

# International Interagency Meeting: Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean

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## FINAL REPORT



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## ACRONYMS

ACF	Administration for Children and Families
AFLP	The Adolescent Family Life Program
AIDS	Acquired Immune Deficiency Syndrome
ARG	Argentina
ASRH	Adolescent Sexual and Reproductive Health
BRA	Brazil
CDC	Center for Diseases Control and Prevention
CIE 10	International Statistical Classification of Diseases
CLAP	Latin American Centre for Perinatology
COR	Costa Rica
DOR	Dominican Republic
EC	Emergency contraception
ENADID	Encuesta Demográfica de la Dinámica Demográfica
ESR	Sex and relationship education (for its Spanish acronym)
Family PACT	Family Planning, Access, Care, and Treatment
GDP	Gross Domestic Product
GSHH	Going Home Staying Home
GYTS	Global Youth Tobacco Survey
HIV	Human Immunodeficiency Virus
ICMER	Instituto Chileno de Medicina Reproductiva
ICT	Information and Communication Technology
IUD	Intra-Uterine Device
IPV	Intimate Partner Violence
LAC	Latin America and the Caribbean Region
LARC	Long-lasting preventive interventions
LEPINA	Ley de Protección Integral de la Niñez y Adolescencia
LNG	Levonorgestrel
MEX	Mexico
<i>MOSAFC</i>	Comprehensive strategy in adolescent development based on the Family and Community Health Model (for its Spanish acronym)
NHDP	National Human Development Plan
OASH	Office of the Assistant Secretary for Health
PAHO	Pan American Health Organization
PER	Peru
Plan-EA	National Strategic Plan to Prevent Teen Pregnancy 2011-2016
PRONISA	Programa Nacional de Atención Integral a la Salud de los Adolescentes
RHAP	Reproductive Health Action Plan
RH	Reproductive Health
SIP CLAP/SMR	Sistema Informático Perinatal
SRH	Sexual and Reproductive Health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNFP	United Nations Population Fund
RBF	Result Based Finance
RH	Reproductive Health

SRH	Sexual and Reproductive Health
STI	SEXUALLY Transmitted Infections
WDC	Women Development Center
WHO	World Health Organization
WB	World Bank

## I. INTRODUCTION

The estimated rate of adolescent age-specific fertility (number of births per 1,000 women aged 15-19) in Latin America and the Caribbean (LAC) is among the highest in the world, with indigenous and young women from lower wealth quintiles being most vulnerable to becoming pregnant<sup>1</sup>. Early motherhood impacts an adolescent's health and wellbeing, education and life prospects, with young women being particularly vulnerable as they already face multiple challenges in exercising their right to the enjoyment of the highest attainable standard of health ("right to health") and other related human rights and achieving their full potential<sup>2</sup>. Furthermore, adolescent pregnancy entails high medical, social, and economic costs, including loss of productivity, for society. In order to successfully prevent adolescent pregnancy and its negative impact on individuals and society, it is important to identify the various risk and protective factors related to adolescent pregnancy in LAC. These factors are varied and are best understood through conceptual frameworks such as the Socio-Ecological Model. Indeed, this model provides a framework for identifying the type of factors impacting adolescent pregnancy at the individual, interpersonal, community and at the societal level, and understanding how these interrelate.

Some of the challenges governments in LAC currently face in their efforts to prevent adolescent pregnancy include a lack of policies, plans and laws formulated in a manner consistent with universal and regional human rights norms and standards; a lack of financial and political commitment by governments to adolescent Sexual and Reproductive Health (ASRH) programs; weak strategic information systems; a lack of integrated and comprehensive health systems and services; a shortage in human resources trained in adolescent SRH promotion, prevention and care. Furthermore, current adolescent pregnancy prevention programs in LAC do not focus on most-at risk populations (including adolescents from indigenous or afro-descendant communities, who live in the most rural areas and are from lower socioeconomic wealth quintiles, etc.); do not consider social determinants of health, human rights norms and/or standards or gender equality approaches; are not based on a life-course perspective; and are not being evaluated for their effectiveness<sup>3</sup>.

Despite the great progress that LAC has experienced in terms of social and economic development over the past couple of decades, it is the only region in the world where adolescent pregnancy has remained relatively stagnant<sup>4</sup>.

The causes for this paradox are various. While social, economic and gender inequalities are recognized as crucial barriers to ASRH in LAC. Impeding structural factors include unsupportive legislative and policy environments; lack of financial and political commitment by governments to adolescent SRH programs; weak strategic information systems; a lack of integrated and comprehensive health systems and services; a shortage in human resources trained in adolescent SRH promotion, prevention and care; the exclusion of family, community, schools

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<sup>1</sup> The World Health Organization defines young people as individuals between the ages of 10 and 24 years old. Adolescents comprise the 10-19 year-old age group and youth the 15-24 year old age group.

<sup>2</sup> See PAHO Directing Council Resolution CD50R8 "Health and Human Rights" Available at: [http://www.un.org/disabilities/documents/paho\\_mh\\_resolution.pdf](http://www.un.org/disabilities/documents/paho_mh_resolution.pdf)

<sup>3</sup> [http://www.paho.org/hq/index.php?option=com\\_content&view=category&layout=blog&id=1107&Itemid=1065](http://www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=1107&Itemid=1065)

<sup>4</sup> <http://events.iadb.org/calendar/eventDetail.aspx?lang=en&id=3300>

and the media in SRH interventions; and fragile strategic alliances and inter-sectorial collaboration<sup>5</sup>.

Furthermore, current adolescent pregnancy prevention programs in LAC do not focus yet on most-at risk populations (including adolescents from indigenous communities, from lower socioeconomic wealth quintiles, etc.); do not consider cross cutting issues including social determinants of health, human rights or gender; are not based on a life course perspective; and are not being evaluated for their effectiveness<sup>6</sup>.

In response to most of the above mentioned challenges, the Pan American Health Organization (PAHO), in collaboration with the World Bank (WB), UNICEF and UNFPA, with the financial support of the Royal Norwegian Embassy, organized a three day international inter-agency meeting on “Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean”, which was held in Managua, Nicaragua, from the 17<sup>th</sup> to the 19<sup>th</sup> of March, 2014.

This document summarizes the information presented during the International meeting and also includes the working group sessions.

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<sup>5</sup>[http://www.populationinstitute.org/external/files/reports/FINAL\\_LAC\\_Report.pdf](http://www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf)

<sup>6</sup>[http://www.paho.org/hq/index.php?option=com\\_content&view=category&layout=blog&id=1107&Itemid=1065](http://www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=1107&Itemid=1065)

## II. MEETING OBJECTIVES

1. To present the current situation of adolescent pregnancy and its major risk factors in the LAC region;
2. To discuss current evidence, lessons learned and best practices regarding adolescent pregnancy prevention and the access and utilization of SRH services by adolescents in the LAC region;
3. To agree on key evidence-based interventions to be implemented at the local, national, and regional level in order to prevent adolescent pregnancy in the LAC region;  
To disseminate and share current evidence, lessons learned, best practices, tools and instruments developed at the national and regional level to prevent adolescent pregnancy.



### III. SHARED PROSPERITY AND ADOLESCENT PREGNANCY

Two key goals of the World Bank are eradicating extreme poverty and promoting shared prosperity, all in an environmentally and fiscally sustainable fashion (a third key goal).

Adolescent pregnancy is intimately intertwined with the twin goals for two reasons. First, a lack of shared prosperity may account for a large share of adolescent pregnancies: becoming a mother at early age may be a rational strategy in the context of social exclusion, absence of educational, labor market and other opportunities, and low ability to make choices to achieve desired outcomes, or agency (WDR, 2012). Indeed, 40 percent of adolescent pregnancies are intended (Azevedo et al., 2012). Although many studies show that there is a significant correlation between early motherhood and negative outcomes for the mothers; negative effects attributed to teenage childbearing reduce significantly, once one controls the co-founding factors. Indeed, the analysis based on comparison of women who gave birth in adolescence with women who became pregnant in adolescent but miscarried, suggests that women who gave birth have on average 0.34 more years of education, and are 21 percentage points more likely to be employed, compared to their counterparts who miscarried (Azevedo, Lopez Calva and Perova, 2012). Rather than downplaying the relevance of adolescent pregnancy from a development perspective, this finding suggests the need to reconsider to what extent adolescent pregnancy may be the consequence, rather than the trigger, of adverse economic and social circumstances adolescents face.

Second, adolescent pregnancy has important intra- and inter-generational consequences that may trigger poverty traps and reduces social welfare. The same study finds that women who gave birth in adolescence are more likely to depend on welfare: their social assistance income is 36 percent higher, and they are more likely to participate in social programs (Azevedo, Lopez Calva and Perova, 2012). Adolescent pregnancy may negatively affect siblings of teenage mothers, as well as their mothers, who frequently bear the burden of care work. Children of women who gave birth in adolescence are at higher risks of behavioral problems when they become adolescents, and are more likely to engage in risky behaviors (Arias and Lopez-Calva, 2012). Moreover, it is important to note that coping strategies are unequally distributed across families: adolescents and their families from a lower end of income distribution have less coping strategies at their disposal (e.g. hired childcare to be able to continue education).

Fertility decisions, especially in adolescence, should be a result of choice, rather than be defined by constraints. Thus, policies aimed at tackling high rates of adolescent pregnancies should widen the set of options for women, as well as their capacity to aspire and to be in effective control over their lives so that teenage pregnancy is not the only option at hand or an unintended consequence of behavioral inconsistencies. Such policies would be completely aligned with the shared prosperity agenda, which implies equitable access to opportunities.

Thus, addressing the issue of adolescent pregnancy is, in fact, advancing shared prosperity. At the same time, policies aimed at lowering adolescent pregnancy and expanding coping strategies for teenage mothers have instrumental value for advancing shared prosperity through mitigating the intra- and inter-generational consequences and lowering social costs.

#### **IV. PANEL 1: CURRENT SITUATION OF ADOLESCENT PREGNANCY AND ITS MAJOR RISK FACTORS AND SOCIAL DETERMINANTS IN THE LAC REGION**

Coordinator: *Dr. V. Chandra-Mouli, Scientist, Department of Reproductive Health and Research at WHO*

The objective of the first panel coordinated by PAHO/WHO, was to provide meeting participants with a situational analysis in terms of ASRH and adolescent pregnancy in the LAC region, its associated risk factors and subsequent negative outcomes. The four main points of this panel included: 1) although adolescent fertility in the LAC region has decreased over the past couple of decades, the decrease has been slow and insufficient compared to other regions; 2) risk factors for adolescent pregnancy include, but is not limited to, socio economic status, geographical location (rural vs. urban), ethnicity, education level, exposure to violence, age of menstruation, use of alcohol and drugs, age of sexual initiation, multiple sexual partnerships, age of sexual partner, etc., 3) adolescent pregnancy entails financial, social and biological costs for the individual, their children, their families and the communities in which they live in; 4) adolescent pregnancy is preventable but requires a multi-sectoral, interagency, inter-programmatic, and a life course approach in order to be successful ((read more about each presentation below).

The highlight of this panel was definitely the exposure of the most updated available strategic information regarding ASRH in the LAC region.

##### ***1. Current Situation of Adolescent Pregnancy and its Major Risk Factors in the LAC Region by Dr. Elizaveta Perova, World Bank***

Latin American and the Caribbean Countries have some of the highest teenage pregnancy rates in the world and the pregnancy and fertility rates in these countries are higher compared to countries in other regions with similar characteristics, in particular those with the same GDP per capita.

There is no explanation for these statistics. In an attempt to address this phenomenon, the Teenage Pregnancy Regional Study from the WB focused on adolescent fertility and reached two conclusions:

1. Adolescent pregnancy is caused by a lack of economic opportunity. Many studies, including the Teenage Pregnancy Regional Study, illustrate the correlation between early pregnancy and its negative effects on education and employment opportunities. However, controlling certain factors significantly reduces these consequences.
2. Early pregnancy promotes a cycle of poverty with high social costs that affect future generations. Girls who become pregnant at a young age drop-out or delay their schooling. In addition, children born to adolescent mothers tend to have increased behavioral problems when they become teenagers, creating additional costs for the family.

The Teenage Pregnancy Regional Study shows that the factors causing adolescent pregnancy are a result of a complex environment and a combination of the following two contexts: (1) macro environment that determines the current opportunities for a teenager who has formal education inequality; and (2) the local or household environment which includes social norms, family history, social networking, and peer pressure.

According to the report, the risk factors associated with adolescent pregnancy in LAC can be divided into two parts:

1. Risk factors that affect opportunities:
  - a. Fertility in LAC is linked to poverty, investments in health, and education.
  - b. Better educated adolescents from stable families in urban areas are less likely to become pregnant at an early age.
2. Risk factors at the local or household levels are:
  - a. Adhering to socially accepted norms
  - b. Girls lack control of their life plans and/or getting pregnant may be seen as the only goal to be achieved and motherhood as the purpose in life.

Within this context, policy objectives should focus on: (a) ensuring that women have control in their lives; (b) creating interventions that take risk factors into account; (c) considering policies and programs that will reduce poverty and gender inequality; and (d) increasing opportunities and assets for teenage girls that will affect fertility choices.

In light of the complex decision making process, these efforts must be implemented at the community and individual levels.

## ***2. Epidemiological Perspective in Adolescent Sexual and Reproductive Health by Dr. Matilde Maddaleno, WHO/WDC***

According to estimates, the rate of adolescent fertility in many Latin American countries is above the global average. This rate not only varies among countries within the region, but it also varies within each country, which is where the greatest inequality exists. Since secondary education is having less of an impact reducing adolescent pregnancy, reforming educational policies will be critical in reducing adolescent pregnancy.

Why has LAC been unable to decrease the rate of adolescent fertility? These are important factors could answer this question:

1. Age of first menstruation: currently there are no statistics for LAC countries but other countries have recorded that the first menstruation occurs around age 10. Since menstruations are a risk factor for adolescent girls, we need to change how the age of an adolescent is defined in order to be more inclusive.
2. Age of first sexual intercourse: in LAC, a large percentage of adolescents have had their first sexual relationship before reaching age 15, which makes this another risk factor contributing to adolescent pregnancy.
3. Use of contraceptives during sexual intercourse has decreased: this factor is directly related with lower income. Additionally, family planning among youths is lagging. In the Caribbean, the use of condoms has increased, indicating that the promotional campaign for condom use has had a positive effect on Caribbean countries and should be used as an example for other Latin American countries to follow.
4. Teen abortion: is a major challenge because the topic is rarely discussed and there is no information available in the region. It is estimated that the rate of unsafe abortions in LAC is 25% which equates to roughly 670,000 adolescents.

5. Marriage: In LAC, the majority of adolescents are single mothers whose fathers are absent, which results in their families taking care of them and their children.
6. Sexual rights: affect both adolescent men and women but the majority of adolescents are unaware of their sexual and reproductive rights.

If we want to prevent adolescent pregnancy, we have to: (i) recognize that adolescents are sexual beings and in this manner we can improve the information available in our countries; (ii) address inequalities; (iii) study and better understand how some socioeconomic and linguistic aspects affect sexual and reproductive health; and (iv) increase contraceptive use during a woman's first sexual experience.

***3. Maternal mortality in adolescents including suicide related to pregnancies in selected countries by Dr. Virginia Camacho, UNFPA/LACRO***

Historically, statistics demonstrated that adolescents between ages 15 and 19 had a 2 to 3 times higher risk of mortality during pregnancy, labor or postpartum. Current data shows inconsistencies, and in some cases contradictions, in whether or not women between the ages 15 to 19 represent a greater risk of maternal mortality.

WHO, in collaboration with UNFPA, conducted a study to estimate maternal mortality in adolescents between ages 15 to 19 using data from official registries and national surveys. The study's main findings suggest that the risk of maternal mortality among adolescents is smaller than expected in comparison to previous studies, yet it is still higher when compared to women over age 20. In most countries, the risk of death in adolescents is higher than for women over 30.

Another study conducted in Honduras, El Salvador and Guatemala between 2011 and 2012 examined the socio-demographic characteristics and challenges associated with pregnancy and postpartum suicide. The main study findings are: (i) A majority of suicides analyzed in this study occurred during the antenatal period and only two suicides occurred postpartum, which differs from the pattern established in other studies; (ii) Following the new classification by CIE 10, all suicides related to pregnancy described in this study would be grouped under direct obstetric causes. No adolescent had prior mental illness; (iii) 58% of suicide cases occurred in adolescents (15-19 years of age); (iv) Self-inflicted poisoning was the most common form of suicide. Pesticides remain the most frequently used substance; (vi) Standardized autopsy facilitates remains a challenge in the region.

This presentation concludes that maternal mortality associated with adolescent pregnancy among girls ages 15 to 19 is not as high as once estimated, but the cases are higher in girls ages 11 to 15. Suicide and other problems related to a pregnancy also account for maternal mortality.

#### **4. Adolescents Pregnancy in LAC by Dr. Susanne Serruya CLAP/OPS.**

In the LAC region interventions by the ministries and others in the health field should primarily focus on developing a standardized manner to provide attention and care to adolescents. This requires proper data collection and record keeping. An example of this is the *Historia Clínica del Adolescente*, regional version (see Annex 1), which was created by CLAP with the help of regional governments. CLAP's database contains 700,000 cases related to adolescent pregnancy in Latin America and the Caribbean from 2009 to 2012 and is available for use by all LAC countries.

In order to prevent and reduce adolescent pregnancies and have an influence on maternal mortality, the following f should be taken into account:

1. Study the causes of unwanted pregnancies.
2. Problems within the health system should be addressed to decrease the number of adolescent pregnancy, especially those who are pregnant for the second time.
3. Access to contraception must be provided in order to decrease the number unwanted pregnancies not only via pharmaceutical companies but also Ministries of Health, which should play a role by storing and distributing contraceptives.
4. Sexual violence needs to be addressed as a separate issue, specially for girls under age of 14
5. More studies about the causes of unwanted pregnancy should be conducted

## **V. PANEL 2: STRATEGIES OF SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS, INCLUDING THE PREVENTION OF TEEN PREGNANCY**

Coordinator: *Dr. Luisa Brumana, Regional Health Advisor, UNICEF/LAC RO*

The second panel of the meeting, coordinated by UNICEF, included five presentations on ASRH strategies and plans of action from the WHO, the World Bank, UNFPA, UNICEF and the CDC. The objectives of this panel were to 1) identify and share existing regional strategies and plans in the field of ASRH; 2) encourage the adoption and adaptation of these strategies and plans at the national level; 3) identify the strengths and areas of work of each agency/institution; and 4) promote interagency collaboration (read more about each presentation below). The two main points from this panel included: 1) there are national and regional strategies that can be adopted and adapted at the national level in LAC; and 2) although all of the agencies have similar strategic objectives and expected results there is room for a stronger interagency collaboration.

The highlight of this panel was the presentation made by Dr Lisa Romero from the CDC on the US approach to prevent adolescent pregnancy. The reason for why this presentation was so powerful was because it provided the framework for this meeting (the “Teenage Pregnancy and the Health Impact Pyramid), and demonstrated very practical examples of how to apply said framework to current effort.

### ***1. The Operational Plan of the World Health Organization (WHO) to meet the needs of adolescents in sexual and reproductive health material by Dr. V. Chandra-Mouli, WHO/Geneva.***

The WHO plan uses three frames of reference: (a) mapping of programming and measurement of adolescents to understand the situation (i.e. determinants that affect behavior), plan interventions, program or project, and plan monitoring; (b) guidance at all levels (i.e., national, state, health centers); and (c) assessment of the success of public health programs.

It is reported that more than 40% of unsafe abortions in the world occur among young women (15-24 years old). Moreover, of the 22 million abortions in 2008, 15% were done to young girls (15- 19 years old). Therefore, it is important to reduce early pregnancy in developing countries.

According to WHO, there are seven elements of success to consider when implementing public health programs for adolescents: (a) technical consensus on a suitable public health approach; (b) political leadership; (c) available innovation at an affordable price and delivered through an effective channel; (d) effective use of information; (e) good management; (f) solid partnerships; and (g) adequate funding.

### ***2. The World Bank Strategy on Reproductive Health and Population by Dr. Rafael Cortez, World/WDC.***

The World Bank’s Reproductive Health Action Plan (RHAP) focuses on improving reproductive health outcomes of women and men. It lays out the key issues, challenges, priorities, and opportunities for the Bank to mobilize greater support for and deepen its work on reproductive health; and reinvigorates the World Bank’s commitment to reproductive health as outlined in its Health, Nutrition and Population (HNP) Strategy of 2007.

The RHAP prioritize interventions in the 57 countries to address persisting high levels of, and inequities in, maternal mortality and fertility through strategic focus on high-burden countries; health systems strengthening; provision of services to the poor; increased focus on the needs of the youth; and leveraging partnerships to improve reproductive services and strengthen outcomes.

The Bank measures the activities and achievements of the reproductive health action plan based on three areas: (a) provision of technical assistance, (b) development of capacities and reproductive health experiences, and (c) improvement in the monitoring of the reproductive health portfolio.

The World Bank's Reproductive Health Action Plan 2010-2015 (RHAP), builds on the Bank's strong expertise in healthcare financing, scaling up of health services, and ability to work across sectors such as education and poverty reduction; and focuses on financial and technical support to countries for health systems strengthening and reaching hard-to-reach/vulnerable populations, including the youth and the poor.

There are still opportunities and challenges and much to do on adolescent RH such as scaling up the most effective ways to incentivize the demand for reproductive health, reaching the most marginalized, poor and vulnerable populations to facilitate their access to health services, promote universal coverage of health services, and ensuring full leverage of the Bank's multi-sectorial advantage to improve RH outcomes.

### ***3. New Guide of Adolescents' Integral Vision by Luz Angela Melo, UNICEF/LAC RO***

According to UNICEF there are ten reasons on why to invest in youth: (a) demographic bonus, (b) invest now to have a good future (i.e., avoid early pregnancy), (c) stop inter-generational poverty, (d) interaction, autonomy and identity building to promote the participation and empowerment of youth, (e) young people develop life skills, (f) critical thinking and break patterns, (g) young people have a framework of human rights, standards and principles, (h) their participation strengthens democracy, (i) teenagers can promote creative solutions to resolve inter-generational differences, and (j) they have access to communication technologies.

UNICEF adolescent's vision has four priority areas in their work: (a) offer quality and a variety of learning options, (b) ensure that adolescents have adequate knowledge, skills, and access to appropriate services, (c) ensure that adolescents grow up in a violence-free environment, and (d) ensure that all adolescents participate meaningfully in decisions that affect their lives.

### ***4. UNFPA's Strategy on Pregnancy Prevention by Ana Elena Badilla/Dr. Virginia Camacho UNFPA/LACRO***

UNFPA has a multidisciplinary and inter-cluster strategy to address early pregnancy. Their global strategy is based on 5 main pillars: (a) advocacy based on evidence, (b) comprehensive sexual education, (c) access to sexual and reproductive health information, (d) prioritize marginalized adolescents and girls (mainly indigenous and African descendants girls in the region), and (e) leadership and participation.

Based on this global strategy, UNFPA is working on a regional strategy aimed to: (a) put the theme of adolescence and youth as a priority in national policies and programs; and (b) strengthen institutions and the role of young people as participants in national, regional and global processes related to youth.

Finally, they have identified four specific areas of intervention: (a) to remove of legal obstacles to access of adolescents to sexual and reproductive health; (b) to strengthen the national capacities for prevention of and to access comprehensive care and justice for women in cases of sexual violence with emphasis on young girls; (c) to invest more in three strategic areas: education, employment and sexual and reproductive health for young people; and (d) to develop a methodology to measure the effectiveness of investments.



## VI. SPECIAL PRESENTATION

***Adolescent Pregnancy Prevention using the Health Impact Pyramid. Dr. Lisa M. Romero, MPH  
Health Scientist, CDC, United States***

The objectives of this presentation were to: (a) explain why teen pregnancy is a public health problem in the United States, (b) describe why preventing teen pregnancy is a CDC “Winnable Battle”, and (c) describe CDC’s efforts to prevent teen pregnancy.

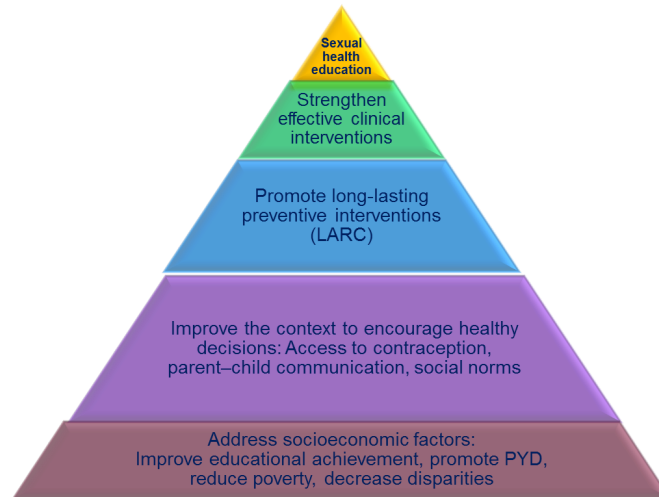
In the United States 3 out of 10 teen girls will become pregnant before the age of 20 meaning that 750,000 teens get pregnant every year. Most of these pregnancies are due to non-use or inconsistent use of contraception. Even though, pregnancy rate has been dropped since 2000, the US still has a high rate in teen births among high-income countries. The cost of teen births in 2010 was US\$9.48 billion mainly expended in health care, foster care, incarceration, and lost tax revenue. But these expenses were positively reflected in the steady decline of the teen birth rate in recent years.

There are three main federal offices that work with health teen issues: the Office of the Assistant Secretary for Health (OASH), the Administration for Children and Families (ACF) and the CDC. The CDC works in adolescent’s health focusing in six groups:

- ✓ Nutrition, Physical Activity, Obesity and Food Safety
- ✓ Teen pregnancy
- ✓ Tobacco
- ✓ Motor vehicle injuries
- ✓ HIV
- ✓ Healthcare associated infections

The CDC identified a health impact factors pyramid (see figure 1) that has been adapted to teen pregnancy. It identifies health strategies that have an impact on teenage pregnancy and health behavior change. The largest impact strategies identified are those that addressed socioeconomic factors like improving educational achievements, promote positive youth development, reduce poverty, decrease disparities, and encourage healthy decisions. The smallest impact strategies are sexual health education since in many cases birth control methods lag behind other health education area such as HIV and STDs. The middle of this pyramid is formed by effective clinical interventions and the promotion of long-lasting preventive interventions (LARC).

**Figure 1. Teen Pregnancy and the Health Impact Pyramid  
Factors that Affect Health**



Source: Adapted from Thomas R. Frieden. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health: April 2010, Vol. 100, No. 4, pp. 590-595. doi: 10.2105/AJPH.2009.185652

Based on the above pyramid, some of CDC efforts to prevent teenage pregnancy are:

- ✓ Provide integrated services, programs and strategies through community-wide initiatives that will provide useful information on prevention efforts using the 5-component model.
- ✓ Support youth friendly reproductive health services.
- ✓ Publication of evidence-based guidance to help providers to manage contraception, e.g. U.S. Medical Eligibility Criteria for contraceptive use 2010, U.S. Selected practice recommendations for contraceptive use 2013, Summary chart of U.S. medical eligibility criteria for contraceptive use, 2010, etc.
- ✓ Creation of a smart phone app on U.S. Medical Eligibility criteria for contraceptive use.
- ✓ Provide recommendations for quality family planning.
- ✓ Increase awareness among providers.
- ✓ Develop and disseminate provider-training materials.
- ✓ Evaluate use of guidance documents.

## VII. PANEL 3: LESSONS LEARNED AND BEST PRACTICES IN ADDRESSING THE SOCIO-ECONOMIC DETERMINANTS TO PREVENT TEEN PREGNANCIES

Coordinator: *Dr. Rafael Cortez, Senior Economist, Department of Health, Nutrition and Population/World Bank WDC.*

The objectives of the third panel of the meeting, coordinated by the World Bank, were to 1) demonstrate the socio economic factors associated with adolescent pregnancy; and to 2) identify best practices in terms of using different financing models and mechanisms to improve health outcomes amongst adolescents and youth (read more about each presentation below). The main points from this panel included: 1) adolescent pregnancy is strongly associated with economic and social factors such as poverty levels and employment conditions; 2) these economic and social factors can be addressed through the strengthening of national legislation and policies; 3) although financial models have not been used as frequently in LAC as in other regions, evaluations from selected case studies in LAC suggest that financial models and mechanisms can be effective in the promotion of adolescent health and prevention of adolescent pregnancy.

The highlights of this panel was the presentation, made by Dr. Amparo Gordillo-Tobar from the WB, on the Financing schemes to address challenges on maternal and child health. This presentation provided a very concrete example of how effective financing schemes can be used to improve the quality of the health services, particularly in maternal delivery options.

### ***1. Financing schemes to address challenges on maternal and child health: Cases of 5 selected countries by Dr. Amparo Gordillo - Tobar, World / WDC Bank.***

When considering financing schemes should be considered: (a) how they are being implemented, and (b) what are some innovative options. Funding mechanisms could be analyzed from two perspectives: (i) supply side: result-based financing, and (ii) demand side: conditional cash transfers. The result-based financing approach means a change in the traditional approach to best allocate funds, where financing is directly related to inputs, processes, outputs and outcomes. It is important to take into account not only how something is funded but also what is being funded (e.g. the initiative to support the young girls). Conditional Cash Transfers is a payment to a group of target population conditioned to participate, attend to receive a health service or any other service previously established.

These innovative financial mechanisms represent changes in the traditional way budgetary allocation takes place. It means empowerment of the government in the context of an expansion of coverage, clear roles and responsibilities at all levels of health care provision and accountability on the health care outcomes.

Funding is essential for policy implementation, but is also limited and therefore it is key to prioritize the most vulnerable groups. Moreover, it is necessary to have an integrated effort among the different agents, to generate synergies and to have a better use of the available funds.

### ***2. The impact of social and environmental factors in adolescent pregnancy in the province of Buenos Aires, Argentina by Dr. Zulma Ortiz, UNICEF/ARG.***

The program that was implemented by the government of Buenos Aires, Argentina was based on a theoretical framework that defined the determinants of teenage pregnancy taking into account the following dimensions:(a) health coverage characteristics, (b) educational level, (c) health status of women, (d) women job entrance, (e) number of kids per women, (f) age of women of first pregnancy, and (g) socio-economic level.

The studies made in Buenos Aires found that the rates of teen pregnancy are high and increasing; and that about 15% of all teenage women (15-19 years old) had a baby. A very striking fact for decision makers is that most teen mothers only had elementary education completed (46.1%) and also had the most number of children. Other factors include: potable water coverage in Buenos Aires is among the worst in the country; 22% of pregnant women are anemic; most adolescents do not use health services; 80% of adolescents never went to a sexual and reproductive health clinic; and 62% do not plan on going to one. In addition, their knowledge of contraceptive methods is limited to a few that are not the most effective ones.

***3. Lessons learned in preventing teen pregnancy using a social-determinant approach in England by Dr. V. Chandra-Mouli, WHO/Geneva.***

In 1999, the Government of England developed a strategy to prevent adolescent pregnancy using social determinants of health. The strategy objectives at a national and local level were: (a) Reduce by 50% the rate of conception of British adolescents under 18 between 1998-2010; (b) Increase the proportion of education, training, or employment for mothers of 16-19 years of age; (c) Support to local areas from the national entity. The strategy was a success and these are some of the main advances: (a) 34 % reduction in the rate of conception of adolescents under 18; (b) all local zones are showing a decrease in adolescent pregnancy; (c) maternity and abortion rates are decreasing; among others.

The project identified ten key factors to have successful local strategies for adolescents pregnancy in England: (1) sexual and reproductive education in schools and colleges; (2) contraceptive and sexual health services for the youth; (3) clear and consistent messages for the youth, parents and professionals; (4) staff training in sexual and reproductive health including youth access to contraceptive services; (5) coordinated support for young parents; (6) ESR and directed contraception/sexual health support; (7) strong usage of data for the implementation and administration of local performance; (8) support dedicated to teen parents-including contraception to prevent repeated pregnancies; (9) support for parents to talk about sex and relationships; and (10) strategic leadership & responsibility.

Between 2008-2011 the strategy main objective was to improve knowledge, access and effective use of contraception. They did a communication campaign to normalize the discussion of contraception to remove the stigma at national and local level. There were four lessons learned: (a) a combined effort is needed, (b) teenage pregnancy is a problem of everybody, (c) we need a clear purpose and leadership, and (d) the strategy must be focused on prevention and parental support.

And finally, some elements of success on the scale of the public health programs are: technical consensus on a suitable public health approach, political leadership, available interventions at an affordable price and delivered through an effective delivery system, an effective use of information, good field management, a solid partnerships, and international local funding.

## VIII. PANEL 4: STRENGTHENING THE REGULATORY ENVIRONMENT TO PREVENT TEEN PREGNANCY.

Coordinator: *Luz Angela Melo, Regional Gender Advisor, Non-discrimination and Adolescents UNICEF/LAC RO*

The fourth panel coordinated by UNICEF, examined the legislative and policy environment affecting ASRH including adolescent pregnancy in LAC (read more about each presentation below). This panel allowed for presentations on: the current situation in terms of national plans, policies, laws in the LAC region; current legislative barriers affecting ASRH in the LAC region; and provided a case study of how Mexico approached national legislation reform to lower adolescent pregnancy, abortion rates and subsequent maternal mortality. The main points of this panel were: 1) the reform of national legislation and policy environments is the most effective approach to promote ASRH, including adolescent pregnancy prevention; 2) although the most effective, this is also the most difficult approach; 3) effective and positive legislative and policy reform cannot occur without the integration of gender and human rights mainstreaming.

The highlight of this panel was the findings that Dr. Ana Elena Badilla from the UNFPA presented in terms of current legislation in LAC affecting adolescent pregnancy and early marriages. These findings were based on a study that the UNFPA developed in 2013, and included data from approximately 30 different countries in territories in the LAC region. The study showed that although many countries have favorable legislation in terms of ASRH and early marriage, existing legislation is sometimes ambiguous and even contradictory. For example, although many countries state 18 as the legal age of marriage, they also permit marriage to under-aged young people granted parental consent. The study further showed that existing legislation is sometimes discriminatory, is not always implemented and/or enforced, and violations of said legislation is not monitored nor penalized.

### ***1. Legislative barriers to sexual and reproductive health of adolescents in LAC by Mr. Javier Vasquez, OPS/WDC***

There are many international laws and mechanisms that support and recognize sexual and reproductive health rights for adolescents, but some countries in Latin America and the Caribbean present deficiencies in their legal system that conclude to several barriers that turn into negative effects on Latin American and Caribbean adolescents, youth, women and children health and life.

Most of these barriers are focused on inconsistent policies, laws and protocols between universal and regional human rights obligations (civil and penal codes); limited knowledge of health personnel and judges on the legal human rights instruments applicable to sexual and reproductive health for adolescents; absent of human rights protection mechanisms within the ombudsmen offices; lack of laws or criminalization acts among incest, rape and sexual abuses; limited access to contraception, family planning or even therapeutic abortion in cases like incest, rape or endangered of the mother's health.

The Health and Human Rights Resolution (CD 50.R8, 2010) presents a way forward that include: (i) the strengthening of the technical capacity of the health authority to work with human rights attorneys and to support the formulation of policies and plans in conformity with human rights

instruments; (ii) the training of health personnel; (iii) the collaboration between courts and parliaments in legislative reforms; and (iv) the dissemination of information: civil society and cooperation with international agencies like UN agencies and the IACHR.

**2. Comparative analysis on teenage pregnancy and early marriage legislation in Latin America**  
by Ana Elena Badilla, UNFPA/LACRO

This presentation reviewed some Latin American country laws related to adolescent pregnancy that include access to information, access to health care services and sexual and reproductive education, and the minimum age of marriage.

Even though marriage age is 18 years old in all of the countries, there are some exceptions where under certain circumstances allow marriage at an earlier age with parental consent, legal representative or judicial authority. Usually women get marriage at a younger age than men and there are countries that discriminate against women and men legal age to marry like Ecuador, Uruguay, Bolivia, Guatemala, México, Panamá, Peru, Venezuela, Nicaragua, Honduras and Dominican Republic.

To conclude, the following are recommendations for adolescent pregnancy prevention and early marriage from the legal point of view:

Adolescent Pregnancy prevention:

1. Access to state and private provision of SRH services without discrimination and with a gender focus.
2. Ensure respect for privacy and confidentiality
3. Incorporate comprehensive sexual education to schools and community settings with a gender focus.
4. Adolescent participation in the formulation, monitoring and evaluation of SRH services and comprehensive sexual education
5. Ensure continuity of pregnant teenage girls in school and strengthen the monitoring of cases of discrimination due to pregnancy, with sanctions on those responsible within the education system.

Early marriage:

1. Apply legislation to rise the minimum age at 18 to give consent and marriage and reduce the exceptions that allow marriage below this age.
2. Remove the legislation that discriminates between men and women legal age to marry without parental or judicial or consent.
3. Repeal laws that provide exceptions to the prohibition of marriage for children under 18 years old in case of pregnancy and living together status.
4. Repeal legislative provisions that exempt adult criminal liability having sex with a minor with or without consent and use it as an excuse to marry under the law if parent's consent is obtained.
5. Adopt legislation to ensure birth registration to facilitate the correct age of the parents and marriage registration whether contracted civilly or religious to prevent early marriages.

**3. Lessons learned in reducing unwanted pregnancy and unsafe abortion in Mexico** by Dr. Raffaella Schiavon, IPAS/MEX

Between 2008-2011, 19.6% of the Mexican pregnancies were among adolescent (10 to 19 years old), and in 2009, 40% of the adolescent pregnancies were unwanted due to either unmet needs for contraceptives, contraceptive failures or sex violence according to the ENADID (*Encuesta Demográfica de la Dinámica Demográfica*).

The data related to maternal mortality showed that between 2000-2011, 13% of maternal mortality was due to maternal causes and 14% of abortion complications among the adolescent group (less than 20 years old), and according to the INEGI 2009, 5.64% of adolescent (15-19 years old) dead was related to maternity causes being the fourth causes of the dead among adolescents after traffic accidents, suicides, homicides and leukemia. The average annual increase of hospitalization for maternal causes and abortion were very similar between 2000-2012 in women from 10 to 54 year old. The rate due to maternal causes is shown always higher than the abortion one, although in the case of adolescents (10 to 14 years old) was reversed, being higher the abortion rate than the maternal rate.

Mexico still have a high rate of adolescent pregnancy, limited access to contraceptives, high number on hospitalization due to maternal and abortion causes among adolescents (10-19 years old) regardless of their legal status, and the perform of abortion under legal conditions is very safe.

Since this legalization took place there has not been a single death among 120,000 women who had a legal abortion in public health facilities in the first quarter, making fatality rate for legal abortion in Mexico City the same as the international rate.

The recommendations to reduce unwanted pregnancy were divided in three areas:

1. Related to adolescents:

- ✓ Recognize adolescents as subjects of rights, autonomy, confidentiality, and privacy in making decisions.
- ✓ Promote their full participation in the design and evaluation of programs and services.
- ✓ Incorporate gender and intercultural frameworks.
- ✓ Recognize and integrate teen diversity.

2. Health prevention:

- ✓ At primary level: information/education/access
- ✓ At secondary and tertiary level: access to long-acting contraceptives, access to postpartum and post-abortion for adolescent and access to legal abortion for adolescents in cases like risk to life and health or rape.

3. State interventions:

- ✓ Comprehensive and inter-sectoral interventions: dropout prevention strategies, increased school enrollment for women and access to decent work for women and men.
- ✓ Focus interventions in rural areas, indigenous, adolescents not in school and vulnerable urban areas.
- ✓ Differentiated interventions in very young adolescents (detection and treatment of sexual violence)

## **IX. SPECIAL PRESENTATION:**

***Current evidence in first and second adolescent pregnancy prevention, Dra. Claire Brindis, Universidad de California, San Francisco/ EEUU.***

Although much information on sexual and reproductive health is available in the United States, there are several myths about sexual health that young people tend to believe. For example, some believe that if a man drinks a soda, he will not produce enough sperm to impregnate someone. Members of the community promote this ignorance by not educating teenagers or openly speaking about sexual health in a public forum. There is also a disconnection between information and action. For example, it is known that pregnancy is closely linked to poverty, but no efforts are being made to create jobs for young people in the community.

Today there is a need to combine strategies and include young people in the preparation of programs as well as teaching them how to: (i) investigate; (ii) analyze; (iii) ask questions of their peers and; (iv) present the evidence.

In recent decades the teen birth rate for girls ages 15-19 has declined in the United States. Latinas have the same sexual activity as adolescents in other racial/ethnic groups and are less likely to use contraceptives or use them inconsistently.

Four lessons that have been learned in primary and secondary pregnancy prevention in Latino populations in the United States are:

1. Evidence-based interventions
2. Adapting programs to different groups of young people: pregnant and parenting teens; young men,; and immigrants
3. Connecting adolescents with service providers that offer contraceptives
4. Changes in laws and health policies

### 1. Evidence-based interventions:

Although evidence-based interventions are important, there is resistance in using this evidence. In order to successfully incorporate the use of evidence-based interventions, we should: (a) differentiate the groups who are to receive the evidence and use different strategies that can be accepted by them; (b) adapt the evidence according to population groups; and, (c) collect the most important actions that can be used for all types of people.

### 2. Adapting programs to different groups of young people: pregnant and parenting teens; young men; and immigrants

In order to develop effective programs and interventions, the designer must be aware of what is happening in the community. Among the actions that must be carried out are: (a) Improve strategies to reach, attract and retain the youth; (b) Promote school retention and completion rates by increasing educational aspirations and expectations; (c) Develop strategies to relate and connect youth with health services; (d) Foster communication between health care providers and adolescents; (e) Take into account the family context and other factors that influence adolescent development such as couples, friends, schooling and the community.

The following programs have been successful in preventing first and second pregnancy in the United States:



A. The Adolescent Family Life Program (AFLP) has been very successful in preventing second pregnancy. Among the most important results are: (i) the decrease in the proportion of repeat pregnancies in 12 months; (ii) the increased use of long-term reversible contraception (LARC); and (iii) the increased use of child care services.

B. Educational programs for young men where the leaders were men working with men. In some of these programs, material incentives were available to men who participated in all sessions of the program (discipline, baby care, ways to be part of the baby's life when they no longer have a relationship with the mother, employment).

C. Prevention programs have been specifically developed to target Latinos, immigrants and first + generations by taking into account cultural factors associated with Latino youth and their relationships with their parents.

In order to ensure the success of these programs, we must implement all parts of the project. States that only implemented portions of the program were unsuccessful in reaching its goal; therefore, we must ensure that effective programs be replicated in full.

### 3. Connecting adolescents with service providers that offer contraceptives

In general, most teens in the United States do not feel comfortable visiting health centers. California developed a successful program called Family PACT that promotes the use of health centers. Young people can go directly to the clinic and are serviced without any charge or need parental authorization. Thanks to Family PACT, 79,200 teenage pregnancies were averted through the provision of contraceptive services, marking this as one of the program's most important achievements.

### 4. Changes in laws and health policies

Good, high-level leadership is important in combating teenage pregnancy. California is required to maintain confidentiality while providing educational services on HIV/AIDS and abstinence to young. Additionally, the Affordable Care Act includes family planning services to minors at no extra cost.

## **X. PANEL 5A: STATE OF THE ART IN COMPREHENSIVE SEXUAL EDUCATION AND COMMUNITY INTERVENTIONS IN LATIN AMERICA AND THE CARIBBEAN.**

Coordinator: *Dr. Raffaella Schiavon Ermani, Director General, Ipas/MEX*

The fifth A panel, coordinated by IPAS, covered the state of the art in integrated sexuality education programs in LAC. This panel provided a situational analysis in terms of the availability of national integrated sexuality education programs in LAC; current evidence of sexuality education and curriculum modification; and lessons learned in terms of the implementation of integrated sexuality education in Costa Rica (read more about each presentation below). The main points from this panel included: 1) there exist a strong international consensus on the importance of integrated sexuality education for young people; 2) current evidence suggest that although some integrated sexuality education programs impact ASRH outcomes and behaviors positively, there are many that are not as effective; and 3) in order for integrated sexuality education programs to be the most effective they need to be integrated into other promotion and preventions efforts, they need a supportive legislative and policy environment, they require inter-sectorial collaboration, community involvement, political will, financial and human resource allocations.

The highlight of this panel included the situational analysis in terms of existing national integrated sexuality education programs in LAC. This analysis can be used for advocacy purposes and for priority setting at both national and regional level.

### ***1. Diagnosis of the state of the Art in comprehensive sexual education in Latin America and the Caribbean by Dr. Virginia Camacho, UNFPA/LACRO***

UNFPA review of its regional work plan in comprehensive sexuality education follows WHO recommendation in preventing adolescent pregnancy by supporting programs that focus in educating children on sexuality, promoting access to services, counseling on contraception and sexual and reproductive health, and seeking community support.

The review's main objective was to provide feedback on the implementation of the regional work plan in the next five years that will facilitate coordination between UNFPA and its counterparts. It will contribute towards promoting the rights of adolescents and youth in the region so that they may live a full, healthy and discrimination free sexual life. This review gathered information on the current status of sexual education policies and programs in 19 countries in the LAC region.

Among these 19 countries just Argentina and Colombia have a specific law on sexual education. Meanwhile, 14 other countries have a general regulatory legal framework without any specific law; Honduras and Costa Rica do not have either of them. The review shows that 9 countries are in the implementation phase, 4 are between the construction and review phases, and Brazil, Bolivia and Panama do not apply.

The following are lessons learned:

1. The success of these programs was directly related to the political support received through institutional decisions and allocation of resources to ensure sustainability.

2. The participation and integration of families and the community in educational activities was a key requirement for the support and success of the programs.
3. The inter-sectoral and joint actions with stakeholders from public and private spaces encouraged greater coverage and made it possible to reach more vulnerable areas outside the current educational system.
4. Strategic alliances between the education and health sectors provided comprehensive education plus respectful and quality access to health services that enabled the adolescents to exercise their sexual and reproductive health rights.
5. In the non-formal education sector, active participation of young people in all stages of the programs was a key element for acceptance and coverage. Peer education has also shown very good results particularly in groups outside the education system.

**2. Current evidence on the comprehensive sexual education by Dr. Esther Corona, Mexican Association for Sexual/MEX Health**

This presentation aims to present current evidence linking teenage pregnancy and comprehensive sexual education. Comprehensive education is defined as a type of education that is based on science; critical thinking and human rights, serving life cycle processes based on for gender equality and equity, respects and celebrates diversity, and supports a positive approach to sexuality.

As we have seen along the presentations, Teenage pregnancy is caused by:

- ✓ Institutional, family and social reluctance against premarital adolescent sexuality.
- ✓ Lack of educational, employment opportunities and autonomous life projects for teenagers, particularly in the poor quintile.

The presentation offered conclusions on the impact of STI/HIV education programs and end with some lessons learned in sexual education. The main findings on these education programs were: (a) Abstinence-only programs show little evidence of positive impact (some are not effective); (b) Sexual education programs in STI/HIV do not increase sexual activity; (c) Some programs of sexual education in STI/HIV delay initiation of intercourse, reduce the number of sexual partners and increase contraceptive use; (d) These programs are not the only solution; they may be an effective component for more comprehensive initiatives; (e) They can reduce sexual risk by about a third.

The following conclusions were made after analyzing the program's impact on attitudes and knowledge that affect behavior:

- ✓ Two-thirds of the programs were effective in changing behavior
- ✓ 100% of the programs increased their knowledge
- ✓ 5% perception risk
- ✓ 60% effect on values
- ✓ 40% group norm
- ✓ 50% efficacy rejecting sex
- ✓ 75% self-efficacy in condom use

### ***3. Challenges and trends in the curricular change in Latin America by Dr. Angela Sebastini/PER***

This presentation introduced the audience to new paradigms in education that focus on learning throughout an individual's life. An emphasis is placed on developing teacher competencies and expertise with a focus on logical, systematic and critical thinking.

Achieving these competencies requires the following:

1. Personal characteristics
2. Skills or potential skills
3. Analysis and interpretation of information received at home, school, the community, and the media
4. Internal filters: self-esteem, emotions and feelings; and external filters: access to and use of resources and cultural norms
5. Strengthening or changing attitudes and values that act as barriers or motivation for new development skills
6. Expression of skills through behavior

This new paradigm in education aims sustainable human well-being development that involves: life, corporal health and integrity, sense of life, ties, freedom of conscience, be valued and supportive, enjoy, live in harmony with nature and environmental control.

This sustainable human well-being development is for everyone and continues throughout life to take care of oneself and others, being responsible, enjoy, learn to live and help create social change. It focuses on critical autonomy (thought and action) and interdependence (empathy and solidarity) as it relates to skills development. The key themes include sexuality as part of the competency level of sexual citizenship and health is a part of its content.

Even though there are some challenges to evaluate this competency, these are some of the biomedical indicators that can be used in this evaluation:

- ✓ Delay the onset of sexual intercourse and its frequency
- ✓ Reduce the number of partners and increase in monogamy
- ✓ Reduce the incidence of unprotected sex
- ✓ Increase the consistent use of condoms and contraceptives
- ✓ Increase access and use of health care
- ✓ Complete compliance with treatments
- ✓ Reduce the incidence of STIs, pregnancy, and birth rates among teens

The end of the presentation identified some key elements in curricula discussions:

1. The emptiness of curricula and their implications
2. Tensions between outcomes and processes
3. The role of teachers
4. Independent learners
5. The evolution of teacher/pupil relationship
6. Schools as learning environments
7. Competency approaches (controversy and innovation)

#### **4. Affectivity and sexuality comprehensive on the third cycle of the basic education (secondary) in Costa Rica by Heidi Jimenez, Ministry of Public/COR Education**

The affectivity and sexuality comprehensive course was included in the third of the basic education system in Costa Rica. This type of education has been included as part of the Sciences curriculum building human bond by promoting emotional, physical and spiritual dimensions in the framework of emotional maturity. The establishment of this theme in the sciences curriculum needed to define its specific areas and different stages before its implementation. The development areas covered are: (i) interpersonal relationships; (ii) culture, empowerment and responsibilities; (iii) pleasure as a source of well-being; (iv) gender; (v) psychosexual identity; (vi) reproductive health; and (vii) human rights. The seven stages of development were implemented in various phases:

- ✓ 2008 Study with support from academia (*Universidad Nacional*) and the civil society (*Red de Ser*)
- ✓ 2011 Team building and writing the curriculum
- ✓ 2012 Program approved, teacher training, materials development, and pilot implementation
- ✓ 2013 Implementation of the program and completion of teachers training

A large communication campaign has been implemented to garner adult and adolescent support. Some examples of the campaign include advertisements on the radio, television, bus-stops, newspapers, social media sites, as well as distribution of promotional materials on shirts and bags.

The first phase identified different challenges related to outdated and unsuitable material, methodological changes, teacher training, and opposition from certain sectors of the civil society. Although these have been improved, the program still phases challenges like: the promotion and improvement of inter-sectorial collaboration; better knowledge management in the classroom; the sustainability of a communications campaign, and systematization of good practices in the classroom (identify and disseminate).

## XI. PANEL 5B. STATE OF THE ART IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Coordinator: *Dr. Renato, Pan American Health Organization, Brazil.*

The fifth B panel, coordinated by the PAHO/Brazil, focused on State of the Art in SRH Services for Adolescents. This panel provided a broad examination of the access as well as barriers to adolescent sexual and reproductive health services across LAC; adolescent pregnancy prevention efforts through Brazil's Stork Network; prevention efforts in first and second adolescent pregnancy in Jamaica and the United States; Dominican Republic's National Plan to prevent adolescent pregnancy; and finally a health services perspective of the advances made in Integrated Adolescent Health (read the summary of the presentations below). The main points from this panel pointed towards the need for: 1) a wider array of quality and universal access to sexual and reproductive health services geared towards adolescents in LAC, including inter-sectorial collaboration; 2) an enhanced financial and political investments in adolescent pregnancy prevention, putting this issue on the agenda and ensuring the provision of adolescent prevention services to the most at risk populations; 3) further efforts in the area of ASRH promotion, prevention and integrated sexuality education; and implementation and scaling up of ASRH norms, standards and guidelines .

### **1. Prevent adolescent pregnancy through the Stork Network (Red Cegonha) in Brazil by Dr. Julia a Rezende Melo da Silva, MINSAL/BRA**

In Brazil 18% of the population consists of adolescents between 10-19 years of age. Health is considered a state right and it is the state's duty to provide comprehensive care services and equity in a decentralized manner. The Ministry of Health makes the policies, standards, guidelines and sets a funding budget. The State coordinates, implements, executes and finances the programs. Municipalities also implement, run and financed programs

Within the Health System, teenagers have free access to the health units. Among the strategies used for the protection more than 21.5 million Adolescent Health Books (*Libretas de salud para los adolescentes*) were distributed in 3,700 municipalities and more than 10,000 primary care services.

The Adolescent Health Book is a tool that has been applied to improve the overall health care of adolescents by promoting healthy growth and development through systematic monitoring of adolescents and their presence in the health centers.

In 2011, Brazil implemented a health care model for women and children, which guaranteed:

- ✓ Women: the right to reproductive planning, humanization of pregnancy, childbirth and puerperium
- ✓ Children: the right to a safe delivery, healthy growth and development
- ✓ Reduction of maternal and neonatal mortality

In 2013, the Stork Network (*Red Cegonha*) expanded its objectives to support the health team's changing attitudes and practices in order to meet the unique and specific needs of adolescents' sexual and reproductive health rights.

The Stork Network has three lines of action:

1. Reproductive Planning- Pregnancy prevention that offer: availability of contraceptives for adolescents, Male involvement, dual protection, emergency contraception and respect for autonomy.
2. Prenatal care that includes: early identification; rapid pregnancy, HIV and Syphilis tests; male involvement and vulnerability assessment in pregnancy (10-14 of age).
3. Promoting sexual and reproductive health with parent's participation and offering sexual education classes.

**2. Preventing first and second adolescent pregnancy in Jamaica by Dr. Sandra Knight, National Family Planning Board/ Jamaica**

Between 2002-2008 Jamaica experienced a decline in pregnancy amongst teens 15-19 years old from 19.9% to 14% (RHS 2002 and 2008). One of the factors contributing to this decline was the reduction of sexual initiation age (15.4 in 1997 to 16.1 in 2008). The increase in contraceptive prevalence from 69.1% in 2002 to 72.5% in 2008 is another contributing factor to the decline of teenage pregnancy. This rise in contraceptive prevalence is due to the increased availability of contraceptives and a wider selection of contraceptive methods.

Dr. Sandra acknowledges two large problems that have not been tackled in Jamaica:

1. After 30 years, Jamaica continues with the same problems. She believes that Jamaica does not know what is being done to prevent teen pregnancy.
2. The family should be the main, stable institution that will teach children values.

**3. National Adolescent Pregnancy Prevention Plan by Dr. Monika Carrion, PRONAIISA/DOR**

In the Dominican Republic, teen pregnancy is a manifestation of social inequality: higher pregnancy rates prevail among less educated individuals, migrants, and rural residents of poorest provinces.

Adolescents represent the 4<sup>th</sup> largest part of the national population and its impact on health indicators can be seen in: (a) High rates of teenage pregnancy (30% were born to teenage mothers in 2011); (b) In 2010 19% of maternal deaths occurred in adolescents; (c) It's the largest age group associated with STI / HIV and AIDS.

Currently the Dominican Republic has a National Strategic Plan to Prevent Teen Pregnancy 2011-2016 (Plan-EA) whose objectives are to:

1. Promote a legal framework of public policies to support teenage sexual and reproductive health
2. Incorporate comprehensive sexual education courses and disseminate DS and DR
3. Strengthen the quality of health services offered
4. Develop skills to empower girls and young women
5. Develop a national information system for adolescent sexual and reproductive health
6. Promote the organization and active participation of adolescents
7. Strengthen strategic partnerships for the prevention of teen pregnancy

In 2011 a law was enacted to commission an execution plan. Then in 2012 the Program of Affective-Sexual Education was reviewed and a cost estimate was conducted. Once an inter-

sectoral agreement was reached, the budgetary allocations were made and the Youth Social Oversight Committee was created. In 2013, again by decree, the National Monitoring Committee to Plan EA/Local Committees and the draft Law on Sexual Health and Reproductive Health were created.

As a result of all the decrees passed by the national government and the implementation of the Plan-EA, the coverage of sexual and reproductive health for adolescents has been expanded locally relying on the program Stronger Families and have recorded the following progress:

- ✓ Reduction of 2 percentage points compared to births to teenage mothers: 2010: 30%; 2011: 29%; 2013: 28% (MSP)
- ✓ Reduction of maternal mortality in adolescents: 2011: 19%; 2012: 16%; 2013: 12% (MSP)
- ✓ Increase the rate of contraceptive use among sexually active adolescents, and increase service and those who are already mothers by 70% (MSP-2013)

Lessons learned from the implementation of PLAN-EA:

- ✓ Territorial intervention models that focus on cost-effective, sustainable interventions create a sense of belonging and foster local development.
- ✓ Benefit of work in national, provincial and local strategic partnerships; to optimize resources, avoid duplication of interventions and improve impacts
- ✓ Advantages of using ICT's and playful activities for the dissemination of adolescent health activities.
- ✓ The introduction of scientific congresses and the creation of the Society for Adolescent Health, as mechanisms to promote research and the generation of scientific evidence on adolescent health.
- ✓ The value of youth participation in services as a factor that increases demand and sustainability
- ✓ Interventions integrating families, schools and communities are key to promotion and prevention.

Challenges encountered:

- ✓ Cultural barriers that limit access to information, services and contraception (incorporating gender and human rights-DS and DR)
- ✓ Continue to comprehensive and integrated sexual and reproductive health coverage for adolescents
- ✓ Emphasize the offer of counseling and contraception, especially contraceptive Post obstetric event and Adolescent Pregnancy.
- ✓ Encourage youth participation and empowerment
- ✓ Increase the use of the school as a setting for health promotion
- ✓ Influence the undergraduate curricula / medical, nursing, psychology, education, social work, among others.
- ✓ Strengthen the use of ICT's for health promotion
- ✓ Continue promoting scientific research on adolescence
- ✓ Ensure the curricular inclusion of sex education so that it can be taken as a right



**4. Advances in Integral Development of Adolescent from the Perspective of the Family and Community Health Model by Dr. Emig Bravo, MD Adolescent's Health Responsible (Ministry of Health, Nicaragua)**

Over 21% of Nicaragua total population is comprised of adolescents (1,304,128) where 51% are adolescent boys<sup>7</sup>. Adolescent pregnancy is still high, 92% in 2011 among 15 to 19 year olds. These rates for early drop outs and intra-familial violence have drawn the national Government's attention to take some actions in the prevention and promotion of healthy habits among adolescents.

Nicaragua has signed and committed to several international laws and regulation to protect women, children and adolescents which has led to the creation of other national laws and regulation. The following are some of these international and national laws:

1. Universal Declaration of Human Rights International Conference on Population and Development, Cairo, (September 1994);
2. Fourth World Conference on Women, Beijing (1995);
3. Declaration of the Millennium Development Goals;
4. Convention on the Elimination of All Forms of Discrimination against Women; among other.

The Ministry of Health regulates the country's health system and bases its policies on the development of the MOSAFC model. This model is based on strengthening health at the individual, family and community level to promote good health habits and prevent bad habits through an integrated intercultural and inter-sectoral approach. The MOH has created several rules and regulations to promote healthcare for every Nicaraguan, here there are some examples:

1. National Health Policy, 2008;
2. Intercultural Health Plan of the Autonomous Region of the Caribbean Coast of Nicaragua (2005 to 2015);
3. National Strategy for Sexual and Reproductive Health (2006/2008 Health);
4. Multi-annual Health Plan (2011-2015); among others

The political will of the Government to support adolescent's health and their good development as citizens have led the MOH create an integrated strategy for adolescent development, ENSDIA (*Estrategia Nacional de Salud y Desarrollo Integral para Adolescentes, 2012-2017*). This strategy has been developed in line with the MOSAFC model and aims to lead an inter-sectoral agreement between key actors on adolescent development like the Ministry of Education (MINED), the Ministry of Family (MINFAM) and the Ministry of Youth (MINJUVE).

The ENSIDA has a bio-psychosocial approach where adolescents, families and community are all involved. Families and adolescents are encouraged to participate in extracurricular activities to promote familiar dialogue. Health personnel need to provide care for the adolescent, and promote and encourage healthy behaviors by communicating, motivating and guiding them. It bases its health promotion and prevention on the MOFAC model with the following key themes: Nutritional status (obesity, lack of exercise, chronic illness); Fertility; Sexuality and gender,

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<sup>7</sup> ENDESA (Encuesta Nicaragüense de Demografía y Salud) 2014

contraception; Violence (bullying, sexual exploitation and commercial); Life project education; Social situation; Multiethnic and Multicultural; Demographics; Migration; Poverty and Child and Adolescent Labor; Prevention of risky behaviors (Snuff, Alcohol and Drug); and Accidents.

As a part of the Government policy, the MOH has been promoting teenager's training as health promoters in both rural and urban areas. These peer trainings have proven to be a positive strategy that greatly influences adolescent's life skills development.

Meanwhile, the MOH has determined four areas in need of intervention:

1. Intercultural comprehensive health services
2. Interventions based on family, community and school
3. Strategic alliances and collaboration with other sectors
4. Media communication and social participation

It has also been working on a regulatory framework for adolescents that includes: a comprehensive care guide for adolescents (N-109), a prevention of gender violence in adolescents and young manual, and an instructions booklet to fill out comprehensive history of adolescents (HIA, N-107). The MOH developed several instruments to tackle comprehensive adolescent health, life skills, strong families and counseling. Here there are some examples:

- ✓ Assessment of depressive disorders during adolescence
- ✓ Screening questionnaire (applicable to victims of domestic and sexual violence)
- ✓ Testicular self-examination guide
- ✓ Breast self-examination guide
- ✓ Develop life skills book for teens working in groups
- ✓ Policy 117- Manual promoting the prevention of adolescent risk behavior to help strengthen families.
- ✓ Policy 074 - Module I counseling manual on adolescent health for the teenage counseling staff.

The MOH has made some progress in the comprehensive strategy for adolescent such as:

- ✓ Institutionalization of the regulatory framework to address adolescent health
- ✓ Inclusion of adolescents strategic activities in the 3rd line of the Short-Term Results Plan "Combating Maternal Mortality ", the Multi-Annual Plan and the National Plan for the Reduction of Maternal Morbidity and Perinatal Mortality
- ✓ Preparation of an adolescent chapter in the ENDESA 2011/12
- ✓ Development of a National Plan for Teenage Pregnancy Prevention
- ✓ Declare a teenage pregnancy awareness week near September 26 (World Day for Prevention of Adolescent Unwanted Pregnancies)
- ✓ Inclusion of ambulatory recording sheet on adolescent variables
- ✓ Promotion of adolescent's active participation in activities promoted by the MOH
- ✓ Management strengthening on teenagers health in the overall MOH network
- ✓ Definition of action lines on adolescent development with the international agencies
- ✓ Institutional and community capacity building
- ✓ Promotion of healthy environments for adolescents to develop skills and empowerment capabilities

- ✓ Strengthening inter-sectoral coordination under the leadership of the Ministry of Youth (MINJUVE).

Even though and important progress has been made in the adolescent strategy, there are some challenges the MOH will need to face:

- ✓ Increase the access of adolescents to SRH services and contraception.
- ✓ Empower health personnel on comprehensive adolescent health protocols
- ✓ Have an adolescent and youth health information system timely and updated
- ✓ Promote the access to long-lasting contraceptive methods
- ✓ Strengthen interagency coordination between MINJUVE, MINSa, MINED and MINFAM.

## **XII. PANEL 6: LESSONS LEARNED REGARDING THE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH BY ADOLESCENTS AND YOUTH.**

Coordinator: *Dr. Suzanne Serruya, Director, OPS/CLAP*

The sixth panel, coordinated by the CLAP/PAHO, examined best practices and lessons learned in terms of access to sexual and reproductive health by adolescents in LAC. This panel included a situational analysis describing the availability of, and access to contraceptive methods amongst adolescent in LAC; state of the art in LARC; current evidence on emergency contraceptive methods; and a case study describing the access to sexual and reproductive health services by adolescents in El Salvador (read the summary of the presentations below). The main points of this panel were: 1) although there has been an increase in the percentage of adolescents using contraceptive methods in LAC, there is still a lot of young people with an unmet need for family planning; 2) long lasting contraceptive methods are the most effective type of birth control method regardless of age; 3) based on scientific evidence, although emergency contraceptive methods are very effective in preventing pregnancy, they are not abortive; 4) although countries in the region are starting to develop and implement ASRH strategies, plans, programs, and interventions, they still have a long way to go. For example, although many countries implement “Adolescent Friendly Services” they do not monitor or evaluate the quality of said services, and therefore do not maximize impact.

The highlights of this panel included the presentations made by Dr. Horacio Croxato from ICMER, and Dr. Gina Secura from the Washington University in St. Louis, Missouri. In particular Dr. Croxato’s presentation centered on the science behind the EC drug and its effectiveness in the hours and days after unprotected sexual intercourse. Dr. Croxato’s presentation provided a review of the empirical data and evidence, leading to the conclusion that EC is not abortive in function. Dr. Secura’s presentation provided a detailed overview of LARC as well as the contraceptive advocacy work undertaken by the Contraceptive CHOICE Project. Dr. Secura, highlighted the advantages of utilizing LARC and pointed towards a strong scientific base of research suggesting its high level of efficacy in preventing unintended pregnancies and the need to reframe the conversation to provide affordable as well as effective methods.

### ***1. Long Lasting Contraceptive Methods by Dr. Gina M. Secura, Project Choice / USA***

This presentation walked the audience through different contraceptive methods. An emphasis was placed on long lasting contraceptive methods followed by a presentation on the CHOICE project.

Based on medical evidence failure rates in contraceptives after the first year of use are higher in male condoms, the female patch, rings or injections and IUD – Copper T 380A, IUD – Levonorgestrel 14mcg and 20 mcg, and sub-dermal implant. These three methods need to be inserted by a healthcare provider. They also provide long lasting contraceptive coverage; the sub-dermal implant lasts 3 years while the IUD-Copper T 380A provides up to 10 years of coverage. Neither has a long-term effect on fertility.

In August 2007, the Contraceptive CHOICE Project started to remove the financial barriers to contraception, promote the most effective methods of birth control, and reduce unintended pregnancy in the St. Louis area. The CHOICE project conducted a study with female residents of Saint Louis City or County between the ages of 14-45 years, who were English or Spanish-speakers, were sexually active with a male partner or planned to become sexually active, were

willing to start a new contraceptive method and had no desire to become pregnant during the next 12 months following the study. The objectives of the study were to:

- ✓ Promote LARC (IUDs and implant) by removing financial barriers
- ✓ Measure choice, satisfaction, side-effects, and continuity across a variety of reversible contraceptive methods, including LARC
- ✓ Provide enough no-cost contraception to greatly reduce unintended pregnancies

There were 9,256 women participating in the study, of which 15.2% were adolescents. LNG-IUS (Levonorgestrel 14mcg and 20 mcg) and copper IUD were the most chosen contraceptive methods among adolescents. Participants could choose from: IUD copper or hormonal implant, sub-dermal implant, contraceptive injection, contraceptive pill, patch, vaginal ring, condoms or emergency contraceptives.

The following are some main findings and conclusions of the study:

- ✓ 75% of adolescents (14-19) and 82% of women (20-45) were satisfied with LARC (long acting reversible contraception) methods in the 12 months following the study, while only 42% of adolescents and 50% of women were satisfied with non-LARC methods.
- ✓ The unintended pregnancy by contraceptive method showed that LARC had lower rate even at the third year, while PPR (pills, patches or ring) had higher rate even at the first year of the study. LARC users had a lower rate of unintended pregnancy, even during the third year of use. PPR (pills, patches or ring) had a higher rate of unintended pregnancy during the first year of use.
- ✓ Women & teens were much more likely to still be using LARC at 1 & 2 years compared to more commonly used non-LARC methods
- ✓ LARC methods are highly effective at preventing pregnancy regardless of age

## ***2. Teenagers' access to contraception LAC: an analysis of missed opportunities by Dr. Bremen Murcio, CLAP/OPS***

This presentation used different data to show pregnancies and the contraceptive methods used by women in the Latin American and Caribbean Region.

The first data came from SIP CLAP/SMR 2014 survey where 709,057 women were studied. This survey distributed the population by age in five different groups (group1: 10-14, group 2: 15-19, group 3: 20-24, group 4: 25-34, and group 5: 35 and older). Even though the pregnancy rate among the two combined adolescent groups (ages 10 to 19) was still high, representing 24.8% of the total, the study showed that the highest pregnancy rate 36.6% belonged to the group of women between 25 to 34 years of age. Another important data in this survey was related to the percentage of unwanted versus wanted pregnancies. The data showed how unwanted pregnancies are higher in both adolescent groups, especially in adolescents between 10-14 years of age where the percentage of unwanted pregnancies represented 61.4% versus 38.6% of wanted pregnancies. Among adolescents 15 to 19 the distribution was very similar, almost half where unwanted pregnancies (49.4%) and half wanted pregnancies (50.6%).

Another set of data from the same source (SIP CLAP/SMR 2014 survey) studies 214,541 women. Here the population was divided by age in four different groups (group 1: 10-14, group 2: 15-19, group 3: 20-24 and group 4: 25-34) to analyze the use of contraceptives. High percentage were showed in the category of Non-contraceptive used among all four group, the percentage of non-

contraceptive use was high among all four groups. In the first adolescent group 40.6% did not use contraceptives, 22% used condoms, and 37.4% used hormones. The second adolescent group (15-19) showed that 39.2% did not use contraceptives, 21% used condoms, and 39.8% used hormones.

Finally, the presentation showed data related to access and wanted methods of contraception among women in a survey with a total population of 3,798 women. 1,558 of these women had access to contraceptives and 2,017 could use their chosen method. In most of the age groups the majority of women had access first to injectable contraceptives followed by IUCs and condoms. Just the group of 35 year-olds or older had access first to IUCs, then injectable contraceptives, pills and condoms.

### ***3. Current evidence Emergency Contraceptive Methods: A regional analysis by Dr. Horacio Croxato, ICMER/CHI***

In 2004 a study was conducted to show how LNG could interfere or not with the ovulation cycle. There were 57 women that participated in this study some of the findings and the comparison with other studies done in rats and monkeys led to the following conclusions about LNG intake:

- ✓ LNG interferes with the ovulatory process in women and animals.
- ✓ LNG does not alter the endometrium gene expression in women neither prevent the implantation in monkeys and rats.
- ✓ LNG prevents pregnancy only when the woman intake the pill before ovulated.
- ✓ When women intake the pill after fertilization LNG does not prevent pregnancy.

In conclusion, the estimated effectiveness of LNG was higher if the dose of 1.5 mg was given in less than 24 hours of an intercourse before women ovulation, although it showed that could be effective until 120 hours after.

### ***4. Lessons learned on the friendly access for adolescents and youth to sexual and reproductive health in El Salvador by Dr. Mario Soriano, MINSAL/ELS***

This presentation explains an analysis of the studies done on El Salvador's adolescent population. Adolescents comprise 22% of the population in El Salvador. As a result of high adolescent mortality rates due to non-communicable diseases and violence, a high level of teenage pregnancy (33% of adolescents gave birth in 2013) and maternal mortality (teens comprised 25.1% of the total maternal mortality in 2013), and the low rate of contraceptive use among teens, the Government of El Salvador began creating strategies to promote adolescent well-being and development.

The following legal actions will help promote adolescent well-being and development:

- ✓ National law for the integral protection of children and adolescents (LEPINA)
- ✓ National law for the youth (Ley General de Juventud)
- ✓ Institutional Alliance for comprehensive health care of adolescents and youth
- ✓ Inter-sectoral plan for comprehensive health care for the adolescent and youth population (2012-2014)

Friendly health services based on inclusion, gender, human rights and diversity were created to instill positive behavior and attitudes toward teen health (self-care). These services have five integrated strategies:

- ✓ Multidisciplinary health personnel: Training courses and graduates
- ✓ Educational Strategies: Parents/tutors, adolescents, pregnant women, teachers, and community
- ✓ Social Media Strategy: Decision makers, opinion makers, teens, family, and community
- ✓ Specific monitoring and evaluation and coordination with the Alliance
- ✓ Research: Human Rights, 2<sup>nd</sup> pregnancy prevention, GYTS, GHSH

There are three types of friendly health services offered in El Salvador: (a) Comprehensive Care Centers for Adolescent Health (CAISA); (b) Attention to areas with large populations of adolescents and youths; (c) Consultation with adolescents and youths.

These services provide information and prevention services on nutrition, healthy life styles, hygiene, disease prevention, sexual and reproductive health, rights and responsibilities, and violence prevention.

Many activities, such as leadership training, youth clubs, creating a strong family strategy, life skills seminars, and community and family work in areas of environmental and social risk, have been done with teens, their families and communities.

### **XIII. PANEL 7: PREGNANCY IN ADOLESCENTS UNDER 15 AND ITS RISK FACTORS**

Coordinator: *Dr. Albertina Duarte Takiuti, State Coordinator of the Adolescent Health Program, Ministry of Health SP/BRA.*

Panel seven was coordinated by a representative from the Brazilian Ministry of Health, examined the current situation in terms of pregnancy amongst girls under the age of 15 in LAC, its risk factors and subsequent negative outcomes. It also examined lessons learned in terms of empowering adolescent girls in Guatemala, and of working with adolescent boys to prevent adolescent pregnancy in Costa Rica (read the summary of the presentations below). The main points from this panel included: 1) although there is an overall lack of information regarding under 15 pregnancies in LAC, the data that does exist suggest that approximately 66,000 of all the live births taking place in LAC, belong to girls under the age of 15; 2) social risk factors associated with under 15 pregnancy include poverty and marginalization, geographical location (rural vs. urban), education level, exposure to Interpersonal and gender based violence (IPV and GBV respectively), low access to health services, etc., 3) pregnant adolescent girls under the age of 15 are at increased the risk of maternal mortality and psycho-social health problems; 4) in order to prevent under 15 pregnancies, interventions need to consider that adolescents under the age of 15 are a different type of cohort than adolescents 15-19 and therefore have different needs and risk factors. Further, considering that IPV and GBV is strongly associated with under-15 pregnancy it is important that pregnancy prevention programs first recognize IPV and GBV as risk factors for under 15 pregnancy; promote gender equality, and that these interventions target both adolescent girls and boys

#### ***1. Pregnancies in adolescents under the age of 15 in selected countries in Latin America by Dra. Nina Zamberlin, MINSAL/ARG.***

Current research on pregnancies in adolescents under the age of 15 seems to be lagging behind due to: (a) its complexity, (b) magnitude of its consequences – physical, psychological and social; (c) legal issues; and (d) limited available information.

The associated risks of the adolescent pregnancy under the age of 15 are mainly biological (e.g. late diagnosis, lower number of prenatal check-ups, difficulty to access legal abortion, among others). Some of the key psychological and social factors are: (a) the need to undertake an adult role; (b) responsibilities and motherhood at an early age; (c) vulnerability; (d) opportunities for education; (e) family decisions and dependency from adults in the family.

The main challenges of the situation are: violence and sexual abuse; the available information does not reflect accurate measures. Other factors that need to be considered are: (a) the need to address under 15 pregnancy as a separate issue; (b) heterogeneity; (c) balance between abuse prevention and the right to sex in adolescents; (d) identify and share successful experiences; (e) support research and data recollection; (f) need for integrated health and education services.

Phase I of a pilot study on adolescent health in Argentina is presently under implementation and will gradually be implemented in selected Latin American countries. The objective of this study is to generate knowledge about the teenage pregnancy that contributes to the reorientation of public policies and programs for adolescent health, especially the age of 15.



## **2. Adolescent Women's Empowerment in Guatemala by Dr. Ludy Rodas, MINSAL/GUT.**

The Program SAQILAJ B'E defines the route to execute the rights of indigenous adolescent girls in Guatemala. The main partner is the Secretary of Planning and Programs of the Office of the President (SEGEPLAN) and works together with - local governments and NGOs. They include the Ministry of Health, Ministry of Education, Ministry of Social Development, municipalities, local leaders, civil society, SVET, DEMI and SEPREM.

The program objective is to empower adolescent girls by contributing to execute the rights of indigenous girls and adolescents to develop to their full potential and have a life free of violence. This is achieved by: (a) promoting access to comprehensive health services; (b) access to formal and informal education; (c) promote their active participation in decision making; and (d) contribute to the knowledge and information sharing about adolescent health.

Success factor: identify adolescent interests that are also recognized by community authorities and their parents.

Progress to date: (a) development of friendly spaces for adolescents; (b) strengthened youth leadership; (c) development of a community strategy to prevent adolescent pregnancies; (d) implementation of the *Familias Fuertes* strategy; (e) implementation of the program *Abriendo Oportunidades*; and (f) development of a program to promote school reinsertion.

## **3. Violence and Adolescent Pregnancy by Dr. Sonja Caffè, OPS/WDC.**

Physical, emotional and sexual violence affect sexual reproductive health (SRH) and increase the risk and vulnerability for undesired SRH outcomes (unintended pregnancy, abortion, STI, etc.). Violence can be random, occur in specific contexts (war, emergency, rape), or take place in the context of family and other close relationships. The most consistent form of violence affecting women (in the LAC region) is intimate partner violence (IPV).

The following are WHO recommendations to address IPV and gender based violence (GBV): (a) recognize GBV/IPV as a public health problem; (b) put women's safety first and ensure confidentiality of information; (c) do no harm: monitor unintended consequences, promote women's safety, mitigate backlash; (d) promote gender equality: gender transformative interventions; (e) facilitate meaningful participation of women and men in design of interventions; and (f) refer to specialized and community services networks.

Conclusions:

- ✓ Adolescent girls are at greater risk to experience IPV;
- ✓ IPV is multidimensional & intergenerational;
- ✓ IPV must be taken into account in interventions addressing adolescent pregnancy;
- ✓ Reproductive coercion includes pregnancy coercion and birth control sabotage;
- ✓ IPV interventions will not necessarily identify women/girls experiencing reproductive coercion; and
- ✓ Providers can help women experiencing RC through counseling about contraceptives less susceptible to partner influence and violence support services.

**4. Experiences and lessons learned from interventions focusing on adolescent males by Dr. Carlos Garita, CCSS/COR.**

In Costa Rica there are several lessons learned from interventions focusing on adolescent males, some of them are: (a) legal framework needs to support processes; (b) need for training materials on the topic; (c) training staff implementing the programs; (d) training of adolescent groups; (e) work with NGOs; (f) ongoing awareness programs; (g) define change indicators for male adolescents; and (h) evaluate implemented actions and programs.

Program implementation includes the following actions: (a) staff training; (b) focus groups for offenders held in national hospitals; (c) include both parents in courses addressing childbirth; (d) workshops and training on sexual and reproductive health for adolescents (boys and girls); (e) health fairs.

#### **XIV. PANEL 8: SUBREGIONAL ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH INITIATIVES.**

Coordinator: *Dr. Amparo Gordillo-Tobar, Health Operations Manager for the World Bank in Nicaragua and El Salvador*

Panel eight coordinated by the World Bank, presented existing sub regional initiatives including 1) the Andean Plan to Prevent Adolescent Pregnancy; 2) the Meso-American Health Initiative 2015; 3) CARICOM's Strategy to Prevent Adolescent Pregnancy; and 4) COMISCA's Initiative to Prevent Sexual Violence. Further, this panel presented a case study on adolescent pregnancy prevention in Guyana (read the summary of the presentations below). The main points from this panel included: sub-regional initiatives have the potential to convoke cross-border political commitment and to promote political accountability; existing sub-regional plans and strategies provide models that other sub-regions can adopt, adapt and learn from; strategically planned regional meetings that involve multiple countries, agencies and sectors have the potential to result in functional regional initiatives; all strategies and plans reinforce the need for strategic information, evidence based interventions, best practices and lessons learned.

##### **1. Evaluating the Andean Plan to Prevent Teen Pregnancy (PLANEA) by Dr. Carmen Calle, MINSAL/PER.**

Ministries of Health of the following countries (Bolivia, Colombia, Chile, Ecuador, Peru and Venezuela) work together towards prioritizing adolescent sexual and reproductive health, focusing in particular on the vulnerable population and the prevention of adolescent pregnancy.

Key strategic areas for this Andean Plan are: (a) Information, monitoring and evaluation systems; (b) institutional strengthening and horizontal technical cooperation; (c) adolescent participation; and (d) advocacy and partnerships.

Some results: establishment of an Andean Week for the prevention of adolescent pregnancy; analysis of the legal frameworks; preparation of the document Andean Policy for Sexual and Reproductive Health with emphasis on Teen Pregnancy; and preparation of training and guidance materials for adolescents under 14 years of age.

Among the advantages of a sub-regional approach the following should be highlighted: the consolidation of efforts to promote development, inclusion and equity to address a common challenge; strengthen the use of contraceptives; knowledge exchange among countries; and possibilities for replication and validation of the most successful experiences.

Upcoming challenges in the Andean Region:

- ✓ Keep adolescent health in the agenda of the region's Ministries of Health;
- ✓ Expand local initiatives on the topic to a national dimension;
- ✓ Youth participation should prioritize vulnerable groups;
- ✓ Work together to overcome barriers related to information and access to sexual education and health services;
- ✓ Emphasize the work with adolescents under 15 to prevent pregnancy and increase health services;
- ✓ Strengthen the work to support vulnerable groups; and
- ✓ Strengthen and increase South-South knowledge exchange.

**2. Central America Health Initiative 2015. (La Iniciativa Salud Mesoamérica 2015) by Dr. Patricia Jara Maleš, Social Protection and Health, IDB.**

The Mesoamerica Initiative included: Belize, Costa Rica, El Salvador, Guatemala, Honduras, México, Nicaragua and Panamá.

The initiative is a public-private enterprise that aims to increase equity in health, especially for the most vulnerable populations. Its main objective is to help achieve the Millennium Development Goals by 2015. The program analyzes the health problems of each country and supports strategies and actions to improve maternal and child health. The program uses results-based financing and promotes policy dialogue to identify and support cost-effective interventions.

Maternal and child health initiatives include: (a) a strategy for healthy child delivery and neonatal care; and (b) an integrated model for adolescent sexual and reproductive health to include a multifactor approach.

The Mesoamerica Initiative has been implementing an integrated service model to prevent adolescent pregnancy. In Costa Rica, diagnosis of the situation brought: limited coverage, availability of services to help identify and prevent pregnancy, acceptance and accessibility of services, and monitor and evaluate the program. The program has defined indicators for an 18 and 36 month implementation period.

Policy challenges:

- ✓ Define effective initiatives to prevent adolescent pregnancy and to provide support to adolescent maternal and paternal health through key programs and services in the social protection system.
- ✓ Align incentives to delay in adolescent pregnancy and increase school attendance (e.g. conditional cash transfers).
- ✓ Emphasize actions addressed to the families so that they can effectively support and protect the adolescents. Emphasize the use of family oriented programs which will effectively support and protect adolescents.
- ✓ Design strategies to prevent adolescent pregnancy by providing services to adolescent mothers and fathers, promoting sexual and reproductive health initiatives addressed to adolescents that take into account intercultural factors to ensure adequate program responsiveness and pertinence.
- ✓ Implement a multi-sectoral approach.

**3. Adolescent Pregnancy Prevention Strategies in the Caribbean by Dr. Morella Joseph. CARICOM.**

Research indicates that sexually active Caribbean children had their first sexual intercourse before the age of 10 (42.8%) mainly due to sexual abuse and exploitation.

The Integrated Regional Framework for the Prevention of Adolescent Pregnancy aims to reduce the number of adolescent pregnancies in each country of the English- and Dutch speaking Caribbean by at least 50% between 2014 and 2017.

The strategic framework has five result areas: (a) access to responsive sexual- and reproductive health services, information and commodities; (b) access to age appropriate comprehensive sexual education; (c) social protection mechanisms for the prevention of all forms of violence against adolescent girls; (d) legal standards; and (e) exchange of knowledge, information and good practices in addressing adolescent pregnancy.

The proposed strategies to implement the framework are:

- ✓ Evidence based policy advice and action
- ✓ Knowledge management to create evidence required for policy advice and action
- ✓ Design and adjustment to policies, programs, laws and implementation mechanisms based on analysis
- ✓ New courses in tertiary education for personnel in these sectors
- ✓ Capacity building in the health, education, child and social protection sectors

Best Practices include early childhood interventions, youth development, involvement of family and other caring adults, boys and male involvement, interventions that are culturally relevant, community service with academic learning, opportunities for increasing employment for adolescents, and access to reproductive health services.

***4. Experiences and lessons learned in the Prevention of Adolescent Pregnancy in Guyana by Dr. Ertenisa Hamilton, Adolescent Health Unit, MINSAL /GUY.***

In Guyana, a multi-sectoral approach has a series of programs and initiatives in place geared towards the reduction of adolescent pregnancies. These institutions include the Ministry of Culture Youth and Sport, the UNFPA, the Ministry of Human services, Women Across Differences, the Ministry of Education.

These are some of the challenges faced in addressing teenage pregnancy in Guyana

- ✓ Traditional norms and values of parents, health care workers and teachers in addressing issues of Sexual and Reproductive Health Education
- ✓ The doctrines of faith based organizations which limits the access to vital information on Sexual and Reproductive Health Education
- ✓ Gender disparity in the promotion of health based information and services
- ✓ Attitudes of Health Care Providers in rendering Primary Health Care Services to Adolescents
- ✓ Poverty and inequalities which place adolescent girls in vulnerable situations such as single parent mothers encouraging their daughters to reach out to men for financial support, and girls engaging in transactional sex for basic necessities
- ✓ Geographic Landscape of Guyana restricts access to the dissemination of information
- ✓ Legislation limits the services offered by health care workers /providers.
- ✓ Although there is a comprehensive Sexual and Reproductive Health Program within the Education Sector, via the HFLE Curriculum, condom demonstration and distribution is prohibited.

Despite the challenges, Initiatives geared towards the reduction of adolescent pregnancies includes: (a) legislation that enables medical termination of pregnancies at any age; (b) Establishment of community adolescent youth friendly spaces; (c) partnership between Women Across Differences and UNFPA to reduce second and third pregnancies; among others.

After the implementation of some initiatives, Guayana has some lessons learned to share:

- ✓ Access to comprehensive SRH services and information has positive outcomes especially in the sexual behavior of adolescents
- ✓ The approach to teenage pregnancy must be modified to fit the different geographic locations
- ✓ Active participation of youths in policy making provides information and approaches that are more effective in achieving set goals
- ✓ New legislation has to be in place so that better health services can be accessed by adolescents without breaking the law. (present legislation does not protect medical practitioners with regards to offering services to minors)
- ✓ Programs designed for adolescents must have mechanisms in place to be sustainable.

Projected work for 2014 includes the following: (a) revision of the Adolescent Health and Wellness Strategy; (b) finalization of the Sexual and Reproductive Health Policy; (c) implementation of the National Youth Policy; (d) collaboration with the Ministry of Finance on efforts to reduce teenage pregnancy in order to achieve the MDG Goal #5; and (e) collaboration with other Ministries to synchronize efforts to prevent teenage pregnancy.

***5. Initiative to Prevent Sexual Violence in Central America by Dr. Addis Dominguez. Technical Commission on Gender and Health, GTGS COMISCA/COMMCA***

There is a strong correlation between sexual violence and adolescent pregnancy. The effects of sexual violence during childhood and adolescence affect a person's autonomy and increase the risk of teen pregnancy. Therefore, it is important that the models and strategies to prevent adolescent pregnancy include gender and sexual violence as variables to control teen pregnancy.

There are a number of regional initiatives to prevent sexual violence in Central America and the Dominican Republic which are based on the principles of human rights, gender equity and female empowerment.

From all initiatives, COMISCA has gathered the following lessons learned:

- ✓ Countries need to invest more in preventive health and local health facilities;
- ✓ A multi-sectoral approach at the national and local levels is key to prevent and address sexual violence;
- ✓ There is conflict surrounding gender related issues, specifically in the legal framework and the barriers associated with a patriarchal society that is typical in the region;
- ✓ There is a lack of research and statistical data ;
- ✓ It is a priority to work on integrated systems to address violence and sexual violence;
- ✓ Regional initiatives are advantageous in enabling and promoting knowledge sharing; These initiatives need to be reflected in policies at the national and local level in order to help address the issue of sexual violence;
- ✓ Regional initiatives show that it is possible to learn and establish new relationships based on gender equity to be able to address sexual violence;
- ✓ There is a need to harmonize indicators to measure sexual violence; and,
- ✓ Current research and investments are limited and sexual violence can easily be considered as "private matter".

## **XV. SPECIAL PRESENTATION:**

***Lessons Learned in the Use of E-health to Prevent Teen Pregnancy Brining the TECH by Dr Bhupendra Sheoran, youth health + tech + (YTH)/USA***

This presentation focused on the lessons learned in E-health in the prevention of adolescent pregnancy. In particular this presentation laid out three key points in the utilization of technology and digital platforms as health resources and tools in promoting ASRH. The material covered included the following: (a) A discussion of current trends in the use of technology observed amongst youth; (b) The sharing of examples of programs using new media and technology (i.e. violence prevention apps); and finally (c) an introduction to new and exciting innovations in tech health as well as its implications in terms of reaching adolescents and in promoting ASRH.

Latin America has the fastest growing Internet population in the world with a 12% of growth between 2012 and 2013 (147 million). From these Latin-American users, youth between 15 and 24 years of age represented 32.4% of users 26% worldwide. Some examples of the technology used in Central America are:

- ✓ 92% regularly visit social networking websites and is among the most popular activities.
- ✓ 2 in every 3 mobile phone owners visit social networking websites with their phone.
- ✓ 7 in 10 smartphone owners regularly use their phones while watching TV.
- ✓ 48% of Internet users visit music websites each month.
- ✓ Half of the Central American online population regularly uses their computers while watching TV.

The usual ways of learning about sex have been through school, family, and friends. In the 20th century, the field of sexual and reproductive health education has moved outside the classroom and into the digital sphere, expanding access to critical information for youth through online and mobile programs to conduct awareness, outreach, advocacy, and parent-engagement.

Right now, young people are frequently online and looking for information. They generate specific questions and need quick responses to find their answers. In many occasions they are not searching the same way adults might or for the terms that institutions expect. They use more colloquial terms and slang phrases when using search engines like Google. They see sexual health pictures and videos through their mobile phones, which is why it is necessary for search engines and the results to be compatible for mobile phone use. Knowing how to use the Internet in a more youth friendly manner is extremely important. Google Adwords is a free tool offered to non-profits where users can type a particular keyword, such as HIV, and can see how many searches there have been in the last month and the exact terms searched.

The following are some programs, websites and technology showed in this presentation:

- TechSex USA. In early 2011, ISIS embarked on a journey to discover trends and patterns about Youth Sexual and Reproductive Health in the Digital Age. There were stakeholder interviews from the digital and social media sphere, philanthropy sector, and program leaders in the field. 1500 youths who were engaged in popular online gaming and virtual world sites were surveyed. Focus groups were conducted with close to 200 youths and young adults ages 13-24. There was also a review of relevant published and syndicated reports within the digital, educational, and consumer arenas. While ISIS set out to discover information about sexual and reproductive health, they found clear technology trends

across various domestic and international areas and processes. Whether social change movements or educational efforts or intergenerational philanthropy - the future was clear: There are immense opportunities to build networks and programs that are cost-effective and sustainable if we stay on top of our technology trend forecasting and remain flexible.

- Justus411.org A collaborative research study was conducted with the University of Colorado. It was an NIH funded study (RO1) that looked at online social networking for HIV prevention. The objectives were to explore, identify, and compare strategies for recruitment and enrollment of online social networking users. The study initially began on Myspace but was shifted to Facebook. To determine the efficacy of exposure to Just/Us on HIV related risk behaviors for individuals and within networks. Just/Us was developed after formative work with youth using Facebook. Recruitment was face to face, online and through ads in college newspapers. Once recruited, participants were exposed to Just/Us content for two months. At the end of 2 and 6 months participants completed follow-up interviews. Condoms intention to use and norms showed improvement compared to control but there was no difference in condom self-efficacy. Intent to use condoms increased when compared to those in the control group, but there was no difference in condom self-efficacy.
- ¡únete latina! It is a mobile website for women in the United States.
- D.I.V.A.S (Developing Individual Values Attitudes and Skills) is a website mainly for African Americans.
- Digital Storytelling. It is an emerging term, one that arises from a grassroots movement that uses new digital tools to help ordinary people tell their own 'true stories' in a compelling and emotionally engaging form. Digital storytelling is a way for individuals to share meaningful stories from their lives. Spoken words form the basis the story, while photographs and music are used to add emotional impact. These elements are combined to produce a short (< 10 minutes), personal multimedia work that can be shared electronically.
- Mobile APPS: 78% of teens now have a cell phone, and almost half (47%) of them own smartphones. The number of smart phone owners is expected to double in the next couple of years. Hence, more teens will be able to download apps on their phones than ever before making mobile phone applications a viable way of working with teens. Apps against abuse, Condom Finder, Teens in NYC Protection, Clinic locator (youth friendly clinic), etc. are all examples of successful mobile phone applications.
- Text Messaging: This tool has been used in many countries because it allows information to be sent and received almost instantaneously. Since it could send the information that we want with a frequency during at least a year. It is an automatic system based on numbers that generate messages. The messages have to be different and are not just about pregnancy prevention. Messages are sent on a wide range of topics such as self-esteem, employment, relationships, stress free life, etc. Some examples are: Zindagi SMS Pakistan, Cell-life South Africa, JHPiego or Hookup (a statewide text-message-based sexual health information and clinic referral service for California youth).



## **XVI. SPECIAL PRESENTATION:**

***Adolescent Pregnancy and Prevention, using Mechanisms for Integration in Central America*** by Dr. Indiana Barinas. *Technical Commission on Gender and Health, GTGS COMISCA/COMMCA.*

The main objective of the Integrated Central American System (SICA) is to integrate Central America and the Dominican Republic into reaching their development

COMISCA's objective is to lead the regional health sector to address and solve regional health problems, which are monitored through the Health Plan to guarantee the population with the right to health.

The strategic areas to institutionalize gender equity in health are: (a) information and communication; (b) access to quality health services; (c) institutional strengthening; (d) information systems; (e) participation in female empowerment; (f) institutionalization and strategic alliances; (g) monitoring and evaluation; and (h) research and data recollection.

The Health Agenda for Central America and the Dominican Republic 2009 – 2018 includes a section on the reduction of inequities and social exclusion within and among the two countries. The main way to achieve this is by strengthening the health systems to ensure a solid sexual and reproductive health program with an emphasis on counseling and contraceptive methods. It also guarantees that SRH is implemented based on human rights and gender, including multicultural factors that affect men and women, and the participation of men in the SRH. It also emphasizes comprehensive policies that address adolescents, adolescent pregnancy and motherhood.

What can be done?

- ✓ Strengthen alliances
- ✓ Say NO to lost opportunities
- ✓ Facilitate cooperation work with the international community, regional initiatives and networks and policies associated with SICA
- ✓ Establish political and technical dialogue with countries
- ✓ Present COMISCA with the main topics to develop a strategic approach towards the prevention of adolescent pregnancy
- ✓ Promote harmonization of indicators across the region
- ✓ Bring models and tools to better analyze gender issues including maternal mortality and HIV

Some of the key aspects to be considered in the post 2015 agenda are: (a) to include a goal for gender and health; (b) highlight adolescent pregnancy as a gender, rights and social justice issue which requires particular policies address the issue; (c) strengthen technical and political leadership among the topic; and (d) promote political spaces and decision making for inter-sectoral coordination including civil society. In the next update of the Health Regional Plan (CA and DR) COMISCA and CTGS are committed to include specific action lines to address adolescent pregnancy and support strategies for SRH related to teen pregnancy prevention and a comprehensive health program for adolescents. COMISCA and CTGS will follow up on the compliance with the *Parlamento Centroamericano y de RD* (PARLACEN) resolution dated March 5, 2014 on adolescent health.

## XVII. NEXT STEPS

1. In collaboration with COMISCA, develop an Interagency Plan to Prevent Adolescent Pregnancy in Central America, drawing on current evidence, best practices and lessons learned. To commence this effort, UNFPA promises to develop and share joint draft TOR's for two consultancies:
  - a. To develop a situational analysis in terms of the legislative environment in Central America including barriers, gaps and challenges.
  - b. To develop a first draft of the Interagency Plan to Prevent Adolescent Pregnancy in Central America to be presented in the next COMISCA meeting.
2. The World Bank will participate in a post-action meeting with all the agencies participating in the meeting. The objective of this meeting is to provide an entry point for future interagency work and to agree on follow-up plan.
3. The World Bank will submit a summary of the nine panels with the other participating agencies.
4. Honduras will explore with the First Lady of Honduras her interest in participating in/ hosting a follow up Sub-regional Adolescent Pregnancy Prevention Meeting.
5. Hold a regional meeting to build capacity at the national level on the implementation of monitoring and evaluation efforts, and on the integration of social determinant of health and the healthy life course approach into current efforts.
6. Strengthen interagency work in ASRH and present initiative in the next meeting Directors' Meeting.
7. Support south-to-south cooperation and integrate sub-regional SRH/HIV/STI and mental health initiatives.

## XVIII. CONCLUSIONS

Some of the main conclusion of this event could be clustered using the Sexual and Reproductive Health for adolescent framework based on a three-level approach: macro-level, micro-level, and individual-level. The macro-level includes systems and institutions that affect the individual indirectly (e.g., through legal, economic, and political levels). The micro-level represents systems and institutions in which individuals have a direct interaction or link (e.g., schools, health services, and community centers). The individual-level relates to the demographic characteristics of adolescent populations (e.g., age, sex, and sexual behaviors).

### At the macro-level:

Improvements at this level have been done in most of the participant countries, making progress by legislating new laws and national plans that will impact directly in adolescents and children development. But even though, there has been some improvement among government officials to comply with these laws they still face challenges in their effort to prevent adolescent pregnancy. There is still lack of political and financial commitment to implement laws that include sexual and reproductive health programs for adolescents, gender and intra-family violence; shortage of comprehensive training of judicial officers on intra-family violence and gender-based violence; weak leadership on coordinating inter-institutional collaboration to promote an integrated adolescent and youth development strategy for the country; weak information systems strategies that will promote healthy habits among the whole society; and inconsistency on the compliance with universal and regional human rights norms and standards for adolescents and children that have been ratified by the countries.

### At the micro-level:

Some countries have been successful at this level by developing different strategies related to health services and education systems. Most of the countries are trying to develop better health services for adolescents and youth by focusing in health prevention campaigns that promote healthy habits; distribution of contraceptives and providing access to family planning; and health personnel and peer-to-peer training on SRH for adolescents. But they are still facing challenges on building capacity by training health care professionals on adolescent SRH and the requirement of health care setting to provide confidential and friendly health services to adolescents and their families; lack of supplies and poor conception in the use of contraceptives, especially in long acting reversible contraception (LARC) among adolescents; lack of inter-institutional collaboration that should be led by the national government; and in some cases weak leadership in the Ministry of Health to support SRH strategy for adolescents.

The Ministries of Education also have worked in improving the national curricula to include healthy habits and life skills competences. Many participants countries have include these new competences in their secondary curricula and some of them in their primary and secondary curricula. The challenges that they face now are focused on the unsuitable pedagogical strategies to teach these competences, the lack of adequate teacher's training, the necessity of accurate didactic material, the weakness of school board leadership to promote these topics among its community and poor parental involvement.

Two other conclusions at this level were identified in this seminar. One is related to how to reach those adolescents that are out of the school system. Proposals were in line with reaching them throughout the health care or the welfare system, promoting young groups in the community, providing skilled training to help them finding a job, or major social campaigns. The

other theme was related to drop outs because of pregnancy. Many countries do not allow pregnant adolescents to continue their studies, although some participants countries have been pushing for laws that force schools to keep pregnant adolescents in their classrooms.

At the individual-level:

The individual level is generally characterized by the society where individuals grow and develop. Social determinants are key at this level like social norms, peer pressure, family history, social-sexual behaviors, etc.

Example of successful actions during the seminar were the ones focused on SRH peer training and the creation of young groups that promote healthy choices, many of which are promoted by the local government, community, local schools and health care centers. But there is still work to be done, especially with parents, relatives and the community as a whole to raise awareness on the respect for adolescent's sexuality and the promotion of behavioral changes that will lead to healthy choices for all.

Major tools were presented during the seminar that will help governments and communities to promote behavioral changes that could impact directly at this level. These tools are the ones used by adolescents and young people like social media and technology. Campaigns using text messages and mobile applications reach the majority of the young population in each country. Web sites and Facebook groups are other tools that have a direct impact on the population.

This sexual and reproductive health framework allows governments to realize that both the macro-level and the micro-level are keystones on the development of an individual. Working in improving both of them as well as giving opportunities to individual will prevent most of the adolescent pregnancies.

## XIX. ANNEXES

### Annex 1: Adolescent Clinical History (Regional version)

CLAP/SMR-OPS/OMS HISTORIA DEL ADOLESCENTE		ESTABLECIMIENTO				I.C. Nº					
APELLIDOS Y NOMBRES _____						Nº Identidad _____					
DOMICILIO _____						FECHA DE NACIMIENTO					
LOCALIDAD _____ Código _____						día _____		mes _____		año _____	
LUGAR DE NACIMIENTO _____ TEL: _____ domicilio <input type="checkbox"/> mensaje <input type="checkbox"/>						SEXO f <input type="checkbox"/> m <input type="checkbox"/>					
COBERTURA Y/O PROTECCIÓN SOCIAL <input type="checkbox"/> Si <input type="checkbox"/> No <input type="checkbox"/> Celular _____ Email _____											
<b>CONSULTA PRINCIPAL</b> Nº _____		FECHA		EDAD		ESTADO CIVIL		ETNIA		ACOMPANANTE	
Consulta espontánea <input type="checkbox"/> Derivado <input type="checkbox"/> Traído <input type="checkbox"/>		día _____ mes _____ año _____		años _____ meses _____		casado <input type="checkbox"/> soltero <input type="checkbox"/> otro <input type="checkbox"/>		<input type="checkbox"/> Blanca <input type="checkbox"/> mestiza <input type="checkbox"/>		solo <input type="checkbox"/> amiga <input type="checkbox"/> ambos padres <input type="checkbox"/>	
S <input type="checkbox"/> No <input type="checkbox"/>						unido <input type="checkbox"/> separado <input type="checkbox"/>		<input type="checkbox"/> indígena <input type="checkbox"/> negra <input type="checkbox"/>		pareja <input type="checkbox"/> padre <input type="checkbox"/> otros <input type="checkbox"/>	
Motivos de consulta según adolescente:						Motivos de consulta según acompañante:					
1				1							
2				2							
3				3							
Descripción de motivo de consulta											
<b>ANTECEDENTES PERSONALES</b>		PERIÓDICA NORMAL		CRECIMIENTO NORMAL		DESARROLLO NORMAL		ALERGIA		VACUNAS COMPLETAS	
no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>	
ACCIDENTES		INTOXICACIONES		CIRUGIA HOSPITALIZAC.		USO DE MEDICAMENTOS		PROBLEMAS PSICOLÓGICOS		VIOLENCIA	
no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>	
Observaciones											
<b>ANTECEDENTES FAMILIARES</b>		CARDIOVASC. (HTA, cardiopatía, etc.)		ALERGIA		INFECCIONES		CANCER		PROBLEMAS PSICOLÓGICOS	
DIABETES		OBESIDAD		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>	
no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>		no <input type="checkbox"/> si <input type="checkbox"/>	
Observaciones											
<b>FAMILIA</b>		<b>NIVEL DE INSTRUCCIÓN</b>				<b>DIAGRAMA FAMILIAR</b>				<b>VIVIENDA</b>	
VIVE		Padre o sustituto		Madre o sustituto		Paraja		ENERGÍA ELÉCTRICA <input type="checkbox"/> si <input type="checkbox"/> no <input type="checkbox"/>			
solo <input type="checkbox"/> no <input type="checkbox"/> si <input type="checkbox"/>		ninguno <input type="checkbox"/> primaria <input type="checkbox"/>		ninguno <input type="checkbox"/> primaria <input type="checkbox"/>		ninguno <input type="checkbox"/> primaria <input type="checkbox"/>		en el hogar: <input type="checkbox"/> fuera del hogar: <input type="checkbox"/>			
en la casa <input type="checkbox"/> en la calle <input type="checkbox"/>		segund, univers, años en el mayor nivel <input type="checkbox"/>		segund, univers, años en el mayor nivel <input type="checkbox"/>		segund, univers, años en el mayor nivel <input type="checkbox"/>		AGUA <input type="checkbox"/> <input type="checkbox"/>			
en instit. protectora, privado de libertad <input type="checkbox"/>		Padre o sustituto		Madre o sustituto		Paraja		EXCRETAS <input type="checkbox"/> <input type="checkbox"/>			
CONVIVE CON		ninguno <input type="checkbox"/> no estable <input type="checkbox"/> estable <input type="checkbox"/>		ninguno <input type="checkbox"/> no estable <input type="checkbox"/> estable <input type="checkbox"/>		ninguno <input type="checkbox"/> Padres <input type="checkbox"/>		HACINAMIENTO <input type="checkbox"/> si <input type="checkbox"/> no <input type="checkbox"/>			
madre <input type="checkbox"/> padre <input type="checkbox"/> madrastra <input type="checkbox"/> padrastro <input type="checkbox"/> hermanos <input type="checkbox"/> paraja <input type="checkbox"/> hijo <input type="checkbox"/> otros <input type="checkbox"/>		Apoyo social o subsidio no <input type="checkbox"/> si <input type="checkbox"/> tipo <input type="checkbox"/>		PERCEPCIÓN DEL ADOLESCENTE SOBRE SU FAMILIA		Observaciones				Observaciones	
En la casa <input type="checkbox"/> En el compart. cuarto <input type="checkbox"/> En la casa <input type="checkbox"/>		Buena <input type="checkbox"/> Regular <input type="checkbox"/> Mala <input type="checkbox"/> No hay relación <input type="checkbox"/>		Observaciones							

## Annex 2: Working Groups

Participants were divided according to three sub regions: 1) the Andean region and South America; 2) Central America and the Caribbean; and 3) English speaking Caribbean. The three sub regions were provided four questions: 1) revise existing strategies, plans and evidence based interventions presented thus far in the meeting and explore how they can be incorporated into sub-regional efforts; 2) identify priorities for horizontal sub-regional cooperation; and 3) determine next steps. In the following tables you will find the work done for every sub-region.

	MEXICO	ANDEAN REGION	CARIBBEAN	BRAZIL	CENTRAL AMERICA
<b>APPROACH AND STRATEGY</b>	<p>Currently Mexico has done a great deal of work on the legal framework for the sexual and reproductive health of adolescents. Although Mexico is a country that adheres to all the rules and covenants, the country has not executed all agreements at the institutional level.</p> <p>A priority in Mexico is to consolidate a strategy for advocacy and policy dialogue that promotes legal reforms supporting adolescents' rights to receive better health care.</p>	<p>The approach has to be based on human rights, social determinants, equity, diversity, gender, intercultural, intergenerational, and differential population along the course of life of adolescents.</p> <p>Strategies that have to be carried out are: a social inclusion strategy; a multisectoral investment strategy; a communication strategy promoting the use of new technologies to target young people; and, an institutional management strategy to ensure professional capacity at the institutional level.</p> <p>These strategies will be prioritized for specific groups: (i) influential actors (authorities); (ii) managers and service providers; (iii) adolescents and youth; and, (iv) families and communities.</p>	<p>CARICOM strategy includes:</p> <ul style="list-style-type: none"> <li>- Evidence based policy advice and action.</li> <li>- Design and adjustment to policies, programs, laws and implementation mechanisms based on analysis.</li> <li>- Knowledge management to create evidence required for policy advice and action.</li> <li>- New courses in tertiary education for personnel in these sectors.</li> <li>- Capacity building in the health, education, child and social protection sectors.</li> </ul> <p>After participating in this workshop and having collected key information on the subject, CARICOM team members believe that some components of its strategy can be improve by adding new components based on evidence of the best practices in other countries. Some components have to be added:</p> <ul style="list-style-type: none"> <li>- Development of an Adolescent Pregnancy Strategic Framework.</li> <li>- Design legislation and adjust national policies.</li> <li>- Monitoring and Evaluation of</li> </ul>	<p>Brazil will continue to use RED Cegonha as a strategy for adolescent health care. Brazil will focus on further strengthening the following strategies:</p> <ul style="list-style-type: none"> <li>- Consider teens under 15 years of age as the most vulnerable, including SSR in adolescents with chronic diseases.</li> <li>- Prioritize counseling for vulnerable young women prior to discharge after childbirth or abortion.</li> <li>- Use "Choice" methodology counseling and design a strategy accompany adolescents prospectively</li> <li>- Check the possibility of implementing the "LARC" provision</li> <li>- Use reminders and reinforcements to support group work.</li> </ul>	<p>Approach:</p> <ul style="list-style-type: none"> <li>- Determinants, including violence, treat, transactional sex.</li> <li>- Provide early sexual education by the Ministries of Education.</li> <li>- Provide a range of adolescent services focused on access to long-term contraception and quality care for adolescent girls during their first pregnancy.</li> <li>- Empower adolescent girls.</li> </ul> <p>Strategies to implement:</p> <ul style="list-style-type: none"> <li>- Applied by levels. Health care in the home. (CA Regional , National and Local including family) COMISCA, communities, ministries, offices of the First Lady.</li> <li>- Review adjustment, changes and implementation in legal frameworks: use of psychoactive substances, delayed age of marriage, social protection system, and violence.</li> <li>- Information System (standardize between countries).</li> <li>- Monitoring and Evaluation: delay the onset of sexual activity, decrease early marriages and age of sexual debut, and reduce teen pregnancy.</li> <li>- Outstanding coordination mechanism for local development.</li> </ul>

			<p>strategy and research.</p> <ul style="list-style-type: none"> <li>- Capacity building, inter-sectorial collaboration and networking.</li> <li>- Resource mobilization.</li> </ul>		<ul style="list-style-type: none"> <li>- Integrated approach, including men and women, masculinity, diversity, disability and women empowerment.</li> <li>- Addressing immigration and human trafficking.</li> <li>- Entrepreneurship and Life Project.</li> <li>- South-South and regional cooperation mechanisms.</li> <li>- Sexual education for those in and out of school and the adult population. Further education on reproductive health to ensure the existence and use of long-acting contraceptives.</li> </ul>
<p><b>HORIZONTAL COOPERATION</b></p>	<ul style="list-style-type: none"> <li>- Experiences with partnerships for comprehensive adolescent health care at a national and international level. Periodically, an intersectoral, interagency meeting is convened by the government and a civil association may participate.</li> <li>- Validated model and advocacy strategies; focused attention models that can be shared with other countries. At present, Mexico can share the national model for comprehensive adolescent health care, which is in its final phase and has been supported by civil associations and all governmental organizations in the country.</li> </ul>	<ul style="list-style-type: none"> <li>- Registry of qualitative and quantitative evidence related to the causes and consequences of pregnancy in adolescents with emphasis on children under age 15; also includes evidence on the role men play in the areas of health care and teen pregnancy.</li> <li>- Repositioning of contraception for adolescents and implementation of LARC methods in the adolescent population.</li> <li>- Financial sustainability and institutionalization.</li> <li>- Detection of gender-based violence; refer victims of gender-based violence to health care providers.</li> <li>- Quality assessment of adolescent differentiated services.</li> </ul>	<ul style="list-style-type: none"> <li>- Technical support.</li> <li>- Strategic information (baseline information).</li> <li>- Training of health care providers, educators, social workers, welfare officers.</li> <li>- Sharing of best practices.</li> <li>- Creation of a center of excellence.</li> <li>- Program development and evaluation.</li> </ul>	<p>The International Seminar of Portuguese-speaking countries will be held in São Paulo on March 31st.</p>	<ul style="list-style-type: none"> <li>- Develop an effective sub-regional plan to prevent teen pregnancy (specifically first and second pregnancies).</li> <li>- Promote horizontal cooperation among countries to share experiences, tools and mechanisms (COMISSCA, CODAJIC, Andean PLAN).</li> <li>- Develop regional policies to ensure contraceptive security.</li> <li>- Review and update the legislative frameworks.</li> <li>- Evaluate of the Ministerial Declaration "Preventing through Education."</li> <li>- Develop Community Advocacy Strategies and integration mechanisms for Central America.</li> <li>- Develop a mechanism to increase adolescent participation.</li> </ul>

	<ul style="list-style-type: none"> <li>- Position theme through the Mexican National delegation at the next meeting's agenda post 2015 (Consensus Montevideo)</li> </ul>				
<b>NEXT STEPS</b>	<ul style="list-style-type: none"> <li>- Mapping of actors and actions taken to improve adolescent sexual and reproductive health.</li> <li>- Strengthening the institutional and inter-programmatic work for the national strategy for adolescent pregnancy prevention.</li> <li>- International Meeting on Prevention of Teen Pregnancy (September 2014)</li> <li>- Information and digital communication for teens.</li> </ul>	<ul style="list-style-type: none"> <li>- Disseminate/share results of this event with local teams and adolescents/youth of our countries in order to democratize information.</li> <li>- Implement programs and interagency or bilateral projects in countries with potential for compliance.</li> <li>- Keep track of the interagency initiatives to prevent teen pregnancy that generate synergies and strengthen interventions.</li> </ul>	<ul style="list-style-type: none"> <li>- Finalization of Regional Adolescent Pregnancy Reduction Strategy.</li> <li>- Development of a Regional Sexual and Reproductive Policy framework.</li> <li>- Revision of drafted strategy; review existing data and identify gaps to develop a policy that can work in the Caribbean.</li> </ul>	<ul style="list-style-type: none"> <li>- Create a TAG to define a "Grant" strategy for adolescents to develop ICT-funded TC 52 (OPS-SES-SP)</li> <li>- TICs areas: <ul style="list-style-type: none"> <li>✓ Increase access to services</li> <li>✓ Using Condoms</li> <li>✓ Circle of Violence</li> <li>✓ Quality of Services</li> </ul> </li> <li>- Technical event on e-Health in Sao Paulo May 21 and 22 in support of YTH</li> <li>- An international e-Health event will be held in December to launch new applications; the Ministry of Health, UNFPA, PAHO, and the Ministry of Health of Sao Paulo will participate in the conference.</li> <li>- 2 training courses on the quality of attention and services for adolescents will be held over two days in April in Brasilia and Sao Paulo</li> <li>- Share best practices from the feelings workshop and Saturdays without barriers (in helping disabled adolescents)</li> </ul>	<ul style="list-style-type: none"> <li>- Develop a sub-regional strategy against teen pregnancy and submit it to COMISCA.</li> <li>- Raise the issue at the highest level, preferably with the President or First Lady.</li> <li>- Create a virtual group to monitor progress between countries as a result of this meeting.</li> </ul>



### **Annex 3: List of participants**

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## XXI. RESOURCES

1. Advocates for Youth – Science and Success: Sex Education and Other Programs that Work to Prevent Teen Pregnancy (Alford, 2008)
  - a. <http://www.advocatesforyouth.org/storage/advfy/documents/sciencesuccess.pdf>
2. Alianza Interinstitucional para la atención integral de la salud de adolescentes y jóvenes (El Salvador):
  - a. <http://www.dipity.com/mariosoriano/Alianza-Intersectorial-para-adolescentes>
3. CDC:
  - a. [www.cdc.gov/winnablebattles](http://www.cdc.gov/winnablebattles)
  - b. [www.cdc.gov/teenpregnancy](http://www.cdc.gov/teenpregnancy)
  - c. <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/Contraception.htm>
4. Choice project: [www.choiceproject.wustl.edu](http://www.choiceproject.wustl.edu)
5. ¡Cuidate! (Take Care of Yourself):
  - a. <http://www.selectmedia.org/programs/cuidate.html>
6. [Health and Human Services \(HHS\) Office of Adolescent Health \(OAH\) Tier 1 Funding List \(with Mathematica Policy Research and Child Trends\)](#)
  - a. <http://www.hhs.gov/ash/oah/oah-initiatives/tpp/tpp-database.html>
7. Programa de Estudio (Costa Rica)
8. <http://www.mep.go.cr/progama-estudio/educacion-para-afectividad-sexualidad-integral-o>
9. Program Archive on Sexuality, Health, and Adolescence PASHA Programs Table (2012). <http://www.socio.com/teenpregnancypreventioninitiative.php>
10. The National Campaign to Prevent Teen and Unplanned Pregnancy:
  - a. [http://www.thenationalcampaign.org/resources/pdf/FastFacts\\_3in10.pdf](http://www.thenationalcampaign.org/resources/pdf/FastFacts_3in10.pdf)  
[http://www.thenationalcampaign.org/why-it-matters/wim\\_teens.aspx](http://www.thenationalcampaign.org/why-it-matters/wim_teens.aspx)
  - b. <http://www.thenationalcampaign.org/why-it-matters/pdf/poverty.pdf>
  - c. <http://www.thenationalcampaign.org/resources/pdf/pubs/WhatWorks.pdf>
11. The Program Archive on Sexuality, Health, and Adolescence (PASHA) of the Sociometric Corporation
  - a. <http://www.socio.com/pasha.php>
12. The World Bank:  
<http://data.worldbank.org/indicator/SP.ADO.TFRT/countries?display=default>
13. United Nations Demographic Yearbook 2011.:  
<http://unstats.un.org/unsd/demographic/products/dyb/dyb2011.htm>

14. US Department of Health & Human Services:

- a. <http://www.hhs.gov/ash>
- b. <http://www.hhs.gov/ash/oah/oah-initiatives/tpp/tpp-database.html>
- c. <http://www.hhs.gov/ash/oah/oah-initiatives/tpp/tpp-searchable.html>

15. Videos de profe en Casa (Costa Rica):

- a. <http://www.mep.go.cr/educatico/afectivo-sexualidad>