they are recycled. An empty bottle can collect rain, and when the bottle fills up with water, it provides a great medium for the dengue mosquito to reproduce.

Other transmissible diseases that pose a threat in the country are tuberculosis and *hidratidosis,* which is a zoonotic disease that is transmitted from a dog to a human through dry feces that blow microbes into the water. Infection can cause a tumor in the infected. HIV and AIDS are also of concern, as they are on the rise in the population, but only slowly increasing. Credit is given to the effort of educating the population, especially on preventative measures when it comes to having sexual relations.

There are also some environmental health problems. Although there are no volcanoes or earthquakes that occur, Uruguay suffers from flooding. It is a country of many rivers, and during the winter the poor, who live in lower lying areas, often get displaced and return to their destroyed homes.

The greatest contributor to morbidity and mortality in Uruguay is chronic non-transmissible diseases. The top three include the following: cardiovascular diseases, especially due to hypertension and diabetes, tumors and cancers, with lung cancer being the highest in Uruguay, and transit accidents. Cardiovascular diseases and tumors and cancers are the two areas that cause the most problems in Uruguay. The health system is promoting better health through individual behavior changes such as physical activity, good nutrition, and tobacco prevention. As many Uruguayans told me, Uruguayans are very sedentary, and such lifestyle interventions involving physical activity are not in the culture. Moreover, it is not easy to change ones habits, especially when popular culture does not support the recommended changes; however, with public policies that are aimed for the good of the people, things can change. For example, the clean air act reduced the number of cigarette sales, and the number of smokers.

The way the government is organized allows for specific problems to be taken care of. In each of the nineteen departments of Uruguay, there is one governor. In each department, there are also numerous mayors. Montevideo has eight mayors, who can bring a certain problem that is specific to their zone to the governor. Both biological and social health concerns are important to consider. This includes violence and mental health. In fact, Cuba and Uruguay are countries with the highest rates of juvenile suicide in Latin America. When a country does not give its youth opportunities for the future, suicide can be an unfortunate result. The Pan-American Organization for Health (*OPS)* works in Uruguay by helping to encourage and implement health development in schools to create productive and rational communities. For instance, the OPS is helping Uruguay with their millennium objective goals for 2015, specifically with the fight against hunger in creating productive and healthy communities. SILOS (*Sistema Locales de Salud*) is a program in Tacuarembó that encourages the participation of those in the community to engage in the topic of health for the sake of their own health. RIMSA is another agricultural program that looks to better the quality of life of those in a particular community. Interestingly, when it comes to local development in agriculture, the women of a community are the ones who unite and carry out agricultural projects. Through these projects, even children observe and participate in learning how to work the land.

The programs that are carried out in communities are not only run by the OPS and other Non-profit organizations, but by the departmental governments within Uruguay. One program gives one male and one female goat to a family to breed, and they are required to give the government division one goat in return to sustain the program. The animals themselves produce cheese and milk to consume and sell. These programs by the departments are usually based on work ethic and community involvement. The goal is not to donate food for people to eat and nourish themselves, but to donate the seeds to cultivate the food. When it comes to public health, the social aspect is just as important as the biological aspect: the people need to feel active and feel good about themselves.

The departmental programs are recognized by the *Feria Mundial del Municipio*, and much of the funding for the local programs comes from donations and international corporations; however, even though there is a positive result in the community, it is difficult to obtain evaluations. The OPS and iSALUD conduct investigations about communities around the

world, but it is difficult to get participation and not all countries respond. In Uruguay, 14 investigations were conducted, and it became evident that the strategy of initiating and maintaining local programs needs to be improved. The best way is to create a national committee that supports local developments. This is an area that OPS representatives in Uruguay admit is hard to convince the country to develop. This is currently underway, but as an agent, Mario assures that with a strong educational background, determination, and a maintained calmness, it is possible to obtain and accomplish goals.

Mario is one of these agents who states, "asking for something for oneself is hard, but asking for others is much easier". He holds workshops in Uruguay that he claims are simple, clear, and involve dancing and laughing. For him, it is gratifying to see how others are gratified. The theme he tackles is healthy nutrition and the work it takes to achieve it. Health is integral and involves the capacity of the people to take care of themselves and to feel good about it. It also involves the participation of the entire community, including women and adolescents. The success that was evaluated for local programs is mostly due to community participation (on average 57%) and sustainability. The sustainability is due to three factors: the initial participation that is planned, the empowerment that allows individuals to look for a way out and that gives initiative, and the political support of the mayor, local government, technicians, and connections within the community.

The effort to understand and engage a target population is essential when it comes to working with a community. In one study, health was measured according to the time invested in joining an activity to improve physical fitness. The two activities were walking and dancing the tango. In the walking workshop, half of the participants left and their measured health improved very little. For those that took the tango route to better health, not one person decided to discontinue the workshop, and their measured health improved enormously. The tango activity was one that united the community and was enjoyable and engaging. It incorporated the local culture, maintained enthusiasm, and encouraged the stimulation and participation of the people rather than the traditional lecture format for communicating information on better health. These types of activities and interventions are ones that provide social support and are effective in changing the dynamics in a community. Instead of focusing on a specific issue such as lack of exercise or preventing teen pregnancy, it is hoped that such issues can be

avoided by enhancing the connectedness of people to one another and concentrating on community empowerment (González, 2010).

Plan CEIBAL

In this paper, "community" is the sense of a population of people within the nation of Uruguay, its 19 departments and local cities and towns; however, there is another type of community that is quickly emerging. This community does not have barriers, is more global, and needs to be taken into consideration by public health efforts: it is the social community that the Internet is forming. This community is becoming strong within Uruguay for two reasons. First, TICs is the Internet service provider in the country of Uruguay and there is free Wi-Fi at numerous accessible institutions that have increased the capacity for communication. Secondly, the recently launched "Plan CEIBAL" is the first of its kind in the world at a national level and allows free access to the Internet. The previous president was known to be a visionary and he wanted every child in Uruguay to have a laptop with Internet connection. The name CEIBAL actually comes from "ceibo", which is the national flower of Uruguay and is metaphorical for the flourishing capacity of the plan for the country. Every child in Uruguay that attends school (about 450,000), as well as every teacher, has a window to the world, and this plan ensures the integration of the country into the modern world. These laptops are small and white with a green cross (as depicted on the cover page) and have a small camera that can take photos and up to eleven minutes of live video.

The impact of these laptops is evident in Uruguay. Children are eager to attend school to use the free Wi-Fi that is provided at the institution, and they even stay when classes are not in session in order to complete assignments and surf the web. The Internet has also become an easy and cheap way for children to keep in contact with one another in a country where a cell phone is a luxury and home phones are too expensive. When a child, especially one that lives in a poor area or lives at or below the poverty line, comes home with a laptop that is capable of Internet access, it provides a great impact on the family. People are starting to learn more from children, and parents are learning about the capacity of a computer. In addition, it is predicted that Plan CEIBAL will help prepare Uruguay for tourism in a few years.

With the positive benefits of plan CEIBAL also comes criticism. The plan is not perfect, but there is a great effort for surveillance of the plan, elaboration, and

evaluation. Other Latin American and Arabic countries have asked Uruguay to be a model for the plan in order to adopt it in the future. It is no doubt that communities in Uruguay have been adapting well to the plan. The plan does come with an expensive cost to the nation, but former president Vásquez noted that, even though Uruguay is in need of many things, this plan will help us. The laptops are secure for the students as well. For example, certain websites are blocked and Internet safety is highlighted in surveillance. Some schools provide workshops for parents to explain the appropriate use of the laptops. In addition, it is rare that these laptops are stolen because if the student does not log into their computer after the third day that it is reported stolen, the computer shuts down automatically and does not function. Concern has been raised about children sitting down all day with their computers; however 2,800 physical education teachers have been hired in Uruguay in the effort to prevent this. Teachers are also encouraged to emphasize the learning process of handwriting now that typing is being introduced to students at such a young age.

It is remarkable that children at age five can have a laptop, when I personally did not have my first laptop until I was 18, nor did I begin to learn how to type until nine years old. But especially at this young age, many positive effects are being shown and this technology will help with health promotion. Children will be more productively occupied and less likely to spend time exposed to dangers and health hazards. In 2010, one of the most watched videos on Youtube was "*parto de una vaca*", which showed the live birth of a calf that was filmed by a child using his CEIBAL laptop in the city of Florida, Uruguay. These laptops have also been used to defend human rights. A student filmed a teacher who did nothing while two girls were brutally fighting in the middle of a classroom, which led to that teacher being fired. The advantages of this technology are undeniable (González, 2010).

UNICEF in Uruguay

The area with the most inequalities in the world is Latin America. UNICEF, which is an organization that has been in existence for more than sixty years, started off as a form of emergency aid for children. It stood for United Nations International Children's Emergency Fund, but after World War II, it became the United Nations Children's Fund. In Uruguay, UNICEF started after the dictatorship. The changes in the government made it hard to keep steering the organization and its efforts in the right direction.

Presently, the organization functions in both possible areas of help for a country: to collect funds and form programs of operation. Uruguay is marked with the impact of infant poverty. Due to the crisis of 2002, the poverty increased in the country, and that of children increased twice as much.

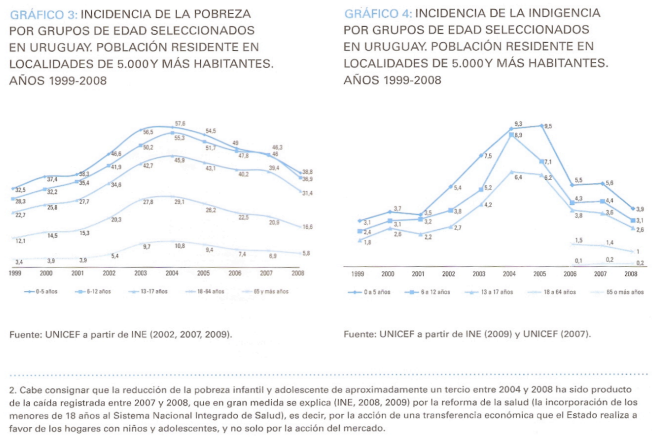


Figure 1. Two graphs depicting poverty incidence rates for different age groups between 1999-2008. The right graph represents incidence rates for people below the poverty line. Notice the increase in 2002, especially for the 0-5 age group in both graphs, and the drastic decline in 2005 when the health reform started (Arroyo, 2009).

In addition, Uruguay is considered a low priority Middle Income Country (MICs). MICs are characterized by the impact of poverty. Part of the process to help a MIC is to improve incomes, especially those of young families. Children do not become poor all by themselves. They are born into young families, and when their income falls, the children are born poor for the first few years, which are vital years in child development. Fifty percent of Uruguayans live their first five years in poverty. Cerebral development depends on the first few year experiences, and when children lack nutrition, health, and family care, they can suffer consequences for the rest of their lives. Uruguay needs to protect the country and its children by way of employment, incomes or social protection (Arroyo, 2010).

Education is another way that the country can protect its children; however, in Uruguay, there is a bad performance in education: only one in three children finish high school. Without education, it is difficult to ascend to qualified jobs. As a result, the nation's productivity rate is low (Arroyo, 2010). According to Álvaro Arroyo, a UNICEF health officer, Uruguay must push hard to invest heavily in children, but this is very difficult for two reasons. First, it is very costly. Secondly, the society is very adult centered. Societies should not regard adolescents as a threat. It is important to try to change society's view of adolescents in a positive manner. Children and adolescents have rights and are protected by laws, such as those against violence. Children have a voice, and they are not the property of an adult.

By investing in infant development, educating, and by providing opportunities for more professional jobs, Uruguay can better the situation of its children and of the country as a whole. The country is already on its

way to improvement due to its universal health care and its dedication to the Millennium Development Goals (MDG). The problem with the MDGs is that Uruguay does not know how much progress they have made because it is difficult to measure the progress. The focus for improvement right now is to change the ideology in Uruguay that family is a private world and that it should stay like that (Arroyo, 2010).

The Formation of a Universal Health Care System

Uruguay's health care system is nationally integrated and is based on primary attention. It is also based on health laws that have been implemented within the last five years. Certain services are free every year because the government believes that it cannot obligate people to utilize certain services if the public is forced to pay for them; however, Uruguay's health care system has evolved into what it is today. This was explained by Liliana Etchebarne, a risk and disaster management specialist. It has gone through many changes, starting with the first public hospitals at the end of the 18th Century and the beginning of the 19th Century. In 1876, the first medical school was created in Uruguay. Before this, doctors were trained in other parts of the world. The medical system was and continues to be based on the French model of medicine. The way Dr. Etchebarne described it, the Anglosaxon model of medicine focuses on the specialization of doctors, while the French model focuses on a doctor's general knowledge of medicine and using a specialization as an accessory. In other words, any doctor can attend to most of the patient's medical needs. Even the textbooks that are used in medical school are translated from French textbooks.

In addition to the formation of doctors now within the country, the first institutions that served as a type of insurance were private insurance companies. In 1853, the most popular insurance was the *Asociación Española Primera de Socorros Mutuos*. This type of insurance was to help immigrants who were coming into the country. In Uruguay, unlike the rest of Latin America, there is almost no indigenous culture present. What is hard to find in textbooks is the fact that there used to be, but a former president had the majority of indigenous people exterminated by 1830 by bloody massacre. With a great wave of immigrants entering Uruguay, it became a country of a collection of ethnicities, mostly Spanish and Italian.

In 1933, the first form of social security was created. This social security is different from what is social security in the

United States, because it is not limited to the elderly. Also, it protected people's occupations by providing a paid salary while a worker was ill. By 1935, *Centro de Asistencia del Sindicato Médico del Uruguay* (CASMU) was also created as a form of insurance for medical support. A year before marked the start of the health sector in Uruguay, forming the base of what it is *Pública* (MSP), or Health Ministry was formed by joining the National Hygiene Council and Public National Care. These two organizations allowed the MSP to be primarily based on health promotion and prevention. Years later, in 1970, another type of support was created for patients who needed certain costly treatments. The *Instituto de Medicina Altamente Especializada* (IMAE) collaborated with the *Fondo Nacional de Recursos* by accepting money from this specialized fund towards costly and frequent treatments for patients with prosthetic hips or knees, for example.

Between 1960 and 1973, medical attention in Uruguay was progressing. During this time, the first request for a national health care system was proposed, and many insurance and social security funds were doubling their cover; however, in 1973, the military government started, and the theme of health was not a priority. Health and the system that was developing collapsed during the military take over. Support such as CASMU was unfinanced, and this was a step backwards for the health progress in Uruguay.

Between 1973 to 1984, it was observed that twenty percent of citizens were without health coverage. In this health care crisis, the private sectors united. Between 1985 and 2004, health politics concentrated on the communities, and *Concertación Nacional Programática* (CONAPRO) started to implement democratization and participation of the community, 100 % coverage of the population, and a National Health Service. The focus on health that characterizes this period was the increase in health cost of the public sector, the promotion of primary care, reform in the human resource politics of the sector, and universal coverage for the sick. By 2004, Uruguay created a law to facilitate the functioning of the health care system. In addition, it consists of two sectors that also exist today: the public and private sector.

The Uruguayan health care system has greatly strengthened from 2005 to today by strengthening three aspects of change: management, primary care, and funding. There are many reasons why the Uruguayan government focused on developing these three areas. First was because of inequity. Those who had the money were able to

obtain better health care and services, and the state was not protecting those who did not have the means to pay. Also, those who needed services the most were not able to receive them. This became a concern, and created am impetus to change the quality of services and to reform a new system. More laws were needed to resolve the health conditions and provide better services for those who need them. The management of the system was viewed as inefficient, and MSP needed to set norms for a baseline in health care.

The first target for change was the model of care. A stronger model of attention that is now implemented is based on the strategy of primary health care. It is a strategy that is capable of resolving illnesses at a low cost. For example, oral rehydration can be applied to treat diarrhea. Home remedies can be taught to parents to diminish life-threatening illnesses in vulnerable areas, and treatment can be avoided altogether, for example, through the use of vaccinations to prevent diseases (Etchebarne, 2010). In Uruguay, the vaccination plan is clearly written as part of health law. For example, order 317/005 entitled "*Vacunación Hepatitis B"* states: The obligation of the vaccine against Hepatitis B is established in the SNIS *(La Construcción del Sistema Nacional Integrado de Salud: 2005-2009*, 108*)*. Many illnesses have been eradicated in the country through the use of vaccines. In order to attend school, children must be vaccinated, and if they are not, the school will seek to provide the vaccination.

An important aspect that is emphasized as part of the new model of care is to have knowledge of and respect for cultural values. Providers must keep in mind culture, historical determinants, demographics, and epidemiology in order to treat individuals and communities. Doctors are not the only providers who know about health: there are differences from one community and the next, and the people have their own beliefs and knowledge that providers must take into account. For example, if a town eats a certain way, a provider cannot just change the culture, but they must incorporate the culture in order to promote health. This is seen as a major responsibility of the provider, but the participation of everyone in the community is a very important factor in primary care, and one that the new system is currently working on enhancing. The understanding between provider and user has been shown to better facilitate greater participation.

Besides the individual and community efforts, the strategy of primary care also focuses on local territories, and the primary care for the nation as a whole. The

reality between the different territories of Uruguay is distinct. The new system is working on analyzing the territorial problems and assigning people, organizations, and programs to be responsible to implement a promotion plan, prevention, and health education. Primary care on the national scale consists of eleven programs, and each program has its own pamphlet that is created with the collaboration of the MSP and can be distributed to anyone as health education material.

The second proposal was to change the model of financing. It used to be that the more money a person had, the better the service. In addition, the elderly and handicapped were denied aid from private insurance sectors because they were considered a risk compared to a person who was young and healthy. But health care should not work in this fashion. Part of the new system is a national health fund, or *Fondo Nacional de Salud* (FONASA). This consists of money from various places, including a small fixed percentage of salary from all users, contributions from companies and firms, and contributions from the government. The funds are distributed to the institutions, which are the public and private health care companies, who then distribute them to their users. The healthier the population is, the more the fund is going to pay the institution. This method ensures the responsibility of the institution to help promote health in order to receive more money.

The third proposal was to change the model of management. Due to the fact that the Health System is nationally integrated, there is a strong political role associated with health care. The government implemented health laws and the creation of the MSP. These efforts are to enhance the participation of all citizens, and to work towards the concept of quality of attention in terms of both efficacy and efficiency. "Good quality" covers health promotion, population education, and participation of all those involved and local development. The MSP focuses on these principal points in quality of health care. The mission of the MSP is to guarantee the right of health for all Uruguayans, as part of human rights. Their vision is to create a part of the government that promotes health and to develop policies that are aimed to increase the quality of life, collective well being, and access to health services for all citizens (Etchebarne, 2010).

The Integration of the Health Care System into Uruguay's Government

In a lecture by Diego Rossi on June 16, 2010, the creation and integration of Ministries and other health components into

the SNIS was explained. There are three governmental powers in Uruguay: the executive power that consists of the president who is elected every five years, the judicial power, and the legislative power. The executive power appoints ministries, which include the ministries of work, education, public transportation, and public health. The Ministry of Public Health (MSP) was created through a law in 1934. Prior to 2005, the *Asociación de Servicios de Salud del Estado* (ASSE) or State Health Services Administration, provided state funds, and the *Instituto de Atención Médica y Colectiva* (IAMC) provided private funds for health care. In 2005, with the change of government and the new nationally integrated health system (SNIS), ASSE and IAMC transformed into a private institution, also known as *mutualista*. SNIS universalized health care and provides funds for everyone, especially for all children and their mothers. In other words, everyone is provided with the basic health care needs under SNIS, but one can go through private institutions in addition to SNIS in order to receive more coverage such as certain elective procedures and extra services. Since 2005, the nation has taken the role of sanitary police, and even the private institutions must follow the rules of SNIS. The private institutions are monitored, and since the government is in charge of the money that they receive, they must comply to receive funds. The structure of this program has proven to be very effective and efficient. Many user injustices are eliminated due to the fact that everyone is provided with the same baseline health care and uses the same doctors, and there is greater participation of workers in this system. The three aspects of health, policy, and the territory where the people live come together and are monitored by the state government, which in turn eliminates inequalities in healthcare between different populations.

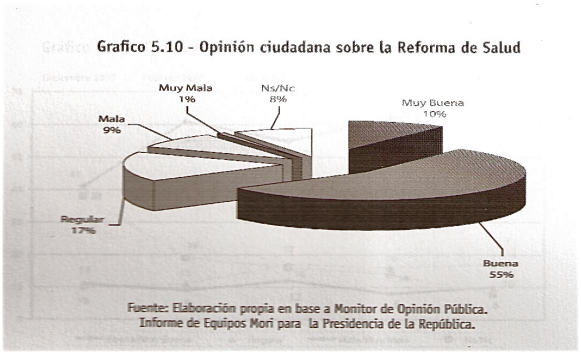


Figure 2. Public Opinion of the Health Reform. Note that 55 percent of citizens believe the reform was "good" (*La Construcción del SNIS)*.

The MSP until 2005 had the responsibilities of elaborating public health policies and taking care of people with low resources. This ministry was also previously a sector of the Ministry of Social Development, or the *Ministerio de Desarrollo Social* (MIDES). By 2005, the MSP separated into its own ministry. MIDES and MSP separated in order to

improve the effectiveness of their many responsibilities, but they still converge on certain tasks. Their biggest combined effort is the creation of twelve programs with manuals to guide medical personnel, technicians, and anyone working in the health field. The programs are the following: adolescent health, elderly health, oral health, ocular health, nutrition, HIV/AIDS, mental health, accidents, women and gender, adult health, tobacco, and management and risk. For example, in the manual for nutritional health, there are recipes for healthy, low cost meals.

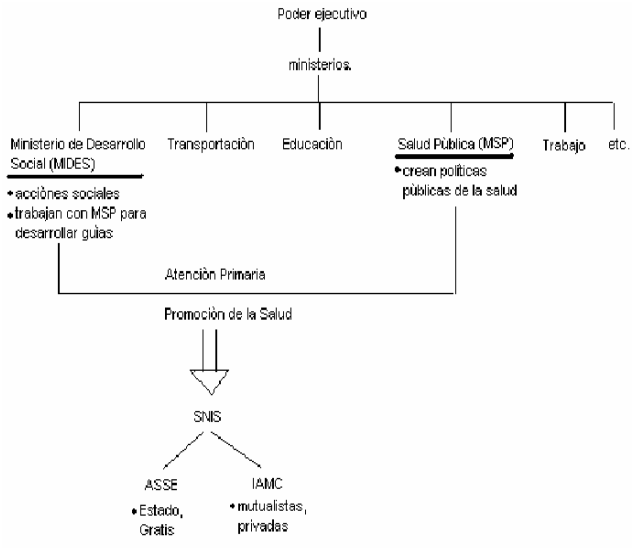


Figure 3. The Organization of SNIS. FONASA is what funds the SNIS (Hofer and Ramírez, 2010)

As previously described, primary attention is the first level of approach for the health of a community. Another concept that is related to, but in policy is argued to be entirely different, is health promotion. In the simplest terms, health promotion looks for those things in a community that make one feel good and protects from other harms and risks. It is difficult to modify lifestyle, but the concern for health is not solely focused on health services or the illnesses that health promotion focuses on preventing; rather, health promotion is also sought out mostly in the workplace and household. The goal of many public policies related to health is for the people to understand that they must carry out health promotion. Generating participation is vital, and one must have the eyes and ears to work with communities. It is important to educate communities, but one must know the knowledge that the communities themselves have as well, and any provider must work with this reality.

The promotion of health involves educating people on their rights and benefits (Rossi, 2010). For example, by law, every adolescent receives one free doctor's consult every year, and every woman is provided with a gynecological exam every year, and every three years is granted a free PAP test. It is also essential to promote that there is a reason and a great importance for waiting in long lines and enduring what can be quite uncomfortable examinations. Going to go see the doctor can be an unpleasant experience, but patients should not to be treated in a bad way. It is almost common knowledge in Uruguay that in the United

States, we treat our doctors as if they are gods and give them a power and position over us. Many policies and organizations in Uruguay make every effort to respect the fact that people have rights, that they have a right to know about these rights and to know when they are being treated badly, and that providers must respect these rights.

The health care system itself cannot provide all the services for health care, but it works with institutional actors, personnel that work in health, and even the nation's schools to help in health promotion and disease prevention. For example, sexual education is instilled in the educational system. Another example is the work that INFAMILA conducts. INFAMILIA is a sector of MIDES that works in every territory in Uruguay and is dedicated to serving the community and their needs. Representatives go out into the communities to see and hear the problems and necessities (Rossi, 2010).

CHAPTER THREE

Uruguay's Concern for their Children and Adolescents

The Role of the *Ministerio de Salud Pública* and MIDES in Adolescent Health

I had the opportunity to visit the Health Ministry and speak with the Director of the National Program for Adolescent Health, Susana Grunbaum. She emphasized that the MSP creates health programs for the entire country, but also focuses its attention on the poorest people. They also focus on management, finance, and epidemiological data. It is also decentralized. The Ministry is not solely located in the capital and does not focus only on the problems of the nation as a whole; instead, the ministry has spread out into different territories in order to identify specific needs. In 2004 and 2005, the ministry created a program for adolescents because they saw the need for an adolescent program, separate from children and maternity (see Appendix 2). Adolescents in Uruguay are defined as age 12 to 19, but the program continues on to the age of 24. In 2007, the program was officially installed and other organizations such as INFAMILIA helped to stimulate the formation of public places made solely to care for the health and well being of adolescents.

A central theme when it comes to adolescent health is that of confidentiality. Because the program focuses on equity, it looks at the needs of the people. The situation that is most common and delicate among adolescents is that of sexual relations and pregnancy. It becomes a cultural matter, because parents want to know through doctors and other health personnel if their children are having sexual relations, but confidentiality must be kept. Doctors are not being accomplices by keeping these things from parents. If a child says something in confidence to an adult, whether it be a doctor or a teacher, it is so that the adult can facilitate action. Since there are no courses permanently instilled for professionals to learn about how to treat adolescents in professional schools, it is required that all health professionals learn the code for children and adolescents, or *Código de Niños y Adolescentes* (CNA) and the guide for primary care for adolescents at the first level of care, or *El Guía de Abordaje Integral de la Salud de Adolescentes en el Primer Nivel de Atención*.

The MSP also funds adolescent programs related to health that stimulate health. For example, "*Arrímate a la Salud"* is a program that translates into "lean towards health" where youth directly educate other youth. It is an effort that adolescents

take upon themselves to investigate problems such as alcohol and STDs, and they receive about $300 for two months to carry out their investigation. The program facilitates youth having a role in society that benefits them and allows them to participate in their own health by going out and acting on it (Grunbaum, 2010).

In another interview with a team from INFAMILIA, a sector of MIDES, I was informed that, along with the MSP, MIDES also recognizes the needs of children and adolescents. In the country, 56 percent of infants are below the poverty line. There is a high level of poverty, and the MIDES' organization of INFAMILIA attends specifically to infants and adolescents in different territories. The territories that are included are not just defined geographically, but also include communities and groups of people. The way that the program attends to territories is through the creation of a group of personnel called SOCAT, which stands for *Servicio de Orientación, Consulta y Articulación Territorial* (Orientation, Consultation, and Territorial Articulation Service). There are 73 SOCATs that are located throughout the nation, one representing each territory. For example, in Montevideo, there are 27 SOCATs, and San José there are two.

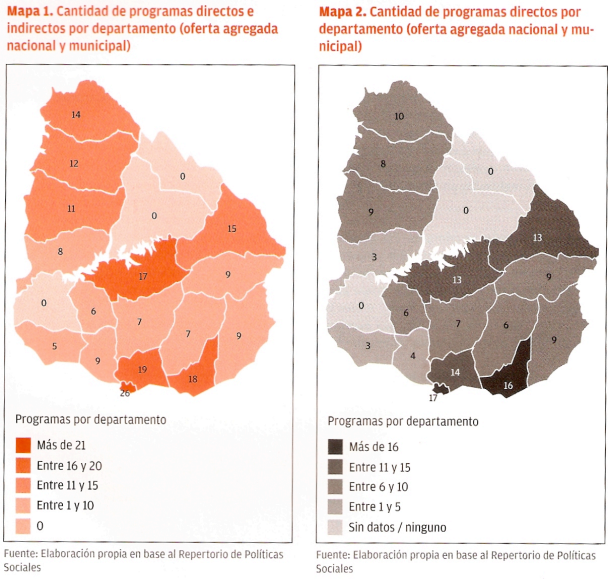


Figure 4. Map of the amount of programs per department in Uruguay. San José has 9 direct and indirect programs (left) and 4 direct programs, while Montevideo has 26 and 17, respectively (*La protección social*, 48).

The SOCAT identifies the specific problems of the zone and develops plans in order to create and carry out the necessary action in order to attend to the problem. They also verify that certain demands are satisfied with the services that are offered in the zone. The SOCAT functions as a consultation space to bring any problem that the people worry about to "the table". The table, or what is known as *la mesa de coordinación zonal* (MCZ) is where the heads of various institutions unite to talk about territorial problems and discuss and debate what can be done about the problems and what organizations can collaborate to take responsibility for the problem. For

example, a preoccupation of the San José territories was oral health in children. Cavities were prevalent in children, when it is the most preventable disease. For this problem, ASSE, IMM, *La Universidad de la República,* and *el Instituto del Niño y Adolescente de Uruguay* were all organizations that were major players in contributing effort and resources for oral health. The people did not have a way to attend to children's cavities the way dentists do, so they decided to bring programs to the schools. The SOCAT used the territorial funds or *Fondo de Inversión Territorial* (FIT) to provide children with the materials to brush their teeth in school and the personnel to diagnose and teach them how to prevent cavities; however, another problem was that there was only one sink for every two hundred children in the schools, so funds were also set aside to build more "cepillodromos" in the schools. This word is derived from "sambodromo", a street in Rio de Janiero, Brazil where people gather to dance samba. Here, these sinks have faucets so that students can gather to brush their teeth. With the preoccupation of the people and the help of the SOCAT, the MCZ was able to decide to invest money into the schools for student's oral health.

The reason why adolescent health branched into its own program in 2007, separate from that of maternity and infants is because too little time and few resources were dedicated to adolescents. In 2005, it was evident that teenage pregnancy was on the rise, especially in poor areas. For example, out of the total amount of deliveries per year at Montevideo's Hospital Pereira Rossell, 24 percent are from adolescent mothers. The most important part the nation's adolescent program is that education and health must be associated with each other. In the words of Susana Grunbaum, the best contraceptive is education. There is a great importance for adolescents in the country, but Uruguay has not been able to prevent emigration and maintain their young population in the country in the past.

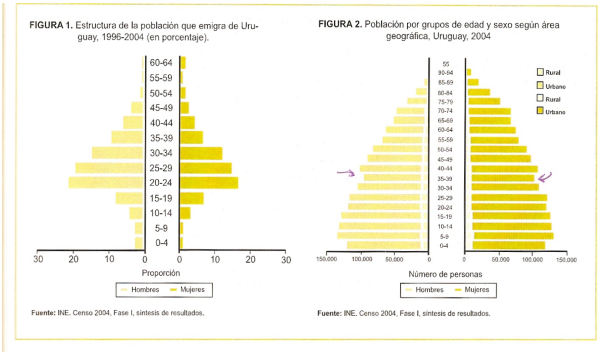


Figure 5. A key demographic characteristic of Uruguay. Left: the majority of emigrants are young, mostly age 20-24. Right: note the arrows that show the "mordidas" or bites in the population (*Desarrollo Saludable, 13).*

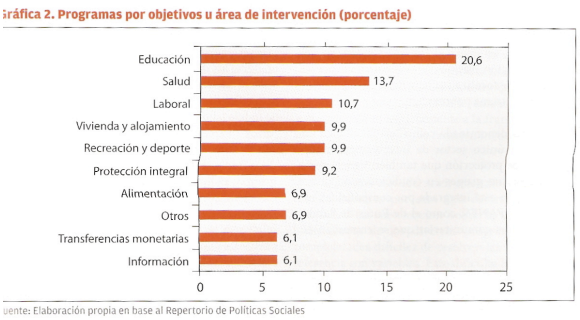


Figure 6. The percentage of focus for different adolescent programs. Note that the focus on education is the highest, followed by health (*La protección social,* 23).

Children are dropping out of school as early as age of 12. In 2006, efforts to create *espacios adolescentes*, or adolescent spaces in Uruguay were aided by the help of MIDES-INFAMILIA, MCZ, the OPS, and the adolescents themselves. The goal is to generate a space that is exclusive to the health of adolescents. These spaces are actual establishments where adolescents can go, where visiting doctors, nurses, and psychologists attend the specific needs of adolescents. The space serves as a clinic just for them, but also caters to the health of adolescents in providing activities and opportunities for this target population. With the current demographics and the fact that well educated young adults are leaving the country, Uruguay has placed a focus on adolescents. There is a need to treat adolescents with quality care because when they come to a clinic, it is for a reason. The quality of care that they receive affects whether they come back for more care. One has to put in the time, the quality of care, and have patience with them. Adolescents used to be asked to leave health centers because they were just annoying and irresponsible, or they were asked to come back another day. Any patient should be treated that same day. The way that adults think about adolescents needs to change. Another challenge in adolescent care is that there is no postgraduate education for doctors to learn how to treat adolescents.

For adolescent health, there is a large demand for mental health services. This service is insufficient in the country, and it is behind the demand for mental health care. Also, Uruguay is known to be a country that depends on pharmacology. In other words, drugs are heavily prescribed and used in order to "solve" mental health problems. Among its youth, there is a high rate of illegal drug use, especially *pasta base* of cocaine, and alcohol use. In addition, accidents and suicides are the highest cause of death.

The adolescent spaces provide contact between the adult world and adolescent world. They provide a space for adolescents to be heard without the pressure of parents or other adults being present. In the space, which is usually a building, doctors come to visit for a day to attend only adolescents. The space also provides

materials for adolescents, such as condoms, videos, and the dolls of *la familia sexuada*. These dolls represent the human body in ways that a typical Barbie doll fails to do so: they have fully developed genitals, and one member is pregnant and comes with a baby attached by an umbilical cord. These materials help strengthen concepts and messages to educate adolescents and to enhance their care by creating a stronger relationship that involves trust between the patient and doctor (Methol et al., 2010).

Case Study: Ciudad del Plata

Ciudad del Plata (which literally translates into city of silver) is more of a town within the department of San José that was built around the "old route" to Montevideo. It lies just outside of the city, where many parents of families residing in Ciudad del Plata work. According to Julio Melgar and Marisa Verstraete, two INFAMILIA officials in charge of territorial responsibilities, the town is also known as a *ciudad dormitorio* (dormitory city), or bedroom community, because parents come back home only to sleep after a long day of work in the capital. It is about a half hour commute to Montevideo. Ciudad del Plata is considered to be different form the rest of the country of Uruguay in that, here in this town, there are a lot of young people. The adolescents in Ciudad del Plata tend to stay home all day taking care of their younger siblings. They can attend school and have the opportunity to do so in Montevideo, but after they reach 15 years of age, they no longer receive free education and many discontinue their studies. The fact that children reside at home in social exclusion with a lack of recreational spaces and adult supervision and other resources continues to be a big problem in the zone (Melgar, 2010).

This problem concerning adolescents has been brought to the MCZ, and there have been some improvements that are evident when going around the town. For example, there was a park close to a local clinic where children could play in order to attract parents with their young children to come to the health center for their own health as well as that of their children.

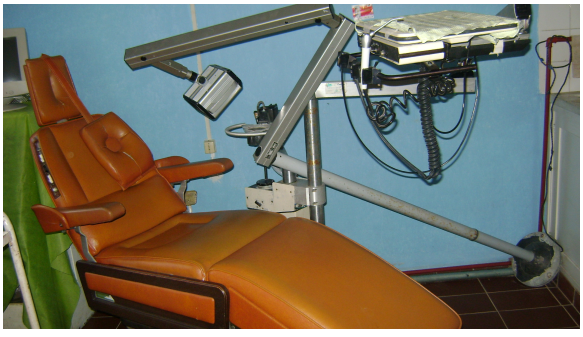
Picture of the playground as described above.

The playground also makes the clinic feel more like a part of the community, rather than a place for sick people.

AN ADOLESCENT SPACE

As was previously described, the main function of the adolescent space is to invite doctors and medical technicians to attend solely to the problems and health concerns of adolescents and also to be a space for different activities. In Ciudad del Plata, there was an old clinic that was closed, and adolescents from the area, along with the help of MIDES-INFAMILIA, helped to receive permits from the town so that the clinic could become an adolescent space. The space was created because adolescents (age 12 to 19) felt they lacked health care access. They were able to form a space, and with some paint and donations of pictures, were able to redecorate it.

The espacio adolescente in Cuidad del Plata



The dentistry room inside the adolescent space

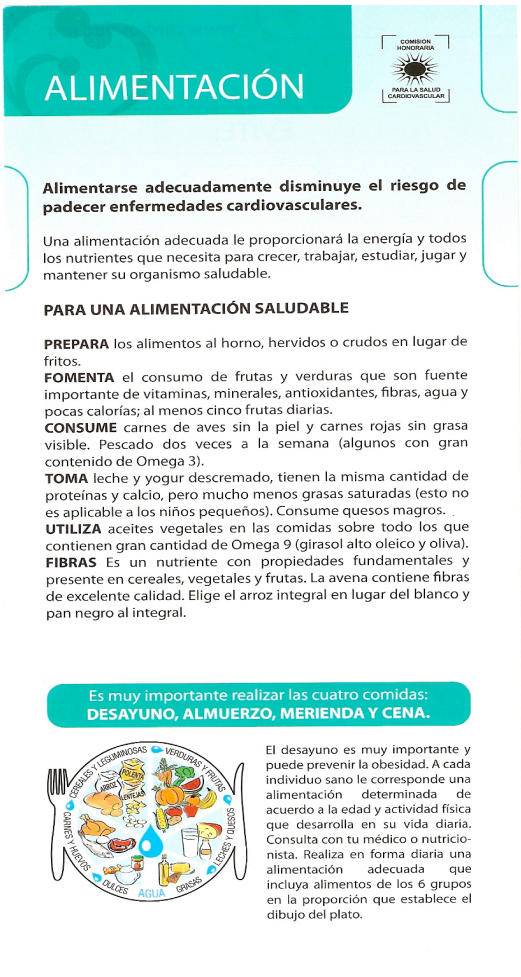
I was able to view the space personally on June 29th, 2010 with the help of Dr. Gustavo Rodrigues, who is the doctor at the health clinic right down the street and two adolescents who help run the adolescent space: Lucia Obelar and Damián De León, who were both 20 years old. The first activity that I witnessed was an excerpt of a Woody Allen play that the theater workshop was practicing. Daniel, the theater teacher, told me that he has a background in Kinesiology but loves theater. For him, all you need is to move. For instance, a person who is born mute can act, as long as one adapts to this and works with it. Some of the youth that are in the theater group already have some experience, but all are welcome to come. Daniel admits that healthy children tend to participate more, but the space needs to work on outreach to the adolescents who are living in poverty, sick, or recovering and would benefit from having some activities in which they could participate.

Once after Daniel left for the day when the theater workshop ended, an interesting misunderstanding took place that made it obvious that some people are not so fond of the space. While the theater group was still waiting to go home, a woman, who was referred to as a "the crazy neighbor", came in and angrily said to the Lucia and Damián, "don't you teach these kids good

manners?". She also wanted to call the police. What happened was that a man outside fell down and the woman assumed that the children were laughing at him, which was not the case. Lucia had to explain to the woman that the adolescent space is a center for health, but its focus is not on diseases, but on promoting health and for kids to have fun. This is the reason why there is a theater group. Lucia also admits that there is a concern for health, especially early on because in the end, it saves money. It costs about 500 dollars a day for a child to be in the intensive care unit (Obelar, 2010).

Based on their experiences, Damián and Lucia defined participation as having three pillars: there must be a physical space for participation, opportunities, and impulses. By providing these three pillars, adolescents can exercise their role in transforming and constructing areas of their concern in a process that is organized, motivating, and simply fun. Another key factor of adolescent participation is *apoyo perceptible*, or perceivable support, which is an expression that focuses on having an adult around who is committed to supervising and providing guidance to the group. Despite the fact that it is most efficient for young people to reach out to young people of their generation and below, an adult should facilitate the activities. Such adult supervisors should provide long-term support for adolescent programs and follow through.

An example of an activity that Damián and Lucia have participated in the past are going to the beaches in the summer, specifically Playa Pascual in Uruguay, where many adolescents hang out and they can reach a larger population of them. They hand out health information pamphlets that they and other adolescent leaders help to create.



ALIMENTACIÓN

COMISION HONORARIA PARA LA SALUD CARDIOVASCULAR

Alimentarse adecuadamente disminuye el riesgo de padecer enfermedades cardiovasculares.

Una alimentación adecuada le proporcionará la energía y todos los nutrientes que necesita para crecer, trabajar, estudiar, jugar y mantener su organismo saludable.

PARA UNA ALIMENTACIÓN SALUDABLE

PREPARA los alimentos al horno, hervidos o crudos en lugar de fritos.
FOMENTA el consumo de frutas y verduras que son fuente importante de vitaminas, minerales, antioxidantes, fibras, agua y pocas calorías; al menos cinco frutas diarias.
CONSUME carnes de aves sin la piel y carnes rojas sin grasa visible. Pescado dos veces a la semana (algunos con gran contenido de Omega 3).
TOMA leche y yogur descremado, tienen la misma cantidad de proteínas y calcio, pero mucho menos grasas saturadas (esto no es aplicable a los niños pequeños). Consume quesos magros.
UTILIZA aceites vegetales en las comidas sobre todo los que contienen gran cantidad de Omega 9 (girasol alto oleico y oliva).
FIBRAS Es un nutriente con propiedades fundamentales y presente en cereales, vegetales y frutas. La avena contiene fibras de excelente calidad. Elige el arroz integral en lugar del blanco y pan negro al integral.

Es muy importante realizar las cuatro comidas:
DESAYUNO, ALMUERZO, MERIENDA Y CENA.

El desayuno es muy importante y puede prevenir la obesidad. A cada individuo sano le corresponde una alimentación determinada de acuerdo a la edad y actividad física que desarrolla en su vida diaria. Consulta con tu médico o nutricionista. Realiza en forma diaria una alimentación adecuada que incluya alimentos de los 6 grupos en la proporción que establece el dibujo del plato.

Example of a pamphlet that is handed out that Damián gave me, explaining proper nutrition. Note that the food pyramid is a food plate. The reverse side of this pamphlet recommended to avoid salt, fats and sugars.

They also organized an event with a well-known Uruguayan rock band, *La Trampa*, who played on the back of a truck outside of schools while informational materials were handed out, including information on health and a brochure with operation hours at local clinics. Also included in the program was a giant condom mascot that dances to the music of the rock band and distributes free condoms (Obelar and De León, 2010).

Another concern of adolescents in Ciudad del Plata is education and the high rate of adolescent pregnancies. During my visits to the Ciudad, I also visited an *aula comunitaria* (community classroom), which functions to motivate young people who are not in high school to return to school and creates a link to help them re-enter. It's a center that provides a one year time period to motivate any child or adolescent who finished middle school, but has lost interest to continue into high school.

CENTERS FOR INFANTS AND FAMILIES

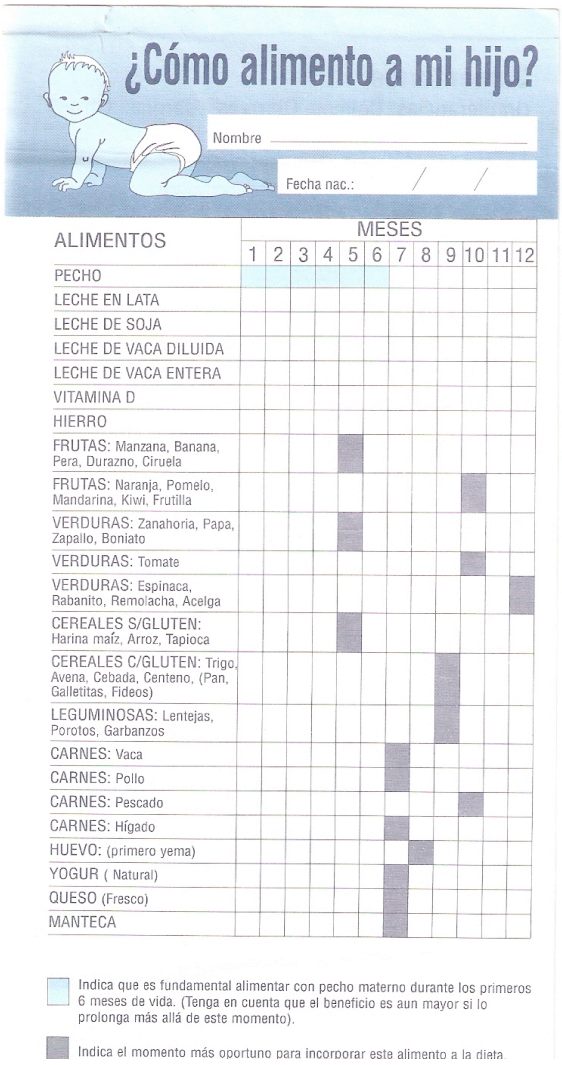
Attention is also geared towards babies and pregnant women through centers known as *Centros de Atención Integral a la Infancia y la Familia* (CAIF), and specific programs at the health center. There are two CAIF centers in the zone that provide services for children from zero to three years of age. I visited both centers on June 30, 2010; one was much larger than the other. At the smaller center, there was a greater focus on services for pregnant women, including workshops where they were provided with essential information and discussed topics that concerned them. During the visit to the second CAIF center, it was evident how much larger the center was, and this center focused mainly on care of the infants, since it could capacitate many children. The center is connected to an elementary school as well, and shares a playground with the school. The center has 120 children from ages zero to two, another 120 children at age three, and the school next door has 66 children. There were several rooms where activities took place. One room had many mirrors and colors to provide a stimulating environment. A physiologist also comes in to evaluate the children and make sure that they are developing properly and at the right stages; if not, they recommend proper attention for that child. The large center also had three kitchens to provide food to all the children. Despite the emphasis on the size of the center, the woman who offered the tour admits that there are still too many children for one building, and not enough personnel.

The adolescent space also provided service for pregnant adolescents, educating them about healthy pregnancy and birth. I sat through one lecture given by Dr. Rodrigues about the risks of smoking during pregnancy. Unfortunately for this workshop, only one audience member showed up. During this lecture, he used simple, direct, and attractive language because he did not only talk about the negative aspects of smoking, but he also gave a little history and spoke of the biological and social impacts of smoking.

A HEALTH CENTER

The health center, which was located right across from the adolescent space that I visited on the first of July, and where Dr. Rodrigues works, had an interesting program geared towards all newborns in Ciudad del Plata. The program, called ADUANA, has documentation on all the children who were recently born in the zone in order to help monitor their health, diet, and vaccination program. The mother has the role of protecting her baby, but if the mothers do not arrive at the health center for any reason, there are people in the program who go and look for them. ADUANA has documentation for about 800 newborns in the zone, and two people go out and do home visits. They recommend no more because the program does not want to cross certain boundaries and make mothers feel uncomfortable or invaded. They also wait a few days after the appointment if the patients did come and make phone calls to follow up. It is understandable that there is anxiety involved in having a newborn child and a lot of responsibility, so time is given, but the program does step in after they attempt calling and reminding and there is still no response. Every day the program receives a list of births and dates of when the babies need management. For example, they recommend six months of lactation, and they

have a recommended vaccination schedule.



Example of a pamphlet that this health center gives to mothers, highlighting the recommended six months of lactation. The reverse side also lists what to give your baby and what to avoid, such as avoiding hard and melted cheeses, and to give water and juice between meals, but not as a substitute for breast milk or formula.

One nurse, Ana Arada, admits that during these domestic visits, there is never the smell of food in the houses, which should be typically present, especially at the time of the visits. The visiting nurses go around 10 or 11 in the morning to make sure that the women are at home. She also doubts that poor health situations result entirely from poverty and an economic situation. She feels that it is a crisis in values and priorities. They might claim to be poor and unable to go to the clinic, yet the same families still have cell phones and televisions. Sometimes they do not care about the condition in which they live or provision of certain necessities, such as healthy food and resources for hygiene, when they would rather have other things.

The nurses added other details about the environment and common concerns of the health center. In all areas and departments, there is lack of personnel. The clinic also cannot handle severe medical injuries and has to transport patients to Montevideo. Also, the *pasta base* (base paste) of cocaine is attacking the youth, dominating the person and destroying him/her. This *pasta base*, also known in short as *el paco* in Argentina for *pasta cocaína*, was explained to me as being similar, but a more harmful product than what we would know of as "crack cocaine". *Pasta base* is the by-product in cocaine processing, and it is very cheap and very addicting. What the clinic needs to improve on is health management: prevention, intervention, and follow-up, especially in mental services. There is one psychologist who treats adolescents only; however, one

person is not enough to accommodate and provide sufficient care. Ana did rave about the change in government and about the former president, who was a doctor, and how it's caused people, especially medical personnel, to look at patients with different eyes. She credits the preventative measures as the reason why the infant mortality rate decreased from 9.2 to 7 per 1000 births.

During a week's visit to Ciudad del Plata, every place that was visited: the *aula comunitaria*, local offices of MIDES, SOCAT, MSP, health centers, the adolescent space, and schools, I observed that the same posters and information were being used in order to promote health. The visits were centered on observing an example of a territory outside of Montevideo and how organizations function there. To me, the use of the same exact posters signifies that the work done to improve the situation of the people is done as a whole team and they have incredible connectivity. It also signifies that the organizations work on the same theme of adolescent health and they are careful not to cross paths in order to maintain maximum efficiency in attaining progress.

Uruguay's Educational System

Besides the health care system, another system that has undergone change is the educational system. In Uruguay, education is obligatory, secular, and free. With the change in government, there is a new vision of educating with the purpose of promoting health and optimal development for children. For example, there is a focus in the teaching of the rights of children, such as informing and discussing about what it means to be mistreated. It not only deals with violence, but also about being neglected. Education is a powerful tool in order to ensure healthy development and to create a complete human.

The structure of the educational system in Uruguay is unique. The educational system is not dependent on the Ministry of Education. The President is at the highest power in charge of education, and education is governed by the *Administración Nacional de Educación Pública* (ANEP). Under ANEP, or the National Administration of Public Education, there is a *Consejo Directivo Central* (CODICEN), which is a central board of directors. There are five members in CODICEN, each elected in different ways. One member is elected by the political opposition, two are chosen by the President, and two elected by teachers in Uruguay. This board of directors creates the educational politics of the country in five levels of education: kindergarten (*inicial)*, elementary (*primaria)*, high school (*secundaria),* technical school (*técnico*

profesional), and school of education (*formación docente*). The policies of these levels of education are subdivided into four more councils to concentrate on the specifics of every level. These councils are named as the following, with a kindergarten and elementary school combined together in one council: *Consejo de Enseñanza Inicial y Primaria* (CEIP), *Consejo de Educación Secundaria* (CES), *Consejo de Enseñanza Técnico Professional* (CETP), and *Formación Docente* (FD) (Rossi, 2010).

It has always been the responsibility of the school to educate so children can obtain knowledge and have a better future. The motive of education has always been to invest in the child, but in a way that does not concentrate on the health and development of the child himself/herself. In other words, teachers have always strived to set their lesson plans to teach "basic materials", such as mathematics, the sciences, and literature; but, there is a lack of demand for teachers to teach about health and human development. As Álvaro Arroyo stated, education should be a tool to promote health so that adolescents recognize their rights. The essential shift that Uruguay is making in their educational system is best described in the words of Claudio Naranjo, a Chilean psychiatrist: what education needs is a valuable and effective element in order to deepen self-knowledge. This would result in good human development and would ensure a transformation for a good coexistence (Naranjo *Cambiar la educación para cambiar el mundo* 181,188).

> *Creo que está teniendo lugar una gran tragedia en la educación: se está aplastando al espíritu humano, con gran ignorancia de lo que se está haciendo"…la educación…por definición, debería ser la avanzada de la conciencia y de la cultura, y sin embargo, pareciera ser la más retrasada y obsoleta de nuestras instituciones….Necesitamos un cambio de rumbo que requiere seres humanos más sanos y sabios y que nada podría contribuir tanto para ello como una reforma profunda de los objetivos y forma de la educación. Como cuando un barco se hunde y se preparan los botes salvavidas, entra en quiebra en nuestro tiempo un sistema patriarcal milenario, y la operación de salvamento consistirá principalmente en la educación, de seres más conscientes y mejores, que en virtud de serlo, podrán encontrar una mejor forma de convivencia.*
>
> I think that a big tragedy is occurring in education: the human spirit is being crushed, with a great ignorance of what is happening…education…by definition, should be the advance of conscience and of culture, and nevertheless, it seems to be the most behind and obsolete of our institutions….We need a change in course that summons the most healthy and wise human beings, and nothing can contribute so much for this as a deep reform of the objectives and form of education. Like when a boat sinks and the lifeboats are prepared, a thousand-year-old patriarchal system falls apart, and the salvation consists principally in education, of beings more conscious and better, that by virtue of being so, can find a better form of coexistence (Naranjo, *Cosas que vengo diciendo* 116, 128).

There is a lack of attention to the child as a human being, which is a problem, especially in such an important stage of human development. This early abandonment in

teaching children and adolescents is considered by many as a threat to the survival of the child and of the society. A healthy identity should not be a responsibility that should be solely placed on health services. The school can also transmit information to teach a child how to take care of himself/herself in order to ensure healthy growth and development.

> *Se le echa la culpa a la juventud, principalmente. Se piensa: 'Estamos en crisis porque la juventud ya no se interesa como antes en sus estudios,' 'los jóvenes ya no son tan serios como en otros tiempos,' 'los jóvenes toman drogas y por eso no son capaces de escuchar a la gente seria que quiere traer estas materias tan importantes al aula." Y no se piensa que tal vez sea al revés: bien pudiera ser que los jóvenes estén adquiriendo una conciencia más despierta que los docentes que han sido programados para hacer una enseñanza tradicional, y que a los jóvenes les basta un contacto breve con la escuela para darse cuenta que no les interesa. Incluso el efecto de las drogas…ha sido principalmente el de abrir cuestiones existenciales, darle un sentido a los jóvenes de que hay muchas cosas en la vida que son urgentes y que en el aula se ignoran como irrelevantes….Yo pienso que ir al colegio hoy en día es como comer arena- comer algo que no alimenta- cuando se intuye que hay otra cosa que sí sería relevante, y es criminal hacer perder tiempo, energía, años de vida a la gente con el supuesto de que esto es lo que necesita. Lo que se necesita es otra cosa: algo que ayude al desarrollo humano.*
>
> The blame is principally placed on the youth. One thinks: 'we are in a crisis because the youth are no longer interested in their studies like before,' 'young people are no longer serious like in other times,' 'young people take drugs and that is why they are not capable of listening to serious people who want to bring these materials that are so crucial to the classroom." And no one thinks that maybe it is backwards: it could well be that young people are acquiring a more sharp consciousness than the teachers that have been programmed to give a formal teaching, and that for young people, a quick encounter with the school is enough for the them to realize that they are not interested. Including the effect of drugs….it has principally been the opening of existential questions, giving young people a sense that there are many things in life that are urgent and that the classroom ignores as irrelevant….I think that going to school today is like eating sand -- eating something that is not nutritious -- when someone realizes that there is something else that is relevant, and that it is criminal to waste time, energy, and years of life from people on the suspicion that its what is needed. What is needed is something else: something that helps human development (Naranjo, *Cambiar* 177-8).

It is important to go to the children themselves in schools, and the example that best embodies this objective is the sexual education program in Uruguay. This program, which has been recently implemented, is integrated into the national educational system, and it offers to help develop healthy subjects for a better community coexistence.

The Sexual Education Program

In a short overview, the *Programa de Educación Sexual* (PES) is a part of ANEP and is integrated into the entire educational system.

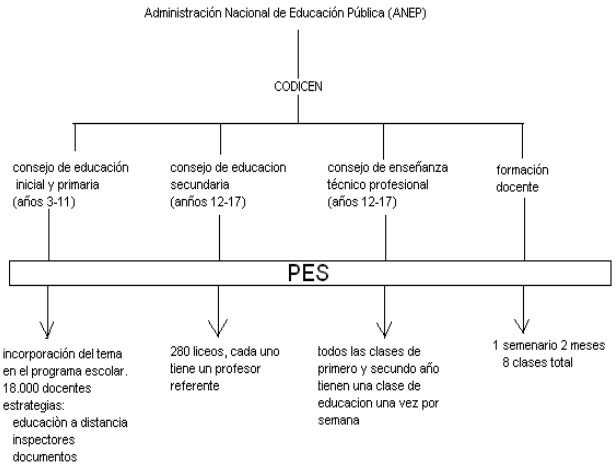


Figure 7. The organization of the national education system and the integration of the PES (Hofer and Ramírez, 2010)

This national program looks at health by means of inclusive education, and has a long-term goal of providing healthy development and socially responsible citizens for Uruguay. Starting at age three, every educational level has its distinct content. For example, elementary school in general focuses a lot on gender. The teachers are prepared by way of their teacher training or by using a virtual form of training for those who are already teachers. This online methodology is known as education at a distance and uses an online forum to train teachers. In this manner, the school promotes well-being by training teachers about human sexuality, because the child has a right to know about himself/herself. With this program, the classroom converts into a free space of integral learning where children are free to ask any questions. It also combines the teaching of prevention, as well as the promotion of health. The program demonstrates what Claudio Naranjo demands in a reformed educational system:

> Convendría que la educación del futuro vaya desprendiéndose de su patrón autoritario y pase a interesarse en los intereses y sentimientos del niño, para que ya comience la gente joven a desarrollar esa autoestima de la cual tanto se habla y que tanto escasea en el mundo…[se debe ofrecer] a la persona joven la experiencia de ser oída y apreciada o la de que sus preferencias sean tomadas en consideración….se debe hacer una educación centrada en el niño, en que los intereses del niño cuenten y no se mate la espontaneidad, que no se castigue la curiosidad y así se preserve el ansia de aprender. Todas las cosas que se 'embuten', después quedan por el camino, sirven por un rato y después impiden la educación real, el aprendizaje real. Y aprendizaje es cambio. Escribir y leer o calcular no son educación, son *instrumentos* de la educación, pero no *fines* de la educación.
>
> It would be convenient that future education detaches itself from its authoritarian norm and begins to embody the interests and sentiments of the child, so that young people can start to develop that self-esteem that is widely spoken about and that is lacking in the world…A young person [should be offered] the experience of listening and appreciating and offer that his/her preferences are taken into consideration…An education should be created that is centered around the child, in that the interests of the child should be taken into account and spontaneity is not killed, that curiosity should not be punished and with that, preserve the eagerness to learn. All the things that are "bottled up", later stay near the path, serve for a little and later impede real education, the real learning. And learning is change. Writing and reading or

> calculating are not education, they are *instruments* of education, but not *ends* of education (Naranjo *Cosas*, 119).

The PES started in 2006 and was officially integrated into each of the five levels of the national educational system in 2007. This includes all public schools, and the intent is to integrate the model into private systems, but to this date it has not been implemented and private schools can do as they please. To prepare and orient teachers so that the goal of the program can be put in place right away, the PES uses the strategies of "education at a distance" (*educación a la distancia),* formal academic training in the Schools of Education and Psychology at the University of the Republic, and at the Center of References and Documentation. The Center of References and Documentation is an online library resource that contains journals related to sexual education, and it also exists as a library in Montevideo at the office building of the PES.

Picture of the Center of References and Documentation at the PES building in Montevideo.

Every teacher in the nation also receives a book on sexual education, which goes into detail about the program. It is entitled *Educación Sexual: su incorporación al Sistema Educativo* (Sexual Education: its incorporation into the Educational System). An example of one of these strategies is education at a distance for those who are already teachers. It consists of five online modules that teachers complete over five months at the rate of one module per month. There are even online forums for teachers to interact with each other and to discuss videos and other teaching aids.

The lesson plans of the PES are incorporated into scholarly programs in different ways. In CEIP, the 18,000 teachers are trained with education at a distance and with the help of inspectors and documents, such as books, scientific journals, and schemas, to integrate the themes in everyday teaching. In CES, there is a reference teacher for every high school (280 high schools in Uruguay). In technical school, all the classes for first and second year students have a course once a week in sexual education. In the school of education, there is a two-month seminar (8 classes), which is also considered a limitation because this is not sufficient time to prepare future teachers (*Educación Sexual*, 2008).

As told by Diego Rossi, a coordinator for the PES, the different ways to prepare the teachers and implement sexual education are indispensible for the existence of an education from a perspective of rights and ethics for the purpose of a healthy development. The quality of teachers is something valuable. The teacher is the powerful tool in the future of education; however, before teaching the children, the professor needs to self-reflect. What is essential is teaching without impeding a form of emotions. There is no one truth; one has to teach that sexuality is a dimension of the human being. Communication also has to be worked on, because it is an essential base to maintain respect and promote relationships with others. This theme has to be worked on and young people must be encouraged to express their true feelings and emotions because this is important in their development (Rossi, 2010).

I was able to visit a *Comisión de enseñanza inicial y primaria* with PES inspectors on June 22, 2010. I was presented the fact that, in kindergarten, the theme that is worked on the most is sexuality. The teacher's guidance is essential because the teachers determine the education and define what they teach. Now that sexual education is integrated into classroom teachings, one does not talk about themes when they randomly come up in class. With this new strategy of teaching, the teacher sometimes tends to want to rely on outside resources, such as consulting a doctor or a nurse, without realizing their own potential. To encourage and guide teachers, the PES has a protocol and a schema to help them. There are various materials that they can use, like posters that other teachers have made, models of the human body, and even dolls known as the "sexualized family". In addition, there are no limitations on themes, not even in kindergarten. The classroom should be a space of freedom to ask any question, and the teacher must be cautious in their reactions. For example, no question should be ignored and a teacher should not respond with "one does not talk about those things". It is part of creating an *escuela amiga*, or a friendly school. A school that allows and stimulates questions is defined as a "friendly" school and a school that promotes health. In creating a space without limitations, it is most probable that sexual education is effective (Meresman, 2009). Also, the promotion of health in schools should be an education that is inclusive. In other words, everyone has the same rights, including the right of having a healthy sexuality. People with disabilities (physical, mental, deaf, blind, etc.) are usually an excluded group of people; but we must leave

this ideology. Few schools can facilitate inclusive education. Better teachers are needed, as well as a better environment and appreciation of diversity (Meresman, 2010).

The teacher must be careful in his/her discourse and eliminate some expressions and everyday practices. For example, at the end of the day, when exiting the school, it in the tradition of schools to line up boys and girls separately, but the teacher can break this hegemonic tradition and mix these lines of boys and girls. It is hoped that these changes in practice will be sustained, and in turn, the students will become better parents (CEIP, 2010).

According to María del Carmen Aranda from this CEIP meeting, there is a good response from the children in the program. They feel more listened to when the teacher talks without taboos. This is due to the fact that the teacher becomes another person of confidence besides a father or a mother, and there is a better teacher-student relationship. The situation that is most difficult for the program and schools is to convince the parents. Parents do not know how to react to the program, and it takes a lot for them to understand that there is a law (1483) of the rights that children have. A child is a subject with rights, and, in Uruguay, there are laws that define those rights for children. For example, Chapter II, Art. 7, of Law N°18.426 states:

> *Todo niño, niña o adolescente tiene derecho a la información y acceso a los servicios de salud, inclusive los referidos a la salud sexual y reproductiva. Los profesionales actuantes deben respetar la confidencialidad de la consulta y ofrecerle las mejores formas de atención y tratamiento cuando corresponda.*
>
> Every boy, girl, or adolescent has a right to information and access to health services, including those referring to sexual and reproductive health. The professionals involved should respect confidentiality of the consult and offer the best forms of attention and treatment as appropriate (*Desarrollo Saludable de los y las Adolescentes en Montevideo*, 33).

Another right, which forms part of law number 8 in the Child and Adolescent Code (CNA) states that one has to ask permission before intervening in themes of the body and life of adolescents. These rights have to be implemented and sustained. When a parent gets involved, it is because he/she is getting involved with his or her own sexuality, and it is internally moving. The families can become a limitation on the program because teachers fear the families. There have even been cases where various parents have threatened teachers. In effect, this causes fear of talking about sexuality in the classroom. Another limitation involves the most difficult theme to tackle: sexual orientation. In kindergarten, most of the focus is on gender, but sexual orientation is the most difficult theme because the

Uruguayan society does not have a position on this theme. There are going to be children with two mothers or two fathers, and the school has to be prepared to confront this (CEIP, 2010).

Case Study: *Escuela* 121

In a visit to School 121 in Montevideo, the importance of the integration of the PES was seen in action. The gaps between policy and practice were also observed. In a classroom of students of 11 to 12 year olds during an English course, the referent teacher entered to give a talk. She talked about the fact that sexuality is not only about having sexual relations, because another manifestation of sexuality is puberty. This includes changes to become a man and a woman. For women, they have more hips and men become physically stronger, but this does not mean more powerful. So therefore, everything is connected with sexuality.

Picture of the students during a sexual education discourse with referent teacher Patricia Pivel.

She also talked about the convention of children's rights, and that a child is a subject, and before a child was considered as an object. "You're opinion was not valued". The reaction of the class was a shocked one: "An object!" "A thing?"

Also, there was a discussion between the difference between disobedience and independence. The students consider themselves to be "big kids" who can have opinions and make certain decisions for themselves. The example that the referent teacher gave was: if your parents are separated and your mother lived with a man who mistreated you, you as a child have a right to say that you do not want to live with your mother. It was evident that the teacher related with the students. She emphasized, that it is important for someone to be by your side guiding you, and that they are not telling you what you have to do.

A classroom activity that showed the importance of starting sexual education at an early age to ensure a healthy development was the following: the referent professor passed each student a piece of paper with an outline of a mirror, and asked the students to write or draw something in the mirror that demonstrated how they see themselves inside and what they think about themselves inside and/or outside, but looking at the mirror in a positive way, because by increasing our self-

esteem (talking about yourself in a good way), we strengthen ourselves. For the students, it was difficult to write/draw something about themselves. They started to talk with the students around them to ask what they though about them. After about ten minutes, most of the students still had an empty mirror.

The advantage of having a referent teacher in the classroom is that they are present every school day. In an interview with Patricia Pivel, a referent teacher for the PES, she assured me that there are positive changes in the children and she has a good relationship with the *chiquilines* (little ones). She goes to visit classes like English and Biology and adds comments to lectures and helps answer and elaborate on questions. Also, if a professor is late, she starts the class. On the downside, there is not a good response from some teachers because they do not want to give her their class to impart these teachings (Pivel, 2010).

Contrary to seeing the teachers as a powerful tool and acknowledging them for their role in civil and humanitarian duty, teachers can also be a barrier, which is a disadvantage to the program. For example, people with disabilities have sexuality, but those that educate on health are not prepared to educate on this theme. Also, teachers come up with an excuse not to teach sexual education, and think that it is too much to do on top of having to teach their subjects of mathematics, science, or language. The teacher's health can also put limits on their teachings. A teacher with bad health may not be a credible person to teach about health, which in turn causes problems in learning (Meresman, 2010). For example, if a teacher smokes, is overweight, or refuses to go to a clinic for a health concern, it is difficult to advocate to children for doing just the opposite.

Even though some teachers try to hide the theme of sexuality, it still emerges. It exists in the life of the classroom and in the communities. The people who are interested in knowing and educating on sexuality care about the health of young people. The *Programa de Educación Sexual* in Uruguay is willing to help in every way possible. There is no lack of resources. The state and the PES offer a many materials (condoms, videos, *la familia sexuada*, etc.) for the teachers to use, and these serve as a way to get closer to young people and fortify messages. One does not need materials to teach on sexual education, however, it has to be very well established in the mind of the teacher in order to teach. Also, despite the policies for training teachers and the training that is made available, there is still a lack of sufficient training and installed and

implemented practice. The principle tool for teachers is the teacher himself/herself. One cannot teach sexual education adequately having a homophobic attitude. Teachers have to know themselves in order to teach these themes, and the difficulty comes in telling a lot of teachers of the country that their role as a teacher in teaching sexuality is to reflect on their own sexuality and to have technical and scientific training in the topic (Rossi, 2010).

Conference on the *Programa de Educación Sexual*

In observing the program, I was invited to attend a conference on the program in order help fight for its existence. Unfortunately, I learned that it is in peril of coming to an end, but the speakers and the people that attended the conference were all determined to have the program continue. They reiterated certain points in my investigation. For example, some transmissible diseases can be prevented with vaccinations, but the focus has to be on prevention from a human rights point of view. Quality information must be offered based on respect and how to make responsible decisions. In Uruguay, HIV is most prevalent in young people, mostly caused by unprotected sex. The prevention should not only focus on the use of condoms and contraception, but also on women's empowerment. Young women must empower themselves to say no and to take charge of taking care of themselves.

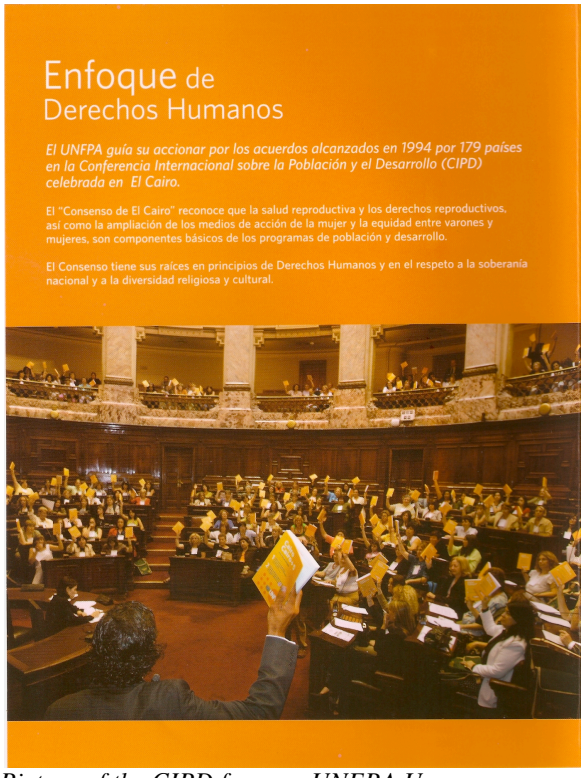
A couple of research groups also presented their investigations. These investigations are ongoing to monitor how the program works and to lend support to the fact that it is indeed needed. One investigation looked at the Internet and how it impacts children in relation to their construction of sexuality and gender. Their findings included that 94% of school children use the Internet, and a majority of boys look up soccer players, while a majority of girls use chat programs. On a survey, when asked if they look up sexual themes online, a big percentage said no, or checked yes, then erased the check box. Among those who did check it, the majority wrote that they looked up pornography; the second highest response was that no theme was mentioned, and in third place, different levels of sexual education were searched.

A second investigation looked at self-care in children and adolescents. The representative population that was interviewed told the investigators more than was expected. For example, findings included that the majority have gone to a clinic, but when asked about violence, the children told them details of the violence

they have experienced in their personal lives, such as being sexually abused by a stepfather. They do not hold back in telling these experiences when they are asked by the investigators, but they have kept these past experiences as secrets until then. There is also ambiguity when it comes to knowing about their rights, and the children take no action against violence. This is something that the educational system cannot let pass by. The teachers must open their minds to communication about sexual violence and abuse. The program will have to wait and see what the government decides to do for the future of the program, but those in favor must fight to keep it, and the program cannot be lost, because then education loses (Conference for the PES, 2010).

Sustainability in Funding and Strategy for the Sexual Education Program

An organization that has heavily helped in the survival and strength of the PES is the United Nations Population Fund (UNFPA). UNFPA opened an office in Uruguay in 2007, and it has helped the cooperation between academia, government, and civil society become much stronger. UNFPA is a cooperation agency that runs internationally and helps countries respond to their priorities through the use of their socio-demographic data to form political strategies and programs to reduce poverty and ensure a healthy life for its citizens. UNFPA uses the agreements made by representatives of 179 countries in Cairo on September of 1994 at the International Conference on Population and Development (CIPD). The agreements made in this conference have their basis on human rights and respect for national sovereignty and cultural and religious diversity. One agreement recognized that a basic component in programs of population and development is acknowledging reproductive health, reproductive rights, and equality of gender (UNFPA Uruguay).



Picture of the CIPD from an UNFPA Uruguay pamphlet given to me by Valeria Ramos (UNFPA Uruguay).

In Uruguay, UNFPA focuses on helping and funding five aspects of sexual

health and well-being: HIV/AIDS prevention, gender equality, population and development, adolescents and youth, and sexual and reproductive health. There is an obvious connection between these five aspects, especially since one topic usually also involves another.

The focus on adolescents and youth in Uruguay is one that all sectors focus on. In Uruguay, half the people who are poor are those 18 years and younger. Valeria Ramos Brum, the national advisor in sexual and reproductive health and HIV/AIDS, tells me that they work directly with the MSP in their program for adolescents. They help with training materials and elaborate the guides for technicians (which took about a year to make). Their new project is to work with the MSP and other organizations that help make the guides that are directed towards adolescents, rather than having them solely for the people who have them in their care. In 2010, UNFPA was working on financing protocols for child and adolescent sexual abuse, including how to apply the protocols and how to use the schema.

UNFPA also played a big role in the creation of the PES. They also funded the design of the program for the training of teachers. In 2010, the government and UNFPA negotiated that the majority of the UNFPA funds were reserved for sexual education. Ramos says that, since the conference in Cairo 15 years ago, things have been improving. For example, the state has significantly elaborated in advancing the situation of "the boy", rather than solely focusing on maternal and infant health. Also, the government has been progressing in what UNFPA believes is a requirement for governments: the goal to publish and implement what is written, especially about health for the happiness and well being of the people.

Uruguay has great policies for its government systems as a whole; however, the country still has not accomplished all of its goals in its vision of an integral system. There is an overall lack of a strategy to place all the components set out in the PES policies into the system. There is also a lack of clear objectives to these policies. In addition, there needs to be more support from human resources at government organizations. Also, in terms of implementing the PES, its implementation relies on the question of culture, which is hard to change. Sexual education is still viewed as part of the private, intimate life of people and families, and that it is up to families to decide when to educate their children on this matter (Ramos, 2010).

There also exists a future strategy for the next 20 years in Uruguay (2010-2030).

The National Strategy of Infants and Adolescents (ENIA) was designed by the IINFAMILIA sector of MIDES. In having a strategy for the future, the actions of the country for the next 20 years can be prioritized and an agreement can be reached. Part of this agreement is opening more possibilities in appropriate job opportunities for young people and to revise the educational system as a way to stop the emigration of the young population, a reality that is a problem for Uruguay. For example, section 1.5 entitled *Las dificultades de adecuación del sistema educativo* (the difficulties of adaptation in the educational system) explains how to further develop education and the necessity of modifying and adding current themes to accompany the changes and problems in today's society. (*Estrategia Nacional para la Infancia y la Adolescencia*, 2008).

Conclusion

Even though this study looked at different health services, the majority of the investigation was spent looking at the way the government intervenes in order to decrease the amount of inequality and improve the quality of life in Uruguay. The state creates a network of organizations, and in this way, can cover a multiplicity of distinct situations related to wellness.

The recent changes the government has made in the educational and health system has set goals that, with time, are attainable. It is not only up to teachers and doctors to make this change, even though their formation plays a major role in the new systems. It is the responsibility of other actors as well: psychologists, nurses, and government organizations. All these actors must have a focus on gender and sexual diversity at the time of treatment. If not, they distance themselves more from a person, and the person who is receiving care will no longer benefit. Working with people cannot only be done at a formal, individual level. This work to transform society must also occur at the community level. It is important to invest in time, patience, and quality of care, because with this effort the country is in the middle of taking a giant step forward to create healthy beings in a healthy world. In addition, the focus on the well being of children and adolescents in Uruguay is different than in other countries and states because it is very strong, direct, and implemented through policy and law. The efforts in Uruguay focus very much on this young generation today in order to create a generation of healthy, well-educated youth with better opportunities in Uruguay who will help the country prosper in the future.

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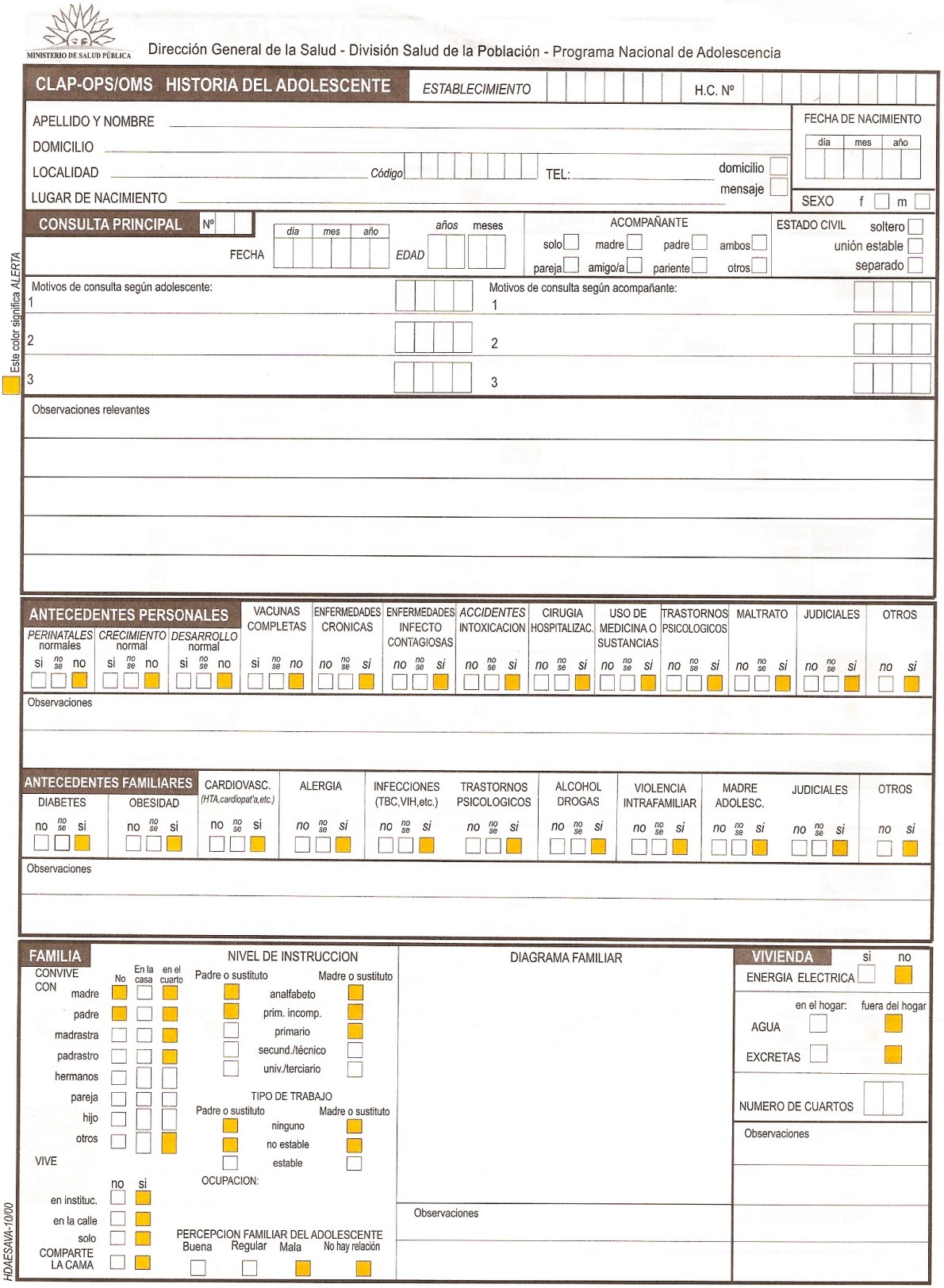
All photographs embedded into this document with captions, including the cover page, were taken by me, Melissa R. Ramírez, during my investigation. The materials such as pamphlets and the adolescent patient history that were scanned into this document were materials given to me by personnel at the clinics/organizations that I visited.

Appendix 1. Glossary of Acronyms

ANEP- *Administración Nacional de Educación Pública*
ASSE- *Asociación de Servicios de Salud del Estado*/ State Health Services Administration
CAIF- *Centros de Atención Integral a la Infancia y la Familia*/ Integral Attention Centers for Infants and Families
CASMU- *Centro de Asistencia del Sindicato Médico del Uruguay*
CEIP- *Consejo de Enseñanza Inicial y Primaria*/ Council for Kindergarten and Elementary Education
CES- *Consejo de Educación Secundaria*/ Council for High School Education
CETP- *Consejo de Enseñanza Técnico Professional*/ Council for Technical School
CIPD- *Conferencia Internacional sobre la Población y el Desarrollo*/ International Conference on Population and Development
CLAEH- *Centro Latinoamericano de Economía Humana*/ Latin American Center of Humane Economics
CNA- *Código de Niños y Adolescentes*/ Code for Children and Adolescents
CODICEN- *Consejo Directivo Centra*
CONAPRO- *Concertación Nacional Programática*
FD- *Formación Docente*/ School of Education
FIT- *Fondo de Inversión Territorial*
FLACSO- *Facultad Latinoamericana de Ciencias Sociales*/ Latin American Social Science Language Faculty
FONASA- *Fondo Nacional de Salud*
IAMC- *Instituto de Atención Médica y Colectiva*
IMAE- *Instituto de Medicina Altamente Especializada*
MCZ- *Mesa de Coordinación Zonal*
MDG- Millennium Development Goals
MSP- *Ministerio de Salud Pública*/ Health Ministry
MIC- Middle Income Countries
MIDES- *Ministerio de Desarrollo Social*/ Ministry of Social Development
OPS- *Organización Panamericana de la Salud*/ Pan-American Health Organization
PES- *Programa de Educación Sexual*/ Sexual Education Program
SNIS- *Sistema Nacional Integrada de Salud*/ Uruguay's Universal Health Care System
SOCAT- *Servicio de Orientación, Consulta y Articulación Territorial*/ Orientation, Consultation, and Territorial Articulation Service
UNICEF- the United Nations Children's Fund

Appendix 2. Example of an Adolescent Patient History (side 1 and 2)

This blank patient history was given to me by one of the nurses at the health center in Ciudad de Plata.



MINISTERIO DE SALUD PÚBLICA

Dirección General de la Salud - División Salud de la Población - Programa Nacional de Adolescencia

CLAP-OPS/OMS HISTORIA DEL ADOLESCENTE — ESTABLECIMIENTO — H.C. Nº

APELLIDO Y NOMBRE

DOMICILIO

LOCALIDAD — Código — TEL: — domicilio — mensaje

LUGAR DE NACIMIENTO

FECHA DE NACIMIENTO (día mes año)

SEXO f m

CONSULTA PRINCIPAL Nº

FECHA (día mes año) — EDAD (años meses)

ACOMPAÑANTE: solo madre padre ambos pareja amigo/a pariente otros

ESTADO CIVIL: soltero unión estable separado

Este color significa ALERTA

Motivos de consulta según adolescente: 1 2 3

Motivos de consulta según acompañante: 1 2 3

Observaciones relevantes

ANTECEDENTES PERSONALES

PERINATALES normales (si no se no) — CRECIMIENTO normal (si no se no) — DESARROLLO normal (si no se no) — VACUNAS COMPLETAS (si no se no) — ENFERMEDADES CRONICAS (no se no si) — ENFERMEDADES INFECTO CONTAGIOSAS (no se no si) — ACCIDENTES INTOXICACION (no se no si) — CIRUGIA HOSPITALIZAC. (no se no si) — USO DE MEDICINA O SUSTANCIAS (no se no si) — TRASTORNOS PSICOLOGICOS (no se no si) — MALTRATO (no se no si) — JUDICIALES (no se no si) — OTROS (no si)

Observaciones

ANTECEDENTES FAMILIARES

DIABETES (no se si) — OBESIDAD (no se si) — CARDIOVASC. (HTA,cardiopat'a,etc.) (no se si) — ALERGIA (no se si) — INFECCIONES (TBC,VIH,etc.) (no se si) — TRASTORNOS PSICOLOGICOS (no se si) — ALCOHOL DROGAS (no se si) — VIOLENCIA INTRAFAMILIAR (no se si) — MADRE ADOLESC. (no se si) — JUDICIALES (no se si) — OTROS (no si)

Observaciones

FAMILIA

CONVIVE CON (No / En la casa / en el cuarto): madre, padre, madrastra, padrastro, hermanos, pareja, hijo, otros

VIVE (no si): en instituc., en la calle, solo

COMPARTE LA CAMA (no si)

NIVEL DE INSTRUCCION (Padre o sustituto / Madre o sustituto): analfabeto, prim. incomp., primario, secund./técnico, univ./terciario

TIPO DE TRABAJO (Padre o sustituto / Madre o sustituto): ninguno, no estable, estable

OCUPACION:

PERCEPCION FAMILIAR DEL ADOLESCENTE: Buena Regular Mala No hay relación

DIAGRAMA FAMILIAR

Observaciones

VIVIENDA (si no)

ENERGIA ELECTRICA

(en el hogar / fuera del hogar)

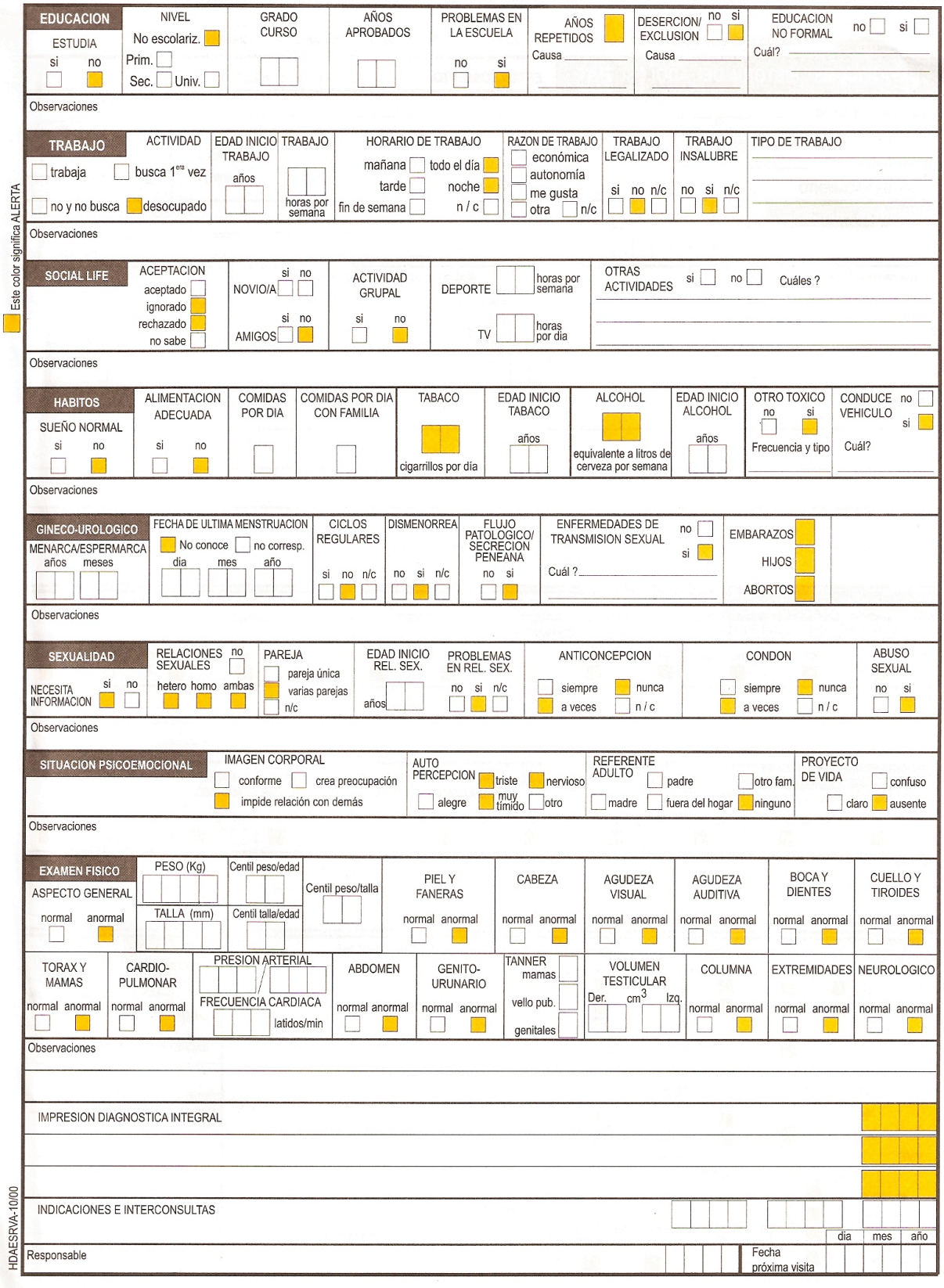
AGUA

EXCRETAS

NUMERO DE CUARTOS

Observaciones

HDAESAVA-10/00


EDUCACION
ESTUDIA si no
NIVEL No escolariz. Prim. Sec. Univ.
GRADO CURSO
AÑOS APROBADOS
PROBLEMAS EN LA ESCUELA no si
AÑOS REPETIDOS
Causa
DESERCION/ EXCLUSION no si
Causa
EDUCACION NO FORMAL no si
Cuál?
Observaciones
TRABAJO
ACTIVIDAD
trabaja busca 1era vez
no y no busca desocupado
EDAD INICIO TRABAJO años
TRABAJO horas por semana
HORARIO DE TRABAJO
mañana todo el día
tarde noche
fin de semana n / c
RAZON DE TRABAJO
económica
autonomía
me gusta
otra n/c
TRABAJO LEGALIZADO si no n/c
TRABAJO INSALUBRE no si n/c
TIPO DE TRABAJO
Observaciones
SOCIAL LIFE
ACEPTACION
aceptado
ignorado
rechazado
no sabe
NOVIO/A si no
AMIGOS si no
ACTIVIDAD GRUPAL si no
DEPORTE horas por semana
TV horas por día
OTRAS ACTIVIDADES si no Cuáles ?
Observaciones
HABITOS
SUEÑO NORMAL si no
ALIMENTACION ADECUADA si no
COMIDAS POR DIA
COMIDAS POR DIA CON FAMILIA
TABACO cigarrillos por día
EDAD INICIO TABACO años
ALCOHOL equivalente a litros de cerveza por semana
EDAD INICIO ALCOHOL años
OTRO TOXICO no si Frecuencia y tipo
CONDUCE VEHICULO no si Cuál?
Observaciones
GINECO-UROLOGICO
MENARCA/ESPERMARCA años meses
FECHA DE ULTIMA MENSTRUACION No conoce no corresp. dia mes año
CICLOS REGULARES si no n/c
DISMENORREA no si n/c
FLUJO PATOLOGICO/ SECRECION PENEANA no si
ENFERMEDADES DE TRANSMISION SEXUAL no si Cuál ?
EMBARAZOS
HIJOS
ABORTOS
Observaciones
SEXUALIDAD
NECESITA INFORMACION si no
RELACIONES SEXUALES no hetero homo ambas
PAREJA pareja única varias parejas n/c
EDAD INICIO REL. SEX. años
PROBLEMAS EN REL. SEX. no si n/c
ANTICONCEPCION siempre nunca a veces n / c
CONDON siempre nunca a veces n / c
ABUSO SEXUAL no si
Observaciones
SITUACION PSICOEMOCIONAL
IMAGEN CORPORAL conforme crea preocupación impide relación con demás
AUTO PERCEPCION triste nervioso alegre muy tímido otro
REFERENTE ADULTO padre otro fam. madre fuera del hogar ninguno
PROYECTO DE VIDA confuso claro ausente
Observaciones
EXAMEN FISICO
ASPECTO GENERAL normal anormal
PESO (Kg)
TALLA (mm)
Centil peso/edad
Centil talla/edad
Centil peso/talla
PIEL Y FANERAS normal anormal
CABEZA normal anormal
AGUDEZA VISUAL normal anormal
AGUDEZA AUDITIVA normal anormal
BOCA Y DIENTES normal anormal
CUELLO Y TIROIDES normal anormal
TORAX Y MAMAS normal anormal
CARDIO-PULMONAR normal anormal
PRESION ARTERIAL
FRECUENCIA CARDIACA latidos/min
ABDOMEN normal anormal
GENITO-URUNARIO normal anormal
TANNER mamas vello pub. genitales
VOLUMEN TESTICULAR Der. cm3 Izq.
COLUMNA normal anormal
EXTREMIDADES normal anormal
NEUROLOGICO normal anormal
Observaciones
IMPRESION DIAGNOSTICA INTEGRAL
INDICACIONES E INTERCONSULTAS
dia mes año
Responsable
Fecha próxima visita
Este color significa ALERTA
HDAESRVA-10/00