HIV Prevention in Young People Using a Human Rights Framework in Central America and the Caribbean

Norway/PAHO Strategic Partnership
October 2008 - September 2013

Progress Report 2011

PAHO/WHO
Family and Community Health Area (FCH)
Office of Gender, Diversity & Human Rights Area (GDR)
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Table of Contents

Glossary .................................................................................................................3

I. Background ................................................................................................................5
   1. Description of Initiative

II. Regional Situational Analysis ....................................................................................8
   1. Violence
   2. STI/HIV
   3. Sexual Reproductive Health
   4. Malnutrition
   5. Mental Health and Behavioral Disorders
   6. Consumption of Alcohol, Drugs and Tobacco
   7. Social determinants of health
      a. Poverty
      b. Ethnicity
      c. Education
   8. Summary

III. Regional, Sub regional and National Achievements .............................................42
   1. Policy and Legislation (Expected Result 1)
   2. Capacity Building of Human Resources (Expected Result 2)
   3. Health Systems and Services (Expected Result 3)
   4. Strategic Information Systems (Expected Result 4)

IV. Outputs Compared to Planned Outputs ...............................................................49
   1. Activity Implementation Rate at the National level.
   2. Activity Implementation Rate at the sub- Regional level
   3. Activity Implementation Rate at the Regional level

V. Summary of Budget Execution ..............................................................................51

VI. Conclusion .............................................................................................................51
   1. Program Efficiency
      A. Problems and Risks
         • Internal Context
         • External Context
      B. Challenges for 2012
      C. Recommendations For 2012

Country and Sub Regional Narrative Reports .........................................................Annex A
Outputs Compared to Planned Outputs .................................................................Annex B
Financial Report ......................................................................................................Annex C
Glossary

ADH—Adolescent Health
AECID—Spanish Agency for International Cooperation
AIDS (sida)—Acquired Immunodeficiency Syndrome
CSO—Civil Society Organizations
CSS—Caja de Seguro Social
CRC—Convention on the Rights of the Child
DAIF—Departamento de Atencion Integral a la Familia
ECOS—equipos comunitarios de salud familiar
ER (RE)—Expected Result
FBO—Faith-Based Organization
GDR—Gender, Diversity and Human Rights
HIV (VIH)—Human Immunodeficiency Virus
HPV (VPH)—Human Papillomavirus
IAT—Indicadores de alerta temprana de VIH/SIDA
IMAN—Integrated Management of Adolescent Needs
LGBT—Lesbian, Gay, Bisexual and Transgender
MARP (PEMAR)—Most at Risk Population(s)
MIFC—Mujeres, Individuos, Familias y Comunidades
MOSAFC—Modelo Salud Familiar y Comunitario
MOH—Ministry of Health
MSM (HSH)—Men that have Sex with Men
MSPAS—Ministerio de Salud Publica y Asistencia Social
NGO (ONG)—Non-Governmental Organizations
OAS (OEA)—Organization of American States
PAHO (OPS)—Pan American Health Organization
PAIA—Programa de Atencion Integral del Adolescente
PHC (APS)—Primary Health Care
PMTCT (PTMI)—Prevention of Mother to Child Transmission
PNS—Programa Nacional de Sida
PNSIA—Programa Nacional de Salud Integral de Adolescentes
PWR—PAHO/WHO Representative
RBM—Results Based Management
RER—Regional Expected Results
SAM—Mapeo de disponibilidad de servicios de VIH y adolescentes
SIAS—Sistema Integral de Atencion en Salud
SIDA—Swedish International Development Agency
SIGSA—Sistema Gerencial en Salud
SIP—Sistema informatico perinatal
SNU—Sistema de Naciones Unidas
SO—Strategic Objective
SRH (SSR)—Sexual and Reproductive Health
STI (ITS)—Sexually Transmitted Infection
SUMEVE—Sistema unico de monitoreo, evaluacion y vigilancia epidemiologica
TB—Tuberculosis
TC (CT)—Technical cooperation
TIC’s—Technology, Information, and Communications
WDC—Washington D.C., Headquarters
WHO—World Health Organization
UN (OMS)—United Nations
UNAIDS (ONUSIDA)—The Joint United Nations Programme on HIV/AIDS
UNESCO—United Nations Educational, Scientific and Cultural Organization
UNFPA—United Nations Population Fund
UNICEF—United Nations Children’s Fund
I. Background.

In an effort to strengthen the capacity of countries in Central America and the Caribbean to develop and implement gender sensitive-human rights based programs and services to reduce the number of new HIV infections in young people (ages 10-24) and promote their sexual and reproductive health (SRH), so that these adolescents (ages 10-19) and youth (ages 15-24) can reach their full political, social and economic potential, the Royal Norwegian Embassy and the Pan American Health Organization/World Health Organization (PAHO/WHO) formed a strategic partnership in 2008 to implement a five year multi country initiative: “HIV Prevention in Young People Using a Human Rights Framework in Central America and the Caribbean”.

According to the agreement of the initiative, an annual narrative progress report shall be submitted in February/March each year for the activities of the previous calendar year. Together with this narrative approach, a certified annual financial statement of income and expenditure of the program shall also be submitted.

As a response to this agreement, PAHO has developed the progress report for 2011. This progress report includes the following: National, Sub Regional and Regional achievements using the Grant Expected Results and Norway Indicators; a description of actual outputs compared to planned outputs (as defined in the work plans); a brief summary of the use of funds compared to budget; an assessment of the efficiency of the Program; an explanation of major deviations from plans; an assessment of problems and risks (internal and external to the program) that have affected the success of the program; an assessment of the need for adjustment to activity plans and/or inputs and outputs, including action for risk mitigation; a brief assessment of achievements in relation to purpose; and a certified annual financial statement of income and expenditure for the program.

1. Description of the initiative.

The “HIV Prevention in Young People Using a Human Rights Framework in Central America and the Caribbean” initiative is an interprogrammatic initiative, integrating topics including Adolescent and Youth Health, Prevention, Treatment and Care for HIV/STI, Gender, Diversity and Human Rights. The initiative cover seven countries including the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama and has a grant ceiling of NOK 35,000,000 (Norwegian Kronor Thirty Five Million) which are not to be used for any other activities than to finance the program in the planned period October 2008- September 2013.

The expected Results of the initiative include the following:

1. Supportive Regional legislative and policy environment established for gender sensitive and human rights based HIV prevention and sexual & reproductive health programs for young people.
2. Human Resources Capacity developed for the provision of gender sensitive and human rights-based HIV prevention and Sexual and Reproductive Health services and programs for young people.
3. Six countries have expanded HIV prevention services for young people, utilizing gender, Sexual and Reproductive Health, and human rights approaches.
4. Regional, Sub-Regional and National capacity strengthened to generate and use strategic information for development and monitoring of HIV programs for young people.

In accordance with the new Pan American Health Organizations strategy of results based management; the Norway grant expected results, the organizational Regional expected results (RER) indicators, and the Norway Indicators are outlined in the table below:

<table>
<thead>
<tr>
<th>Norway Grant Expected Results</th>
<th>PAHO RER Indicator</th>
<th>Norway Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Regional legislative and policy environment established for gender sensitive and human rights based HIV prevention and sexual &amp; reproductive health programs for young people.</td>
<td>4.6.1</td>
<td>Number of countries with a functioning adolescent and youth health and development program</td>
</tr>
<tr>
<td></td>
<td>2.2.1</td>
<td>Number of countries with health sector policies and medium term plans in response to HIV in accordance with Universal Access Framework</td>
</tr>
<tr>
<td></td>
<td>4.1.2</td>
<td>Number of countries that have a policy of universal access to sexual and reproductive health</td>
</tr>
<tr>
<td></td>
<td>4.7.1</td>
<td>Number of countries that have reviewed public health policies related to sexual and reproductive health</td>
</tr>
<tr>
<td></td>
<td>7.4.1</td>
<td>Number of countries using 1) international and Regional human rights norms and standards; and 2) human rights tools and technical guidance documents produced by PAHO/WHO to review and/or formulate National laws, policies and/or plans that advance health</td>
</tr>
<tr>
<td>Human Resources Capacity developed for the provision of gender sensitive and human rights-based HIV prevention and Sexual and Reproductive Health services and programs for young people.</td>
<td>2.5.4</td>
<td>Maintain the number of countries that have involved communities, academia, persons affected by the disease, civil society organizations, and the private sector in planning, design, implementation and evaluation of HIV programs</td>
</tr>
<tr>
<td></td>
<td>2.1.7</td>
<td>Number of countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with STIs diagnosed, treated and counseled at primary point-of-care sites).</td>
</tr>
<tr>
<td>Six countries have expanded HIV prevention services for young people, utilizing gender, Sexual and Reproductive Health, and human rights approaches.</td>
<td>2.1.1</td>
<td>Number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV positive pregnant women.</td>
</tr>
<tr>
<td></td>
<td>4.6.2</td>
<td>Number of countries implementing a comprehensive package of norms and standards to provide adequate health services for young people's health and development (e.g. Integrated Management of Adolescents Need [IMAN]).</td>
</tr>
<tr>
<td></td>
<td>6.6.1</td>
<td>Number of countries that have implemented new or</td>
</tr>
</tbody>
</table>
improved interventions at individual, family and community levels to promote safer sexual practices

<table>
<thead>
<tr>
<th>Region, sub-Regional and National capacity strengthened to generate and use strategic information for development and monitoring of HIV programs for young people.</th>
<th>2.4.1</th>
<th>Number of countries reporting HIV surveillance data disaggregated by sex and age to PAHO/WHO guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1</td>
<td>Number of countries that implement information systems and surveillance systems to track sexual and reproductive health, maternal, neonatal and adolescent and youth health, with information disaggregated by age, sex and ethnicity.</td>
<td></td>
</tr>
<tr>
<td>4.2.2</td>
<td>Number of PASB systematic reviews on best practices, operational research, and standards of care</td>
<td></td>
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</tbody>
</table>

In order to be able to monitor and evaluate the effectiveness and success of this partnership, PAHO has made a great effort, through this initiative, to strengthen Regional, sub-Regional and National capacity to generate and manage strategic information. For example, through the Regional Adolescent Health portal (hiss.paho.org/sa), all countries (except Haiti) of the initiative are collecting, uploading and managing information on: mortality; mental health; violence; substance abuse; sexual and reproductive health; nutrition; physical activity; oral health and socio demographic indicators. The information available in this portal is downloadable for any user and can be used in a variety of different settings. Furthermore, the information collected through this portal is currently being adopted and disseminated through PAHO’s Regional Health Observatory.

In addition to this effort, this initiative is also contributing towards the development of analyses and evaluations summarizing the state of: National and Regional Legislative Policy Environments; National Human Resource Capacity; and on National Health Systems and Services in the Region.

The following two sections: “Regional Situational Analysis” and the “Regional Achievements” will summarize the key information collected and analyzed with the funding of this initiative.
II. Regional Situational Analysis

On the brink of the twenty-first century the adolescent and youth population is the largest cohort in the history of the Latin American and Caribbean (LAC) Region, representing 24.5% (approximately 232 million) of the total population (CIA, 2011). These young people face myriad obstacles excluding them from access to health that are closely linked with poverty, marginalization, and discrimination. In fact, out of the 232 million adolescents and youth who live in the LAC Region, thirty-nine percent live in poverty (Situation and Challenges of Young People in Iberoamérica, United Nations, 2008).

According to the document “Mortality and Morbidity amongst Adolescents and Youth”, which was developed in 2011 through this initiative, while morbidity and mortality is relatively low during adolescence, approximately 150,000 young people between the ages 10-24 die every year in the Region of the Americas (PAHO Regional Observatory, 2012). Indeed, according to the most recent mortality data from the Region, the mortality rates for all causes approximate 74.1 in North America, 96.7 in Central America and the Caribbean, and 78.5 in South America (PAHO Regional Observatory, 2012).

Figure 1. Trends in Mortality Rates amongst Young People (10-24) in the Americas (2000-2008)

The main causes of death for this age group are external causes including injuries such as homicides, accidents, and suicides, followed by communicable diseases such as HIV, non communicable diseases, and finally complications of pregnancy, childbirth, and the puerperium (PAHO Regional Observatory, 2012). As shown in figure 1, deaths from injuries account for 58.5% of all deaths; communicable diseases for 4.6%; non communicable diseases for 3.9%; complications of pregnancy, childbirth, and the
puerperium for 2.7%, and finally all other causes of deaths, including the undefined causes, account for 30.3% of all deaths (PAHO Health Observatory, 2012).

Figure 2. Causes of Death amongst Young People (10-24) in the Americas (2009)


These causes of death affect young women and men disproportionately: while women have mortality rates, for all of causes, ranging between 53.5 in Central America and 43.6 in South America, men have doubled those mortality rates: between 139.2 in Central America and 112.5 in South America (PAHO Regional Observatory, 2012).

Figure 3. Mortality Rates due to all Causes amongst Women (10-24) in the Americas (2000-2008)

Given the number of deaths of adolescents and youth in Region, the main causes of death, and that the main causes of deaths are all preventable, an immediate and integrated response is needed. However, before developing a plan of action, one should analyze the situation further to identify the interrelated risk and protective factors of morbidity and mortality amongst adolescents and youth in the Region.

In order to do so, the initiative developed various situational analyses of young people in the LAC Region. The section below will briefly summarize some of the key findings on risk factors and protective factors including: Violence; Sexual Transmitted Infections/Human Immunodeficiency Virus (STI/HIV); Sexual and Reproductive Health (SRH); Malnutrition; Mental health and Behavioral Disorders; the Consumption of Alcohol, Drugs and Tobacco; and Social Determinants of Health including Poverty, Ethnicity and Education.

1. Violence

According to a recent multi-country study (covering 83 countries) conducted in 2008 by the Brazilian research group Latin American Technological Information Network on global youth violence, Latin America and the Caribbean have the highest homicide rates for young adults in the world (36.6 and 31.6 per 100,000 respectively) (Map of Violence: The Young People of Latin America, Latin American Technological Information Network, 2008). Based on these same statistics, youth ages 15-24 are approximately 15 times more likely to be murdered in Latin America than their North American neighbors, and 30 times more likely than European youth. While El Salvador has the highest murder rates in the Region (92 per 100,000), Colombia, Venezuela, Guatemala, and Brazil follows closely with similar rates. These rates could be correlated by the high number of gangs that exist in Latin America. In fact, it is estimated that the number of Gang
members in El Salvador, Guatemala and Honduras reach between 30,000 and 285,000 (Map of Violence: The Young People of Latin America, Latin American Technological Information Network, 2008).

As well as the high murder rate, statistics have also demonstrated that there is an extremely high occurrence of domestic violence against women in Latin America, with young women being four times more likely than older women to be victims of sexual assault (Map of Violence: The Young People of Latin America, Latin American Technological Information Network, 2008). Indeed, surveys using school-based samples conducted in different Latin American countries found that between 5% and 40% of adolescents report having been sexually abused at some point in their lives (Ni una mas! El derecho a vivir una vida libre de violencia en America Latina y el Caribe, 2007). In the Caribbean, between 52% and 73% young women report having had experiences of sexual violence by their partner (Interpersonal violence in three Caribbean countries, 2008).

In addition to murder rates and partner violence, according to recent mortality statistics, suicide is one of the main causes of injuries for young people aged 10-24 in the Region (PAHO Regional Health Observatory, 2012). Indeed, according to the most recent Global School Based Student Health Survey (GSHS), the percentage of students’ ages 13 to 15 years old from 16 countries in the LAC Region who ever seriously considered attempting suicide during the past 12 months, ranged between 10% and 23%. These statistics were significantly higher amongst young women (13%-29%) than amongst young men (8%-20%).

Figure 5. High Rates of Students aged 13-15 who have seriously Considered Attempting Suicide During the past 12 months (2007-2011).

Furthermore, trends covering suicide rates in 16 countries in the Region over the last couple of decades portrayed increasing rates of suicides by young people in six countries (Panama, Mexico, Trinidad and Tobago, Ecuador, Argentina and Brazil), and stagnant rates in the other 10. Mexico have had the worst increase of suicide rates amongst young people with a 150% increase in suicides amongst the age group 5-14, and a 74% increase amongst the age group 15 to 24 years old. As a matter of fact, as the statistics stand today, 17% of all suicides in Mexico belong to adolescents (Epidemiología de los trastornos mentales en América Latina y el Caribe, 2009).

Clearly violence amongst adolescents and youth is a public health concern in the Americas and more effort is needed to prevent it from occurring. This effort requires governmental commitment, intersectorial and interprogrammatic collaboration, civil society participation, and perhaps technical and financial cooperation from NGO’s, donors and international organizations.

To raise awareness and prevent violence, the Norway/PAHO initiative has taken a couple of necessary measures and implemented various different activities in the Region. For example, the initiative advocates for “violence” to be included as an indicator in all of the National Adolescent and Youth Health strategies and Plans. This is done by raising awareness on the issue of violence—gender violence in particular—and disseminating the PAHO Regional Plan and Strategy for Adolescent and Youth to the country level—as it includes violence as an indicator—for them to revise and adapt/adopt.

The Norway/PAHO initiative also offers scholarships for professionals in the Region from various different fields who work with adolescent and youth health, to attend a Distance Education Program on Integrated Adolescent Health and Development which includes Violence Prevention as a course (Prevención de la violencia en adolescentes y jóvenes). The purpose of this course is to not only build capacity amongst professionals who work with adolescents and youth, but also strengthen the quality of services offered by the health care system (http://medicina.uc.cl/diplomados/diplomado-en-desarrollo-y-salud-integral-del-adolescente).

In addition to these activities, one effort to reduce teen violence which has been proven very successful in the past couple of years is the “Strengthening Families Program (SFP)” (Familias Fuertes) which is being implemented in several countries around the Region including the countries of this initiative. SFP is an internationally recognized parenting and family strengthening program for high-risk and regular families. It is an evidence-based family skills training program found to significantly reduce problem behaviors including violence, delinquency, alcohol and drug abuse amongst children and adolescents and to improve social competencies and school performance.

Furthermore, in response to the need for epidemiological data on the violence spectrum the initiative has included “violence” as an indicator in the Adolescent Health Portal. Today the Adolescent Health Portal collects information on: % of students who have felt threatened; % of students who have considered committing suicide; % of young women who have experienced emotional, physical or sexual violence from their partner.
2. Sexual Transmitted Infections/Human Immunodeficiency Virus (STIs/HIV)

In the Americas, STIs affect one in 20 adolescents every year, with the most common infections being chlamydia, gonorrhea, syphilis, HPV, and trichomoniasis (PAHO Regional Strategy and Plan of Action for Adolescents and Youth 2010). If left untreated over the long term, these infections may heighten the risk of cancer and the contraction of HIV, and may be responsible for half of all infertility cases (UNAIDS and the WHO's Report on the Global AIDS Epidemic, 2010). Moreover, in pregnant adolescent girls, STIs increase the risk of delivering premature and low birth weight infants (UNAIDS and the WHO's Report on the Global AIDS Epidemic, 2010).

While the prevalence of HIV among adolescents and youth in the LAC Region is relatively low in comparison to the rest of the world, AIDS is still among the five leading causes of death among young people in the Caribbean, and an estimated 0.2% of women and men aged 15-24 in Central and South America are HIV positive (UNAIDS and the WHO's Report on the Global AIDS Epidemic, 2010). While the main driver of HIV transmission in the Caribbean is through heterosexual transmission, the epidemic is more concentrated amongst men who have sex with men in Latin America (UNAIDS and the WHO's Report on the Global AIDS Epidemic, 2010).

In terms of the seven countries of this initiative, recent data on HIV amongst adolescents and youth indicate that three of the seven countries (El Salvador, Honduras, and Nicaragua) have experienced a decrease over the past three years: El Salvador had an estimated HIV prevalence rate of 0.9 in 2007, and a 0.4 in 2009; Honduras had an estimated HIV prevalence rate of 0.7 in 2007, and a 0.3 in 2009. Nicaragua had an estimated prevalence rate of 0.3 in 2007, and a 0.1 in 2009. Guatemala did not have any numbers reported in 2007; however they had an estimated HIV prevalence rate of 0.5 in 2009. Dominican Republic, Haiti, and Panama did not have any data registered for 2009 however in 2007 their rates were 0.3, 0.6, and 1.1 respectively (UNAIDS and the WHO's Report on the Global AIDS Epidemic, 2010).

Figure 6. Estimated Young Women and Men (15-24) Living with HIV in 2009 in the Americas.

Furthermore, the next two graphs show that males and females between the ages 15-24 seem to have experienced a decrease in estimated HIV prevalence rates between the years 2007-2009.

**Figure 7. Trends in Estimated Young Men (15-24) Living with HIV in 2009 in the Americas (2007-2009).**

![Graph showing trends in estimated HIV prevalence amongst males 15-24 in 2007-2009 for various countries.]


**Figure 8. Trends in Estimated Young Women (15-24) Living with HIV in 2009 in the Americas.**

![Graph showing trends in estimated HIV prevalence amongst females 15-24 in 2007-2009 for various countries.]

Despite this decrease however, as can be seen in the graph below there are still a worrying amount of young people in the Region who do not have enough HIV knowledge to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (Situation Analysis: Elimination of Mother-to-child Transmission of HIV and Congenital Syphilis in the Americas, 2010).

Figure 9. Relatively low Percentage of Young People aged 15–24 (females and males), who both correctly Identify ways of Preventing the Sexual Transmission of HIV and reject major Misconceptions about HIV Transmission, by sex (2007–2009).

In an effort to reduce HIV while protecting and promoting the human rights of young people, a sub-regional consultation was conducted in 2011 to develop human resources capacity in the areas of HIV prevention and SRH promotion of imprisoned people including young people and other groups in situation of vulnerability. This included the participation of Ministry of Health and Ministry of Justice representatives from nine Central American and Caribbean countries.
Furthermore, this consultation also trained human resources on human rights obligations and raised awareness amongst imprisoned adolescents on their rights, including their sexual and reproductive rights. The outcome of this effort has included a “next steps” plan of action: the formulation of a human rights based assessment tool, which will be used to assess of health conditions in prisons for health personnel as well as for imprisoned adolescents, including LGTBI groups; the implementation of national workshops to raise awareness amongst relevant stakeholders, including the Ministries of Justice as well as civil society. More information regarding these efforts can be found using the following link:

http://new.paho.org/els/index.php?option=com_content&task=view&id=498&Itemid

3. Sexual and Reproductive Health (SRH)

The timing of sexual initiation and the context in which it occurs have health implications (Sexual Behavior in Context, WHO 2009). Recent data have shown that the average age of sexual initiation is low in LAC, ranging between 13 and 19 years old, according to the most recent health Surveys. Indeed, the graph below reflects the results from the most recent Demographic Health Survey (DHS), indicating that many of the adolescents and youth in the countries of the Region start having sexual intercourse before the age of 15. These statistics are worrisome considering that they also denote a decreasing trend in the age of sexual debut over the last decade.

Figure 10. High Percentage of Young Women and Men aged 15-24 who have had Sexual Intercourse before the age of 15 (2005-2009).

The negative consequences of early sexual initiation are not just health-related and are often interwoven. For example, studies show that early sexual debut augments the risk of multiple partnerships, wider age gap between partners, decreased usage of contraception, which in turn increases the risk of sexually transmitted infections (STIs), unintended pregnancies, increases school drop out rates, lowers income, and increases the occurrence of partner violence. (Van Rossemst, & Agha, 2006).

Interrelated with the trend of early sexual initiation in the region, is the knowledge vs. usage of contraceptive methods conundrum: Although nearly 90% of Latin American and Caribbean youth reported familiarity with at least one method of contraception, the overall Regional usage of contraception amongst adolescents aged 15-19 is relatively low. For example, as figure 12 shows, among adolescents aged 15-19 an average of only 14% (ranging from 6% in Mexico to 27% in Colombia) reported currently using a contraceptive method (the most recent DHS data). These statistics point towards the fact that although information and delivery of contraceptive methods are necessary, they are not sufficient.
Figure 12. Low usage of Contraception amongst Adolescents between the ages 15-19 (with most recent available data).


In many settings, adolescent girls ages 15-19 retain the lowest level of contraceptive use, often facing policies or attitudes that prevent or discourage them from seeking these services. Indeed, according to a series of reports by the Guttmacher Institute published in 2019, the unmet need for contraception among young women ages 15-19 was 48% in Honduras, 38% in Guatemala, and 36% in Nicaragua (Adolescent Sexual Behavior and Reproductive Outcomes in Central America: Trends over the Past Two Decades, 2010). Other studies have found that in seven countries throughout the Region, unmet need for family planning was higher among 15-19 year olds than among 20-24 year olds. For example, among 15-19 year olds, the unmet need ranged between 19.1% in Brazil and 52.4% in Haiti, while unmet need among 20-24 year olds ranged between 11.6% in Colombia and 40.8% in Haiti (The most recent DHS data). These statistics point towards the need for implementing family planning programs amongst earlier age groups (age groups 10-14).
Reasons as to why unmet need remains high in the Region may be attributed to the stigmatization, marginalization, the lack of health services, and the lack of empowerment amongst adolescent girls that increase their vulnerability, especially to pregnancy-related ill health (Unmet need Affects Millions, FHI 1999). Without access to adequate family planning services, health services or contraceptive methods, adolescents risk making choices that can adversely affect them and their sexual partners for the rest of their lives without the basic information about contraception, HIV/AIDS, and other reproductive health issues (Unmet need Affects Millions, FHI 1999).

Interrelated to the early age of sexual initiation and the low usage of contraception amongst adolescents and youth is the high rate of adolescent fertility in the Region. According to the most recent data, half of the countries in the Region have an adolescent fertility rate above 71 (per 1,000 women aged 15-19), ranging from 45 in Haiti to 111 in Nicaragua. By comparison, Canada has an adolescent fertility rate of 12 while the United States has a fertility rate of 33 (United Nations Population Division, World Population Prospects, 2012).
Although adolescent fertility rates and birth rates have declined substantially in the Region (from 91.1 in 1990 to 73.9 in 2007) (see Figure 15), both rates remain high compared to global statistics. Indeed, Ecuador, Venezuela, Honduras, and Nicaragua have adolescent birth rates above 100 (per 1,000 women aged 15-19) (see Map 1) (United Nation Population Division, 2012).

**Figure 15. Decreasing Trends in Adolescent Fertility Rate (2002-2009).**

![Graph showing decreasing trends in adolescent fertility rate from 2002 to 2009.](image)

- Panama
- Guatemala
- Honduras
- Dominican Republic
- Nicaragua
- El Salvador
- Haiti


**Map 1. Countries with high adolescent birth rates are concentrated in sub-Saharan Africa and Latin America and the Caribbean**

![Map showing countries with high adolescent birth rates.](image)

Adolescent birth rates by country, most recent estimates (Number of births per 1,000 women aged 15-19)

*Sources: United Nations Population Division*
Furthermore, 18% of all births that take place in the LAC Region today occur among adolescents aged 15-19 – the highest percentage of total live births to adolescent mothers than in any other part of the world. As seen in figure 16, most of these pregnancies occur among 15-19 year-olds as compared with pregnancies among 10-14 year-olds (PAHO Regional Observatory, 2012).

Figure 16. Most of Teenage Pregnancies occur among 15-19 year-olds as Compared with Pregnancies among 10-14 year-olds (2005-2009).

Adolescent pregnancy is a serious issue that may seriously impact the future of a young woman and her baby. Indeed, studies have shown that adolescent mothers are more vulnerable to maternal mortality and at greater risk to experience complications including anemia, toxemia, high blood pressure, placenta previa, and premature birth of the baby (Teenage pregnancies and risk of late fetal death and infant mortality, 2005 http://www.ncbi.nlm.nih.gov/pubmed/10426676).

Furthermore, early pregnancy also impact on girls’ education and life prospects. For example, as seen in the figures below, studies have shown that teen fertility is associated
with negative consequences such as poor education outcomes and poor employment statuses (*Quality Education-An effective Form of Birth Control?* 2011 [http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36560861]).

Figure 17 & 18. Marked Differences in outcomes by Teen Mother Status: Education & Employment (with most recent DHS available data).

To improve SRH, including increasing the age of sexual initiation, contraception usage, and decreasing the unmet need for family planning and adolescent pregnancies, this initiative has made great effort in advocating for National Teenage Pregnancy Prevention and Adolescent and Youth SRH Plans and Strategies. This effort has included regional meetings on the State of the Art in SRH, the publication and dissemination of key documents on “Reaching Poor and Vulnerable Adolescents with Sexual and Reproductive Health”, and technical cooperation on best practices and lessons learned on how to develop National Teenage Pregnancy Prevention and Adolescent and Youth SRH Plans and Strategies.
Furthermore, in order to ensure the reformation and alignment of national policies, plans and programs with international human rights norms and standards, the initiative has implemented training workshops on international human rights norms and standards on sexual/reproductive health and HIV—always following the recommendations of the UN treaty bodies—in Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Panama. In addition to these efforts, PAHO, upon the request of the Ministries of Health of these six countries, held a capacity-building workshop to address some of the issues relating to sexual and reproductive health, mental health and HIV of young people (including LGBTI groups), as identified by the UN/OAS human rights bodies.

In response to the lack of access to family planning and sexual and reproductive health services by adolescents and youth, PAHO has collaborated with the CEDAW and CRC Committees and the Inter-American Commission on Human Rights in identifying limitations in access to sexual and reproductive health, particularly maternal health and HIV prevention by adolescents. The limitations identified were concluded in a technical report which was presented to CEDAW and the Inter-American Commission on Human Rights.

As a result of the interventions mentioned above, PAHO has also been able to collaborate with the legislative, executive, and judiciary branches to amend legislation and practices related to access to therapeutic abortion, emergency contraception, gender violence and HIV prevention in many countries in LAC. Indeed, in 2011 PAHO provided a technical opinion to the Ministry of Health, Parliaments and Supreme Courts on emergency contraception and assisted in the reformation of a couple of public health laws ensuring access to therapeutic abortion emergency contraception by adolescents.

In order to support countries to expand HIV prevention services for young people, the Norway Initiative is also supporting the region to implement the Regional Initiative for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. This Initiative was formally adopted by the PAHO Member States by resolution in 2010, and one of the four critical lines of action entails the strengthening of access to comprehensive sexual/reproductive health services for all women, in particular vulnerable women such as adolescents, teen mothers, and women living with HIV, which includes support for healthy, rights-based reproductive health choices, prevention of unintended pregnancies, and reduction of sexual and intimate partner violence.

Furthermore, direct support is being provided to priority countries such as Haiti and the Dominican Republic in collaboration with UNICEF, UNAIDS and UNFPA, a training package for frontline health workers on HIV, Gender and Human Rights has been developed in collaboration with UN Women, and ongoing advocacy is conducted to maintain high level political commitment for this elimination initiative.

The initiative has also tried to strengthen Human Resource Capacity at the National level, in order to create a workforce capable in meeting the SRH needs of adolescents and youth. This has been done by training a critical mass including professors, health care personnel, community leaders, and youth leaders through service packages such as the
Integrated Management of Adolescent Needs (IMAN); through distance adolescent health education programs offered to health care providers in the targeted countries; and through self guided CDs such as “Putting it All Together” (Un Modelo Para Des-Armar”) to develop competencies among primary health care providers to work with youth on SRH issues, and “Adventures to the Unknown” which builds capacity among peer educators and youth promoters. By strengthening human resource capacity in meeting the SRH need of adolescents and youth, the initiative simultaneously increases the quality of health systems and services.

In addition to strengthening human resource capacity in the Region, the initiative has also made great strides in supporting integrated and comprehensive adolescents health systems and services through intersectorial, interprogrammatic and interagency efforts. For example, through interprogrammatic meetings such as “The International Meeting on Integrated Health Systems and Services for Adolescents and Youth” that was held in Honduras in October of 2011, experts in the fields of Health Systems and Services, Adolescent Health, Gender, Diversity, Human Rights and HIV, representatives from the Ministry of Health from nine different countries in the region, PAHO regional and country focal points and other UN agency representatives were given the opportunity to meet, share knowledge and collaborate on developing national plans of action for strengthening national health systems response to the needs—SRH needs in particular—of adolescents and youth in selected countries in the Region. All the material presented during this meeting, including presentations and modules material can be found using the following link: https://sites.paho.org/hlcop/edu_a_distancia/SitePages/Home.aspx. This meeting was simultaneously being transmitted via the online forum elluminate, allowing for the participation of nearly 230 people from 12 different countries. Recordings from this meeting can be found using the following link: https://sas.elluminate.com/site/external/recording/playback/link/table/meeting?uuid=M.1E19F80AB4897ED53DBFBA4266835B.

In order to strengthen strategic information on Adolescent SRH in the Region, the Adolescent Health Portal collects information on estimated HIV prevalence amongst adolescents and youth; % of young people who are aware of their HIV status; % of young people who can correctly identify ways of contracting HIV; estimated STI prevalence amongst adolescents and youth; adolescent fertility rates; % of teenage mothers; % of unplanned pregnancies; unmet need for contraceptives amongst adolescents; % of students who used contraceptive methods during their last sexual encounter; % of students who used contraceptive methods in their last high risk sexual encounter; age of sexual initiation; and % of adolescents who have had sexual intercourse before the age of 15. This portal is currently being updated and implemented in all of the countries of this initiative.

4. Malnutrition

The period of adolescence is a period of intense growth, second only to infancy (Anemia among adolescent and young adult women in Latin America and the Caribbean: A cause for concern, 2009). Thus, similar to infancy, overall nutrient needs during adolescence
are high in order to support optimum growth and development. Unfortunately, in many countries, the inequities between males and females make adolescent girls at particular risk for poor nutrition and health. Furthermore, nutritional problems during adolescence in developing countries have been largely ignored both as the subject of research in the scientific literature and as a target of public health and nutrition programs (Underweight, Short Stature and Overweight in Adolescents and Young Women in Latin America and the Caribbean, 2010). Indeed, Nationally representative data on anemia among young women in the countries of Latin America and the Caribbean are scarce; however, the data available indicate that anemia is a significant problem in several countries, varying from 7% in El Salvador to 45% in Haiti (Anemia among adolescent and young adult women in Latin America and the Caribbean: A cause for concern, 2009).

Figure 19. Anaemia Prevalence among Females 15-24 years of age (2009).

Much emphasis has been placed on the negative and irreversible developmental effects of iron deficiency during infancy and childhood. However, the negative effects of iron deficiency on cognitive performance may not be limited to just younger ages, but continue through adolescence (Anemia among adolescent and young adult women in Latin America and the Caribbean: A cause for concern, 2009). Indeed, in a randomized controlled iron-supplementation trial in iron-deficient adolescent girls who had not yet become anemic, girls receiving iron supplements performed better on a test of verbal learning and memory than girls with similar iron status receiving a placebo. Similarly, adolescents in the United States with iron deficiency had twice the risk of scoring below average in math than did adolescents with adequate iron status (even after adjusting for various confounding factors), though there was no effect on verbal skills in this population. Thus, even before anemia develops, negative effects of iron deficiency on cognitive performance in adolescents are evident (Anemia among adolescent and young adult women in Latin America and the Caribbean: A cause for concern, 2009). The recognition of anemia as a public health concern among young women in several LAC countries (and likely in others) and the potential negative effects of iron deficiency and
anemia during adolescence on growth, school performance and reproductive outcomes, indicates that improved monitoring of this outcome is essential in more counties.

In addition to the prevalence of anemia amongst adolescent females, Latin America and the Caribbean are faced with the double burden of recent increases in child and adolescent overweight and obesity. According to recent statistics of the Region, overweight was the most prevalent nutritional problem, exceeding all other anthropometric indices for 15-19 year olds in five of eight countries analyzed, and in all eight countries for the age group 20-24 year olds. While Ecuador had the highest amount of overweight young people between the ages 15-19 and 20-24, El Salvador had the highest amount of obese young people between the ages 15-19 and 20-24 (see figure 24 and 25) (Prevalence of Overweight, Obesity, Underweight and Short Stature among 20-24 years olds, 2010).

Figure 20. Prevalence of Overweight, Obesity, Underweight and Short Stature among 15-24 years olds (2001-2005).

Figure 21. Prevalence of Overweight, Obesity, Underweight and Short Stature among 20-24 years olds (2001-2005).
As can be seen in the graphs below, overweight and obesity occurs in both rural and urban areas (Underweight, Short Stature and Overweight in Adolescents and Young Women in Latin America and the Caribbean, 2010).

**Figure 22 & 23. Prevalence of Overweight and Obesity among 15-10 and 20-24 years olds by Rural and Urban Areas (2001-2005).**

This “double burden” is the result of various factors. Progress in improving community infrastructure and development of sound public health systems has been slow, thwarting efforts to reduce under nutrition; while rapid urbanization and the adoption of Western diets high in refined carbohydrates, saturated fats and sugars, combined with a more sedentary lifestyle are commonly cited as the major contributors to the increase in overweight and chronic diseases. Anemia, overweight and obesity have been strongly associated with noncommunicable diseases (NCDs) such as diabetes, heart disease/hypertension, respiratory disease and cancer. Indeed, much of the risk of these NCDs are associated with behaviors that are
established during adolescence, including 1) an unhealthy diet, 2) sedentary lifestyle, 3) harmful use of alcohol, and 4) tobacco use. Simply put, during adolescence and young adulthood, individuals are making choices that affect their lifestyle—as well as their future health burden, costs of health care, and risk of death (Global Status Report on noncommunicable diseases (NCDs), WHO 2010).

Adding to this problem, less than 30% of young people between the ages 10-24 do any sort of physical activity (see figure below).

**Figure 24. Low Percentage of Young People who are physically active between the ages 10-24 (with most recent GSHS available data)**

![Graph showing physical activity percentages for young people in various countries](http://www.cdc.gov/gshs/index.htm)


Although decreasing malnutrition, including anemia, overweight and obesity, and increasing physical activity is not directly part of the expected results (ER) of the Norway/PAHO initiative, it is part of PAHO’s Strategy and Plan of Action for Adolescent and Youth Health: meaning that when the initiative is supporting adolescent and youth friendly regional legislative and policy environments, ensuring that human resources in health are meeting the needs of adolescents, strengthening health systems and their services in order for adolescents and youth to receive quality and integrated care (including the adaptation and implementation of Integrated Management of Adolescent Needs (IMAN) norms and standards at the national level), and improving strategic information, it is indirectly also promoting the decrease of malnutrition and increase of physical activity amongst adolescent and youth in the region.
5. Mental Health and Behavioral Disorders

Although the studies on psychological epidemiology in children and adolescents in LAC have been scarce and often incomparable, a couple of trends in terms of disorders amongst adolescents and youth have been able to be identified in the Region. While the crude prevalence estimation of all types of mental disorder amongst adolescents and youth in LAC is 20%, the most common are those linked to anxiety or behavioral disorders. While young women have higher rates of disorders linked to anxiety and depression, young men have higher rates of attention deficit and oppositional defiant disorders. These statistics do not include autism, mental retardation, nor does it include any type of psychosis (Epidemiología de los trastornos mentales en América Latina y el Caribe, 2009).

Mental health is not only influenced by internal factors such as genetics and personal resilience, but also by external factors including social, economic, and cultural factors. When adolescents and youth live in poor and violent environments with a low social and familial support, they are more at risk for mental and emotional health disorders (Epidemiología de los trastornos mentales en América Latina y el Caribe, 2009).

Poor mental health can be detrimental if left untreated. Indeed, psychiatric disorders are associated with over 90% of all cases of suicides—one of the main causes of death for young people aged 10-24 in the Region (Prevention of Suicidal Behaviors: A Task for all, WHO 2011). Furthermore, mood disorders—depression in particular— has been associated with people living with HIV. In fact, one study estimates lifetime prevalence of depressive disorders range from 22.1 to 60.0 in HIV positive populations (HIV and Clinical Depression, 2002). This figure is worrisome and particularly important to this initiative. In order to ensure adolescents and youth mental health, effort needs to be placed on ensuring their access to education and to health services including counseling services and other external support networks as well.

Although not tackling mental health and behavioral disorders directly, the initiative is contributing towards improving mental health by increasing the number of countries with functioning adolescent and youth health and development programs; by increasing the number of countries that have reviewed, developed and implemented a policy of universal access to SRH; by maintaining the number of countries that have involved communities, academia, persons affected by the disease, civil society organizations, and the private sector in planning, design, implementation and evaluation of HIV programs; by increasing the number of countries that have achieved targets for prevention and control of sexually transmitted infections; by increasing the number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV positive pregnant women; by increasing the number of countries implementing a comprehensive and integrated package of norms and standards that meet the need of adolescents and youth (IMAN); by increasing the number of countries reporting HIV surveillance data disaggregated by sex and age; and by increasing the number of countries that implement information systems and surveillance systems to track SRH,
maternal, neonatal and adolescent and youth health, with information disaggregated by age, sex and ethnicity.

6. Consumption of Alcohol, Drugs and Tobacco

Two of the many concerns facing adolescents and youth today are those of alcohol and drug consumption. In fact, across the life course, the prevalence of alcohol, tobacco and illicit drug use and abuse is highest amongst adolescents and emerging adults (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008). This is of concern given that early age of first use of alcohol and drugs is associated with increased risk of suicide, violence, delinquency, adolescent pregnancy, the transmission of STIs and HIV, and drug abuse. In fact, studies have shown that those who drink before the age of 14 are four times more likely to develop alcohol abuse and dependence than those who begin drinking at 21 (Why Do Adolescents Drink, What Are the Risks, and How Can Underage Drinking Be Prevented? US Department of Health & Human Services, 2006).

According to the most recent GSHS, more than 40% of students aged 13 to 15 years old in 12 out of 18 countries reported having had at least one drink containing alcohol on one or more days during the last 30 days—the risk of alcohol consumption being the greatest amongst young men than in young women.

Figure 25. Alcohol Consumption amongst Students between the ages 13-15 (with most recent available GSHS data).
In addition, in terms of drug use amongst students aged 13 to 15 in the Americas; more than 50% in 5 of the 12 countries reported having used drugs one or more times during their lives, with the highest consumption percentage in Argentina, Dominica and Jamaica. Like alcohol consumption, boys ages 13-15 were more likely to have used drugs one or more times during their lives than girls their same age (the most recent GSHS).

Figure 26. Drug Consumption amongst Students between the ages 13-15 (with most recent available GSHS data)

Smoking, illicit drugs, and heavy alcohol use during adolescence and youth can deplete the economy of productive human capital. Harmful alcohol use is associated with lost productivity, traumatic injury, early death, crime and violence, and neglect of family responsibilities (Youth at Risk in Latin America and the Caribbean Understanding the Causes, Realizing the Potential, 2008). Furthermore, several studies suggest a high correlation between alcohol and drug use and negative sexual behaviors such as: failure to use condom; earlier age of sexual initiation; and multiple sex partners (Timing of Alcohol and Other Drug Use And Sexual Risk Behaviors Among Unmarried Adolescents and Young Adults, Guttmacher Institute 2001).

Although reducing the consumption of alcohol, drugs and tobacco by adolescents and youth is not part of the Expected Results (ER) of this initiative, the topic is indirectly being tackled through activities of this initiative. For example, PAHO is advocating for
the reduction of substance use to be an indicator in National Adolescent and Youth Strategies and Plans. Substance abuse prevention amongst adolescents and youth is also a topic which is being discussed in one of the courses of the Distance Education Program offered by the Catholic University of Chile, with the funding from this initiative. Furthermore, programs, such as SFP and IMAN, which are currently being implemented through this initiative, have components that deal with substance abuse prevention. Finally, the Adolescent Health portal collects information such as: % of students who have used drugs; % of students who have smoked tobacco, % percentage of students who have had at least one drink of alcohol on one or more days in the past 30 days.

As can be seen in the health situational analysis above, young people are facing a range of health risks in the Region today: violence, STI/HIV, poor SRH; malnutrition; mental health and behavioral disorders; and the consumption of alcohol, drugs and tobacco. This situation is partly due to the fact that young people are subject to a host of prevailing socioeconomic, territorial, ethnic, and gender inequalities that mold their health and social opportunities—Inequalities that are often referred to as the Social Determinants of Health.

7. Social Determinants of Health

According to the WHO, “the social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries” (Social Determinants of Health, WHO 2011). Some circumstances, such as family and peer relationships, are not very easily measured, however examples of circumstances that can be measured include: adolescents and youths access to health care; their schools and education; employment; their homes, communities, and rural or urban settings. In order better understand the risk factors for poor health amongst adolescents and youth, the section below will very briefly present some of the measurable circumstances that we have been collecting information on through this initiative including: 1) Poverty; 2) Ethnicity; and 3) Education.

a. Poverty

In all countries of the Region, the poorest and most socially excluded are often adolescents and youth who belong to indigenous, ethnic and racial minorities, and those that live in female-headed households, and/or in rural communities (Growing up Global: the Changing Transitions to Adulthood in Developing Countries, 2005). Indeed, thirty-nine percent of youth live in poverty in Latin America and the Caribbean, and females are more likely to being poor than men their age. Indeed whether single or married, most adolescent women are without monetary resources of their own or poor – some because they are still in school, others because they are married with little or no control over household income (Situacion y desafios de la juventud en Iberoamerica, 2008).
Ironically, early marriage and early childbearing are most common among poor women and those with little education - in fact, the poorer the country and region, the greater the likelihood that adolescent women are married (Growing up Global: the Changing Transitions to Adulthood in Developing Countries, 2005).

The links between poverty and adolescent health are extensive, strong and persuasive. In fact, virtually all aspects of health are worse amongst adolescents living in poverty than among adolescents from affluent families. For example, mortality, including infant and maternal, is higher amongst the less developed; accident rates are higher amongst adolescents in deprived geographical areas; adolescents psychological, emotional, and developmental wellbeing are also closely associated with socioeconomic status (Poverty and the health of children and adolescents, 1997).

Furthermore, Young women, aged 15 – 24, in the lowest wealth quintile had a greater unmet need for contraception than their sisters who were better off in the highest household wealth quintile; fewer poor adolescents use contraceptive methods and as a consequence higher fertility and birth rates and STI rates among teenagers are strongly correlated with poverty rates (The Paradox of Stagnant Adolescent Fertility in Latin America and the Caribbean, IDB 2011).

Figure 27. Higher unmet need for Family Planning among the Economically Disadvantaged (Most Recent DHS series).

Figure 28. Less Contraceptive usage among the Economically Disadvantaged (Most Recent DHS series).

Figure 29. More Teen Mothers among the Economically Disadvantaged (Most Recent DHS series).
Given that poor and excluded groups and groups in situations of vulnerability are often invisible, voiceless, and victims of stigma and discrimination, health promotion activities associated with disease and pregnancy prevention need to make an effort in making invisible groups visible and protecting the rights of young people in situations of vulnerability. Further, it is important to design service activities which take into account the circumstances of marginalized adolescents, as well as seek the participation of excluded adolescents. Within this context, PAHO in collaboration with the Royal Norwegian Embassy and the Spanish Agency for International Development developed the policy document “Reaching Poor and Vulnerable Adolescents with Sexual and Reproductive Health” with the hope that, by disseminating this document, the countries of Latin America and the Caribbean will make significant advances in securing the health and well-being of poor and excluded adolescents and adolescents in situations of vulnerability.

b. Ethnicity

The indigenous adolescent and youth cohort represents a large segment of the total adolescent and youth population in LAC. (Salud de la Poblacion Joven, CEPAL 2010).

Figure 30. Proportion of indigenous young people (ages 10-24) to all the young people (ages 10-24) in the region (Most Recent Census).

The majority of these indigenous adolescents and youth live under poor and rural condition.
These adolescents face racism and discrimination that impede on their physical, emotional and physical well being. For example, illiteracy rates amongst indigenous youth between the ages 15 to 24 are high, compared to non indigenous youth between the ages 15-24 in the Region, and are higher amongst indigenous women between the ages 15-24 than amongst indigenous men between the ages 15-24.

In terms of sexual and reproductive health, indigenous adolescents and youth (10-24) are more likely to have their sexual debut earlier; less likely to know of at least one form of contraceptives; less likely to use contraceptives; and indigenous women between the ages...
15-24 are more likely to be mothers than non indigenous women from the same age group.

**Figure 33.** Indigenous women between the ages 15-24 are more likely to be mothers than non indigenous women from the same age group (Most Recent Census).

This trend also hold true when comparing indigenous young mothers between the ages 15-19 to non indigenous mothers between the same age group.

**Figure 34.** Indigenous women between the ages 15-19 are more likely to be mothers than non indigenous women from the same age group (Most Recent Census).

One explanation for why indigenous young women have higher rates than non indigenous women the same age, could be that indigenous young women between the ages 15-24 are more likely to be in a union that non indigenous women from the same age group.
In addition to higher illiteracy rates, poorer sexual and reproductive health knowledge and higher fertility rates, indigenous youth also demonstrate having higher rates of disabilities, higher rates of mortality due to injuries and accidents, and worse mental health. Indeed, over the last decade there has been a significant increase in suicides amongst indigenous youth in Brazil, Chile and Paraguay (Salud de la Población Joven, CEPAL 2010). Furthermore, indigenous youth often face social and institutional discrimination impeding their access to health services (Reaching the Poor and Vulnerable Adolescents with Sexual and Reproductive Health, PAHO 2011). Obstacles they face include: 1) Marginal political and legal status; 2) Limited access to economic opportunities and employment; and 3) Barriers to health and other services.

Minority ethnic groups are often invisible and overlooked in studies and surveys. Exclusion in health is often directly tied to ethnicity and race where language, discrimination, location of services, and the culture of service providers may present obstacles to access services and information. Importantly, indigenous populations often comprise many and separate ethnic communities that may not feel a common bond or share a common language. Countries should acknowledge and provide for the diverse nature of indigenous populations. To respond to this need, this initiative has, during 2011, started placing more emphasis on improving and raising awareness of the sexual and reproductive health needs of indigenous adolescents and youth. These efforts have included the development of two key policy documents describing the situational analysis of the indigenous adolescent and youth population in Bolivia, Ecuador, Guatemala, Honduras, Nicaragua, and Peru.
In addition to these two documents, the initiative has during 2011, also made progress in creating the first *Pan American Indigenous Leaders Youth Network for Health*. This network was developed during a meeting that was held in October of 2011 in Peru, gathering youth leader participants from seven countries: Guatemala, Honduras, Nicaragua, Bolivia, Ecuador and Peru. The network is currently active using several different online tools including Facebook, Twitter, Blogs, and YouTube.

To strengthen the capacity of Human Resources in Health to respond to the needs of indigenous adolescents and youth, this initiative also developed, during 2011 a module on ethnic diversity for the distance education program at the Catholic University of Chile.

c. Education

Today’s LAC adolescents and youth are the most educated cohort in the region’s history, but they are lagging behind the rest of the world. Indeed, more than 20 million secondary school-age people in LAC are not enrolled in school or are lagging behind the school year they should be in, which is equivalent to one in every three secondary school-age young person. The range for the region for non-enrolled young people is a low of 4.5 percent in St. Kitts and Nevis and a high of 71.8 percent in Guatemala. The poor are lagging even further behind, with only 33 percent of young people from the poorest 40 percent of the LAC population having completed 9th grade, compared with 67 percent of young people from the wealthiest 20 percent of the population (*Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential*, the World Bank, 2008).

Although the number of years of completed education has doubled in LAC between 1960 and today, the increase has been even greater in other regions that had levels of
educational attainment comparable to LAC in 1960 (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008).

Perhaps even more worrisome than the lagging educational attainment is the fact that young people are not learning. Results from the Program for International Student Assessment (PISA) education-quality tests show that LAC students consistently perform below the level expected of them given their countries’ levels of GDP per capita. And those from the poorest LAC households are the worst performers in the global sample (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008).

Feeling disconnected from school has emerged from the research as an explanatory factor for all kinds of risky behavior, and some argue that it is the most important factor affecting all kinds of behavior. School connectedness—feeling that someone in a young person’s school cares about his or her well-being—is negatively correlated with school repetition, school leaving, premature employment, risky sexual activity, early sexual initiation, violence, and substance use (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008).

Men and women engage to different extents in different kinds of risky behavior. Males are more likely to drop out of school, to enter the workforce prematurely, to engage in violent behavior, and to engage in substance abuse. Girls also engage in certain kinds of behavior. Early and risky sexual activity and early marriage may be perceived as ways to connect and to have a role in society (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008). Indeed, as can be seen in the figure below, adolescents with lower education levels are much more likely to give birth before the age of 20 and for every additional year of schooling, fertility rates in Latin America decreases by 5-10% (DHS series 2005).

Figure 36. More Teen Mothers among the Lower Education Levels (DHS 2005 series).
Equality in educational opportunities is particularly important in LAC as a way to reduce the inequality and poverty that characterizes the region. Education is one of the main determinants of income, and higher levels of education are associated with a higher degree of intergenerational mobility. Part of the observed income inequality in LAC is probably the result of differences in educational opportunities rather than differences in ability or effort. To the extent that a group of young people in LAC do not enroll in school or enroll late, drop out, or are promoted slowly through the school system, they are not taught (or do not learn) adequate skills and abilities, which will perpetuate the high inequality and low social mobility found in LAC (Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential, the World Bank, 2008).

This initiative is supporting equality in educational opportunities in LAC through advocacy efforts such as the establishment and strengthening of Regional gender sensitive and human rights based legislative and policy environments. For example, by advocating and giving technical support for the development of intersectorial Adolescent and Youth Health Plans and Strategies, countries are developing Adolescent and Youth Health plans and strategies that include not only the health sector but also the educational sector, the social sector, etc. Education is therefore included in all efforts planned and implemented.

9. Summary

As demonstrated in the text above, although the goal of this initiative is to “halt and begin to reverse the spread of HIV among young people (10-24 years) in Central America and the Caribbean by using an integrated SRH approach that incorporates the tenants of human rights and gender equity”, the initiative does do much more than that. It prevents the prevalence of violence, STIs, malnutrition and consumption of alcohol, drugs and tobacco amongst adolescents and youth, and it improves the SRH, Mental health and Behavioral Disorders of adolescents and youth.

Furthermore, it supports regional legislative and policy environment established for gender sensitive and human rights based HIV prevention and sexual & reproductive health programs for young people; it develops Human Resources Capacity for the provision of gender sensitive and human rights-based HIV prevention and SRH services and programs for young people; it ensures that HIV prevention services for young people are expanded, utilizing gender, SRH, and human rights approaches; and finally it strengthens Regional, sub-regional and national capacity to generate and use strategic information for development and monitoring of HIV programs for young people.

Today, we are at the midpoint of the PAHO/Norway initiative—as it has been active for approximately three years. In order to demonstrate the outcomes of this initiative thus far, the next section will include the Regional Achievements in terms of: Policy and Legislation (Expected Result 1), Capacity Building of Human Resources (Expected
Section III. Regional Achievements

1. Policy and Legislation (Expected Result 1)

One of the Expected Results of this initiative is “Supportive regional legislative and policy environment established for gender sensitive and human rights based HIV prevention and SRH programs for young people”. As part of this expected results, the initiative has made great efforts to advocate and give technical support in order for countries to establish a National Adolescent and Youth Health Strategy and Plan of Action; a National Adolescent and Youth SRH Policy/Plan and/or Strategy; a National Teenage Pregnancy Prevention Plan/Strategy; laws that protect the human rights of HIV positive Adolescents and Youth; and laws that protect the human rights of LGBT adolescents and Youth.

For example, through the recently approved Resolution CD 50 R.8 “Health and Human Rights” of the Pan American Health Organization/World Health Organization (PAHO/WHO), the office for Gender, Diversity and Human Rights reiterates the continuous support of PAHO Member States to technical cooperation in the formulation, review and, if necessary, reform of national health plans, policies and legislation on HIV and sexual/reproductive health, incorporating the applicable international human rights instruments, especially those related to the protection of groups in situation of vulnerability such as young persons.

Furthermore, in order to support the Region to develop effective policies and programs for adolescent and youth health and human rights promotion, prevention, and care, these efforts have also included Regional intersectorial and interprogrammatic STH meetings and the development of key policy recommendation documents analyzing current adolescent Human Rights, Adolescent Health, HIV and SRH situation. For example, in 2010, the Office for Gender, Diversity and Human Rights developed a key study on “The Right of Young People to Health and Gender Identities: Trends and Targets for Public Health Action”, compiling observations, trends and public health recommendations based on first-hand experiences from 11 human rights capacity-building workshops held in 11 countries between 2008 and 2010. The workshops included an average of 35 participants per workshop. Participants included staff from governmental agencies (ministries of health, labor, education, and finance) and civil society (including media, LGBTI groups and youth associations) as well as judges, legislators and ombudspersons (recommendations made in this report can be found under section “VI Conclusion” of this document). The document can be found on the following link:


As a result of this effort, the regional legislative and policy environment has improved significantly. In deed, as can be seen in the table below, five of the seven countries have
developed and implemented Adolescent Health Strategies and Plans of Action; six of the seven countries have developed and implemented National Adolescent and Youth SRH Policies/Plans/Strategies; all seven countries are implementing an Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis Strategy; five of the seven countries have established laws that protect the human rights of HIV positive adolescents and youth; and finally five of the seven countries have established laws that protect the human rights of LGBT adolescents and Youth. Lagging behind these accomplishments is the development of National Teenage Pregnancy Prevention Plans. As can be seen in the table below, only one out of the seven countries (DOR) has a National Teenage Pregnancy Prevention Plan developed and implemented. Despite this fact however, most countries include teenage pregnancy prevention in their Adolescent Health/SRH Plans and Strategies. A country that is not progressing as well as the others is Haiti. Haiti has not progressed in any of the areas outlined below. However, given their tough situation and circumstances, this may not be that surprising.

In terms of the laws that protect the human rights of HIV positive or LGBT adolescents and youth, although some countries do not have a specific law targeting adolescents, they do have general laws that protect the human rights of all people, including adolescents and youth, living with HIV or are part of the LGBT community. These particular countries are still marked with green. The only countries marked with red are those that do not have a specific law that protects the human rights of HIV positive or LGBT adolescents and youth, and whose general laws excludes adolescents and youth. For example, Guatemala does not have a specific law that protects the human rights of HIV positive or LGBT adolescents and youth, and even though they have a general law, minors are excluded from this law as they are not allowed to be tested on HIV without the consent of their legal guardian.

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Despite these advances however, findings of the document “The Right of Young People to Health and Gender Identities: Trends and Targets for Public Health Action” revealed that there is considerable lack of awareness among the population of the regional and international human rights framework and its application in the context of young people, women, children, LGTBI persons, and people living with HIV; that high levels of discrimination and violence against women, children, adolescents and LGTBI groups is still a constant in the Region; that legislation, policies, and plans do not take into consideration the needs of members of the LGTBI community; that there are no mechanisms to monitor implementation of international and regional instruments or to evaluate the impact of laws, policies, and programs; there is a shortage of family counseling services and parent education programs; that adolescents do not have access to safe, legal, and confidential sexual and reproductive health services—including information, counseling, and pregnancy termination; that contraception is not widely available; and that children, adolescents, and pregnant women do not have universal access to HIV-related prevention, treatment, care, and support.

These findings point towards the fact that although we have come a long way, we still have a long way ahead of us, and there is still a lot more work to be done in the Region.

Ensuring the successful continuance of this effort, the initiative supported a global conference on health and human rights at Washington College of Law, American University (March 21-22, 2012) where governmental officials from Central America, civil society organizations (including young persons and LGTBI groups), PAHO experts, students, professors and international organizations discussed how to more effectively use international human rights treaties and standards to reduce maternal mortality and reform national policies and laws on HIV, sexual and reproductive health of young people. The UN Special Rapporteur on the Right to Health participated in this conference where 200 persons examined national health policies, plans and laws of the Region in light of international human rights obligations. As a product of the conference, a tool with 6 modules will be produced by American University and PAHO to be used in the field among legislators and judges who make decisions on the right to sexual health of young people, reproductive rights, HIV and gender identities, including LGBTI youth. More information on the conference, speakers and topics can be accessed at: http://new.paho.org/wcl/

2. **Capacity Building of Human Resources (Expected Result 4)**

The second Expected Result of this initiative is “Human Resources capacity developed for the provision of gender sensitive and human rights-based HIV prevention and SRH
services and programs for young people”. In order to achieve this result, this initiative has made great efforts to involve communities, academia, persons affected by HIV/AIDS, civil society organizations, and the private sector in the planning, design, implementation and evaluation of HIV programs.

For example, two training packages were developed to strengthen the capacity of health workers to provide non-discriminatory and appropriate health care for vulnerable populations, with a strong focus on young persons. The first training package, titled “Men’s health, HIV and Sexual Diversity”, is a 16-module comprehensive skills-based and experiential training package for frontline health workers, aimed at increasing their knowledge and skills to provide care for sexually diverse men of all ages. Over 200 persons in the Caribbean have been trained in this package through Regional training, and the training has proven to serve as a catalyst for the reduction of stigma and discrimination, and the improvement of the quality of services for sexually diverse men. The training is now being rolled-out nationally in various countries. The second package on Comprehensive Sexual Health is being finalized for dissemination.

Furthermore, through the implementation of the Integrated Management for Adolescent Needs (IMAN), all of the countries of the Norway/PAHO initiative (except Haiti) have been supplied with the tools (and the training of the implementation of these tools) for focalization on the most vulnerable population groups; for age and gender appropriate evidence-based interventions at the primary level of care; for human resource development; and for policy advocacy and social communication.

To further contribute towards the achievement of the expected result 2, the Norway/PAHO initiative has funded, together with an initiative between PAHO and the Spanish Cooperation for International Development, approximately 240 personnel who work in the field of adolescent health in the various countries in the initiative.

As can be seen in the table below, although all countries offer personnel who work with adolescent health to attend the distance education program, very few of them offer National Graduate Degrees in Adolescent and Youth Health through National Universities or through other institutions at the National level. In order to continue strengthen human resource capacity for the provision of gender sensitive and human-rights based HIV prevention and SRH services and programs for young people, the initiative should support, using eHealth, the development of comprehensive adolescent and youth health human resources training programs at the National level.

<table>
<thead>
<tr>
<th>Country</th>
<th>Distance Education Courses (2008-2011)</th>
<th>The Existence of National Graduate Degrees in Adolescent and Youth Health</th>
</tr>
</thead>
</table>
3. Health Systems and Services (Expected Result 3)

The third Expected Result of this initiative is “Six countries have expanded HIV prevention services for young people, utilizing gender, SRH and Human Rights approaches”. To achieve this result, this initiative has made a very big effort (as can be seen in the table below) in establishing functioning National Adolescent Health and Development Programs; establishing centers that offer integrated packages for adolescents and youth; establishing a basic integrated intervention package for adolescents and youth; integrating adolescent and youth health services into the health system; providing integrated adolescent HIV and SRH services; and finally providing adolescents and youth with access to modern contraceptives.

<table>
<thead>
<tr>
<th>Country</th>
<th>Functioning National Adolescent Health and Development Program</th>
<th>Centers that offer integrated health to adolescents and youth</th>
<th>A basic integrated intervention package for adolescents and youth (IMAN)</th>
<th>Are adolescent and youth health services integrated into health system?</th>
<th>Integrated Adolescent HIV and SRH services</th>
<th>Do adolescents and youth have access to Modern Contraceptives?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOR</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>In process</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>ELS</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>GUT</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>HAI</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>HON</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>NIC</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>PAN</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>
In addition to those achievements, the initiative is also supporting the implementation of various different programs at the country level. For example, the Strong Families Program is currently being implemented in all countries except Haiti, and Teach VIP Youth is part of the Distance Education Course on Integrated Adolescent Health and Development.

<table>
<thead>
<tr>
<th>Country</th>
<th>Teach VIP Youth</th>
<th>Strong Families Program (Familias Fuertes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOR</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>ELS</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>GUT</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>HAI</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>HON</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>NIC</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>PAN</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

4. Strategic Information Systems (Expected Result 4)

The final Expected Result of this initiative is “Regional, sub-regional and national capacity strengthened to generate and use strategic information for development and monitoring of HIV programs for young people”. In order to achieve this expected result, advocating effort has been made towards increasing the number of countries who report on HIV surveillance data, disaggregated by sex, age and ethnicity; increasing the number of countries that implement information systems and surveillance systems to trace SRH, maternal, neonatal and adolescent and youth health, with information disaggregated by age, sex and ethnicity; and finally increasing the number of PASB systematic reviews on best practices, operational research, and standards of care.

Although all advances made during the last couple of years in the area of Strategic Information Systems cannot solely be attributed to the work carried out through the support of the PAHO/Norway initiative, it is fair to say that the initiative “HIV prevention in Young People Using a Human Rights Framework in Central America and the Caribbean 2008-2013”—together with support from other cooperation’s such as the Spanish Cooperation—has significantly contributed towards these advancements.

Today, the majority of the countries (except El Salvador and Haiti) implement the Adolescent Information System (SIA); they implement the Adolescent Health Portal; and they have their own National Health Systems where they gather information on adolescents and youth. In addition to these systems, they all implement some sort of health survey. The majority implement the Demographic Health Survey (DHS), National
Census, and National Survey on Young People in LAC. On the negative side, only two out of seven countries implement the Global Student Health Survey (GSHS).

Most of these systems and surveys have started collecting information disaggregated by age and gender, ethnicity; and almost all (except Haiti) collect information on HIV prevalence amongst young people. Furthermore, five out of seven countries collect information on the access to HIV services by young people.

<table>
<thead>
<tr>
<th>Types of Health Information Systems used by Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country</strong></td>
</tr>
<tr>
<td>DOR</td>
</tr>
<tr>
<td>ELS</td>
</tr>
<tr>
<td>GUT</td>
</tr>
<tr>
<td>HAI</td>
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<tr>
<td>HON</td>
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<tr>
<td>NIC</td>
</tr>
<tr>
<td>PAN</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>National Health Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country</strong></td>
</tr>
<tr>
<td>DOR</td>
</tr>
<tr>
<td>ELS</td>
</tr>
<tr>
<td>GUT</td>
</tr>
<tr>
<td>HAI</td>
</tr>
<tr>
<td>HON</td>
</tr>
<tr>
<td>NIC</td>
</tr>
<tr>
<td>PAN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Data Disaggregation in National Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country</strong></td>
</tr>
<tr>
<td>DOR</td>
</tr>
<tr>
<td>ELS</td>
</tr>
</tbody>
</table>
In an effort to ensure transparency and improve on donor-recipient reporting, the section below provides an analysis, comparing the initiative outputs vs. planned outputs. Furthermore, through this analysis, PAHO can also more easily track activities, identify outstanding activities, analyze challenges and barriers, avoid activity duplication/repetition, and conclude recommendations in order to improve the planning and implementation of the initiative for 2012.

Section IV. Outputs compared to Planned Outputs

As a preparation for 2011, all countries, sub regions and Regional programs part of this initiative developed Plans of Action for 2011. These plans of action were formed in collaboration between the country focal points and the national Ministries of Health, and revised by the management team at the Regional level. During the annual meeting between PAHO and the Royal Norwegian Embassy, which took place in Nicaragua in April of 2010, these plans of action were approved.

1. Activity Implementation Rate at the National level.

In total, the national plans of action included 73 activities, spread throughout seven countries, covering the areas of Gender, Diversity and Human Rights (GDR), Adolescent Health (ADO), Sexual and Reproductive Health promotion and HIV/STI prevention (STI) (to get more information on executed activities, please see ANNEX A, which includes the National and Sub regional narrative reports for 2011). These activities were distributed according to PAHO/Norway initiative Health Indicators (see table 1 under first section), and contributed to the four “grant expected results”: 1) Supportive Regional legislative and policy environment established for gender sensitive and human rights based HIV prevention and sexual & reproductive health programs for young people; 2) Human Resources Capacity developed for the provision of gender sensitive and human rights-based HIV prevention and Sexual and Reproductive Health services and programs for young people; 3) Six countries have expanded HIV prevention services for young people, utilizing gender, Sexual and Reproductive Health, and human rights approaches; and finally 4) Regional, sub-Regional and National capacity strengthened to generate and use strategic information for development and monitoring of HIV programs for young people.

According to a survey developed, disseminated and returned by all country-offices part of this initiative (see ANNEX B for surveys returned), 70 (96%) of the planned activities were successfully implemented and/or still ongoing, and three (4%) were not realized at all (see table below).
According to this same survey, the main reasons for why activities did not get 100% executed at the national level included both internal and external barriers. More details on barriers/problems and risks facing the initiative in 2011 and recommendations on how to improve processes for 2012, can be found under the section “VI Conclusions”.

2. **Activity Implementation Rate at the sub-Regional level.**

In total, the plans of action of the sub regional offices, the PAHO HIV Caribbean Office (PHCO) and the Central American (CA) office, included 12 major activities, all which were executed and even expanded to include more activities during 2011.

<table>
<thead>
<tr>
<th>Sub-region</th>
<th>Activity Implemented/Still Ongoing</th>
<th>Activity Not Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>PHCO</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>CA</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100%</td>
</tr>
</tbody>
</table>

Although all the activities were implemented with a 100% success rate, the sub-regional offices still shared the external challenges that the countries experiences, and included some extra internal challenges. More details on barriers/problems and risks facing the initiative in 2011 and recommendations on how to improve processes for 2012, can be found under the section “VI Conclusions”.

3. **Activity Implementation Rate at the Regional level.**

The 2011 plans of actions for the programs at the Regional level included a total of 26 activities, 25 of which were implemented and/or ongoing (96%) and 1 activity (4%) which was not realized. This one activity is planned to be implemented during 2012.
In total, the initiative had an implementation rate of 97% during 2011. More details on barriers/problems and risks facing the initiative in 2011 and recommendations on how to improve processes for 2012, can be found under the section “VI Conclusions”. However, before presenting the conclusions of 2011 advances, the section below will summarize the budget execution for 2011.

### Section V. Summary of Budget execution

According to a financial report (attached in annex C) prepared by PAHO’s finance department reflecting the financial situation of the initiative as of March 31\textsuperscript{st}, 2012, the initiative currently had approximately an unobligated cash balance of USD166,305.00. Since the 31\textsuperscript{st} of March, another 65,000 has been obligated for initiative activities. Based on the fact that during 2011 we received approximately 917,700.00, our execution rate for this year was approximately 90%.

The delay in activity implementation was due to several factors including internal and external factors. Details about these factors can be read in the section below.

### Section VI. Conclusion

#### 1. Program efficiency

**Internal Context during 2011**

Internal factors affecting the success of the initiative include structural changes such as shifts in management at the Regional and National level, and changes in coordination at the Regional, Sub Regional and National level.

**Structural Changes:**

This past year has included a couple of shifts in management at the Regional and National level. For instance, in 2011 the Regional Coordinator of the Prevention, Treatment and Care for HIV/STI Project, Dr Kathleen Israel, retired and Dr. Massimo Ghidinelli came to assume the role as the Regional Coordinator. This transfer went...
smoothly, but as always, required some time for readjustment and reorganization. Another program that experienced change was the Gender, Diversity and Human Rights (GDR) program, as the Regional Coordinator, Dr. Marijke Velzeboer-Salcedo, retired in the end of December 2011. In addition to this retirement, the GDR program also lost their Diversity Advisor, Dr. Maria Ines Barbosa. This post was given to Dr. Florence Levy and transferred to Panama. This transfer created a temporary lag for the Norway initiative, as certain key publications had to be revised, edited and approved by the Diversity Advisor. In addition to these three situations, in April of 2012, the HL project will change coordinators from Dr. Matilde Maddaleno to Dr. Carlos Samayoa—a change that will be disruptive for the various initiatives implemented under the HL course project and demand a greater attention to coordination and redistribution of workload.

In addition to Regional turnover, there has been some National turnover as well. For instance, both PAHO offices in El Salvador, Honduras and Panama had to replace their Adolescent Health focal points. These replacements created a time lag for the implementation of activities funded by the initiative. Other countries that experienced turnover are Haiti and Guatemala. While Haiti experienced a long administrative process to hire a Family and Community Health advisor, Guatemala was without a national HIV advisor for the first six months of 2011, affecting the coordination of plans and the implementation of initiative activities.

Changes in Coordination:

Although the integration of six programs (Nutrition, Maternal Health, Neonatal and Child Health, Adolescent and Youth Health, and Elderly Health) under the umbrella project—the Healthy Life (HL) Course Project—occurred in 2010, the programs are still adjusting to the change. As mentioned in the 2010 report, the HL Course Project uses an integrated and multisectorial approach to address the health needs of the population throughout the life course. The approach provides a more comprehensive vision of health and its determinants, which calls for the development of health service networks that are centered on people’s needs at each stage of their lives and addresses the social determinants of health. This integration has at times been challenging for the programs involved; however, it has also created more opportunities for anchoring Adolescent Health on the political and public agenda.

The advancement towards greater integration continues to create a greater need for an internal coordination of the project at three different levels—Regional, sub-Regional, and at the country level. However, documents such as the Adolescent and Youth Regional Strategy and Plan of Action 2010-2018 and the Health and Human Rights resolution, continues to assist in aligning perspectives, provide feedback loop from countries and the sub-Region to the Regional level, and allow for improved coordination.

Integration and coordination has also allowed for improved strategic interagency alliances in countries and in the Region. In 2011, PAHO continued to increase its role with United Nations institutions in the countries, the Inter-American Commission on Human Rights, the UN Special Rapporteur on the Right to Health, sub-Regions and the
Region, and expanded its country level partners outside of the traditional Ministry of Health, into other ministries and non-governmental and Faith Based organizations who also contribute to the provision of youth health services.

External Context during 2011
During 2011, the success of the initiative was challenged by several external factors at the country level including political elections, ministry of health turnover, National legislation, natural disasters, and the state of global financial affairs.

Legislative and policy environment:

During 2011, Haiti, Guatemala and Nicaragua all held presidential elections. While Nicaragua’s president Daniel Ortega got re-elected with over 62 percent of the votes, Guatemala opted for change, throwing out their centre-left government and electing Otto Perez, a former military general who heads the right-wing Patriot party.

Both the elections in Guatemala and Nicaragua caused political polarization and unrest as the victory of Otto Perez marked the first time that an ex-soldier has been in charge since the democracy was restored in 1986, reminding many inhabitants of Guatemala’s brutal civil war, and the victory of Daniel Ortega fueled numerous complaints about the electoral process and voting irregularities. Prioritization of the elections caused the focus to temporarily be shifted away from development cooperation, hindering plans and derailing some of the ongoing effort of the initiative. Furthermore, political turnover in El Salvador and Nicaragua caused the Ministry of Health to lose its Central Adolescent Health country focal point, delaying processes required for the implementation of the PAHO/Norway initiative.

In addition to these events, the Region has also witnessed legislative decisions which could jeopardize the Initiative’s future efforts and prove detrimental to ASRH. For instance, in the beginning of 2012, Honduran Supreme court upheld the strictest ban on emergency contraception (EC) in the world, cementing the fate of women trying to avoid unintended pregnancy—whether from unprotected sex, contraceptive failure or rape. The absolute ban would criminalize the sale, distribution, and use of EC, by imposing punishment for offenders equal to that of obtaining or performing an abortion, which in Honduras is completely restricted. On the other hand, Honduras has included, as part of the activities of their National Plan for Sustainable Development, the integration of the Integrated Adolescent Health Program into various new sectors. Furthermore, this plan also includes the indicator “Reduction of Teenage Pregnancy”.

As seen by the case of Honduras above, not all political turnover and change in legislation proved to be detrimental to the initiative. For instance, in El Salvador the following law ratifications have been made: the ratification of a law on Tobacco Control (Ley de Control al Tabaco), protecting the selling or purchasing of tobacco by minors; the ratification of a National Youth Law (Ley Nacional de Juventud), creating an National Institute for Youth; and finally the ratification of National laws on Medicines (Ley Nacional de Medicamentos) and Vaccinations (Ley Nacional de Vacunas). In
addition, Guatemala officially launched a proposal for an Integrated Health Model (*Modelo de Atención Integral en Salud –MAIS*), offering universal access to health based on the right to health.

_Natural Disasters:_

According to recent cross-National statistics on natural disasters, compiled by the WHO, the Latin American and the Caribbean Region experiences more climate-related hazards per capita than any other Region—with the countries of Guatemala, Honduras and Nicaragua being particularly vulnerable. (*National and Local Vulnerability to Climate-Related Disasters in Latin America: The Role of Social Asset-Based Adaptation*, 2012). Indeed, during 2011, countries such as Guatemala, Nicaragua and El Salvador all experienced floods and landslides, killing more than 80 people, washing away bridges, roads and international highways, leaving villages isolated and causing thousands of families to their homes and crops. These natural disasters forced the organization and host country institutions to shift away from their normal procedures and priorities in order to respond to the various situations. These shifts in procedures and priorities decelerated planned activities and delayed the success of the initiative.

_The State of Global Financial Affairs:_

As mentioned in the progress report of 2010, as a result of the global financial crisis, there has been an overall decrease in funding for development at the global level. Since then, the initiative has been facing the repercussions from this decrease, struggling to find alternative ways to sustain.

One of the areas that have experienced a significant decrease in funding is HIV/AIDS. Indeed, in 2010, international funding for AIDS programs in developing countries across the world dropped by 10%—with certain countries losing up to 90% of their funding for HIV—raising concerns about the future of HIV prevention. Although part of the decline was linked to exchange rate fluctuation, it was also noted that in some cases there was deliberate decreases by some of the donors due to the financial crisis. For the HIV team at PAHO this decrease in funding has meant a hindrance to contracting new personnel; a deceleration of planned activity implementation and interference to the development, production/reproduction, dissemination and application of already developed materials in the field.

Other external circumstances challenging the success and sustainability of the initiative include shifts in donor government priorities, causing less overall funding for health in the Region. In 2010, Sweden—which has provided assistance to Latin America for over thirty years, and also been a major partner for the adolescent and youth health program at PAHO—decreased its development assistance to Latin America, and thus reduced its presence from ten to three countries, as well as terminating its large Regional program. This change has been a tremendous loss to the adolescent health program at PAHO, and as a consequence alternative funding is being explored to ensure the sustainability of the program at the country level.
In addition to decreases in donor funding, the state of financial affairs in certain countries of the initiative have seriously impeded the success of the initiative. For example, the financial affairs in El Salvador caused prices of medicines and medical supplies to drastically increase in 2011, hindering youth and the most poor and vulnerable populations from accessing medication and services, and thus threatening the success of the initiative.

Challenges for 2012

I. After having been in a state of emergency for nearly three years, the government of Haiti has finally asked for technical cooperation in the area of adolescent health. This request presents both opportunities and challenges for this initiative. It creates opportunities such as: the development and implementation of a national adolescent and youth health program; the sustainability of short term projects; and the closure of non sustainable pilot projects. On the other hand, challenges include: the language barrier, as all the tools developed through this initiative will be needed to be translated into French; and the potential of political instability and natural disasters during extreme poverty

II. The sustainability of effective resources and leadership at the regional and national level to support member states in the reform of services, health policies, plans, and laws

III. The sustainability of resources to use tools, already developed through this initiative in other public health areas; effective implementation of CRC recommendations on health—especially those for SRG and HIV prevention among young people involving other sectors such as police, judiciary, legislators, ombudspersons, and civil society

IV. Appropriate use of international human rights treaties and standards to reform outdated laws that do not include other “gender identities”, “gender expressions” and “sexual orientations” issues/problems in order stop human rights abuses and inhumane treatment related to health and killings of young LGTBI persons, especially in the context of the work of national tribunals, health services, national parliaments and Ombudspersons

V. Adequate personnel and material resources to involve civil society, ministries of health, judges, parliamentarians, police and other actors in the implementation of these laws with the support of PAHO national offices, regional teams and UN/OAS treaty bodies

Recommendations

In an effort to improve initiative efficiency and ensure expected results, a couple of recommendations have been identified in the following areas: Regional Legislative and Policy Environment; Human Resource Capacity; Health Systems and Services for Adolescent and Youth Health Promotion HIV prevention; Strategic Information; Strategic Alliances and Collaboration with Other Sectors; Initiative Management. The recommendations can be summarized as follows:
2. Supporting the Regional Legislative and Policy Environment using a Human Rights Approach

In an effort to continue strengthen the capacity of countries in Central America and the Caribbean to develop and implement gender sensitive-human rights based programs and services to reduce the number of new HIV infections in young people (ages 10-24) and promote their sexual and reproductive health (SRH), so that these adolescents (ages 10-19) and youth (ages 15-24) can reach their full political, social and economic potential, a number of recommendations for this project, PAHO Member States and other relevant stakeholders has been identified. The recommendations can be summarized as follows:

I. a) The concepts of “health”, “sex” and ‘gender’ continue to evolve, and in that respect there is a need to widen the scope of the measures to protect the right to the enjoyment of the highest attainable standards of health (“right to health”), especially in the context of national laws and policies that protect young people.

II. b) Introduce measures to raise awareness about international and regional instruments and standards relating to the right to health of young people, including LGTBI persons and persons living with HIV among health workers and prisons personnel.

III. Provide young people with information regarding sexual and reproductive health and STIs prevention following international and regional human rights instruments and standards.

IV. Ensure mechanisms of protection, investigation, monitoring and enforcement of human rights violations to avoid discriminatory and violent practices against young people, including LGTBI groups and that those persons responsible for murder and/or acts of violence and discrimination are penalized adequately.

V. Issue and enforce laws that prohibit discrimination with respect to young people, including LGTBI persons and other groups in situation of vulnerability, including prisoners, sex workers, and drug users.

VI. Include the needs of adolescents in national laws, policies and plans that respond to their needs for access to sexual and reproductive health and in particular guarantee procedures on informed consent, the right to privacy and freedom of expression.

VII. Decriminalization of same-sex conduct and other forms of punishing individuals because of their gender identity, gender expression, or sexual orientation as a strategy to facilitate the enjoyment of the right to health, including access to health care services.

VIII. Designation or establishment of national monitoring mechanisms in Ombudsperson’s offices to monitor implementation of the international and regional human rights instruments and recommendations from international human rights treaty bodies in health services and prisons, with a particular emphasis on young people’s sexual and reproductive health.
IX. PAHO, upon request of the Inter-American Commission on Human Rights, could provide the Commission with technical opinions on the sexual/reproductive health of young persons in the context of the Commission’s final reports or in the context of precautionary measures related to young persons living with HIV.

X. Utilize political windows of opportunity such as the introduction of the HPV vaccine amongst “Global Alliance for Vaccines and Immunization (GAVI)” countries, to develop successful integrated adolescent girls’ interventions.

XI. Utilize political windows of opportunities such as the placement of “integrated adolescent and youth health services” on the UN conference of Non Communicable Diseases (NCD) agenda to reinforce effort made through the PAHO/Norway initiative.

3. Human Resources Capacity Building

I. Ensure the sustainability of current Human Resources Capacity building efforts, and strengthen, using eHealth, the development of national and Regional undergraduate degrees in Adolescent Health.

4. Strengthening Health Systems and Services for Adolescent and Youth Health Promotion HIV prevention

I. Maintain and increase the coverage of adolescent and youth health services—especially in geographical areas with the worst health indicators.

II. Provide technical support for the establishment of successful health systems financing mechanisms, ensuring the sustainability of National Adolescent health programs.

III. Continue supporting countries to accelerate integration and decentralization of HIV programs and services from a health systems and primary health care perspective, in particular in light of the current global financial situation and the reduction of global resources earmarked for HIV.

IV. Guarantee non-discriminatory access to health care facilities (prevention and treatment) and services by the LGTBI community, especially young people.

5. Strengthening Regional, sub-regional and national capacity to generate and use Strategic Information

I. Even though the initiative has managed to anchor adolescent and youth health on the political and public agenda by supporting the collection of strategic information on the health and wellbeing of adolescent and youth in the Region, a continued effort is still needed to advocate for the strategic information to be disaggregated by social and health determinants. This disaggregation will support countries to start using an equity lens when developing plans and programs, thus more effectively reaching adolescents and youth living in vulnerable situations.
In order for countries to better develop and manage sustainable national adolescent and youth health programs, countries need to start administering National/Global School-based Health Surveys.

In order to ensure global standardization, information on policy and legislation should be collected using newly developed WHO tools.

6. Strengthen Strategic Alliances and Collaboration with Other Sectors

I. Collaborate with the World Bank on activities such as the implementation of a “Central American Adolescent SRH meeting”, which have expected results aligned with those of the PAHO/Norway initiative.

II. Collaborate with the Embassy of the Netherlands located in Honduras on activities such as the implementation of a “For youth by youth SRH meeting”, which have expected results aligned with those of the PAHO/Norway initiative.

III. Collaborate with the Member States of the Caribbean Community (CARICOM), the permanent mission of Chile to the United Nations, and UNFPA to implement a “Prevention of Non-Communicable Diseases in Adolescents and Youth” side event, during the 45th session of the UN ECOSOC Commission on Population and Development.

IV. Strengthen the newly established “Pan American Indigenous Youth Leader Network” using new Medias and technology.

V. Collaborate with the Inter-American Commission on Human Rights in the organization of capacity building activities on the human Rights of young persons in the context of their sexual and reproductive health involving International agencies, governmental officials, health personnel, ombudspersons, professional associations, judges, LGBTI organizations, students and journalists, among others.

VI. As part of its visits to countries, explore the possibility of joining the Inter-American Commission on Human Rights including visits to indigenous communities, general hospitals, prisons, health centers and other public institutions where there are young persons deprived of liberty or living with HIV.


I. Decentralize funding in order to maximize activity implementation, thus strengthening monitoring and evaluation and ensuring success at the country level.

II. It will be discussed whether it would be a better idea to instead of disbursing funding biannually to the countries, disburse smaller amounts of funding three times a year. This will hopefully increase motivation at the national level, ensuring a more rapid and regular activity implementation.
III. Take necessary steps to select consultants and agree on Terms of References, in order for the initiative midterm evaluation to be implemented in a timely manner.

IV. Improve initiative transparency, and encourage collaboration using eTechnology (facebook, blogs, twitter, PAHO website, etc).

V. Launch key documents developed through the PAHO/Norway initiative using new technology.

VI. Establish Norwegian Embassy focal point in order to ensure the reporting of PAHO/Norway activities.