

ADOLESCENT *and* YOUTH

Sexual Reproductive Health

OPPORTUNITIES, APPROACHES, AND CHOICES



**Pan American
Health
Organization**

Regional Office of the
World Health Organization



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Also published in Spanish with the title
La Salud Sexual y Reproductiva de los Adolescentes y los Jóvenes: Oportunidades, Enfoques y Opiniones

PAHO HQ Library Cataloging-in-Publication

Pan American Health Organization
Adolescent and Youth Sexual Reproductive Health: Opportunities, Approaches, and Choices
Washington, D.C.: PAHO © 2008

ISBN: 978-92-75-12935-7

I. Title

1. ADOLESCENT HEALTH
2. SEXUAL BEHAVIOR
3. REPRODUCTIVE HEALTH SERVICES
4. SEXUALLY TRANSMITTED DISEASES – epidemiology
5. HIV SEROPREVALENCE
6. ACQUIRED IMMUNODEFICIENCY SYNDROME – prevention & control
7. LATIN AMERICA

NLM WS-460

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Washington, D.C. 20037, USA

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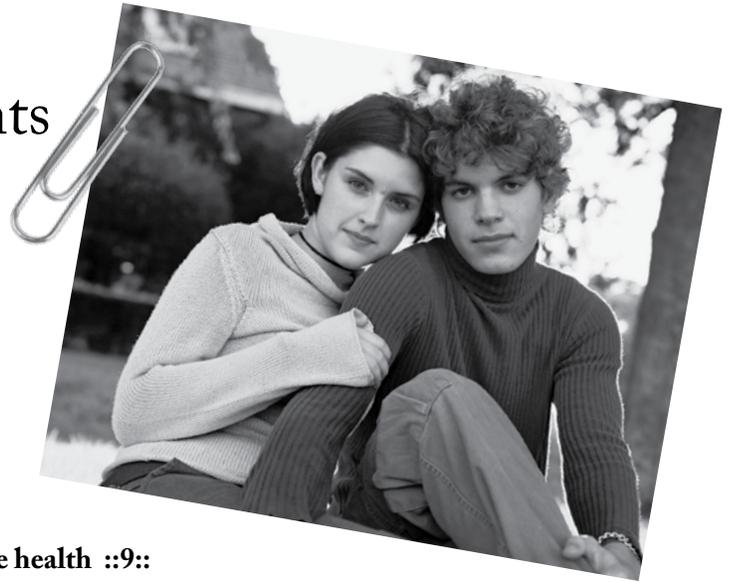
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Acronyms



AGI	Alan Guttmacher Institute
ASRH	Adolescent Sexual and Reproductive Health
CCS	Country Cooperation Strategy
CSO	Civil Society Organizations
DHS	Demographic Health Surveys
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GLBT	Gay, Lesbians, Bisexual and Transgender
HIV/AIDS	Human Immunodeficiency Virus/Autoimmune Immunodeficiency Syndrome
HPV	Human Papillomavirus
ICPD	International Conference on Population and Development
IDU	Injecting Drug Users
LAC	Latin America and Caribbean
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MSM	Men Who Have Sex With Men
OAS	Organization of American States
PAHO	Pan American Health Organization
PHC	Primary Health Care
PLWA	People Living With AIDS
PRSP	Poverty Reduction Strategy Papers
STI	Sexually Transmitted Infections
SWOT	Strength, Weakness, Opportunities, Threats Analysis
TFR	Total Fertility Rate
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Populations Fund
VCT	Voluntary Counseling and Testing

Introduction



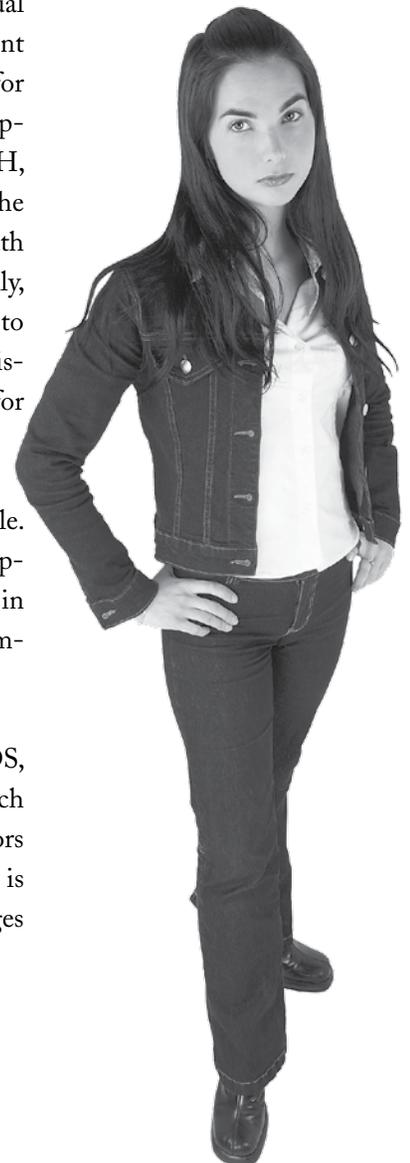
Adolescent sexual and reproductive health (ASRH) continues to be a pressing issue in Latin America and the Caribbean (LAC), with HIV/AIDS, unsafe abortions, complications during pregnancy, childbirth and the puerperium contributing to some of the main causes of mortality and morbidity for young people in the Region (1). Unplanned pregnancy, sexually transmitted infections (STI) and lack of access to contraception continues to have a negative impact on their wellbeing. The development of young peoples' health is often worsened by the fact that ASRH is seldom a political or financial priority for politicians and governments. A combination of lack of equal access to quality health services, insufficient sexual education programs and health services that are not convenient for youth to use continue the cycle of poor sexual and reproductive health for most at-risk populations (1,2).

The main object of this report is to propose entry points for promoting adolescent sexual reproductive health (ASRH) in Latin America and the Caribbean (LAC).

The main object of this report is to propose entry points for promoting adolescent sexual reproductive health (ASRH) in Latin America and the Caribbean (LAC). The document starts with a discussion of indicators to measure ASRH. It then suggests a framework for identifying possible entry points for interventions to improve ASRH. It proposes four approaches to be pursued in a coordinated and systematically manner for promoting ASRH, and then goes on to highlight the seven lines of action that are included as part of the Pan American Health Organization's Regional Strategy for Improving Adolescent Health 2008-2018, which was passed on October 1, 2008, by the 48th Directing Council. Finally, it discusses other issues to be considered when promoting ASRH. It does not claim to provide all the answers; rather, it is hoped that this document will provide thought for discussion that will lead to approaches that result in improved sexual reproductive health for young people in the Region.

Difficulties arise in measuring ASRH as indicators for healthy sexuality are not available. Due to problems of attribution, conventional indicators used for assessing ASRH are population-based and are of limited use when determining whether we have been successful in promoting ASRH in LAC. Other indicators are available but they are also often "problem-focused" instead of measuring healthy behaviors.

ASRH is influenced by several factors, such as gender roles, health inequalities, HIV/AIDS, non-communicable diseases, sustainable health and health systems. Because work in each of these areas impacts ASRH, collaboration across different units, institutions and sectors is required. A conceptual framework that suggests various entry points for interventions is therefore proposed; it considers the individual, social and structural factors and the linkages among them that influence ASRH.





Four approaches for promoting ASRH are recommended. While activities relating to some of these approaches have been carried out earlier, it is recommended here that they be systematically carried out together. The four approaches are:

- ◆ Focus on reaching poor and vulnerable young people
- ◆ Strengthen capacity at country level
- ◆ Strengthen operationalization of the Paris Agreement at country level
- ◆ Address underlying factors

Finally, the document draws on the seven lines of action from PAHO's Regional Strategy for Improving Adolescent Health. The strategy is assembled with information, evidence and knowledge, and rests on the following pillars: primary health care, health promotion, social protection and the social determinants of health. It calls for an integration of approaches, programs and services to tackle health issues of concern and through this integrated approach, ensure a better ASRH outcome.

Background



Young people are a sizable age group, comprising 30% of the population in Latin America and the Caribbean;¹ earlier sexual maturity, later marriages and increased emphasis on education have contributed to the acceptance of adolescence as a distinct phase in life (3). Adolescents are generally perceived to be a relatively “healthy” segment of the population and their health needs are often overlooked. Nevertheless, because young people are central to the HIV/AIDS pandemic, adolescent sexual reproductive health deserves careful attention. Many behaviors developed during the adolescent period can have long-lasting effects into adulthood. Early parenthood, sexually transmitted infections (STI), health-seeking behavior, violence and risk behavior need to be addressed in order to improve ASRH.

¹ Young people are defined from age 10 to 24 years old, youth from age 15 to 24 years old and adolescents 10 to 19 years old.

AIDS is already one of the five leading causes of death for young people in the Caribbean, with approximately 1.6% of 15-24 year-olds infected with HIV. In Latin America, prevalence is 0.3% (1). Additionally, one in 20 young people in the Region is infected with an STI (1).

Unplanned pregnancy continues to be a problem in the Region, as 25% of young women in LAC are mothers before they are 20 years old and 45% of these pregnancies are the result of misuse or lack of contraceptives (2). A study in 2008 found that this could be attributed to a lack of policies related to sexual and reproductive health education that efficiently respond to the increasingly lower age of adolescents' first sexual experience (2). For example, 50% of young women in some countries of Central America have engaged in sexual intercourse by the age of 15 (1). Nearly 90% of youth in LAC have reported familiarity with at least one method of contraception, but between 48% and 53% of sexually active youth never used contraception. Among those who had used a contraceptive method, approximately 40% did not use contraception regularly (4). This shows that increased access to quality health services in a combination with improved sexual education would prevent both STI/HIV and unplanned pregnancies, which in turn points to a high level of unmet need for safe contraception (5).

50% of young women in some countries of Central America have engaged in sexual intercourse by the age of 15.

It should also be noted that female adolescents in rural areas are more likely to become pregnant at an early age than those in urban areas, as are those who are in the lowest socioeconomic level compared to the highest (5). These young mothers are generally poor, without social support networks and have little education, thus continuing the vicious inter-generational cycle of poverty.

Besides the social ills early and unplanned pregnancy causes, there can be negative biomed-



ical effects as well. Obstetric conditions were the most common cause of hospitalization for women in the Region in 2007 (1). Also, women below the age of 24 accounted for 45% of the estimated deaths due to unsafe abortions in 2003 (1).

Cultural and social gender norms often restrict adolescent girls' access to basic information and knowledge and prescribe an unequal and passive role in sexual decision making. This undermines their autonomy and exposes many of them to sexual coercion and abusive relationships; for example, violence against young women or the threat of violence often increases their vulnerability. Also, traditional expectations related to masculinity are often associated with behaviors that increase the risk of HIV/ITS infections among young boys. Significant advances in gender equity are required to improve young people's sexual and reproductive health, such as empowering adolescent girls and increasing sensitization of adolescent boys (1).

Since the International Conference of Population and Development (ICPD) held in Cairo 1994, 179 countries have agreed to the Program of Action, which reiterates the need for improved ASRH, especially to prevent the transmission of STIs and HIV, with a focus on those between the ages of 15 and 24 years (6).

The importance of a holistic approach to sexual health to these issues was also recognized in 2000 with the Pan American Health Organization's (PAHO) consultation in Guatemala and the resulting publication, *Promotion of sexual health: recommendations for action* (7). A human development perspective was an integral part of the ASRH framework that was developed in 2003 and is articulated in *Sexual health and development of adolescent and youth in the Americas: program and policy implications* (8). This was further elaborated in the PAHO publication, *Youth: choices and changes*, which provides a comprehensive review of theoretical frameworks for health promotion and adolescent development (9).

Traditional expectations related to masculinity are often associated with behaviors that increase the risk of HIV/ITS infections among young boys.



Indicators for Adolescent Sexual and Reproductive Health



The document *Sexual health and development of adolescents and youth in the Americas: program and policy implications* presents a conceptual framework that moves from problem prevention, e.g. early pregnancy or STI/HIV prevention, to a wider perspective that includes issues of gender, sexuality, and cognitive & psychosexual development within an overall socio/cultural/institutional context (8). Unfortunately, although the document refers to positive aspects of healthy sexuality, Box 2 (p. 23) of this publication, “Model characteristics of Sexually-Healthy Adolescents,” does not provide indicators that would help measure the change in focus toward a more positive framework of ASRH.

Because little data on young people is collected systematically across countries, general sexual reproductive health data must be used.

We are left to measure progress with impact indicators that are usually problem-focused; e.g. early childbearing, STI, maternal mortality, contraceptive use, knowledge (or lack thereof) of HIV/AIDS and risk behavior. Concern has been expressed that there has been little progress in these indicators among young people in the Region.

The first step is to assess the adolescent sexual and reproductive health situation in Latin America and the Caribbean. Because little data on young people is collected systematically across countries, general sexual reproductive health data must be used.

Eleven countries have been selected to give an overview of the Region. Four countries were selected because of their large population size. Together Brazil, Mexico, Argentina and Colombia make up 67% of the population in LAC. Five countries were selected because they have been designated as priority countries for PAHO’s work². Together they contribute slightly less than 6% of the population in LAC. Jamaica is included because it is a Caribbean country with high HIV prevalence and Guatemala because of the continued interest in it by development partners.

² PAHO priority countries are Bolivia, Guyana, Haiti, Honduras and Nicaragua.

Table 1 below shows that the maternal mortality ratio (MMR) has improved in six countries and deteriorated in four countries. Comparison data with 1990 is not available in Guyana. The total fertility rate (TFR) has declined in all countries. The age specific fertility rate for young women age 15–20 has decreased in all countries except Brazil.

According to this information, it does not appear that childbearing among young people has remained unimproved over the past 15 years, but that some progress has been made. However, recent analyses from the Alan Guttmacher Institute (AGI) indicates that childbearing among teenagers 15–19 in Honduras, Nicaragua and Guatemala is higher than indicated in the data below (5; 10–11).³

³ Honduras (137 births per 1000 15–19 year olds), Nicaragua (119), Guatemala (114).

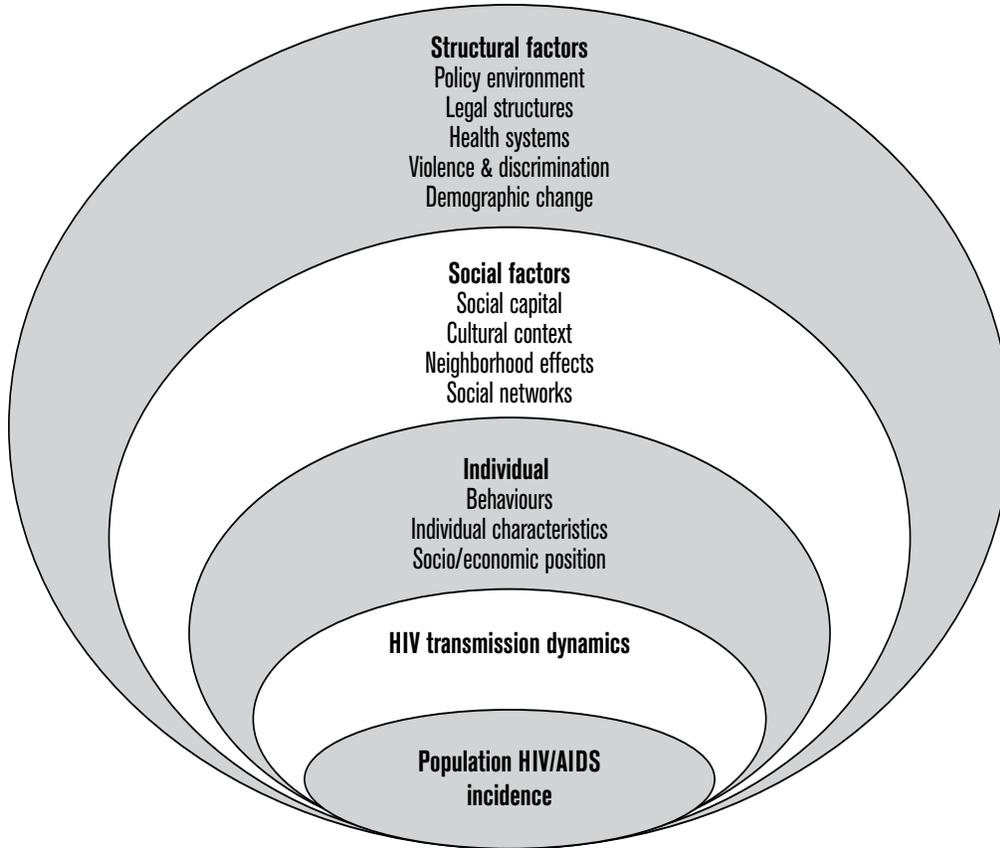
MMR, TFR and age-specific fertility rates are all population-based impact indicators that result from many different factors. It is important to remember that improvement with such indicators requires long-term commitment of efforts. Moreover, many of the factors impacting these results are outside the health sector's usual sphere of influence. When or if there are changes, it is difficult to identify just which factor or combination of factors led to the change (10).

TABLE 1. Sexual reproductive health indicators in selected countries, 1990 and most recent information

	MMR: deaths per 100 000 live births		Age-specific fertility rate Women 15-20		Total fertility rate Women 15-49	
	1990	Most recent	1990	Most recent	1990	Most recent
Argentina	100	82	73	59	3,0	2,6
Mexico	110	83	83	67	3,5	2,8
Brazil	220	260	82	90	2,9	2,6
Colombia	100	130	91	77	3,1	2,8
Bolivia	650	420	89	81	4,9	4,2
Guyana	NA	170	92	62	2,6	2,4
Haiti	1.000	680	84	61	5,4	4,5
Honduras	220	110	131	98	5,1	4,2
Nicaragua	160	230	163	119	4,9	3,9
Guatemala	200	240	130	111	5,6	4,9
Jamaica	120	87	108	78	3,0	2,6

Source: UNFPA, *Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005* (17)

Figure 1. A social epidemiology framework for identifying interventions to enhance ASRH (13. Used with permission).



Source: Poundstone KE, Strathdee SA, Celentano DD. *The social epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome*. *Epidemiol Rev* 2004; 26: 22–35





Maternal mortality ratios, total fertility rates and age-specific fertility rates are all population-based impact indicators that result from many different factors

Conceptual Framework for Identifying Interventions for Adolescent Sexual and Reproductive Health



The three documents referred to above with their suggested program interventions point to individual developmental factors and influences in the social/environmental context that impact ASRH and development. Consistent with the conceptual frameworks in these documents is a social epidemiology framework developed by Poundstone *et al* applied to understanding HIV incidence. Here the factors are grouped into different levels: (See Fig. 1) (13).

- ◆ *Individual factors* including behaviors, individual characteristics, and socioeconomic position.
- ◆ *Social factors* including social capital, cultural context, neighborhood effects, and social networks.
- ◆ *Structural factors* including war and militarization, demographic change, structural violence and discrimination, legal structures, and policy environment.

A suggested modification to this framework is to include health systems among the structural influences. This should include not only health service availability but also whether they are relevant to the identified health needs, provided in a manner that is acceptable to users, and accessible geographically and financially.

This framework could also be applied to other key ASRH problems, such as early child-bearing, maternal mortality, non-consensual sexual activity or unsafe abortion. The levels are “porous” and there are linkages between and among the different factors. In order to identify entry points for interventions for a specific health problem, it is important to identify the relevant key factors and to discern the linkages among them. Table 2 gives examples of individual, social and structural factors that can be addressed or enhanced when improving ASRH.

In order to identify entry points for interventions for a specific health problem, it is important to identify the relevant key factors and to discern the linkages among them.



Table 2. Individual, social and structural factors and implications for interventions

Levels of Factors	Implications for Interventions
Individual: characteristics (age, gender, ethnicity, marital status), behavior, socioeconomic	Focus on identifying vulnerable individuals with a view to reducing their vulnerability; ensuring access to information and services; and effecting behavior change.
Social: social networks, cultural context, social capital	Focus on addressing the social determinants of the patterns that lead to the ASRH problem, promoting cultural norms that promote healthy outcomes, capturing social capital which enhances healthy outcomes in social groups.
Structural: policy environment, legal systems, structural violence & discrimination, demographic changes	Focus on enhancing the policy environment, strengthening human rights, strengthening health system, reducing discrimination & violence.

Box 1 illustrates the example of maternal mortality and identifies some individual, social and structural factors. These can suggest some entry points for addressing maternal mortality among young people.

Box 1. Factors related to maternal mortality

Social Epidemiology of Maternal Mortality

Individual factors

- ◆ Individual characteristics: age, gender, residence, poverty status, ethnicity, education, marital status
- ◆ Behaviour: limited contraceptive use, exposure to unsafe abortion, non-attendance for antenatal care, not obtaining skilled attendance at birth.

Social factors

- ◆ Cultural context: early marriage, reticence to obtain contraceptive information or make use of health services, language and cultural barriers, gender roles
- ◆ Social networks: role of partners and other family members
- ◆ Social capital: community recognition of signs of complications of delivery, community support for accessing referral care
- ◆ Neighbourhood effects: non-parenting opportunities, e.g. employment, education.

Structural factors

- ◆ Policy environment: parental notification affecting adolescent access to contraception; safe abortion; maternity social protection policies
- ◆ Health systems: unmet contraceptive need, availability of information and services; skilled attendance at delivery, availability of referral level care; payment mechanisms for services; acceptability (quality) of services to diverse groups e.g. based on age, gender, ethnicity; access to comprehensive post-abortion care
- ◆ Legal structure: protection against early marriage; protection against sexual coercion both within and outside marriage; obstacles for young people to access contraceptives.

Approaches for Moving Forward

Main approaches

Four main approaches are suggested to promote ASRH in LAC:

- ◆ Focus on reaching poor and vulnerable young people
- ◆ Strengthen capacity at country level
- ◆ Strengthen the operationalization of the Paris Agreement at country level
- ◆ Address underlying factors

What is suggested here is an effort where these approaches are coordinated and systematically pursued together, i.e. directing efforts toward identified poor populations around social or structural factors together with other United Nations (UN) agencies and building capacity at country level to enable them to better carry out the activities.

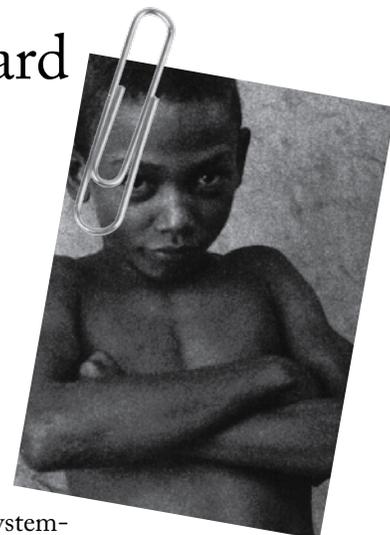
Approach 1: Focus on reaching poor and vulnerable young people

There are different ways of defining poor people and vulnerable groups. Directing attention to poor young people can mean out-of-school youth, street children, migrant laborers, minority ethnic groups, unemployed youth and/or those in the informal economy, as well as groups most at risk, (MSM, IDU [Injecting Drug Users] GLBT, etc.) to HIV. These are generally people with little “voice” who are often overlooked.

When focusing on poor people, attention is often drawn to the countries identified as priority countries for PAHO’s work. Together they comprise 30 million people, which is 5.8% of the population of LAC.

However, with an estimated population of 568 million in LAC, it is important to also address the large populations found in Brazil (pop. 188 mil), Mexico (pop.108 mil), Colombia (pop.46 mil) and Argentina (pop.39 mil) (14). Together these countries make up more than two-thirds of the population of in the Region. While the proportion of people in these countries living under the poverty line as a whole is less than in PAHO priority countries, they nevertheless amount to large numbers of people - often exceeding in number the total population of many countries in the Region.

Moreover, disparities exist between the wealthy and poor people in these larger middle income countries and are often substantial. Table 3 shows selected sexual reproductive health outcomes in the 11 countries. It can be seen that there are considerable differences among provinces, between rural and urban communities, and between women in the wealthiest and poorest households. Efforts should be made to target poor and rural populations, as they are often the same.



The main object of this report is to propose entry points for promoting adolescent sexual reproductive health in Latin America and the Caribbean.

While recent reports may not be available for each country, the methodology is so widely disseminated that it can be applied by others to available DHS data.

The analysis of household assets by quintile based on Demographic Health Surveys (DHS) data is a well-established methodology, made widely known by the World Bank. Country reports are available for nine countries in LAC (15). While recent reports may not be available for each country, the methodology is so widely disseminated that it can be applied by others to available DHS data.

Efforts directed to poor people in each country would have the greatest impact on the population-based impact indicators. It is important to identify poor people in the large low and upper middle-income countries. The tables show that many countries can identify specific provinces with the poorest outcomes. It is recognized that reaching “the poorest of the poor” can be challenging and that barriers may exist that are exceedingly difficult to overcome. However, this should not divert commitment to reaching poor people, as they are also often the ones with the highest health needs. Efforts can be directed to reaching the second lowest asset quintile, as these interventions sometimes also reach the bottom quintile.

Table 3. Disparities in SRH outcomes in selected countries of LAC, 2005

	Urban population (%)	Age specific fertility rate 15–19 yrs				Adolescent women 15-19 begun childbearing %		Deliveries attended by skilled attendants % Women 15-49					
		Urban/rural		Poorest/richest quintile		Urban/rural		Urban/rural		Poorest/richest quintile		Provincial low/high	
Argentina	91	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na
Mexico	76	62	95	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na
Brazil	84	78	122	176	28	17	24	98	94	72	99	95	98
Colombia	77	71	134	180	24	17	26	94	70	64	99	78	98
Bolivia	64	68	124	168	27	13	22	78	39	20	98	43	84
Guyana	39	Na	Na	Na	Na	Na	Na	100	80	Na	Na	22	100
Haiti	39	61	100	105	25	13	23	52	11	4	70	10	57
Honduras	46	114	162	Na	Na	Na	Na	83	38	Na	Na	35	90
Nicaragua	58	99	153	213	58	21	30	89	46	78	99	35	94
Guatemala	47	85	133	203	54	34	42	66	30	9	92	19	71
Jamaica	52	114	133	Na	Na	Na	Na	95	94	Na	Na	94	96

NA = Not available

Source: UNFPA, *Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005* (17).

Approach 2: Strengthen capacity at country level

Capacity building is recommended towards the following professional groups:

2.a Professional group within PAHO country offices

Capacity and commitment are required at country level in order to promote ASRH.

- ◆ A systematic approach is recommended, which would:

- ascertain whether and how ASRH is included in the Country Cooperation Strategy (CCS);
- assess the degree of commitment to ASRH in country offices in terms of budget, human resources, and activity levels;
- survey capacity needs of the ASRH focal points and
- review management processes that improve performance around ASRH.

◆ A common core competence defined

ASRH focal points often vary in terms of their backgrounds, commitment to ASRH issues and extent to which they have other competing areas of work. Moreover, they work in very different country contexts with dissimilar health systems, stakeholders and issues. It is however, suggested that steps should be taken to ensure that all ASRH focal points have core competence in:

- ASRH issues, including HIV/AIDS;
- how to get ASRH issues on the national agenda, e.g. how to identify key stakeholders, work with partners, make use of media, strategically make use of technical advice for advocacy purposes and learn from each other;
- human rights and gender approach to ASRH to ensure that the human rights of young people are not left unprotected in national policies and/or practice;
- how to make use of the global health initiatives, e.g. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to promote ASRH.

2.b Professional group within national authorities

◆ Strengthen national authorities' ability to advocate for health

National authorities need to increase their ability to advocate for health in a competitive environment, to use human rights instruments to protect the health of their population and to protect and strengthen their health systems in the face of global health initiatives.

The five priority countries and two others in LAC have Poverty Reduction Strategy Papers (PRSP). ASRH will be given more attention by national authorities if the needs and contributions of young people are given adequate attention in their country's PRSP. Youth aged 15–24 make up between 19–35% of the population in PAHO priority countries, yet appear to be mentioned in only one PRSP (Nicaragua) and receive only minor focus in its action plan (16). Including the health sector in a country PRSP would strengthen the possibilities of promoting ASRH.

While young people are generally overlooked by national authorities, a growing concern in many countries is the increasing level of random street violence. This could be the entry point by which to engage the attention of national authorities to the developmental needs of young people.

We suggest working actively with national authorities when planning for a DH.

◆ Assist national authorities to obtain relevant information about ASRH

The Demographic Health Survey can provide a wealth of information on a range of reproductive health issues on a regular basis. Since they were first started in 1984, these surveys have been carried out in 15 countries of LAC. Compared to other regions, surprisingly few countries in LAC have ever carried out a DHS.

We suggest working actively with national authorities when planning for a DHS. Issues that are decided by each country are the:

- modules to be included in the survey, e.g. information on contraceptive use, attended deliveries, comprehensive knowledge of HIV/AIDS, attitudes toward domestic violence, women's decision-making in the household;
- information about the respondents, e.g. residence in regional areas, age (segmented into five-year age groups) and household asset status;
- availability of the data after it is collected and
- dissemination of the results.

Table 4. HIV knowledge and prevalence among adolescents in selected countries of LAC, 2005

	Estimated HIV prevalence 15-49	Estimated HIV prevalence 15 - 24	% women 15-24 who know a person can protect herself from HIV by consistent condom use	% men 15-24 who know a person can protect himself from HIV by consistent condom use	% women 15-24 who know that a healthy-looking person can transmit HIV
Argentina	0.7	0.6	NA	NA	NA
Mexico*	0.3	0.2	NA	NA	NA
Brazil*	0.7	0.6	NA	NA	79
Colombia*	0.7	0.5	67	NA	83
Bolivia*	0.1	0.1	56	NA	64
Guyana*	2.5	3.6	69	NA	84
Haiti*	5.6	4.5	46	72	68
Honduras*	1.8	1.4	35	NA	81
Nicaragua*	0.2	0.2	NA	NA	73
Guatemala*	1.1	0.9	NA	NA	NA
Jamaica	1.2	0.8	NA	NA	NA

NA = Not available

Source: UNFPA, *Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2005 (17)*

*DHS surveys carried out

Data can sometimes reveal results that governments may not wish to disseminate widely. For this reason, it is important to ensure that data collected will be readily available to research groups who wish to conduct further analyses, e.g. of poverty status or geographical

differences. Similarly, it is important that DHS results are disseminated in a manner so that potential users can easily understand the results. These are issues to be decided in the planning stages.

Table 4 shows available information about HIV knowledge in the 11 countries looked at earlier. Nine have conducted at least one DHS. The information in the three columns on the right relating to HIV knowledge is standard for one of the DHS modules. As can be seen, this information is missing in many cases, despite the substantial HIV prevalence in a number of these countries. This is an example of how we could actively engage with national authorities in determining the content of the DHS.

2.c Professionals in civil society organizations

Civil society organizations (CSO) provide opportunities that ministries of health cannot provide. Most notably, CSO often represent special interest groups and can actively advocate for specific issues. CSOs made up of young people usually have a better understanding of their situation, can often come up with practical, feasible solutions to their problems and can tap into resources which are only available to them.

Some CSOs lack experience in working within “the system.” Capacity building would improve their possibility for effective advocacy. This means strengthening their ability to understand official documents and produce documents that will be used by national authorities; increasing their confidence to speak out in the public arena; improving their financial literacy and increasing their knowledge base about ASRH so that they can speak out with authority.

Approach 3: Strengthen operationalization of the Paris Agreement at country level⁴

Coordination and collaboration of United Nations (UN) agencies is part of the UN reform. Honduras has been given as an example of good inter-agency collaboration in the area of Adolescent health and SRH. It has not been possible to find out more about the critical components that facilitated this example of good practice. However, the main question should be: can this be replicated?

Because ASRH obviously has much in common with the work of different UN agencies in terms of their shared concern over adolescents, sexual reproductive health and human rights, it is suggested that a situation analysis is conducted of how PAHO and UN agencies work at country level. Questions to be asked are:

- What does improved collaboration mean in operational terms at country level?
- What has been done to systematically encourage country offices to work with other UN agencies and to actively participate in the United Nations Development Assistance Framework (UNDAF) process?

⁴ The Paris Declaration on aid effectiveness, ownership, harmonization, alignment, results and mutual accountability, 2005, can be accessed at <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

- Which theme groups do the PAHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP) and other offices lead?
- How many joint programs have been submitted to donors for support?

Approach 4: Identify underlying factors contributing to Adolescent Sexual Reproductive Health outcomes

By directing attention to poor and vulnerable young people and working more closely with other UN agencies, the focus for interventions can arise after identifying social and structural factors related to ASRH. Additional capacity building efforts beyond those discussed above can be tailored to the identified interventions.

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The unequal distribution of damaging health experiences is in no sense a natural phenomenon; together the structural determinants and conditions of daily life constitute the social determinants of health (18).

Gender inequity, which is pervasive in all societies, is one such example of a structural determinant. Gender biases in access to resources and power, as well as cultural norms, contribute to the ill health of adolescent women and men. Gender inequity influences health in various manners: discriminatory feeding patterns, violence against women, inability to negotiate sex, lack of decision-making power and unfair division of work, leisure and possibilities of improving one's life. Maternal mortality and morbidity remain high in many countries and reproductive health services remain hugely unequally distributed within and between countries.

One of the main conclusions from the World Health Organization (WHO) Commission on Social determinants on Health was to urgently address these root problems and increase investments in sexual and reproductive health services and programs, with the end goal of universal coverage and rights (18).

As such, there are many opportunities for working on the previously mentioned underlying factors. Three inter-related areas are highlighted here:

4.a A human rights approach

A human rights approach for promoting ASRH is a critical area for attention. The Convention on the Elimination of Discrimination Against Women and the Convention of the Rights of Children have been signed by the majority of countries in the region.

Most countries in the Region have also adopted the following instruments of the Inter-American System for the Protection of Human Rights (1):

- American Declaration of the Rights and Duties of Man
- American Convention on Human Rights
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, or Protocol of San Salvador
- Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention “Belém do Pará”)

Efforts to improve *human rights literacy* are needed to familiarize country staff, national health personnel, UN organizations, civil society and others with the different conventions and protocols, their relevance to health (especially Millennium Development Goals [MDG] 3, 4, 5 and 6), standards, mechanisms for accountability and mechanisms for reporting non-compliance. ASRH issues are:

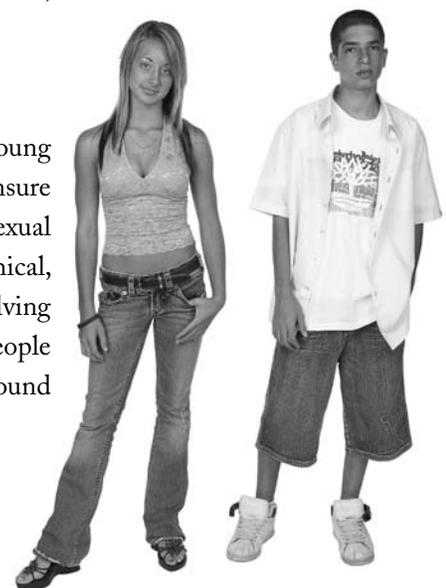
- discrimination against young people (because of their age) in access to information and services;
- discrimination against marginalized groups (e.g. out-of-school youth, street children, commercial sex workers, migrant workers) in access to services and/or information, often due to their lack of connection with established communities;
- stigma & discrimination, which blocks access to services for people living with AIDS (PLWA), men who have sex with men (MSM), injecting drug users (IDU);
- non-consensual sex for married and unmarried young women;
- non-consensual sex for young males;
- unsafe abortion and
- maternal mortality.

Discourse around reproductive rights from the early 1990s clearly draws links between women’s health and specific human rights found in internationally agreed declarations, covenants, and conventions (19).

4.b Services for young people/primary health care (PHC)

Work with health care authorities and NGOs to improve the quality of services for young people is needed. PAHO/WHO has developed a set of tools and protocols that ensure that the quality of the services is satisfactory. Young people have many and diverse sexual reproductive health needs. Along with gender roles and norms, significant geographical, economic, social and educational differences exist, which are in addition to the evolving capabilities of young people characteristic of their age. Large numbers of young people may be disconnected from their families and communities and many youth are also found

Gender biases in access to resources and power, as well as cultural norms, contribute to the ill health of adolescent women and men.



among groups of the vulnerable and marginalized, e.g. homeless people, commercial sex workers, MSM and injecting drug users.

An often over-looked fact is that many adolescents, especially females, are in long-term unions and are often mothers. It appears that in the larger countries, approximately one-quarter of women aged 15–19 years have begun childbearing; in some priority countries, levels are higher. Attention should be given to these young women, who often live in rural areas and whose networks of support or (lack thereof) are different from a young urban teenager.

STI information, diagnosis and treatment services for young men are often missing among conventional SRH services that emphasize maternal child health and family planning services oriented toward women. Services addressing young men's health should also be established within the norms and protocols of primary health care.

The following areas and dimensions should be considered for providing quality health care services:

- *Efficiency* - Services that provide health care in a manner that optimizes resources and avoids wasting them.
- *Accessibility* - Health care services that take into consideration geographical location and financial constraints, and are in an environment that has medical personnel and resources available.
- *Acceptability/patient-centered care* – services that take into consideration the preferences and wishes of each user and each culture in the community.
- *Equality* – Services that provide health care where the quality does not vary depending on personal characteristics, like gender, race, ethnic group, geographical location or socioeconomic status.
- *Safety* – Services that reduce the chance of risk and dangers in caring for the users.

4.c Gender imbalances

Gender-based attitudes and behavior are powerful social institutions that influence attitudes toward sex and the way people talk about it, sexuality, risk-taking behavior and gender roles. These distinctions place males and females at risk for different reasons. Gender-based institutions go beyond sexual relations. Due to age and gender-based imbalances of power, young people often do not have access to financial resources, are not protected from domestic violence and are unable to make decisions regarding their reproductive health.

Generally, knowledge about HIV/AIDS prevention is higher among men than women and among people who are economically better off. Women have been found to encounter greater difficulty accessing information, care and treatment due to poverty, discrimination,



lack of mobility and stigma. Gender-based power imbalances, especially at the household level, are significant obstacles to ASRH.

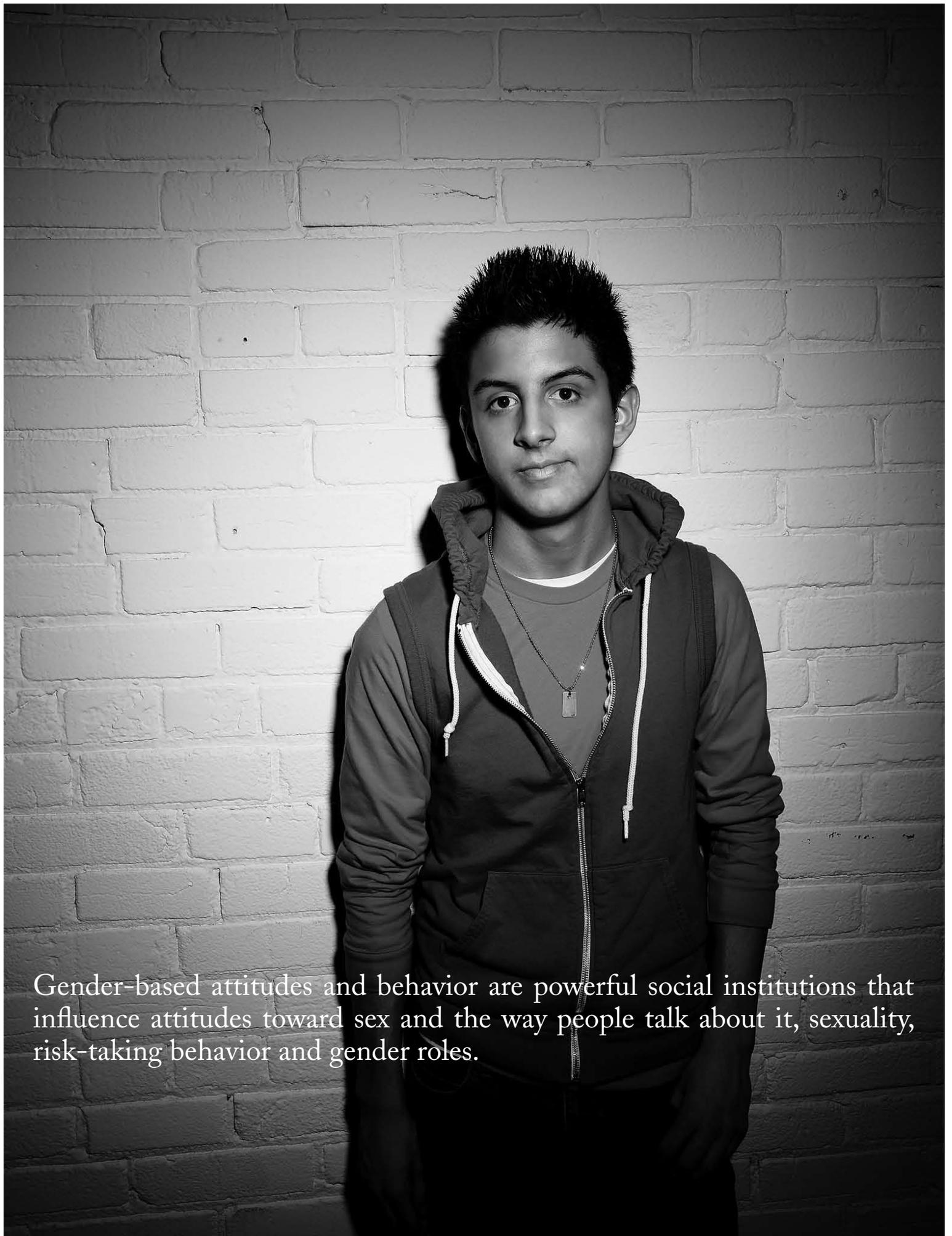
Gender-based violence, including violence between intimate partners, is a factor in the spread of HIV. A small number of small-scale studies have found that males are also victims of coercive sexual activity but prevailing gender norms make it very difficult for them to discuss non-consensual sexual activity. Armed conflict is associated with higher HIV prevalence, but patterns of transmission differ between males and females.

Gender-based violence, including violence between intimate partners, is a factor in the spread of HIV

In order to improve ASRH, young people themselves must be able to:

- recognize when they need to seek out services,
- know where services can be found,
- use services when needed and
- carry out the advice of health professions to protect their own health.





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Other Entry Points



Six other areas provide entry points for promoting ASRH. They are presented separately here because discussion of them in the main framework of this document would have diverted attention from the overall thrust of the earlier recommendations.

1. Gather information on unsafe abortion

One of the key factors contributing to maternal mortality among young people is unsafe abortion. In 2005, it was estimated that 15–19 year-olds accounted for 14% of the Region's unsafe abortions, while 20–24 year-old women accounted for 29% of the total unsafe abortion (20). One can often get a sense of the magnitude of the problem in each country by looking at hospital admissions related to incomplete abortions. Local universities are good resources for carrying out this type of small research project. Consideration should be given to collaboration with NGO's, such as Ipas, an international organization with a presence in Bolivia, Brazil, El Salvador, Mexico and Nicaragua that works for women's reproductive rights to combat abortion-related deaths.

2. Link with alcohol abuse

There is substantial evidence of the links between sexual risk behavior and alcohol use; this is especially apparent among young people. Alcohol use leads to a dangerous combination of loss of self control and a diminished ability to comprehend risky situations on the part of the drinker (21). Data on young people (in segmented 5-year categories and by gender) should be collected.

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3. Consider more mass media activities

Levels of illiteracy among young people still remain high in some countries, e.g. Haiti (32% males 15–24), Nicaragua (28% males 15–24), Honduras (14% males 15–24), Jamaica (8% males 15–24) and Brazil (5% males 15–24) (17)⁵. Mass media activities should be supported as this is an excellent way to reach out-of-school young people. Music is a key mode of communication and comics, soap operas, helplines and agony aunt columns can also be an opportunity to reach young people with limited formal education.

⁵ <http://www.unfpa.org/worldwide/indicator>

4. Increase staff ability to comfortably talk about sexuality

Are staff comfortable talking about adolescent or adult sexuality? Activities for staff might help to increase comfort zone with ASRH. Possibilities include:

- an informational meeting for parents on the human papillomavirus (HPV) vaccine
- an interactive course for parents on how to talk to their children/adolescents about sex and relational issues
- an interactive course for parents on substance abuse among young people
- staff development around the issue of PLWA.

5. HPV roll-out

The HPV roll-out provides an excellent opportunity to get ASRH issues on the table, particularly in relation to appropriate, acceptable and accessible information and services for young people. It is also an opportunity to encourage autonomous decision-making and discuss issues related to sexuality.

6. Scaling-up successful projects

There is always a desire to take successful interventions/projects to scale. So many project evaluations focus on measuring outputs or looking at whether project objectives have been achieved. This does not easily lead to identifying what it was that made the project a success. There is a need to identify the social capital factors critical to project success and determine how these can be replicated and scaled up.

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Recommendations



In September of 2008, the 48th Directing Council of PAHO approved Resolution CE 142.R18, which endorsed the Regional Strategy for Improving Adolescent and Youth Health (1). This strategy calls for member states to effectively and efficiently respond to current and emerging needs in adolescent and youth health with specific consideration to prevailing inequalities in health status, as well as to strengthen the health system response to develop and implement policies, plans, programs, laws and services for adolescents and young people.

The strategy is assembled with information, evidence and knowledge, and rests on the following pillars: primary health care, health promotion, social protection and the social determinants of health. The strategy calls for an integration of approaches, programs and services to tackle health issues of concern and ensure better outcomes. Gender, culture and youth are crosscutting perspectives.

Gender, culture and youth are crosscutting perspectives.

This strategy proposes seven lines of action and promotes their systematic and simultaneous integration to address the primary causes of mortality and morbidity and fundamental adolescent and youth health issues: strategic information and innovation; enabling environments and evidence-based policies; integrated and comprehensive health systems and services; human resource capacity building; family, community and school-based interventions; strategic alliances and collaboration with other sectors; and social communication and media involvement.

A high level of political support for ASRH currently exists, as can be seen by the ministers of health and education in 37 countries in LAC meeting in Mexico to state in a declaration the importance of promoting sexual health and the provision of comprehensive sexual education in the education system (22). At this meeting, which was held in August of 2008 before the XVII International AIDS Conference in Mexico City, these ministers pledged to implement programs to promote sex education and reproductive health. They also committed to including comprehensive sexual education in their schools' curricula as a means of preventing unwanted teenage pregnancy and the transmission of HIV/AIDS and STIs (23).

Based on these two landmark resolutions and on lessons learned on this topic, as well as the research and information presented in this document, we put forth the following recommendations:

An essential component of tracking progress for ASRH is the availability of good data.

1. Improving strategic information and monitoring

An essential component of tracking progress for ASRH is the availability of good data. We propose strengthening the capacity of the countries to generate quality health information on adolescent and youth sexual reproductive health and their social determinants, disaggregating information by age, sex, ethnicity and socioeconomic level.

The collection, analysis and dissemination of appropriate information will provide essential tools to establish priorities and guide the national action plan and programs, including the development of policies, planning and evaluation of programs.

This strategic line of action proposes action to:

- a) Reach consensus on a list of basic indicators, including those related to SRH, that allow for the identification of gaps and inequities in adolescent and youth health. These indicators will be used for the development of a virtual platform with regional data, disaggregated by age (data reported in age groups 10-14, 15-19, 20-24), sex, ethnicity and income. The platform could form a regional observatory on adolescent and youth health, including ASRH.
- b) Support the countries to build capacity to: strengthen their national health information systems, develop an Adolescent Health Information System (AIS) that incorporates ASRH and to monitor and evaluate the quality, coverage and cost of national adolescent and youth health programs, health services and other interventions, and to align efforts with PAHO and other global work in progress in the topic.
- c) Promote the analysis, synthesis and dissemination of integrated information from different sources on the state of ASRH and social determinants at the national and regional levels so that national collaborators can easily see regional age and gender differences. Likewise, a timely report back system should be established. Data quality improves when those providing data (e.g. provinces, districts, units) receive information that allows them to compare their results with others.
- d) Support regional and national research on the impact of new and innovative methods to improve ASRH and to disseminate effective interventions and best practices.



2. Enabling environments and evidence-based policies

We recommend promoting and securing the development of enabling environments and the implementation of effective, comprehensive, sustainable and evidence-based policies on ASRH by:

- a) Establishing public policies that support a better state of health for young people, emphasizing action among the most vulnerable youth and based on WHO and PAHO resolutions and their recommendations. These policies should guarantee specific budget allocation for adolescent and youth health, including ASRH, and allow for the follow-up of commitments and ensure accountability.
- b) Developing, implementing and complying with evidence-based policies and programs

in a manner consistent with the UN Convention on the Rights of the Child and the UN/OAS human rights instruments.

- c) Advocating for environments that promote health and development among young people, with an emphasis on ASRH, considering social determinants of health and the promotion of health and secure communities.

ASRH issues need to be raised systematically, consistently and frequently; for example, young people should be included when support is given to countries that are developing a policy of universal access in SRH. Similarly, when applying a rights-based approach, the rights of young people need to be emphasized and protected. And, in the case of payment systems for health care financing, the full range of SRH services (e.g. contraceptive services including emergency contraception, voluntary counselling and testing [VCT], post-abortion care, first level and referral delivery services) should be covered for all family members.

However, promoting ASRH requires more than being prepared to enter policy discussions should issues related to ASRH arise. ASRH is not a priority for most governments and “solid evidence” is seldom sufficient to get a topic into national plans and programs. Decisions to progress or not to progress ASRH are the result of the push and pull of several factors.

Cases of human rights abuses can be highlighted and work is required to hold governments accountable for not ensuring human rights for poor and young people. This involves making “evidence” available to other groups for use in their lobbying efforts and working actively with organizations seeking to improve ASRH, e.g. targeting capacity-building activities toward organizations that seek to hold governments accountable for human rights abuses. Non-government organizations are especially effective in this area. Increasing their understanding of ASRH issues can help to ensure that suitable and sensitive components are incorporated at policy, program and project levels.

Because the policy environment is different in each country, more general questions regarding the role of “evidence” can be posed, such as, “How can evidence be used to influence government decision-making?” “How useful is evidence in the face of weak government?” “How can evidence influence policy and practice in the face of weak national capacity regarding adolescent health?” and “How can ASRH be promoted when some member states have a non-evidence based approach?”

A Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis around ASRH at country level may be useful. Another tool to help get ASRH on the agenda would be software such as “Policy-maker” (24).

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Support for the development and revision of current policies and legislation in priority health topics for young people, especially in those that have an impact on health service access, is also necessary.

3. Integrated and comprehensive health systems and services

The effective extension of social protection should be supported. Adolescent and youth health promotion, prevention and care require primary-level health care services based on quality standards and best practices. We propose to:

- a) Integrate services with referral and counter-referrals between the primary, secondary and tertiary levels.
- b) Increase access to quality ASRH services with the development of quality standards of care and ensure availability of critical public health supplies.
- c) Develop models of care, including alternative and innovative service provision that can increase access, such as mobile clinics, health services linked to schools and pharmacies, among others.
- d) Conduct studies on the availability, utilization and cost of ASRH services.

4. Human resources capacity building

Support for the development and strengthening of human resource training programs in ASRH, especially those in health sciences and related fields, is needed in order to develop policies and programs for adolescent and youth health promotion, prevention and care.

Health and service providers (for example, school and university teachers and community health promoters, among others) are instrumental to improving ASRH and therefore multidisciplinary teams are required.

We propose to:

- a) Develop and implement training programs in the health and development of adolescents and youth, especially ASRH, at the undergraduate and graduate levels and in-service, with the use of new technologies, such as e-learning platforms, and including key topics such as the dissemination and clarification of the UN Convention on the Rights of the Child and the previously mentioned UN/OAS human rights instruments with regard to issues like confidentiality, privacy, informed consent, equal protection of the law and non-discrimination in the context of cultural diversity.
- b) Include the topic of ASRH in curricula for health and education professionals.
- c) Advocate for the capacity building of primary health care providers using evaluated courses in comprehensive adolescent health supported by PAHO and currently available on diverse e-learning platforms.
- d) Incorporate current scientific evidence on young people and the topic of monitoring and evaluating programs in available e-learning courses and others.



5. Family, community and school-based interventions

It is necessary to develop and support ASRH promotion and prevention programs with community-based interventions that strengthen families, include schools and encourage participation. Behavior change in adolescents and youth is influenced by the environment in which they live, study and work. A favorable family environment is essential to achieve sexual health. We propose to:

- a) Develop and disseminate evidence-based tools that help strategic actors in interventions that strengthen the family; for example, the evaluated PAHO program “Strengthening families with adolescent children with love and limits.”
- b) Support community mobilization to change institutional policies and to create communities that are favorable to youth development and health.
- c) Develop tools to promote the meaningful participation and empowerment of adolescents and youth and their communities, starting with the identification of their strengths and weaknesses to effectively contribute to the decision-making process to the design and implementation of programs that affect them.
- d) Improve the relationship between the health and education sectors to develop comprehensive ASRH education and to monitor and evaluate their impact. As part of building alliances between strategic partners in promoting ASRH, strengthening the connections with educational sector is of utmost importance in order to promote comprehensive sexual education and adolescent health, which can both delay sexual intercourse in non-sexually active students and increase contraceptive use in those that are sexually active (25). Bearinger et al recommend that health officials and policy makers consider curriculum-based programs as an important component of efforts to achieve regional and national goals for preventing STIs, including HIV, and early pregnancies. The recommendation was made after a review of the effect of 85 evaluated school-based sex education programs in developed and developing countries (26).

Behavior change in adolescents and youth is influenced by the environment in which they live, study and work. A favorable family environment is essential to achieve sexual health.

6. Strategic alliances and collaboration with other sectors

The implementation of ASRH programs requires concerted action on the part of multiple partners and strategic actors from different sectors. Furthermore, it requires action at various levels of government, from NGOs, multilateral organizations and the local level, among others.

Therefore, we recommend to:

- a) Develop integrated and coordinated actions between the health sector and with strategic partners at the regional, national and local levels; for example: government entities (education, judicial system, labor, public security, housing services, environment, among others), private organizations, universities, media, civil society, youth organizations, faith-based organizations and communities (including teachers, parents and young people).
- b) Increase and strengthen adolescent and youth interagency programs between and among

- UN agencies and organs and agencies of the Organization of American States (OAS).
- c) Establish mechanisms for south-to-south cooperation and to share best practices and lessons learned in the region.

7. Social communication and media involvement

Support for the inclusion of social communication interventions and innovative technologies in national adolescent and youth health programs and ASRH plans, programs and services is necessary.

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The mass media and new technologies have a significant impact on the health of adolescents and youth. It is essential to work with mass media to promote a positive image of adolescents and youth and to incorporate new technologies in health promotion.

We propose action to:

- a) Promote positive images, values and behaviors regarding adolescent sexual health.
- b) Strengthen countries to use social communication techniques and new technologies to increase access to sexual and reproductive health interventions and services.
- c) Support the generation of evidence in this topic, especially in the use of new technologies and their impact on health.

The implementation of these recommendations is a huge challenge, that will require political commitment, resource mobilization and integration with close collaboration among UN agencies and stakeholders. ■

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