Sexual Health and Development of Adolescents and Youth in the Americas

Program and Policy Implications

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Abbreviations
AGI: Alan Guttmacher Institute
CDC: Centers for Disease Control and Prevention
DHS: Demographic and Health Surveys
ECLAC: Economic Commission for Latin America and the Caribbean
FPA: Family Planning Association
GDP: Gross Domestic Product
HIV: Human immunodeficiency virus
ICPD: International Conference on Population and Development
IEC: Information, Education and Communication
IDB: Inter American Development Bank
IPPF: International Planned Parenthood Federation
NGO: Non-governmental organization
PAHO: Pan American Health Organization
SIECUS: Sexuality Information and Education Council of the United States
STI: Sexually Transmitted Infection
UNESCO: United Nations Organization for Education, Science and Culture
UNICEF: United Nations Children's Fund
UNFPA: United Nations Population Fund
UNAIDS: The Joint United Nations Programme on HIV/AIDS
UNPOPIN: United Nations Population Information Network
UNF: United Nations Foundation
WAS: World Association for Sexology
WHO: World Health Organization
YARH: Young Adult Reproductive Health

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▷Preface

The Pan American Health Organization (PAHO) has been a leader in addressing the health of adolescents and youth within the context of their social and economic environment. The creation of the adolescent health and development unit at PAHO in 1992 demonstrated the organization's commitment to youth in the Americas.

When the Plan of Action for Adolescent Health and Development (1998-2001) drew to an end, countries in the Region had embraced the conceptual framework for adolescent health and development and recognized that health and development are complementary goals. There have been a number of important steps forward in the inclusion of sexual and reproductive health in National Adolescent Health Programs adopted in recent years. However, numerous countries in the Region still view sexual and reproductive health as an area that can be improved upon, according to a survey evaluation of 23 countries conducted in 2001 (Nirenberg et. al., 2002).

As the Program on Adolescent Health and Development embarks on a new Plan of Action for 2002-2006, countries are increasingly concerned about youths' sexual and reproductive health, particularly in light of the AIDS epidemic. Recent literature and past program evaluations indicate that adolescent sexuality and health must be addressed from a broader development perspective. Adolescent sexuality should not be viewed as a problem but must be addressed from a health promotion and protection perspective.

In response to these concerns, PAHO is proposing a new conceptual framework that addresses adolescent sexuality from a human development perspective, integrating sexual health into the broader framework of health and development. The approach recognizes that sexual health is an aim of human development and sexual health outcomes are linked to factors such as culture, family and the social, political and economic environment in which adolescents live. The approach is one of positive development and recognizes youth as an opportunity for the Region. It is designed to reach different levels of influence, such as policy makers and program planners at the country level, to encourage them to integrate preventive and protective programs, policies and services.

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▷Introduction

Adolescence is a powerfully formative period that shapes how girls and boys live out their lives now and as future adults--not only in the reproductive arena, but in the social and economic realm as well (Mensch et. al, 1998). The health of adolescents (10–19 years of age) and youth (15–24 years of age)[1] is a key element for the social, economic and political progress of the Americas. Far too often, however, adolescent needs and rights are absent from public policies or from the agenda of the health sector, except when adolescents misbehave. One contributing factor is that compared to very young children and the elderly, adolescents suffer from few life-threatening conditions. However, many unhealthy habits that later produce mortality and morbidity in adults are acquired during the period of adolescence (PAHO, 1998b). Therefore, a health promotion and prevention approach is crucial to a healthy adolescence and adulthood.

Costs to governments and individuals when youth fail to reach adulthood in good health, with an adequate education and without pregnancy, are substantial. These costs are almost always greater than the costs of programs that help youth achieve these goals. Cost analysis from the United States found that the country spends roughly $20 billion annually in payments for income maintenance, health care and nutrition to support families begun by adolescents. Integrating the adolescent age group into the health plans of the Region's countries and building the infrastructure for promoting the development of youth is a solid investment in the future (Burt, 1998).

This paper argues for a paradigm shift for policy makers and program planners to take on a new, positive outlook on youth, with a holistic approach to their development that includes their sexuality. Policy makers, program planners and adult society often associate adolescence and youth as a problem age group. Terms such as "adolescent delinquency," "youth violence," and "problem youth" lend a negative image to this age group. Programs focus narrowly on the prevention of "teen pregnancy," the promotion of abstinence and condom use, where the term "adolescent mother" is categorically regarded as a program failure, although this may not *always* be the case. Many programs neglect sexuality as part of the human development experience and concepts of love, feelings, emotions, intimacy and desire are not often included in sexual and reproductive health interventions. Indicators of success and positive youth development, such as connectedness with family, school and/or community have been identified as developmental assets that prevent risk behaviors, and should be promoted. Rather than being stigmatized and discriminated for belonging to a certain age category, young people need to be recognized as strategic partners for sustainable development and positive social change.

This document focuses on youth in the Region of the Americas, but in no way is this group considered homogeneous. On the contrary, it is important to recognize that adolescents vary in their social environments, economic circumstances, culture and sub-culture, gender and marital status. Youth are students, laborers, soldiers, mothers and fathers, married, single, divorced, indigenous, of various ethnic origins, homeless, street children and orphans. Together they represent a rich and dynamic segment of the population. Although the specialized needs of each sub-group are too complex to include in this paper, programs and policies need to consider the richness and uniqueness of each adolescent sub-group in order to be effective (PAHO, 2002).

[1] PAHO and WHO define adolescence as the period between 10 and 19 years of age and youth as the period between 15 and 24 years; the term "young people" has been coined to include both groups. WHO. A Picture of Health? Geneva, 1995.

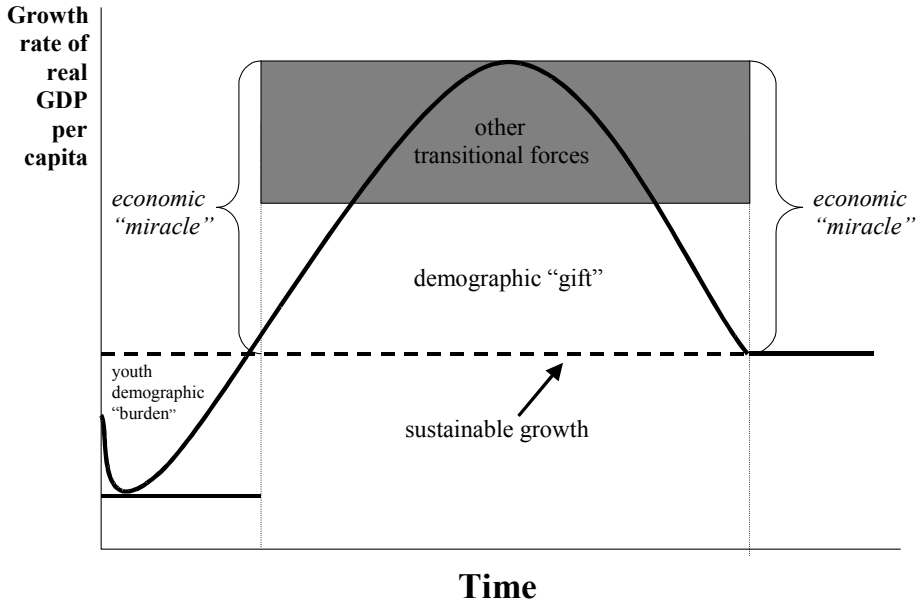
▷Situation of Youth in the Americas

▷▷Population and the "Demographic Gift"[2]

Young people represent a large and increasingly important segment of the population. In Latin America and the Caribbean, young people between the ages of 10 and 24 make up 30% of the population, with adolescents aged 10–19 representing 20% of the population. This distribution is evenly split between males and females (CEPAL, 2000). The number of young people in the Region is at 155 million (2000 data) and is expected to reach 163 million by the year 2025 (Population Reference Bureau, 2000). It is estimated that 80% of the Region's youth live in urban areas (CEPAL, 2000) and that 65% live in poverty (CEPAL, 1997). The growth of the youth population varies within the Region. In the Caribbean, for example, the youth population is expected to remain at 11 million, while in Central America and South America this population group is expected to increase with the exception of Uruguay, Guyana and Panama (Population Reference Bureau, 2000).

According to Harvard University, population dynamics can contribute to the economic growth of a country, as occurred in several East Asian countries, whose rapid economic growth came to be known as the "Economic Miracle" (Bloom and Williamson, 1998). The miracle occurred in part because East Asia's demographic transition resulted in its working-age population growing at a much faster rate than its dependent population, thereby expanding the per capita productive capacity of East Asian economies between 1960 and 1990. East Asia's growth depended in part on the government's timely investment in health and secondary education. These economies had what is referred to as a "Demographic Gift".

Economic Growth and the Demographic Transition



***Source**: Bloom and Williamson, 1998.*

[2] Based on Harvard University, Harvard Institute for International Development, April 1998.

Demographic Gift

According to this model, if governments invest to provide universal secondary education and reduce drop out rates, over time, when the "dependent" age cohort (or "demographic burden") reaches working age, it will be productive and can contribute significantly to Gross Domestic Product (GDP) growth, as indicated by the upward curve. This potential economic miracle depends on the level of education, health and productivity of the youth population once they enter the work force.

Several countries in the Region are experiencing a demographic transition that can be considered a demographic gift (Bloom and Canning, 2001). The current demographic situation in the Region is characterized by a large cohort of "dependent" youths. As youth reach working age and enter the labor market, there will be an increased ratio of working to non-working age populations, which are potential indicators for future economic growth in the Region. According to this analysis, countries with higher fertility rates such as Bolivia, Guatemala, Haiti, Honduras and Nicaragua have the potential to realize this gift. However, this analysis depends on solid economic policy for growth and investments in secondary education and health. Latin American policy makers need to act now and invest in this generation of youth and help them become productive once they start to work, to take advantage of the demographic gift. With the right investments, the economically active youth population will be the motor of economic growth and an agent for social change in the Region (Bloom et. al, 1999; Jacinto et. al, 2000). However, if youth are marginalized, their growth will tax health, education and labor systems that are already unable to meet youth needs and demands.

▷▷Education

Female literacy bears one of the strongest negative relationships to fertility

Educational attainment is a significant variable in predicting certain reproductive health outcomes, such as pregnancy, small family size, late age marriage, delayed sexual activity, abstinence and condom use (Magnani et. al, 2001). The literature suggests a strong empirical association exists between fertility declines and women's increased schooling (Behrman et. al, 1999). Female literacy above four years (roughly equivalent to functional literacy) bears one of the strongest and most consistent negative relationships to fertility.

Education levels of youth in Latin America and the Caribbean have improved dramatically over the last few decades. The illiteracy rate for those aged 15 and older has dropped from 26% in 1970 to 12% in 2000; the female illiteracy rate decreased from 30% in 1970 to under 13% in 2000, based on 1999 estimations (UNESCO, 1999). The improved literacy rates demonstrate that the Region has made strides towards providing universal access to education at the primary level. However, as the youth population fulfills its primary education goals, the demand for education at the secondary and tertiary level rises. This is evidenced by the demand for tertiary education in countries such as Argentina, Brazil and Mexico, which enroll between 1 and 2 million students (Bloom and Canning, 2001).

Despite these advances, it is important to recognize that education levels vary greatly from country to country and even within the same country. The Economic Commission for Latin America and the Caribbean has conducted studies to determine the minimum education level necessary to achieve a basic standard of living in rural and urban areas in the Region (CEPAL, 1997). ECLAC

estimates that in urban areas, at least 12 years of education are necessary; while in rural areas, 9 years of education are necessary. According to this analysis, an average of 80% of urban youth in the Region come from households where their parents received less than 10 years of education, below the threshold necessary to achieve a minimum standard of living. Although youth achieve more years of education than their parents, of the nine countries with available data[3], only urban youth in Chile come close to achieving the 12 years of education necessary for a basic standard of living (11.7 years of education), followed by Panama at 11.0 years. In Brazil, the average urban youth achieves 7.9 years of education, while in Honduras, the average is 8.6 years. In rural areas, the situation is more severe. In Chile, youth living in rural areas average 8.8 years of education (close to the threshold of 9 years) while in Brazil, youth only reach 4.2 years of education (less than half the threshold); and 5.3 years in Honduras (CEPAL, 1997).

In addition to the rural/urban disparities, there are slight gender disparities among education levels in youth. Overall, illiteracy rates in the Region for those 15 years of age is greater among females and in rural areas. Interestingly, compared to other regions in the world, girls in Latin America and the Caribbean are more likely to have secondary education levels on par with their male counterparts. According to an Alan Guttmacher Institute study, the only countries studied where boys had a higher level of secondary education than girls were Bolivia, Guatemala, and Peru (Alan Guttmacher Institute, 1998). Nevertheless, despite considerable advances in the education of women, the majority of Latin American children are conceived and raised by mothers who have not surpassed primary education and whose level of fertility is generally double that of women with higher levels of education (ECLAC, 2000).

▷▷Labor and Employment

The burden of unemployment falls mainly on vulnerable groups, among them youth

Male youth between the ages of 15 and 24 constitute between 44% (Chile) and 71% (Brazil) of the economically active population in the Region (CEPAL, 2001). Female youth between the ages of 15 and 24 make up a smaller percentage of the economically-active population; percentages range from 30% in Chile to 51% and 52% in Brazil and Paraguay, respectively (ibid). The conditions for youth employment are not optimal: the official youth unemployment rate for the Region is at 16% (Jacinto et. al, 2000); six out of ten new jobs created in the last decade corresponded to the informal sector (ECLAC, 2000); approximately 10 million children under 14 years work illegally, with no social security benefits, are paid low wages and often work under hazardous conditions; and there are limited opportunities for on the job training or learning (Jacinto et. al, 2000). The Inter-American Development Bank estimates that the gap in earnings according to schooling and corresponding skill levels has widened rapidly in the Americas.

Despite these conditions, the Region's youth are twice as likely as their adult counterparts to want or need employment, but are at a greater disadvantage for obtaining work. The burden of unemployment mainly falls on vulnerable groups—young people, women and the economically disadvantaged. Although education and literacy rates have increased over the years, youth have more difficulty integrating into the labor market. This is particularly true of those

[3] For this analysis, CEPAL collected data from the following nine countries: Brazil, Chile, Costa Rica, Colombia, Honduras, Panama, Paraguay, Uruguay and Venezuela.

who come from economically disadvantaged families (ibid). Educational insufficiencies together with labor market constraints tend to exclude these groups from the better paying job opportunities. Although there has been an increase in the percentage of females in the work force, particularly in urban areas, there are twice as many males working as females. Data from household surveys in 15 countries show that youth (aged 15 to 24) who neither study nor work represent between 12% and 40% in poor households and between 2% and 10% in richer households (CEPAL, 1997). In many countries, the labor market is increasingly unable to absorb low-skilled workers and guarantee coverage of social benefits, a situation that primarily affects working-class urban youth. According to this analysis, the technology revolution in Latin America should provide today's children with ample opportunities in the upcoming years—so long as they have well-developed skills and education. Those not fortunate enough to obtain the necessary skills will find themselves deciding between poor jobs or better-paid illicit activities (Moran, 2000).

▷▷Family Structure and Dynamics

Family is repeatedly cited as a determining factor in adolescent development[4], yet the family structure is changing in many countries. Today, many youths in the Region are raised in households headed by women. CEPAL (1997) estimates that since 1994, one in five households in Latin America has been headed by women, many of which had adolescent children under 18 years of age. In Costa Rica, 21% of households are headed by women and 44% of births were registered as "father unknown" (1998). In El Salvador, 35% of households are headed by women (Nuñez et. al, 2000); in Trinidad and Tobago, 25% of households are headed by females with the prevalence reaching 32% in urban settings (UNICEF, 1998). A recent study in nine English-speaking Caribbean countries indicates that 48% of adolescents live with both their parents, 34% live with their mother only and 17% live with other youth. These living conditions can have a negative implication on a youth's situation, particularly since the incidence of poverty is higher in female-headed households (WHO/PAHO, 2000). For example, it is estimated that 80% of adolescent mothers in urban areas and 70% in rural areas belong to the poorest 50% of households (CEPAL, 1997).

Communicating with parents and being "connected" to an adult figure are important factors in youth resilience

In the Caribbean, the family unit has unique characteristics whereby unions can be divided into several categories: visiting relationships, where one partner (usually the male) visits the other for companionship; common law unions, which are non-legal stable unions that involve living together and pooling resources for the maintenance of a family; and marriage, which is a legal contract. Many families are headed by grandmothers, wherein a daughter bears her first child in her mother's home (UNICEF, 1998).

Little data is available on the interpersonal dynamics within the family structure. However, the survey in the English-speaking Caribbean sheds light on this area. Adolescents reported family problems such as drinking (13%), violence (9%) and mental health (8%). Twenty-four percent of youth report that their mother "understands little about their problems" and 32% of fathers "understand little about their problems". Surveys conducted with adolescent boys in nine countries in the Region corroborate the findings in the Caribbean,

[4] See references on Blum, R. and Kirby, D.

whereby adolescent males would like to communicate more about sex with their parents. They indicate that sexual information received from parents is often provided too late, loaded with myths and taboos, too prohibitive and does not explore issues of intimacy or pleasure (Aguirre and Güell, 2002). Such family dynamics have implications on youth development, as they could be an indication of a lack of communication with parents and not being "connected" to an adult figure—important factors contributing to the resilience of youth (WHO/PAHO, 2000).

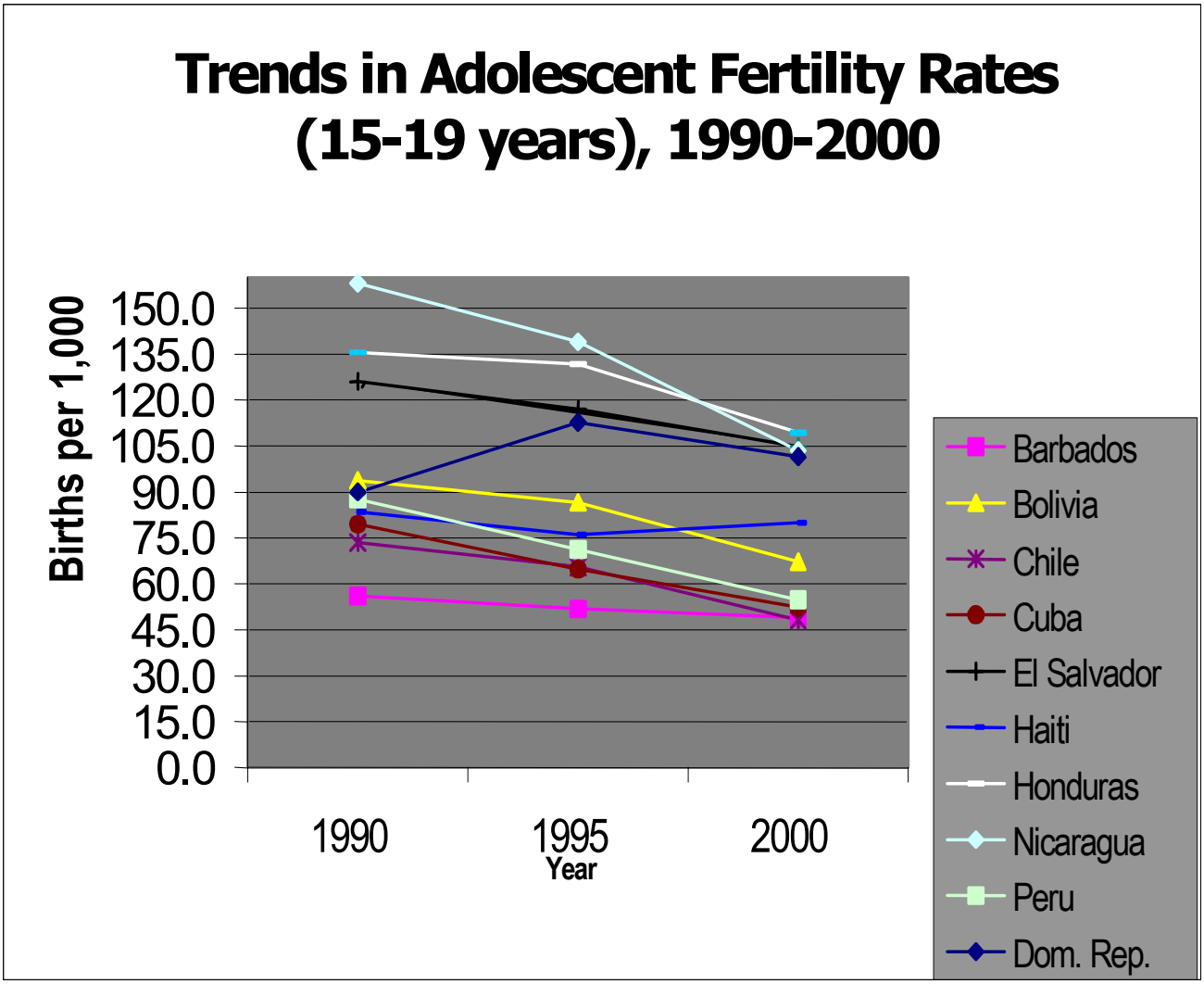
▷▷Sexual and Reproductive Health

Little is known about healthy sexuality of young people within their cultural environment

The majority of youth programs in the Region focus on adolescent sexual and reproductive health or young adult reproductive health (YARH). However, the emphasis is more on reproductive health, with most program goals and objectives looking to reduce teen pregnancy and prevent HIV/STIs among youth.

As such, the reproductive health situation in the Americas indicates some improvements. Adolescent fertility rates are above 50 per 1,000 in most countries (see Graph 1). Overall fertility rates for adolescent females aged 15-19 years have decreased in the Region, which is attributed to the increases in education levels. But fertility rates remain higher than 100 per 1,000 in Central America, (except Costa Rica) Dominican Republic, Jamaica and Belize (Guzman et. al, 2000). Awareness of contraception is high, as is awareness of HIV/AIDS in most countries (Camacho-Hubner, 2000).

Graph 1


Trends in Adolescent Fertility Rates
(15-19 years), 1990-2000
Births per 1,000
150.0
135.0
120.0
105.0
90.0
75.0
60.0
45.0
30.0
15.0
0.0
1990
1995
2000
Year
Barbados
Bolivia
Chile
Cuba
El Salvador
Haiti
Honduras
Nicaragua
Peru
Dom. Rep.

Broader concepts of sexual health and development, however, have not been included in many programs. Little is known about healthy sexuality of young people within their cultural environment. Much more needs to be learned about values, identity and attitudes of both sexes. Indicators for adolescent sexual and reproductive health focus primarily on reproductive health outcomes—leaving out sexual health and development indicators such as awareness and appreciation of one's body, development of meaningful relationships and negotiation skills. This is in part due to the fact that such characteristics are difficult to measure, but it is also a reflection of the focus on reproductive health.

Box 1, "Important Facts on Youth Sexuality," provides a panorama of the sexual and reproductive health situation of youth in the Region. Youth are sexually active at an early age, although for young women, sexual activity is usually within marriage (Singh et. al, 2000). Some countries even show an increase in sexual activity among younger age groups, which has several health implications (UNFPA, 1997). There are significant gaps in information and knowledge among adolescent age groups, and behavior has remained relatively unchanged. For example, despite high levels of knowledge, contraceptive utilization rates are still low in many countries, sometimes due to a lack of access, such as in the case of condoms. This situation has led to certain adverse reproductive health outcomes such as unplanned adolescent births, STI and HIV infection and unsafe abortion, which contributes significantly to adolescent maternal mortality. There is also increased reporting of young women as victims of domestic violence and abuse where incest, coercion and rape occur.

Box 1
Important Facts on Youth Sexuality

Youth are sexually active and at an early age

- Approximately 50% of adolescents under the age of 17 are sexually active in the Region[5].
- Between 53% and 71% of women in the Region had sexual relations before the age of 20[6].
- The average age of first sexual intercourse is approximately 15–16 for girls in many Latin American and Caribbean countries; for boys, the average age is approximately 14-15[7]. Youth in certain Caribbean countries have initiated sex as early as 10 and 12 years[8].
- A significant number of adolescent girls are married or in union. Between 18% (Peru), 38% (El Salvador) and 34% (Trinidad and Tobago) of adolescent girls are married by 18 years of age. Most sexual relationships among young women occur within marriage.[9]

Knowledge levels are high but there are still gaps

- In general, knowledge levels of contraception and awareness of HIV is high, but adolescents know less about other STIs and modes of transmission for HIV[10].
- Between one-fourth and one-half of girls aged 15-19 in Guatemala, Peru, Haiti and Brazil do not know that a person with AIDS may appear healthy.[11]

Behavior remains unchanged

- Only 30% of youth in the Caribbean worry about getting pregnant; 26% always use birth control.[12]
- Surveys in the Caribbean suggest that 40% of girls and 50% of boys have no access to contraceptives at first sexual intercourse.[13]

Adverse reproductive health outcomes

Young women are getting pregnant

- Between 35% and 52% of adolescent pregnancies in the Region were not planned.[14]
- On average, 38% of women become pregnant before age 20.[15]
- In most LAC countries, between 15 and 25% of all babies are born to adolescents.[16]

Youth are getting infected with STIs, including HIV

- Each year, 15% of adolescents between 15 and 19 years of age acquire an STI, the main cause of reproductive tract infection.[17]
- In Haiti, 4.9% of males between 15 and 24 years old are living with HIV[18].

[5] UNFPA, 1997.
[6] Based on DHS surveys, 1990 - 1999.
[7] Camacho-Hubner, 2000.
[8] UNICEF, 1998; WHO/PAHO, 2000.
[9] Singh et. al, 2000.
[10] UNFPA, 1997.
[11] UNICEF, 2000.
[12] WHO/PAHO, 2000.
[13] UNICEF, 1997b.
[14] UNFPA, 1997.
[15] UNFPA, 1997.
[16] UNICEF, 1997b.
[17] UNFPA, 1997.
[18] UNICEF, 2000.

Box 1
Important Facts on Youth Sexuality

Young women are aborting and are victims of maternal mortality

- Maternal mortality remains one of the leading causes of death for adolescents.[19]
- In Chile and Argentina, where abortion is highly restricted, more than one-third of maternal deaths among adolescents are a direct result of unsafe abortion.[20]
- Between 21% and 30% percent of pregnancies in Mexico, Colombia, Brazil, Dominican Republic, Chile and Peru end in abortion.[21]

Young Women suffer domestic violence and abuse

- Adolescents are at greater risk to experience sexual violence. In Peru, 40% of young women reported that their first sexual encounter occurred under pressure or coercion.[22]
- In Nicaragua, 26% of adolescent girls 15-19 have experienced some type of physical or sexual violence[23] (1998).
- In Costa Rica, a study revealed that 95% of pregnancies among girls aged 15 or younger was due to incest.[24]
- A Caribbean report reveals that of the 38% of adolescents who have had intercourse, half reported their first intercourse was forced. [25]

Socioeconomic influences on reproductive health: Outcomes have common roots

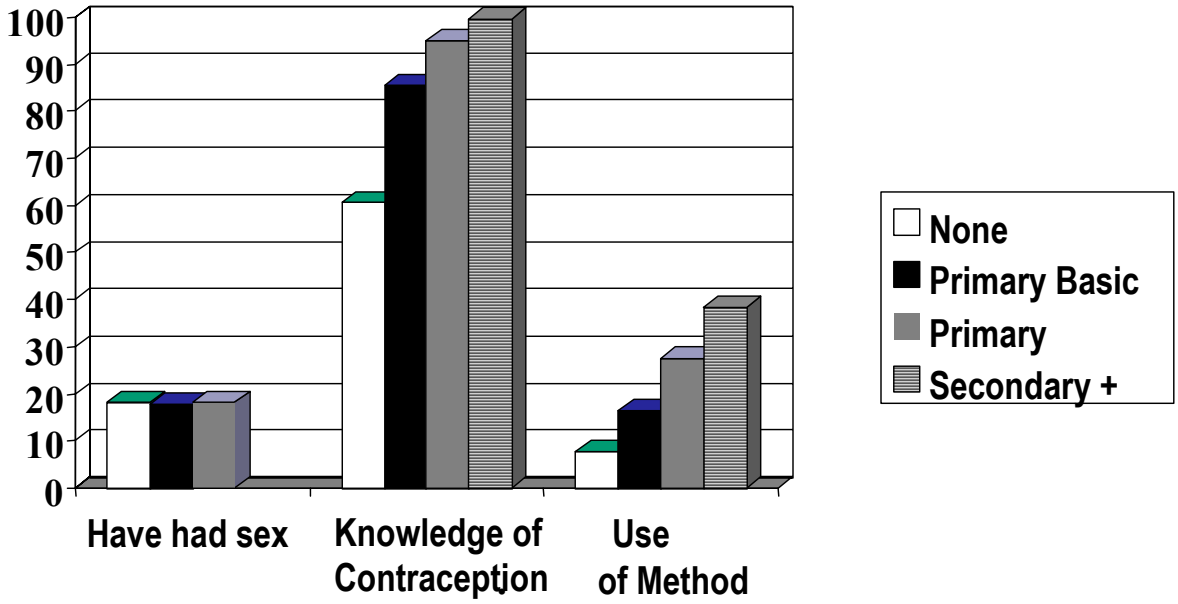
- In Colombia, Dominican Republic, Guatemala and Mexico, girls who received 10 or more years of education were four times less likely to have initiated sexual activity by age 20 than those who had less education.[26]
- In Peru, youth at greatest risk of adverse reproductive health outcomes appear to be from families with low socioeconomic conditions.[27]
- "Connectedness" with family is associated with a lower likelihood of having had sex.[28]
- In Ecuador, the percentage of young women between 15-24 that have been pregnant decreases with education, from 60% (no education) to 29% (university education).[29]

[19] Allan Guttmacher Institute, 1994.
[20] Advocates for Youth, webpage, www.advocatesforyouth.org.
[21] Allan Guttmacher Institute, 1994.
[22] Cáceres, et. al, 2000.
[23] Macro International, 1998b.
[24] PAHO, 1999.
[25] WHO Collaborating Center on Adolescent Health/PAHO, 2000.
[26] UNFPA, 1997
[27] Magnani et. al., 2001.
[28] Ibid.
[29] CEPAR, 2000.

Outcomes have common roots whereby there is a relationship between reproductive health, socioeconomic influences and determinants of health. There are important disparities between the diverse adolescent sub-groups. Poorer, marginalized youth with less education seem to suffer increased adverse reproductive health outcomes. For example, the1998 Demographic and Health Survey (DHS) in Bolivia indicates that education levels or residence have little influence on age at first sex (Macro International, 1998a). However, there is a correlation between education, income levels and knowledge about a contraceptive method, and even more so when it comes to method utilization (see Graph 2). This is evident in other countries as well.

Graph 2

Educational Influences on Sexual Behavior, Bolivia, 1998

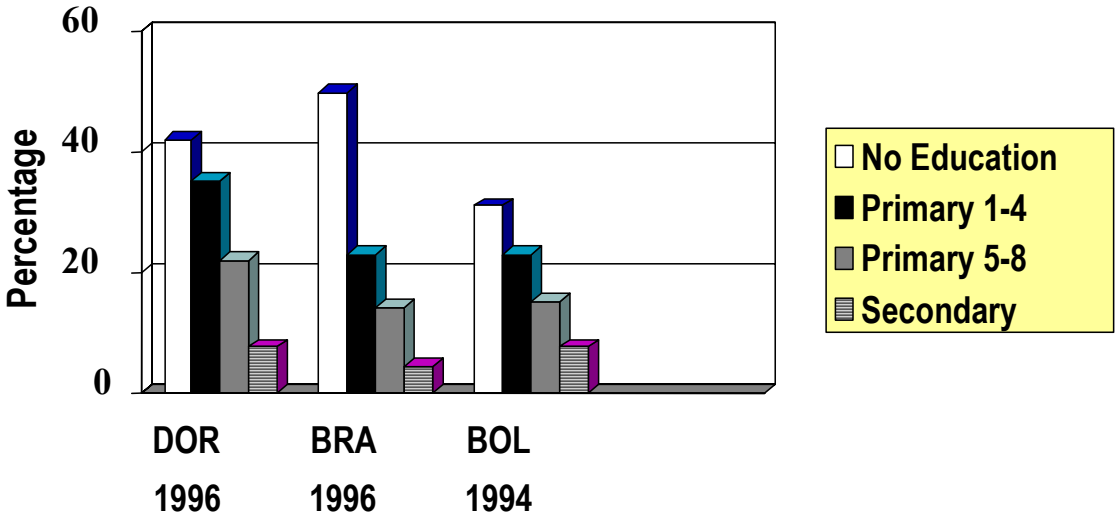


***Source**: Demographic and Health Surveys, 1994-1996*

Similarly, as Graph 3 indicates, education levels have the same negative correlation to adolescent childbearing, whereby adolescent girls with lower education levels are more likely to have had a child than those with higher education levels.

Graph 3

Percentage of Adolescent Girls (15 and 19) Who Gave Birth in 1994-1996, by Education Level



***Source**: Demographic and Health Surveys, 1994-1996*

When analyzing this information, it is again important to consider the heterogeneous background of youth, as these educational influences could be due to cultural factors inherent in indigenous populations that value alternative educational achievements than the "mainstream" or dominant culture. This highlights the importance for culture specific programming for youth and recognition of the heterogeneous backgrounds and lifestyles of youth.

▷▷▷HIV/AIDS epidemic

There are an estimated 560,000 young people, aged 15 to 24, living with HIV/AIDS in Latin America and the Caribbean; 69% of those infected are males, and 31% are females. (UNICEF/ UNAIDS/WHO, 2002). There are 330,000 orphans due to AIDS in Latin America and 250,000 in the Caribbean (UNAIDS, 2002). The recent trends in the epidemic indicate that youth are most affected by HIV/AIDS, and around half of all new HIV infections are in people aged 15-24, the range in which most people start their sexual lives. Young people are particularly vulnerable to HIV infection, due to risk behaviors, and lack of information and services for youth. Furthermore, youth carry the burden of caring for family members living with HIV/AIDS, or are forced to live without their parents, if left orphaned by AIDS. The stigma of living with AIDS or having a family member affected by HIV/AIDS is damaging to youth, since they are at a developmental phase when they are trying to consolidate their identity and establish their roles.

The behaviors youth adopt now and those they maintain throughout their sexual lives will determine the course of the AIDS epidemic for decades to come

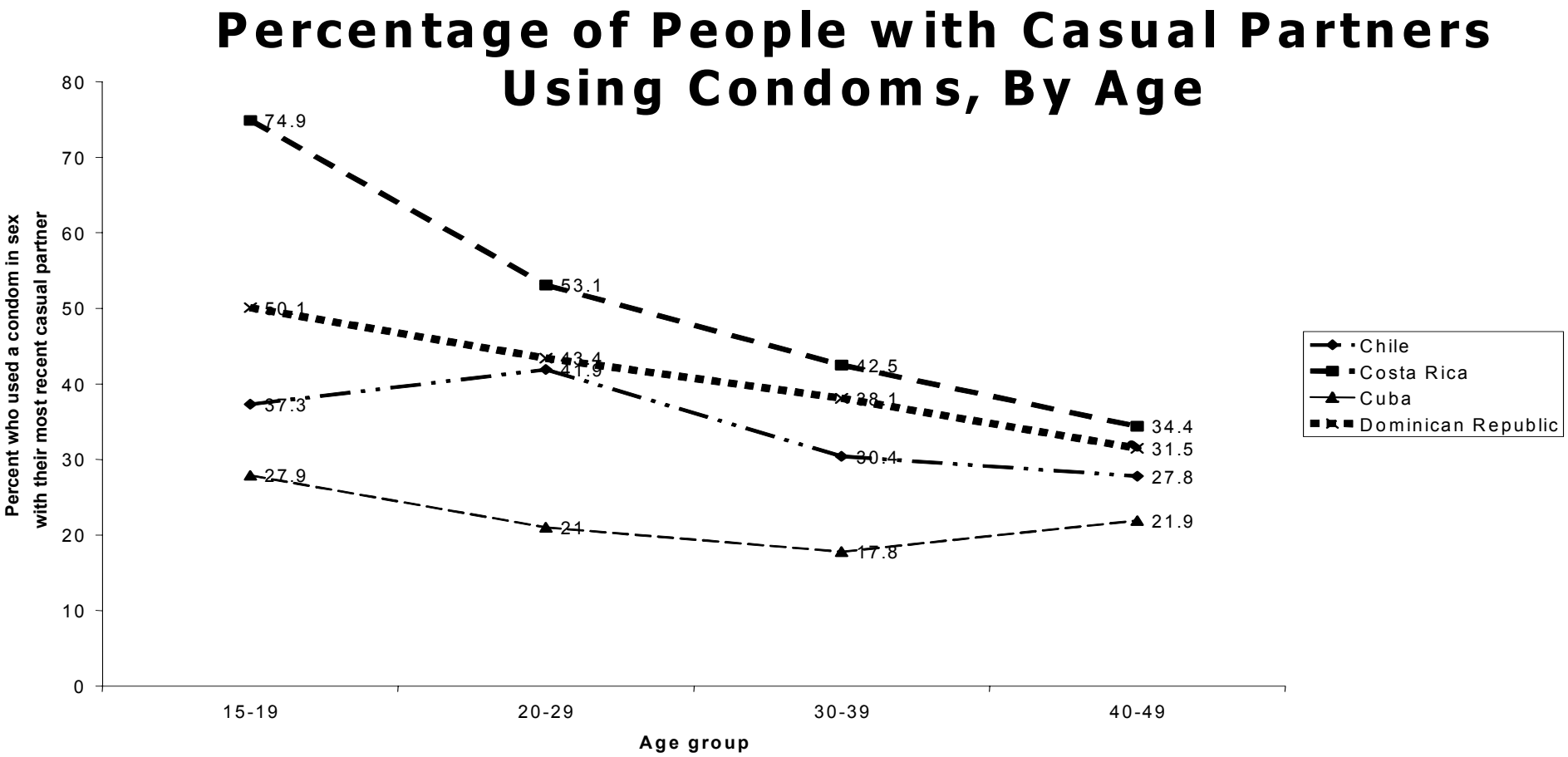
The Caribbean and Central America have substantially higher rates of infection. Transmission is mainly heterosexual, and there is a marked difference in infection rates between high and low risk populations (UNAIDS/WHO/PAHO, 2001). Youth in Haiti, Honduras, Panama, Brazil and various English-speaking Caribbean countries are particularly affected by the epidemic. It is estimated that 4.9% of adolescent males between 15 and 24 are infected in Haiti and 1.7% of adolescent girls and 1.4% of adolescent boys in Honduras (UNICEF, 2000). In Brazil, 0.7% of adolescent boys are estimated to be infected, and given the population size of Brazil, the actual number of adolescents with HIV is reason for concern because of their potential to spread the virus (ibid).

The distribution of AIDS cases in the Southern Cone indicates that the epidemic is shifting towards younger populations—for example, from 1983 to 1989, the median age group for AIDS cases hovered around 32 years; between 1990 and 1992, this shifted to approximately 25 years of age (UNAIDS/WHO/PAHO, 2001). Although the rate of infection is considered low among Argentinean youth, intravenous drug use is the main cause of HIV infection among them. It is estimated that 46% of males and 32% of adolescent females are infected due to drug use (based on a 1999 study) (PAHO, 2002).

In general, men are more likely to use condoms in casual relationships than women. Evidence shows that although youth may have more partners, sexually active youth are more likely to have used a condom with their most recent casual partner than older age groups (see table). Condom use in risky sex also rises with educational level in all countries studied (UNAIDS/WHO/PAHO, 2001).

The future of the HIV epidemic lies in the hands of young people. The behaviors they adopt now and those they maintain throughout their sexual lives will determine the course of the epidemic for decades to come. Young people will continue to learn from one another, but their behavior will depend largely on the information, skills and services with which the current generation of adults choose to equip their children. Research shows that young people adopt safer sexual behavior provided they have the means to do so (UNAIDS, 1998). Given the chance, young people are more likely than adults to protect themselves (see Graph 4).

Graph 4



Source: *UNAIDS/WHO/PAHO: HIV and AIDS in the Americas, 2001*

▷Conceptual Framework for Adolescent and Youth Sexual Health and Development

Latin America has been at the forefront of developing policies, plans, programs and services for adolescents in the Region. However, many of the programs that currently exist adhere to the concept of disease prevention and focus on specific problem behaviors, such as HIV, pregnancy prevention and promotion of abstinence. Traditional programs and policies have been curative in nature and often defined success as a lack of problems rather than a healthy development. Such programs and services are vertical in approach and do not integrate concepts of families, culture, values, determinants of health and the overall context in which behaviors occur. Interventions try to change behavior once they are fairly well entrenched. This is referred to as "tertiary attention" or trying to fix something after it is already badly broken (Burt, 1998). Youth do not fully participate in program design and implementation; therefore, interventions do not speak to their desires or concerns. Many interventions are not well coordinated, causing costly duplication of efforts. Programs concentrating solely on preventing specific youth problems without attention to social context typically have been unable to document any long term effects (Scales and Leffert, 1999). Programs need to move beyond a problem-oriented approach to a development approach that promotes protective factors and resilience in youth; from individualized interventions to family and community interventions; from youth as recipients to youth as active participants; and, from vertical approaches to coordinated, integrated efforts in health promotion and prevention (ibid).

Youth development and community development must be seen as inseparable goals

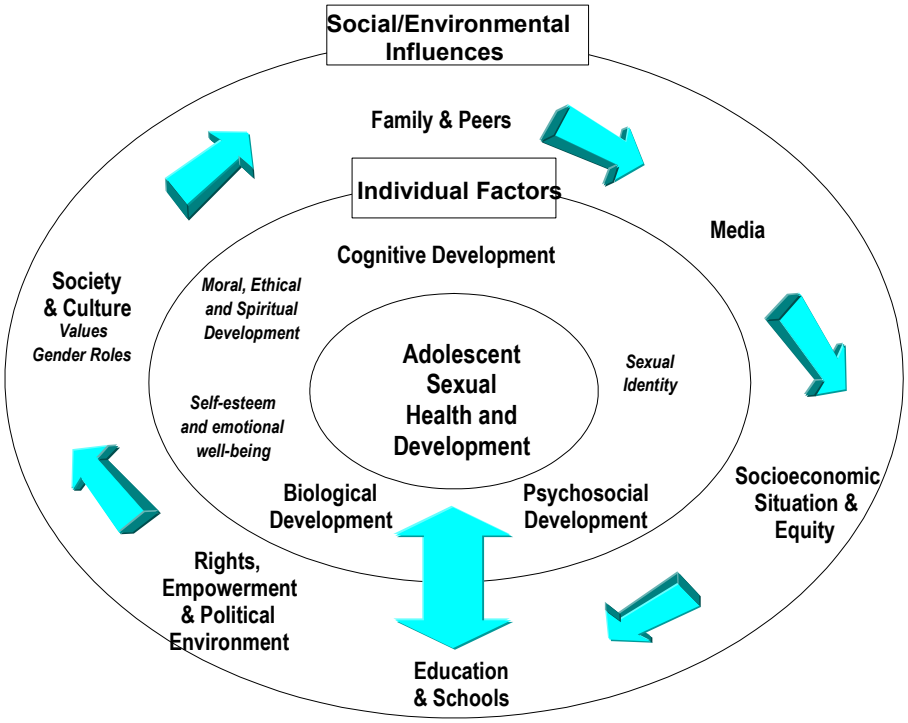
PAHO has developed a framework for adolescent health and development (PAHO, 1998b) as well as a document on the promotion of sexual health that includes a set of recommendations for action (PAHO, 2000). However, the Region needs a new conceptual framework that addresses the sexual health and development of adolescents that falls within the broader human development and health promotion approach. The assumption is that when society does not fulfill and protect adolescent rights and fails to help youth achieve a healthy development, problems arise. Rather than treating youth problem-prevention, youth development and community development as competing priorities, they must be seen as inseparable goals (Pittman, 1996). Success needs to be defined not as the absence of problems but broadened to include expected competencies such as social, physical, civic livelihood and vocational skills that enable youth to assert themselves as individuals. Other indicators of success include being connected, caring and committed, having a solid sense of safety and structure, membership and belonging, a sense of purpose, responsibility and self-worth. Therefore, PAHO proposes a new conceptual framework for sexual health that includes a development-centered approach within the context of the family, culture and the environment.

Success is not just the absence of problems; it includes competencies that enable youth to assert themselves as individuals

As Graph 5 suggests, the PAHO conceptual framework is centered on healthy development, with sexual health and development as an integral component of overall health. The following sections will define the concepts of adolescent sexual health and development and the various characteristics of a sexually healthy adolescent, along with the desired sexual and reproductive

health outcomes that the PAHO framework aims to achieve. It will also describe the various factors that influence sexual health and development outcomes. These include biological, psychosocial, and cognitive development at the individual level. At the social and environmental level, factors such as family, peers, schools and education level, society, culture, socioeconomics, equity rights and empowerment influence an adolescent's sexual development. All are interwoven and interdependent.

Graph 5



▷▷Adolescent Sexual Health and Development

Sexual and reproductive health is a human right that includes the safety of the sexual body, privacy, love, expression, choice and access to care

Health is universally acknowledged as a fundamental human right, and sexual health is an integral component of overall health. Therefore, sexual and reproductive health, including that of young people, is a human right that includes the right to sexual integrity, safety of the sexual body, privacy, equality, love, expression, choice, education and access to care. The concept of sexual rights is acknowledged and supported by International World Conferences, such as the International Conference on Population and Development (1994, Cairo), the Fourth World Conference on Women, (1995, Beijing), The World Conference of Human Rights and the World Association of Sexuality Declaration of Sexual

Rights, (XIII World Congress of Sexology, Valencia, Spain, 1997)[30]. Most importantly, this concept is being promoted by youth leaders from around the world who not only recognize their rights but are beginning to demand that their rights be respected, as described in the IPPF Youth Manifesto (Appendix).

▷▷Adolescent Sexual Health and Sexuality

High-risk youth behaviors grow from a common soil and are interrelated

Adolescence is often characterized as a period of opportunity and risk—and risk-taking behavior extends to sexuality. The links between adolescent sexual behavior and broader adolescent health concerns are clear. Research indicates that high-risk youth behaviors grow from a common soil and are interrelated. For example, adolescents confronting issues such as unwanted pregnancy, unsafe and unprotected sex, and abusive relationships often are the same that indulge in substance use and perform poorly in school. Studies indicate that substance use is linked to high-risk sexual behavior, which, in turn, leads to increased incidence of unintended pregnancy and STIs, including HIV/AIDS (Jessor, 1998). As already discussed, high adolescent fertility is linked to low educational attainment and poverty, and vice versa (Buvinic, 1997, 1998); furthermore, sexual risk-taking behavior is linked to poor educational performance and decreased supervision and support from family (Advocates for Youth, 2001). The underlying causes of such concerns stem from poor psychosocial development and inadequate social and environmental factors.

Adolescent sexuality and sexual well being are integral components of adolescent health and development

Adolescent sexuality and sexual well being are integral components of adolescent health and development. All human beings are inherently sexual and sexual development evolves during childhood and adolescence, laying the foundation for adult sexual health. Adjusting to sexual changes and protecting their reproductive health are among the greatest challenges for adolescents. The period of adolescence is an opportune time to address sexual health and sexuality concerns in order to improve the overall health of youth.

A healthy sexual development depends upon the satisfaction of basic human needs, such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Sexual health includes reproductive health, but extends beyond the care related to reproduction. Sexual health is the experience of the ongoing process of physical, psychological and socio-cultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. The term sexual health implies a sense of control over one's body, a recognition of sexual rights and is strongly influenced by an individual's psychological characteristics, such as their self-esteem and emotional and mental well being (PAHO/WAS, 2000; Tsui et. al, 1997; Neinstein, 1996), and the culture and context in which they live.

Full development of sexuality is essential for individual, interpersonal and societal well being and includes sex, gender, sexual and gender identity, sexual

[30] The literature includes many references to the International Conferences which form the basis of sexual and reproductive health and rights referred to in this document. As such, this document will not discuss the outcomes of these conferences but refer the reader to bibliography, which includes the references to these Conferences. Furthermore, the PAHO document written by Alejandro Morlachetti analyzes Latin American and Caribbean countries' obligations with respect to these Conferences.

orientation, eroticism, emotional attachment/love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships. Healthy sexuality is predicated upon one's control over when and whether sexual activity starts, control over the choice of one's sexual partner, and control over the frequency of sexual activity. Healthy sexuality includes the right to delay and to refuse sexual relations, particularly if it could lead to an undesired outcome such as exposure to an unintended pregnancy or infection (WAS, 1999).

Recognition of sexual rights is inherent to healthy sexuality, where individuals have the right to sexual freedom, privacy, equity, pleasure and to make free and responsible choices. Rational beings need to know the potential consequences of their actions, and one person's autonomous decisions cannot be called healthy if they are coercive to another person (PAHO/WAS, 2000; Tsui et. al, 1997; UNPOPIN, 1994).

Sexuality is constructed through the interaction between the individual and social structures, and family is an important influence in adolescents' sexual behaviors (Sieving et. al, 2002). Studies point out media and television, school and peers, and home (in that order) are the three primary sources of sexual information for adolescents (SIECUS, 2002). Nevertheless, parents are most frequently identified by young people as their primary influence for their actual sexual decision-making (38%), followed by friends (32%), with the media far behind (4%) (National Campaign to Prevent Teen Pregnancy, 2001). A striking positive social influence of parents regarding sexual decision-making has also been found (Schaalma, 1993).

Families play a crucial role in effectively communicating their own values to their children

A large body of descriptive research has revealed that parents and their adolescent children commonly have difficulty talking with each other about sexuality. Among Caribbean adolescents 24% of youth feel that their mothers "understand little about their problem," and 32% of adolescents feel the same lack of understanding from their fathers (WHO Collaborating Center on Adolescent Health/PAHO, 2000). Adolescent boys from nine countries in the Region indicate that sexual information received from parents is often provided too late, and loaded with myths and taboos (Aguirre and Güell, 2002).

Increasing the role of parents as the primary sexuality educators of their adolescents is a priority. Young people, while craving for grown-up experiences, are confronted with two controversial and opposing choices, condoms or abstinence, leaving them with little resources to explore sexuality at their own pace and learning to make developmentally-appropriate decisions. Families play a crucial role in effectively communicating their own values to their children, delivering not only information but also skills that will help adolescents adopt healthy decisions when exploring sexuality.

▷Desirable Outcomes for Adolescent and Youth Sexual Health and Development

▷▷Sexual Health Outcomes

Sexual health, sexuality and reproduction of youth bring out a set of complex and often emotionally charged issues. Many of these issues tend to be viewed negatively. However, many can be positive. Recognizing that sexuality is a natural part of the human development process, each society needs to define what is considered to be a sexually-healthy adolescent. Box 2 gives examples of some of the characteristics of sexually-health adolescents in the U.S.

Box 2 **Model Characteristics of Sexually-Healthy Adolescents** [31]
• Appreciate one's own body
• Understand pubertal change and view it as normal
• Seek further information as needed
• Affirm that human development includes sexual development, that may or may not include reproduction or genital sexual experience
• Identify and live according to one's values
• Take responsibility for one's own behavior
• Practice effective decision-making
• Communicate effectively with family, peers and partners
• Understand consequences of actions
• Distinguish personal desires from that of the peer group
• Assume one's own sexual identity and orientation and respect that of others
• View family as a valuable source of support
• Express love and intimacy in appropriate ways
• Develop and maintain meaningful relationships
• Exhibit skills that enhance personal relationships
• Understand how cultural heritage affects ideas about family, interpersonal relationships and ethics

[31] Adapted from Guidelines for Comprehensive Sexuality Education, National Guidelines Task Force, and the SIECUS Report of the National Commission on Adolescent Sexual Health. Guidelines adopted by PAHO in collaboration with the World Association for Sexology in the publication Promotion of Sexual Health: Recommendations for Action in May, 2000. It is our recommendation that countries recognize the heterogeneous nature of the adolescent population and respect the social and cultural environment.

Box 2
Model Characteristics of Sexually-Healthy Adolescents

- Maintain appropriate balance between family roles and responsibilities and growing need for independence
- Respect the rights of others
- Interact with both genders in respectful and appropriate ways
- Have an adult (in or out of the family) to talk to, ask questions and serve as a role model
- Know parents' and personal expectations
- Enjoy and express one's sexuality throughout life
- Express one's sexuality in ways congruent with one's values
- Enjoy sexual feelings without necessarily acting on them
- Discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others
- Express one's sexuality while respecting the rights of others
- Seek new information to enhance one's sexuality
- Ensure that sexual relationships are age-appropriate, consensual, non-exploitative, honest and protected.
- Prevent sexual abuse and avoid exploitative or manipulative relationships
- Practice abstinence or use contraceptives effectively to avoid unintended pregnancy and avoid contracting or transmitting a sexually transmitted infection, including HIV
- Practice health-promoting behaviors, such as regular check-ups, and early identification of potential problems
- Believe girls and boys have equal rights and responsibilities for love and sexual relationships
- Distinguish between love and sexual attraction
- Act consistent with one's own values in dealing with an unintended pregnancy and seek early prenatal care
- Demonstrate respect for people with different sexual values
- Exercise democratic responsibility to influence legislation dealing with sexual issues
- Assess the impact of family, cultural, religious, medial and societal messages on one's thoughts, feelings, values, and behaviors related to sexuality
- Promote the rights of all people to accurate sexuality information
- Avoid behaviors that exhibit prejudice and intolerance
- Reject stereotypes about the sexuality of diverse populations
- Educate others about sexuality
- Promote equalities between men and women

▷▷▷Healthy Sexual Behavior

Sexuality and sexual behavior are expressed at individual, interpersonal and community levels. They are characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure and wellness (PAHO/WAS, 2000). Responsible adolescent sexuality should be encouraged in order to avoid the negative consequences of sexual behavior. A sexually-healthy adolescent is able to communicate with his/her family, is able to interact with peers (of the same sex and opposite sex) in a respectful manner, and is able to express love and intimacy appropriately. Healthy sexuality implies psychosocial and cognitive maturity that enables one to behave in a manner conducive to their health, including their sexual health. In other words, one must have the developmental skills to be able to appreciate one's sexuality, enjoy sexual feelings, take responsibility for one's sexual behavior and be able to avoid situations that lead to undesirable consequences. Healthy sexual behavior includes developmental maturity that allows young people to express sexuality in ways consistent with their values and understanding the consequences of sexual behavior. This implies avoiding sexual relations before one is emotionally mature and the use of modern contraceptives if they are sexually active.

Sexually-healthy adolescents are able to communicate with their families, interact with their peers in a respectable manner and express love and intimacy appropriately

▷▷▷Healthy Perception of One's Body

Sexual health includes the appreciation and understanding of one's body. This is a challenge during the early and middle adolescent periods, as it is marked by dramatic physical changes. Yet it is important for youth to understand pubertal change and appreciate it as a normal part of growth and maturing. The notion that the "The Body is a Temple" should be promoted, and exercise and healthy eating are important components that contribute to this. Girls and boys who participate in sports, exercise and eat healthily are less likely to engage in risky health behaviors and tend to practice healthier behaviors such as delayed initiation of sexual activity, abstinence from alcohol, tobacco and other drugs and undergoing regular check-ups (CDC, 2000; Mensch et. al, 1998).

▷▷▷Free from Sexual Abuse and Coercion

Many women, particularly young women, experience some form of sexual violence (WHO/PAHO, 2000; McAlister, 2000; Macro International, 1998b; PAHO, 1999). In Peru, early age at first intercourse is highly associated with coercion compared to older women (Cáceres et. al, 2000). Data is limited because such issues are considered private and sensitive and are rarely discussed or surveyed. However, anecdotal evidence from the Region suggests that gender-based violence, domestic violence and intra-family abuse, including rape, are prevalent. Additionally, violence and abuse has only recently been recognized as a public health and rights issue.

Gender-based violence has an obvious impact on young women's control over their sexuality and development. The negative consequences of violence that have a direct bearing on reproductive health include physical injuries, STIs, pelvic inflammatory disease, unwanted pregnancies and unsafe abortion or miscarriage—as well as mental or psychological aspects such as depression, anxiety and low self-esteem. The fear of violence can make a woman unable to negotiate condom use or practice contraception. Research

indicates that the majority of acts of violence against women, including rape, are committed not by strangers but by persons known to the woman, including family members (Tsui et. al, 1997; Neinstein, 2002; Cáceres et. al, 2000).

Another type of abuse is the sexual exploitation of young children, including rape and incest. For example, rape sometimes occurs to young women who refuse or do not accept sexual relations. The consequences of this sexual abuse are likely to be even more traumatic and long lasting to the development of youth than other types of violence. Evidence from the United States indicates that a history of childhood sexual abuse is associated with unhealthy adolescent and adult sexual behavior and a greater incidence of sexually transmitted diseases (Tsui et. al, 1997).

Studies on domestic violence in Nicaragua have shown that children of battered women are more than twice as likely to suffer from learning, emotional and behavioral problems compared to children whose mothers had never been abused (Zelaya et. al, 1999). Boys are also victims of physical and sexual abuse, although the data is even more scarce than for girls. This could be due to lower incidence, or the fact that boys are less likely to report the abuse; studies found that few male victims of abuse told anyone and most have difficulty talking about the issue (WHO, 2000).

▷▷Reproductive Health Outcomes

Reproductive health refers to the physical, mental and social well being of women and men in matters relating to the reproductive system and to its functions and processes. The majority of adolescent programs in the Region deal with adolescent reproductive health, and in the prevention of certain reproductive health outcomes, such as pregnancy and STIs, including HIV/AIDS. Few programs focus on the broader sexual health issues discussed above.

▷▷▷Safe from Unintended Pregnancy[32]

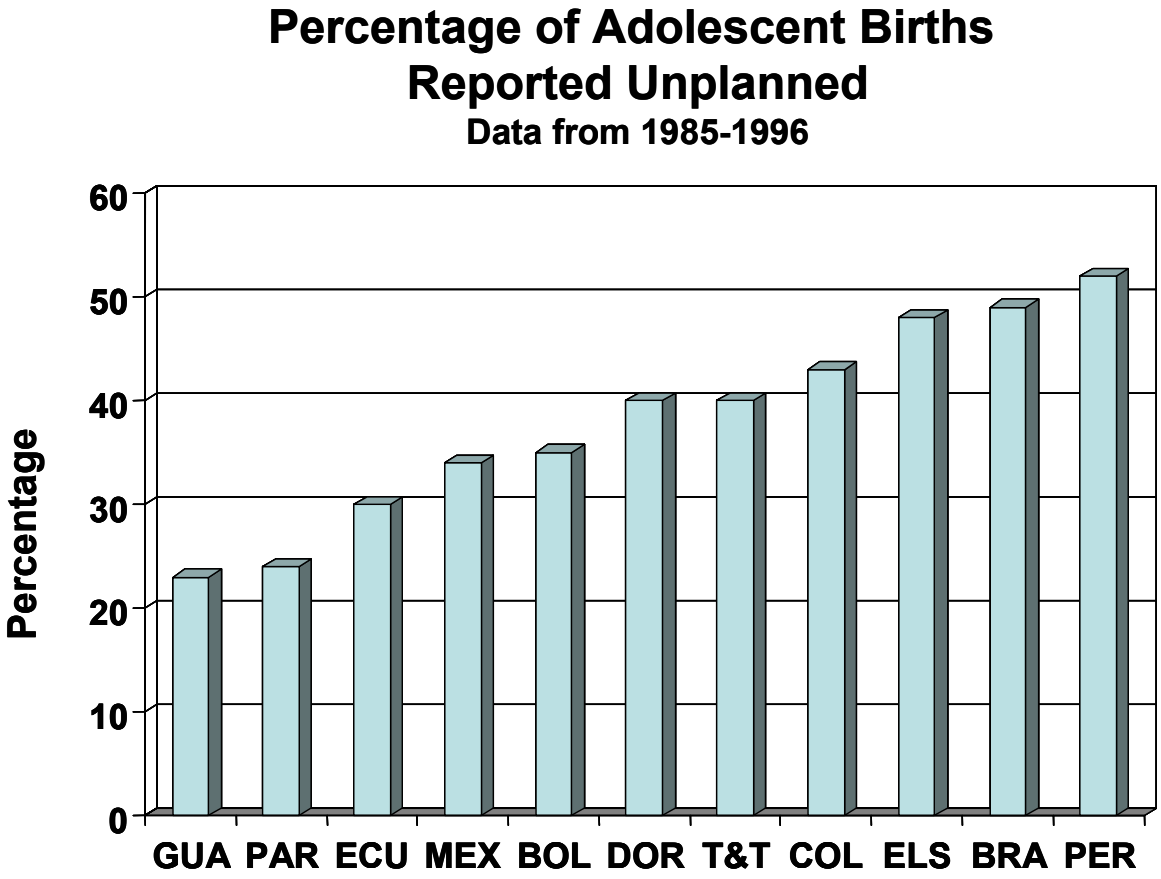
Studies indicate that healthy sexual development leads to better decision-making which, in turn, leads to behaviors such as increased contraceptive use, delayed onset of sexual activity and prolonged periods of abstinence, all leading to a decreased incidence of unwanted pregnancies.

Unintended pregnancies can result in unhealthy consequences for adolescents, particularly adolescent girls: unsafe abortion, early or forced marriage, decreased educational and income earning opportunity, not to mention the undesired consequences of early childbearing, which have health and economic implications for both child and mother. Pregnant adolescent girls tend to seek prenatal care late or not at all in comparison to adult women, which could lead to a greater risk of pregnancy-related complications.

[32] According to the Centers for Disease Control, “unintended pregnancy” is a term that includes pregnancies a woman characterizes as either unwanted (the woman had no plan to ever become pregnant at the time of conception) or mistimed (the woman did not plan to become pregnant until later in life).

Historically, adolescent pregnancy has been viewed as a female concern, with the male treated only as a silent partner. Because males do not get pregnant, or face the same consequences as adolescent girls who become pregnant, and most contraceptive methods are geared towards female usage and compliance, their role in contraceptive use is often ignored. However, adolescent males can positively or negatively influence a young couple's decision to use a contraceptive. Many times boys admit to feeling pressure to become independent, take risks and hide emotions, reinforcing concepts of machismo. Boys are also more likely to see sexual activity as a rite of passage into manhood and to take the lead when making decisions regarding sex (WHO, 2000). Although males have fewer contraceptive options, the condom is probably the most important method for young couples, as it provides dual protection from pregnancy and infections. Furthermore, adolescent boys tend to initiate sex earlier than girls and tend to accumulate more sexual partners over their lifetimes. Therefore, they are at a higher risk of contributing to an unintended pregnancy as well as contracting an infection (ibid).

Graph 6



***Source**: Allan Guttmacher Institute, 1998*

▷▷▷Prevent Unsafe Abortion

Abortion on demand is illegal in most Latin American and Caribbean countries[33]. Yet, as the statistics indicated, many adolescent girls that become pregnant seek abortion services. Adolescent girls facing an unwanted pregnancy with restricted or limited income often cannot afford private abortion services that tend to be safer than those provided by untrained practitioners. Poorer adolescent girls, therefore, are more likely to seek less costly back street abortion services, where unsafe conditions contribute significantly to the morbidity and mortality rates of young girls.

In addition, adolescents tend to wait longer to seek abortion services, which frequently lead to later-term abortions that substantially increase the risk of complications. The risks of maternal mortality can be substantially reduced through measures such as preventing unsafe abortions. The best prevention against unsafe abortion is to prevent pregnancies through the promotion of abstinence or the effective use of modern contraceptives.

▷▷▷Safe Childbearing

Although the majority of adolescent pregnancies are unplanned, many are desired and efforts should be made to contribute to healthy outcomes for young women who decide to bear children. Childbearing at an early age shapes the life of a young mother. If a young woman is poor, malnourished and uneducated, she is more likely to suffer negative ramifications (Singh and Wolf, 1991; Tsui et. al, 1997). In a situation where anemia and malnutrition are common and where access to health care is poor, childbearing among young women whose physical growth is incomplete may bring disproportionate health risks (Singh, 1998). These risks exist not only for the mother, but for the offspring as well. Infants born to young adolescent mothers are more likely to have low birth weights, which greatly contributes to increased perinatal outcomes such as small gestational weight and premature birth. In addition, infants born to adolescent mothers are more likely to have neurological problems and childhood illness (Santrock, 1998). However, in a situation whereby a young woman experiences high nutritional levels and widespread access to high-quality prenatal care, the physical risk of having a child may not be considered significant.

▷▷▷Safe from Sexually Transmitted Infections (STIs), including HIV/AIDS

STIs are a serious adverse health consequence of sexual behavior, particularly affecting young adults. Initiating sexual intercourse at an early age is associated with an increased likelihood of contracting certain STIs. For girls, this is, in part, related to biological factors. Ectropy of the cervix, a common finding in young adolescents, facilitates infection with Chlamydia, Human Papilloma Virus (HPV) and other possible viruses such as herpes and HIV (Coupey and Klerman, 1992).

[33] Abortion is illegal in all countries in LAC except for Barbados, Belize, Cuba, Guadeloupe, Martinique and Puerto Rico. Countries differ in the magnitude of restrictions against abortion.

Other reasons for the association of early adolescent sexual activity and STIs are behavioral and apply to both girls and boys. Young adolescents are less consistent and effective users of barrier contraceptives than are older adolescents and adults. They do not benefit to the same degree from the protective effects of these devices. In addition, initiating sexual intercourse in the early teenage years usually means that the young person will have more sexual partners and thus more potential exposure to disease than the individual who delays the onset of sexual activity until later adolescence or young adulthood (Coupey and Klerman, 1992, Howard, 1992; Morris, 1992).

Young women are particularly vulnerable to contracting STIs, Chlamydia, gonorrhea, syphilis, and HIV/AIDS. First, their physiology makes them more susceptible than adolescent boys or even older women. Young women have fewer protective antibodies than do older women, and the immaturity of their bodies increases the likelihood that exposure to infection will result in transmission of HIV or other STIs. They also have reduced vaginal secretions, which causes more friction and abrasion during intercourse and more likelihood of transmission. Young women are more vulnerable than males because the vagina has a greater surface area exposed to the virus than the penis. Also, there is a higher concentration of HIV found in male sperm than in a woman's vaginal secretions (UNAIDS/WHO/PAHO, 2001).

In addition to biological factors, young people are vulnerable to HIV/AIDS due to their cognitive and emotional development. Youth are at a concrete stage of cognitive development that makes analytical and decision-making difficult. As a result, youth tend to be more susceptible to peer opinions, which can affect their ability to negotiate sex and use condoms. According to the Johns Hopkins Center for Communication Programs, there is a correlation between cognitive maturity and sexual activity, whereby those with a higher level of cognitive maturity are less sexually active (Kiragu, 1991).

Social and behavioral factors also put young people at higher risk for HIV/AIDS simply because they are less likely to be married and have more casual partnerships. The spread of HIV/AIDS depends heavily on youth behaviors.

▷Factors that Influence Adolescent Sexual Health and Development

Adolescent development describes a transition where youth experience a series of biological, cognitive and psychosocial changes that affect how they later live as adults. These changes are influenced not only by the gender and level of physical, psychological and cognitive maturity of the individual, but also with the social, cultural, political and economic environment in which the adolescent lives. Given the understanding of adolescent sexual health, it is crucial to understand the life cycle process of adolescent sexual development and its influence on adolescent behavior[34]. This section will examine the multiple factors–both individual and social/environmental—that lead to the desired outcomes described above. Their degree of influence may vary at different points and times but they all shape how young people experience the transition from childhood to adulthood.

▷▷Individual Influences on Adolescent Sexual Health and Development

Cognitive growth is highly linked to the psychological and emotional processes of human development, including sexual development

During adolescence, youth undergo a series of biological, cognitive and psychosocial changes that influence their sexual health. These changes are part of the life cycle and depend on the individual's development process. They are all inter-dependent, in that, biological processes stimulate cognitive growth and cognitive growth is highly linked to the psychosocial and emotional processes of human development, including sexual development.

▷▷▷Biological Factors

Puberty marks the onset of adolescent growth and development where a series of biological, cognitive and psycho-emotional changes occur. The adolescent years are marked by the most rapid phase of human development, apart from the period just before and after birth. During puberty, both girls and boys experience important changes which include an increase in height and body mass, accompanied by the emergence of secondary sexual features.

Puberty differs among boys and girls, whereby girls tend to initiate puberty earlier than boys and girls' puberty lasts for a shorter period of time. In girls, puberty is characterized by an increased secretion of hormones, which result in growth spurts, enlargement of breasts and hips, genital development, apparition of pubic and auxiliary hair and onset of menarche, or the first menstruation. On average, menarche occurs between the ages of 9 and 11, and the average length of time for completion of puberty is 4 years. In boys, puberty is characterized by growth spurts, testicular enlargement, apparition of pubic and facial hair, deepening of the voice, and spermarche, the first emission of sperm. Spermarche occurs between the ages of 11 and 15 and puberty in boys can last

[34] WHO suggests that the life cycle is divided into the following categories: pre-puberty before age 10, early adolescence age 10-14, middle adolescence age 15-19 and late adolescence or young adulthood age 20-24.

up until 20 or 21 years of age. It is important to recognize that there can be wide variations in the onset and duration of pubertal development in both girls and boys. (Juszczak and Sadler,1999; Silber et. al, 1992; Santrock,1998).

Menarche and spermarche are the major development landmarks of puberty in that they mark the start of youths' reproductive competency. In both sexes, puberty results in a stronger awareness of sexuality, sexual feelings, eroticism and increased sexual motivation and attractiveness. Self-stimulation or masturbation can be a frequent sexual outlet for many adolescents; however, it is associated with feelings of guilt, anxiety and fear. Masturbation is often denounced by religions, cultures and traditions as dangerous, a sin, and the cause of insanity and premature death, but it has safer health consequences for youth than intercourse (Santrock, 1998; Silber et. al, 1992).

Today, young people are reaching sexual maturity at younger ages, which has long-term implications for sexual behaviors, including intercourse. Data indicates that first intercourse for both girls and boys occur one to two years after girls' menarche and boys' first nocturnal emission (Morris, 1992; Haffner, 1995). Premature initiation of sexual activity without sufficient cognitive maturity could lead to emotional stress for young people. Youth tend to initiate sex during the middle adolescent years (between 15-19 years), a developmental phase where they spend increasingly more time with their peers. They tend towards feelings of omnipotence and immortality, leading to risk-taking behaviors and which can have repercussions such as early adolescent pregnancy, STIs and HIV infection. Readiness for sexual relationships requires that adolescents are mature enough to understand and deal with the consequences of their actions.

Adjusting to the biological changes that occur during puberty is a major task of early adolescence, therefore, adolescents need to be adequately prepared. Sexual health includes the ability to appreciate one's own body and to accept these changes as a normal event. Achievement of these goals is dependent on parents' and other adults' preparing young people in advance of pubertal events, as well as supporting them during this important transition (Haffner, 1995). Increased sexual motivation and concerns about appearance provide an opportunity to encourage youth to adopt and maintain lifestyles that can influence physical attractiveness. As physical changes that take place in the body can lead to a greater concern about body image, it is an opportune time to inform youth of the adverse effects of tobacco on oral hygiene and skin or the benefits of exercise and nutrition on the body. Adolescent girls' concerns about appearance can be associated with dieting, not meeting nutritional requirements and developing eating disorders. The increased concern over attractiveness provides programs with an opportunity to promote healthy eating behaviors and educate youth on the negative health impacts of smoking and drug use on appearance and physical growth (Juszczak and Sadler, 1999).

▷▷▷Cognitive Factors

The cognitive growth process, based on Piaget's cognitive theory (1969), is associated with the development of formal operational thought that includes increases in the capacity for abstract reasoning, hypothetical thinking and formal logic. This results in adolescents who are increasingly likely to reason abstractly, understand the social context of behaviors, think about alternatives and consequences when making decisions, assess the credibility of information,

consider the future implications of actions and control impulses (Juszczak and Sadler, 1999; Haffner, 1995).

Healthy adolescent development includes skills to resist pressures, negotiate interpersonal interactions successfully and behave in accordance to personal values and beliefs

These cognitive abilities evolve over time and occur at no single prescribed time (Juszczak and Sadler, 1999), but most adolescents show a general pattern. As a result, it is important to understand this developmental process and nurture its growth. Cognitive changes that occur during puberty cause youth to move from concrete thinking to more abstract thoughts and behavior. During this phase of concrete thinking, youth are preoccupied with themselves and manifest egocentric or self-centered behavior. Adolescents tend to feel that they are constantly on stage and the center of attention, and have an imaginary audience. Frequent daydreaming and fantasy is common where youth sometimes set unrealistic or idealistic goals about their futures. Self-interest and introspective behavior is also common where adolescents tend to spend more time alone. Youth often feel that their problems are unique and insurmountable and therefore nobody else could possibly understand. During this period, youth experiment with roles and fantasy in order to develop their identity—which includes their sexual self-concept, gender identity and sexual orientation.

As adolescents move to more abstract thinking, they are better able to make decisions that can contribute to healthy behaviors. In order to develop strong cognitive and reasoning skills, adolescents require practice and experience to effectively cope with new experiences and situations, and adults need to encourage this practice. It is important to explore youths' perceptions, values or attitudes that influence behavior. This may lead to healthy adolescent development where youth possess a set of skills to resist pressures, negotiate interpersonal interactions successfully and behave in accordance to their personal values and beliefs (Haffner, 1995; Juszczak and Sadler, 1999; Moore and Sugland, 1997).

▷▷▷Psychosocial Development

Psychological development is dictated by adolescents' perceptions of themselves in relation to their social and environmental surroundings

Healthy sexuality and behavior cannot be achieved without understanding the psychosocial development process that influences adolescent sexual behavior. While biological and cognitive changes occur involuntarily, psychosocial development is dictated by adolescents' perception of themselves in relation to their social and environmental surroundings. Cognitive changes also manifest themselves through certain psychosocial behaviors that are common to most adolescents. Their behavior varies by level of physical, psychological and social capacity of the individual. The major influences on psychosocial development include sexual identity, moral, ethical and spiritual development and independence/dependence struggles between peer and parental influences (Juszczak and Sadler, 1999).

Sexual Identity and Development (Haffner, 1995; Silber et. al, 1992, Neinstein, 1996, 2002; Kohlberg, 1987)

During early (10–13) and middle adolescence (ages 14-17), young people solidify their gender identification by observing gender roles[35] of adults in their environment. They develop personal images and ideals of masculinity and femininity based on social sex-role stereotypes (Kohlberg, 1987). Gender

[35] Gender roles are social constructs that refer to the behaviors that go along with being male or female.

identification includes recognition and awareness that one is male or female and understanding the roles, values and responsibilities of being a man or woman. This is the most basic aspect of identity development and happens quite early in the development process. Most young people have a firm sense of their gender identity prior to adolescence and recognize the roles that characterize males and females, but during adolescence, youth identify more strongly with adult gender roles.

Sexual self-concept involves an individual's reflection and evaluation of his or her sexual feelings and actions. During adolescence, young people become more aware of their sexual attractions and love interests and adult-like erotic feelings emerge. Attractions are triggered by hormonal growth and during early adolescence, youth become conscious of which sex they are attracted to. Youth also begin to develop an awareness of their sexual orientation, their sexual and/or emotional attractions to males, females or both sexes. Although many gay and lesbian adults recall adolescence as a period of confusion about their sexual orientation, most do not self-identify as gay until late adolescence, although this might be related to social values and the taboos associated with homosexuality.

Independence-Dependence Struggles (Juszczak and Sadler, 1999; Neinstein, 1996)

Although this phase can begin during early adolescence, it is during middle adolescence (14–17 years of age) that youth tend to assert their independence by disconnecting and separating from their parents and other adults. During this phase, they are reluctant to accept parental advice and criticism and tend to be strongly attached to their peer groups. Their feeling of invincibility gives them a strong urge to prove their independence and autonomy. Social and environmental influences determine whether this behavior becomes constructive or destructive to adolescent health and well being. Constructive deviance is reflective of youth that strive for independence and attempt to get involved in adult lifestyles. Adolescents whose behavior reflects "destructive deviance" are prone to greater risk-taking behavior such as premature sexual activity and illicit drug use. Destructive deviance tends to be more common in adolescents that lack parental support and a healthy environment to nurture their cognitive and psychosocial growth. Deviance can be destructive in youth who feel alienated from society and their communities and therefore may commit to unconventional and often destructive lifestyles (Juszczak and Sadler, 1999).

During late adolescence, (ages 18-21), youth begin to develop the need for intimacy and struggle between intimacy or isolation in interpersonal relationships. At this higher stage of development, peer group conformity has lost much of its earlier significance and young people tend to look for more emotional relationships. Physical closeness, sexual affection and desires are part of this phase, and intimacy implies the establishment of emotional ties, love, empathy and sharing of private feelings with another person. Unions between couples should include a healthy balance of love, affection, friendship and respect. However, young people's inexperienced search for love, intimacy and commitment can lead to unhealthy attachments and infatuations (García, 1998). Young people who have uncertainties in their identity will shy away from interpersonal relations or may seek promiscuity without intimacy, sex without love, or relationships without emotional stability (Muus, 1996). Detachment and distancing in interpersonal relationships may emerge in such cases, which again

highlights the link between the human development process and health outcomes.

Emotional Well Being

The major physical changes that occur during puberty influence the way young people perceive themselves and are perceived by others. The hormonal and physical changes that the body undergoes during adolescence give rise to feelings of self-consciousness and self-awareness in relation to body image and physical attractiveness.

Self-esteem is an important determinant in the emotional well being of youth and is considered a protective factor in helping young people overcome challenging situations. Social support systems, particularly relationships with parents and peers, contribute to boost adolescents' self-esteem. High self-esteem and emotional well being provides adolescents with the personal and decision-making skills that lead to a healthier sexual life. Alternatively, low self-esteem is implicated in health problems such as depression, suicide, anorexia nervosa, delinquency, sexual risk taking and other adjustment problems (Santrock, 1998; Juszczak and Sadler, 1999)

Young girls' and boys' pubertal development may affect their self-esteem differently. Although young boys may welcome the physical changes that occur during puberty, young girls may have a particularly difficult time with pubertal growth, leading them to feel less self-confident and assertive, and contributing to poorer self-esteem (Santrock,1998; Muus, 1996).

Gender Implications of Psychosocial Development

Machismo socializes men to be self-reliant and independent, not to show emotions and not to be concerned with or complain about their physical health

Although the major psychosocial behavioral patterns are common to youth independently of culture, it does play a role in influencing these behaviors. In Latin America, self-identity and gender roles heavily influence and put pressure on adolescent girls and boys. For girls, menstruation is a physiological process that is considered a rite of passage into adulthood. Machismo[36] plays an important role in the self-identity development, where males are socialized to be self-reliant and independent, not to show emotions and not to be concerned with or complain about their physical health, nor to seek assistance during times of stress (WHO, 1999a). Furthermore, this socialization encourages boys to prove their masculinity through the number of sexual partners and the frequency of sexual activity. Many societies increase adolescent boys' risk of infection by condoning and encouraging early sexual activity and multiple sexual partners for men. It is not uncommon for males to report that their first sexual experience was with a commercial sex worker. In Guatemala, for example, 45% of males between 15 and 17 report that their first sexual experience was with a sex worker (Camacho-Hubner, 2000). This, however, varies by country and is not the norm in all Latin American countries. Studies are now showing that young men often want more involvement in decisions regarding parenting and reproductive health but that social constructs inhibit them from doing so (WHO, 1999a). Girls, on the

[36] Machismo is and cultural concept and ideology associated with masculinity. Machismo stresses male physical aggressiveness, high-risk taking, breaking the rules, casual and uninvolved sexual relations, infidelity in relationships, and negligence of domestic or household responsibilities. It represents a stereotype with deep-rooted value judgments and cultural assumptions (Francoeur, 1991).

other hand, feel the pressure to restrain their sexual impulses and attractions, in order to uphold an image of purity (García, 1998).

Early-maturing girls and late-maturing boys are at heightened risk for adjustment problems (Juszczak and Sadler, 1999; Santrock, 1998; Silber et. al, 1992). Early maturation can be particularly stressful for young women, placing them at risk for depression, eating disorders, poor coping skills and a greater likelihood of becoming sexually active and using/abusing substances. The latter two problems have been suggested to occur because a more mature appearance makes adolescents more likely to associate with a chronologically older peer group. Research on psychological development indicates that boys are more psychologically at risk than girls throughout the years of childhood, and then girls are at high risk in adolescence for depression and suicide (Gilligan, 1996). For boys, early maturation is often seen as an advantage, because physical growth in stature and muscle mass may place boys in a better position, athletically and socially (Juszczak and Sadler, 1999). On the other hand, late maturing boys have been found to suffer disproportionately high rates of depression, poor coping skills and problems with alcohol.

Early-maturing girls and late-maturing boys are at heightened risk for adjustment problems

Studies on adolescent boys and masculinity in Latin America and the Caribbean indicate that most adolescent males feel that masculinity is instinctive, uncontrollable and sometimes aggressive. Young males state that being a man means being a provider, sexually active, strong, risk-taking and having children. Adolescent males feel that their role can include domination over women, risk-taking and treating women as sexual objects. However, an emerging concept of masculinity exists where young males state they know about sexuality, express fear and frustrations, and have feelings of fear during their first sexual experience (Aguirre and Güell, 2002). Adolescent boys often admit to a lack of communication with their fathers, and in many cases where communication exists, messages promote irresponsible sex, encourage early sexual activity and reinforce concepts of machismo (ibid).

Young males state that being a man means being a provider, sexually active, strong, risk-taking and having children

Adolescents experiment with various roles, as they try to find their true selves. This permits easier adoption of health-related behaviors, either compromising or enhancing (Juszczak and Sadler, 1999). It is a period when decisions and choices shape later life prospects, therefore, concerted efforts must be made to provide the counsel, support and skills that are needed to place youth on a safe and productive life course (Gottlieb, 1998).

Moral, Ethical and Spiritual Development [37]

An important consequence of cognitive growth and development is moral development, which includes moral judgment and behavior. Moral judgment is an individual's intellectual or reasoning ability to evaluate the goodness or rightness of a course of action in a hypothetical situation. Moral behavior refers to the individual's ability in a real-life situation to help others, to resist the temptation to steal, cheat, lie or commit other immoral acts. According to Piaget's theory of youth cognitive development, during puberty, youth evolve from a phase where a child expresses blind obedience to authority to a phase where a young person considers other alternatives and the emotional capacity to empathize with others. As a young person passes through this phase, they

[37] Based on Piaget's ideas on cognitive disequilibrium theory and Kohlberg, Child Psychology and Childhood Education: A Cognitive-Developmental View, 1987.

begin to understand that rules are created by adults and they consider the intentions and consequences of their actions. As adolescents move into a phase of reasoning where they think more abstractly, they develop a sense of ethical, moral and often spiritual responsibility based on principles of what is right and wrong. Spirituality plays an important role in many societies, particularly in the development of norms and behavioral expectations and often dictates what is considered acceptable behavior. A young person's sense of morality is highly dependent on culture, society and family values. Culture plays a strong role in what people judge to be right and wrong, and this obviously extends to sexual behavior.

▷▷Social and Environmental Influences on Adolescent Sexual Health and Development

Countries with government support on issues such as HIV and pregnancy prevention tend to have greater success in achieving national goals

Biological, cognitive and psychosocial changes alone do not explain adolescent sexual health outcomes and behaviors. Social, cultural, political and environment characteristics, such as socioeconomic situation, family and peer relationships, media, education and legal policies are important influences in adolescent sexual health and development. Countries with political support and commitment from the government to address issues such as HIV, pregnancy prevention and other issues from a broader perspective tend to have greater successes in achieving national goals and objectives.

▷▷▷Family and Peers

In the Latin American and Caribbean context, family, including extended family, is probably the most important factor contributing to adolescent health and development. Family relationships can nurture and guide young people, set limits and challenge certain assumptions and beliefs prevalent within a culture. Caring relationships with adults and friends, and positive school experiences are significant aspects of a supportive environment for adolescents. It is through such relationships that youth develop the resilience to challenge social and cultural practices that can be harmful to their development and sexual health (WHO, 1999b; Scales and Leffert, 1999). Research shows that parents who adopt an "authoritative-democratic" style characterized by warmth, firm control, limit setting and attention to the development of the child's social and cognitive skills tend to foster self-confidence, self-control and effective coping skills in their children. On the other hand, autocratic parents, especially severely critical, protective or anxious parents, tend to undermine their children's sense of self-worth and self-efficacy, impairing psychological development (Gottlieb, 1998).

Family is probably the most important factor contributing to adolescent health in Latin America and the Caribbean

Family can be a protective factor in the lives of young people. The most protective family characteristic is connectedness--the perception of closeness that a young person has with at least one parent or adult figure (Blum, 1999). Access to an extended family has also been found to be highly protective. Evidence indicates that young people in chronically stressful situations, such as poverty, or those who experience trauma, such as the death of a parent or sibling, withstand such hardships more effectively when they have at least one significant, positive adult attachment. Access to a caring, concerned adult who offers guidance and security sharply reduces the probability of adverse developmental outcomes (Gottlieb, 1998).

During middle adolescence, while youth balance between defining their autonomy and depending on their parents, young people tend to identify closely with their peers. Peer acceptance plays an important role in adolescents defining their identity and their self-esteem. Peer influences are multidimensional and teens are not uniform in their susceptibility to it (Feldman and Elliott, 1990). Some adolescents look to their peers for reinforcement of behaviors and beliefs and often conform to the behavior of their peers. Others are non-conformist and do not allow their peers to dictate their behavior. Gender is a factor whereby girls are slightly more susceptible to peer pressure than boys. Susceptibility to peer influence is negatively correlated with adolescents' confidence and social skills (ibid). Other studies indicate the power of peer groups on boys, which may tend to spend more time on the street with their peer groups. In such cases, peer groups can serve several important functions, such as providing a sense of belonging as males seek independence (WHO, 1999a; Aguirre and Güell, 2002).

The most protective family characteristic for young people is connectedness

Parents, teachers and other adults can help adolescents to deal with peer pressures through increased communication and participation in their lives and social network. Helping young people to clarify their values and act on them will help youth resolve their daily situations, dilemmas and pressures. Research has demonstrated that most young people share the intrinsic values of their parents. The differences typically arise over more superficial practices of dress, music and leisure activities which are natural ways for young people to be creative and express their emerging identities (Friedman, 1999).

As such, parents should take a more active role in discussing sexuality issues with their children. Difficult issues such as rape, violence, abuse and coercion should also be approached so that children are aware and recognize signs of abusive behavior when it occurs. Parents can serve to enhance life skills, including negotiation skills, which help young people assert and act upon their desires, as well as recognize and potentially avert coercive situations.

▷▷▷Education and Schools

Education is a key defining variable for almost all health outcomes, positive and negative. Increased educational opportunities lead to increased economic and employment opportunities, and young people's ability to secure their autonomy and economic future. When young people fail to receive an adequate education, the cost to society is substantial. In the United States, young people that do not finish high school cost the country $360 billion annually, through welfare programs and lost tax revenue (Burt, 1998). As previously cited, in most Latin American countries, families do not meet the minimum educational requirement to rise above the poverty level. The price of an uneducated, unskilled young population is almost always greater than the cost of promotion and prevention programs designed to help youth achieve these goals (PAHO, 1998b; CEPAL, 1997). Given the potential "Demographic Gift" in the Region, as mentioned earlier, it is important for governments to recognize the worth of investing in the education of its youths.

Educational opportunities are linked to increased positive sexual and reproductive health outcomes, particularly for girls. It is well documented that increased educational opportunities lead to later age of marriage for girls, later childbearing and fewer children over the course of their lives (Ashford, 1995; Singh, 1998). Increased education is also linked to later initiation of sexual

activity, in both girls and boys. Those with increased education levels reported experiencing first intercourse at a later age (Morris, 1992; Singh, 1998). These findings are supported by other studies relating social conditions to initiation of sexual activity.

Outside of the family, schools have the largest influence on adolescent development. Adolescents spend the majority of their time in school, an institution that can play an important role in encouraging healthy behaviors. Increasing evidence from the United States shows that students who feel connected to their schools (teachers, peers and school environment) are less likely to use substances, engage in violence or initiate sexual activity at an earlier age. Characteristics such as an encouraging classroom environment and strong classroom management, participation in extracurricular activities, tolerant disciplinary policies and small school size were associated positively with higher school connectedness (McNeely et. al, 2002). Although more research needs to be done in this area, the role of schools and their relationship to its students warrants consideration.

In addition, studies in Barbados, Chile, Guatemala and Mexico indicate that attaining a certain level of schooling and providing income to the family are two protective factors that help adolescent mothers stem an otherwise vicious cycle of poverty for themselves and their children (Buvinic, 1997).

Education and skills lead to increased empowerment and control over adolescents' own lives, which enable them to make healthier decisions

Despite its importance, there are several cultural barriers to education. In many countries, providing education to boys and girls clashes with traditional ways of life and interferes with their need to have children and/or generate income for the family. The costs of school fees, books and other items often outweigh the perceived benefits of schooling in families with limited economic means. This perception must be adjusted by demonstrating the long-term benefits of skills training and education as a potential source of income to the family, the community and the overall economy.

It is important to ensure that youth obtain the necessary competencies and skills in order to secure a healthy future. WHO define these "life skills" as "the ability for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life" (WHO, 1999b). These life skills enhance the cognitive development of young people; they include decision-making and problem solving skills, creative and critical thinking, communication and interpersonal relations, self-awareness, self-efficacy and coping with emotions and causes of stress. The teaching of skills is intended to equip young people with new and improved abilities in selected areas. Education and skills lead to increased empowerment and control over lives, which enable youth to make decisions that lead to healthier outcomes.

▷▷▷Society and Culture

Cultural values regarding sexuality and gender roles exert powerful influences on the decision-making process of adolescent sexual activity and behavior (Gage, 1998). According to Michel Foucault's sexuality theories, sexuality is analyzed as a social construction and is defined and exists within a specific cultural context (Foucault, 1976). This means that society and culture shape the way individuals learn about and express their sexuality and dictate norms and taboos concerning gender roles and sexual behavior. Certain social norms and cultural practices can involve values, attitudes and practices that may

be harmful to young people or can prohibit people from expressing their sexuality. For example, the belief that adolescent girls do not need to go to school is one example of a harmful attitude with serious consequences. The machismo attitude that is prevalent in many Latin American countries also gives way to beliefs and values that can have harmful consequences to young girls and boys (Coupey and Klerman, 1992; Morris, 1992; Howard, 1992).

Parents and family also influence gender roles by allowing boys more independence than girls. Concerns about girls' physical and sexual vulnerability cause parents to monitor their behavior more closely and ensure that they are chaperoned. As a result, boys generally spend more time on the street or outside the home in unsupervised circumstances than do girls. Therefore, the independence-dependence struggles are more evident in boys than girls, who tend to be more confined to the home. Boys tend to feel more social and family pressure as a result of not being able to live up to the standards society dictates for "manhood". Society often pushes boys too early towards autonomy and independence and represses the expression of emotion and vulnerability. Young men tend to see sexual initiation as a competency that helps affirm their identity as men and provides them status in the male peer group. Sexual experience is seen as a rite of passage to manhood and an accomplishment rather than an opportunity for intimacy. Adolescent women, however, more frequently report having premarital sexual intercourse within the context of a relationship, while young men report having sex with multiple sex partners and in more casual relationships (WHO, 2000; Aguirre and Güell, 2002).

It is important to analyze cultural double standards, yet recognize that even within a country, multiple sub-cultures exist within communities and even within generations. The Region has many sub-cultures, such as indigenous cultures, that speak different languages, and have a social and cultural identity distinct from the dominant society. Many of these sub-cultures are marginalized from mainstream culture and have different needs and interests.

▷▷▷Socioeconomic Situation and Equity

There are strong links between socioeconomic status, equity and health outcomes. Indigenous and refugee populations, as well as gay or lesbian youth, tend to be marginalized by the mainstream population and are often left out of the process of economic development. They tend to live in less accessible places, are more likely to be poor and have limited access to services. It is well known that poverty and social inequity are associated with many unhealthy outcomes for adolescents, including their sexual health. These include poor nutrition, inadequate health care (including prenatal and reproductive health care) and poor school achievement. Adolescent mothers are more likely than older mothers to be poor. Youth from poorer families are more likely to initiate sexual intercourse at a younger age, become pregnant and bear children. Teens with less education and fewer opportunities for income generation become victims to a perpetual cycle of poverty (Buvinic, 1998; Singh, 1998; Tsui et. al, 1997).

If the stresses of poverty could be decreased, and appropriate care made available, the overall health of young people might have fewer negative consequences

Poverty, policy and legislation may pose access problems for youth who have the psychological maturity and development to seek sexual and reproductive health services, including contraceptive services. All of these factors pose barriers to youth fulfilling their potential for sexual health and development. If the stresses of poverty could be lightened and appropriate care

made available, the overall health of young people might have fewer negative consequences (Coupey and Klerman, 1992)

Lack of economic independence limits young women's ability to leave relationships that they consider risky and predisposes them to exchange sex for economic gain. Studies have shown that commercial sex work[38] is a result of women's economic hardship and very limited alternative opportunities for employment. Most young mothers have little education, come from poor families and spend their earnings to provide for their families (Tsui et. al, 1997). In addition, younger women are sought after for commercial sex work as they are least likely to be infected with an STI or HIV and are considered more desirable by men. Females are also more vulnerable to health problems because of biological factors, as previously mentioned, such as unwanted pregnancy and an increased risk for sexually transmitted infections (WHO, 1999b; Coupey and Klerman, 1992).

The human rights of adolescent girls are not widely acknowledged or protected, especially with respect to their sexual health and reproductive choices. Adolescent girls' ability to make free and informed choices about their sexuality and marriage can be undermined by their social position, their families and their partners. Increased social mobility, such as the freedom to decide who and when to marry, can improve the lives of adolescent girls and typically raise the average age at which females begin childbearing. This translates into improvements in their own health, that of their children, reductions in fertility and high returns in overall economic productivity (UNF, 1999).

▷▷▷Rights, Empowerment and Political Environment

The policy environment, including the availability or restriction of rights at the macro level is also linked to adolescent sexual development, the prevention of health problems and the provision of services. Many countries have restrictive laws, policies and regulations that hinder adolescents from exercising their rights and taking advantage of available opportunities.

Youth participation in the policy and legislative process is a fundamental mechanism to ensure that the political environment is conducive to adolescent development. Youth have enormous potential to contribute to the development of their countries; however, they are socially and politically excluded and they often do not have the skills or experience to make change without the guidance of adults and a youth-friendly political environment. Active youth participation provides young people with experiences in organization dynamics and leadership and helps develop youths' overall self-reliance and self-esteem while creating networks to actively support the needs of youth at the local level. Involving local leaders and youth may achieve positive change leading to more relevant laws and policies to promote the health of young people, allocate adequate resources, disseminate appropriate information and support equity. Additionally, incorporating youth participation into youth health and development activities fosters youth empowerment (PAHO, 1999).

[38] The United Nations Global Programme on AIDS study defines commercial sex work as "a sexual contact within the last 12 months, with a non-regular partner, for which gifts or money were exchanged".

▷▷▷Media and Communication

Few developments in society over the last 30 years have had a greater influence on adolescents than radio, print and television (Santrock, 1998). Social and cultural norms are expressed throughout the media, which serve to solidify certain norms and taboos regarding sexuality and gender roles. The media has a profound effect on information, values and behavior regarding sex and sexuality and provides an opportunity to promote positive messages to youth. Much of the information, values and behaviors portrayed through media are not conducive to healthy development. Violence, sex, gender and ethnic stereotypes are prevalent throughout most media programming. Studies indicate a strong link between media violence and adolescent aggression. Aggression is a learned behavior that can be acquired, reinforced and primed by media messages. Extensive exposure to media violence can also desensitize young people and make them more callous toward real-world violence. In others, it can lead to an exaggerated concern and fear of becoming a victim of violence (Strasburger and Wilson, 2002).

Media also teaches young people about sex. Unrealistic images of sexual behavior portrayed by the media may lead to confusion about sexuality. On American television, a content analysis found that 75% of prime-time shows on the major networks contain sexual content, but only 10% of incidents include any mention of the risks or responsibilities of sexual activity or the need for contraception (ibid). There are consistent messages that glamorize sex without discussing the options of abstinence, or the potential negative consequences of sexual behavior, such as unwanted pregnancy and STIs.

On the positive side, surveys indicate that television is responsible for teaching young people about AIDS (Macro International, 1996). Studies have documented television's ability to transmit information and to shape attitudes and influence social behavior and cultural norms (Strasburger and Wilson, 2002). Media should be encouraged to promote knowledge among youth. Parents and sexuality education programs have a limited impact on adolescents as few schools offer comprehensive, high quality programs, and parents often feel uncomfortable talking about sex. Media has a role in promoting positive images and accurate information to young impressionable adolescents and preadolescents (ibid). In Latin America and the Caribbean, the majority of information that adolescents receive on health and sexuality, they obtain either through their peers or the mass media. Media is a powerful tool that has demonstrated positive effects on adolescent sexual health and development. In Brazil, an AIDS prevention video entitled "Via de Rua" (Street Life) contributed to an 18% increase in condom use among youth targeted in the program. The program also increased youth knowledge levels by 20% (UNICEF, 1997b). Interactive media and youth participation is another successful media approach. Latin MTV broadcasted a show for young people called "Smart Sex" which registered a viewing audience of 3-4 million young people and later received 2,800 calls on the telephone hotline. Seventy-eight percent of youth that saw the program recommended it to their peers, and 91% approved of the messages broadcasted (ibid). Obtaining youth feedback through radio call-in sessions, letters to newspaper editors with sexuality education questions and adolescent television talk shows are all examples of the media's role and contribution in improving adolescent's healthy sexual development.

When designing programs for youth, it is important to take into consideration the age and cognitive level of development appropriate for that age group. In order for messages to be effective, they must be simple, consistent, straightforward, utilize visual information, come from a variety of sources and be repeated frequently and over a long period of time. It is important to begin prevention messages early as children begin to imitate behaviors very early in life. Messages can be targeted to youth as early as 8 to 10 years, before the onset of sexual activity and once their cognitive skills are developed enough to comprehend messages. Messages should accommodate and adapt to the heterogeneous nature of young populations and take into consideration cultural and environmental differences and include young people in programming (McNeal, 2000).

▷Policy and Program Implications for Adolescent Sexual Health and Development

As the conceptual framework indicates, healthy sexuality and development as an outcome must be addressed through a holistic, integrated development approach. Although past programmatic efforts have focused on the prevention of specific health problems, it has been demonstrated that interventions that focus on a specific behavior are less effective. Holistic approaches start early, offer enrichment, growth and development opportunities and stick with youth for a long period of time (Burt, 1998). Holistic approaches address the complex needs of youth in a compassionate way with a positive outlook that incorporates families, communities and other service sectors. The Region should promote protective factors and development approaches that recognize the potential of youth and view them as assets to the community and society.

Holistic approaches start early, offer enrichment, growth and development opportunities and stick with youth for a long period of time

This section will provide an overview of programmatic interventions and a series of programmatic and policy recommendations based on successes and lessons learned. It is important to understand, however, that successful programs cannot be applied uniformly and should be flexible, based upon the diversity of the adolescent population in terms of stages of development, socioeconomic status, culture, language and religion. Program planners must emphasize and value the vital role that organizational performance plays in creating social impact. Programs need solid organizations behind them, with strong organizational capacity and a clear mission in a changing environment (Letts et. al, 1999). Human and financial capital is also important to the sustainability and performance of organizations to produce lasting social benefits. One of the main ingredients to a successful program is a highly skilled and committed staff that is able to adapt to meet the wide range of needs of young people. Successful programs also must analyze their costs and outputs to ensure that program plans are consistent with the financial and human resources available. Non-governmental organizations (NGOs), due to their non-political nature are in a position to support the implementation of adolescent health and development programs. Similarly, government policy makers and bilateral agencies are pivotal in providing the framework for adolescent health and development and coordinating the various programs.

Several of the evaluation results presented are based in the United States. The impact of youth programs on adolescent sexual behavior is scarce in the United States, and even more so in Latin America and the Caribbean. Program evaluation in the Region focuses on tertiary prevention projects that address specific problems related to adolescent sexual health. As of late, there is a trend to document and evaluate successful youth programs, and much of the published information is based in the United States. The more successful adolescent programs are based on positive youth development. Given this, the programs suggested are applicable to other cultural contexts. Nevertheless, the local environment must be considered when adapting and building upon existing programs in another setting. As such, it is increasingly important to document approaches taken in order to provide lessons and successes to other countries in the Region.

Holistic approaches address the complex needs of youth with the help of families, communities and other service sectors

▷▷What Works and What Doesn't

Approaches that work involve the varied contexts of young people's lives and the adults who figure in those lives

In general, the literature suggests that "multifaceted approaches that work involve the varied contexts of young people's lives and the adults who figure in those lives, including parents, religious leaders, peers and teachers, as well as the media." Successful programs include content that goes beyond admonitions and slogans and are based on behavioral and social learning theories (Scales and Lefferts, 1999). Services that attract youth are youth-friendly, inviting and non-judgmental, and tend to be broader in scope than those aimed at a single problem, such as pregnancy prevention. However, messages must be clear, unambiguous and provide youth with options (Scales and Lefferts, 1999; Kirby, 2001; Kirby, 1997; Dryfoos, 1998).

▷▷▷Youth Development Programs[39]

Evaluations conducted in this area show a link between connectedness, environment and health outcomes[40]. Studies in the United States have shown that youth development approaches are effective in promoting healthy sexual behaviors among young people. Youth development programs represent a more holistic, alternative way to achieve desired sexual and reproductive health outcomes for young people. These programs do not focus exclusively on pregnancy prevention. Instead, they strive to improve adolescents' life skills, belief in their future, opportunities or "life options" more generally. Youth development programs recognize that one's motivation to avoid undesired sexual health outcomes (such as pregnancy) is a critical aspect of an adolescent's decision making process. A young person with developed cognitive skills will weigh the costs and benefits of a behavior, which, in turn, will determine their level of motivation to avoid a negative outcome. A youth development framework approach provides "mechanisms for youth to fulfill their basic needs, including safety and structure, belonging and group membership, self-worth and contribution, independence and control over one's life, closeness and relationships with peers and nurturing adults. Once these needs are fulfilled, youths can more effectively build the necessary competencies to be successful and productive adults, and are more motivated to avoid early childbearing" (Kirby and Coyle, 1997a).

When youths' basic needs are fulfilled, they an effectively build the necessary competencies to be successful and productive adults

A review of youth development programs in the United States indicates that the approach has contributed to the reduction of teen pregnancy. Service-learning youth developing programs, which include voluntary service by teens in the community and structured time for preparation and reflection before, during and after service, have the strongest evidence of any intervention that leads to behavior change. In these programs, participants develop relationships with program facilitators, they gain a sense of autonomy, feel more competent in their relationships with peers and adults and feel empowered. Also, the time spent during these activities simply reduces youths' opportunity to engage in risky behavior (Kirby, 2001). Given the burden of adolescent pregnancy to society, this is an approach that should be adopted by country programs.

[39] Based on a paper by Kirby, D. and Coyle K. entitled Youth Development Programs. 1997; and Kirby, D. Emerging Answers, 2001

[40] Based on WHO/UNICEF Meetings on Programming for Adolescent Health and Development: What Should We Measure and How? May, 1998 and June 2000.

Several countries have implemented National Youth Policies that embrace the youth development approach. Experiences from the Region highlight the importance of support from influential political leaders in combination with a strong coalition of youth advocates as key success factors to implementing a National Youth Policy, as seen in Bolivia and the Dominican Republic. Another important strategy is to involve parents, community and peers in the planning and implementation of programs (Dryfoos, 1998; Schorr, 1998a).

Children's Aid Society-Carrera Program

This US--based program offers comprehensive, long-term, intensive interventions to youth in both sexual and reproductive health and development. These include family life and sexuality education; individual academic assessment, tutoring, help with homework and preparation for exams; work-related activities, including a job club, stipends, individual bank accounts, employment opportunities and career awareness; self-expression through the arts; sports activities; and comprehensive health care, including mental health, reproductive health services and contraception. This program has a positive impact on sexual and contraceptive behavior, pregnancy and births among girls over a long period of time.

▷▷▷Youth Development Programs with Sexuality

(Kirby, 2001)

Three studies examined programs that address youth development and reproductive health simultaneously. Two of the three program evaluations indicated delayed sex and decreased pregnancy. All three indicated decreases in the frequency of sex. One particular program, the Children's Aids Society Carrera Program, did significantly delay the onset of sex among girls, increased the use of condoms and other effective methods of contraception, and reduced pregnancy and birthrates. This program is long-term, intensive and includes many components (see box).

▷▷▷Sexuality Education Programs[41]

Most countries in the Region agree that sexuality education is important and many countries such as Argentina, Chile, Colombia, Brazil and Peru have implemented National Sexuality Education programs. The discrepancies arise in how to implement sexuality education and there is considerable disagreement throughout the Region on what age, where to implement, and how to approach sexuality education for youth. Experts say that the quality and extent of sexuality education is inadequate,[42] and that this is an area that needs increased attention.

[41] Information taken from a paper written by Douglas Kirby and Karin Coyle that synthesized 35 evaluations of specific school based programs designed to reduce sexual risk-taking behavior, including sex and HIV education programs, school-based health centers and school condom-availability programs.

[42] Based on PAHO programmatic documents and meetings on sexuality education. Also referenced in the Senderowitz paper "A Review of Program Approaches to Adolescent Reproductive Health", June 2000.

Evaluations of abstinence-only programs that promote abstinence from sexual intercourse until marriage and do *not* discuss contraceptive options have been found to be ineffective in achieving the desired outcome. A review of over 35 school-based adolescent programs in the United States found that abstinence-only did not demonstrate any significant impact on delaying the onset of intercourse. A recent study (2001) found that abstinence-only programs do not show an overall positive effect on sexual behavior or affect contraceptive use among sexually-active youth (Kirby, 2001). A different study suggests that a narrowly defined, absolutist approach to sexual activity could even have the reverse effect on young people, given their increased tendency to experiment and exercise autonomy from adult figures and values. The study suggests that this is particularly the case of youth that lack motivation and a strong, supportive psychosocial environment (Rossi, 1997). These studies also suggest that in order for an abstinence program to stand a chance at success, it needs to target youth well before the onset of sexual activity. Given the fact that sexual activity can begin as early as 10 to 12 years, abstinence-only messages would need to target much younger age groups.

Programs that provide sexuality education that includes both abstinence and contraception are found to be more effective. It was initially thought that sexuality education programs that discuss condoms and other methods of contraception would lead to increased sexual activity among youth. Evaluations found, however, that such programs do not increase sexual activity among youth. Actually, a few of these programs reduced sexual behavior, either by delaying the onset of intercourse or by reducing the frequency of intercourse. Additionally, it was found that some of the programs that focused on HIV education actually increased condom use among sexually active youth. (Kirby, 2001, 1997).

▷▷▷School-Based and School-Linked Family Planning Services

Studies of schools with health clinics and schools with condom availability programs have consistently shown that the provision of condoms or other contraceptives through schools does not increase sexual activity. Given the relatively wide availability of contraceptives in most communities, most school-based clinics, especially those that did not focus on pregnancy or STD prevention, did not appear to markedly increase the school-wide use of contraceptives. In other words, there appeared to be a substitution effect, meaning that teens merely switched from getting contraception from a source outside of school to getting it in school (Kirby, 2001).

School-based interventions evaluated worldwide that aim to reduce HIV/AIDS show no differences in overall rates of abstinence or sex with a condom between the intervention and the control group. However, among sexually inexperienced youth, students who received the intervention were more likely to remain sexually inexperienced one year later (Merson et. al, 2000).

▷▷▷Sexuality Education at Home[43]

[43] Adapted from Douglas Kirby, Sexuality and Sex Education at Home and School.

According to a similar survey in the United States, many parents, as well as society, believe that parents should be the primary sexuality educators of their children. Adolescents also mirror this belief and have expressed the desire for their parents to be their primary sexuality educators. Despite this finding, only a minority of parents actually discuss sexual intercourse, contraception, or other topics with their adolescent children.

Although research in this area is still scarce, studies are linking increased parent-adolescent communication to positive sexual and reproductive health outcomes. For example, parent-adolescent communication may have a positive affect on contraceptive use. Additionally, studies find that if the adolescent is female and if parent communication takes place early enough, it could lead to a delay in the onset of intercourse. Educational programs for parents to feel comfortable and to increase and improve the quality of parent-adolescent communication, have demonstrated encouraging short-term effects. For example, studies on sex and HIV education programs for parents and families have demonstrated increases in parent/child communication, as well as increases in parent comfort with communication (Kirby, 2001). This preliminary research indicates that sexuality education at home could have positive effects on adolescent sexual behavior. Efforts should be made to help adults understand adolescents, the development process and the importance of family to their overall health.

The study also suggests that family characteristics such as connectedness, parental support and supervision are more closely associated with increased parent-adolescent communication. This corroborates the fact that family connectedness and parent-adolescent education are protective factors in adolescent sexual health and should be encouraged.

These findings are particularly important given the lack of adequate sexuality education in schools. Schools in many countries in the Region are influenced by religion and politics and perpetuate many of the taboos and myths surrounding adolescent sexuality and development. Parents and family may be one of the venues to increase communication with youth on sexuality and break some of the taboos surrounding these issues.

Radioprogramas del Perú--Era Tabú

Peru has a radio program entitled "Era Tabú" (It was Taboo) that airs nation-wide on Radioprogramas del Peru (RPP), one of the largest radio stations in the country with the widest listening audience. Era Tabú is an interactive radio program that allows for caller feedback and covers topics of sexuality that are traditionally considered taboo. Topics are widespread and relate to human sexuality with a particular emphasis on youth. The program airs during afternoon hours. This strategy of using media allows for topics of sexuality to enter the home and provides a window for communication among family members on sexuality. The program has an audience of one million that ranges from urban populations in metropolitan areas to more rural areas.

▷▷▷Multi-service Youth Centers

In Latin America and the Caribbean, youth centers have been developed with multiple health and social services to address the broad needs and concerns of youth. These centers are located in the community, affiliated with national youth organizations and linked to schools. Multi-service centers should be considered by youth to be a "safe haven" in the sense that youth feel physical safety (for those living in harsh environments) as well as emotional security and confidentiality. These centers provide life skills training, educational, vocational and recreational services along with counseling and reproductive health care. The provision of diverse psychological and health services also allows for treatment of young people in a more holistic way, thus addressing root causes of problems and meeting various needs at the same time. Such centers also attract young people, particularly boys, in ways that traditional health facilities fail to do. Multi-service programs with vocational and employment training are more attractive to adolescents and provide them with meaningful employment opportunities in the future.

Research shows mixed results for such programs[44]. Successful programs included intensive outreach efforts, but when the intervention ceased, behavior changes were not sustained. Results also found that the costs of maintaining the centers in view of clients served were high compared to costs of supporting program activities. Attendance at centers tend to be low for reproductive health services, yet youth come in for non-educational, recreational activities (Senderowitz, 2000). Therefore, youth centers should ensure that recreational activities are linked to more educational and development strategies that work towards improving adolescent health behaviors. As youth become comfortable with a youth center and its staff, they are more likely to consult the center when reproductive health needs arise. Solutions include establishing strong links, networks and collaboration between different community groups and services, including schools. This would provide youth with the full range of services required, yet would not overburden the financial or human resources required to provide high-quality services under one roof.

Additionally, youth centers should be encouraged to conduct cost/benefit analysis to ensure cost-effectiveness, particularly since many youth centers are constrained by limited donor funds.

▷▷▷Youth Peer Programs[45]

Peer programs are those that train and deploy as educators, or even mentors, youth of a similar age, place of residence, occupation or interest area to those who are targeted to receive a designated intervention (Senderowitz, 2000). Peer programs are widespread throughout the Region and typically combine several important factors useful in health promotion and development. These include strong identification with the social and cultural environment of the target groups, promotion of social norms and values supportive of positive attitudes and healthy behavior, and actual involvement of young people in programs targeted to them. Peer programs have been identified as a useful mechanism to recruit participants to existing centers and activities. Peer programs offer a direct and meaningful way for young people to participate in programs whereby adolescents reach and communicate with their peers, and can also provide useful feedback to program planners on what works and what doesn't.

[44] Based on evaluations from Merson et. al (2000), Kirby (2001) and Senderowitz (2000).
[45] Adapted from FOCUS on Young Adults programmatic reports.

Evaluations have been conducted of peer education programs and studies show that there is a much greater effect on the peer educators themselves than on their intended target audience (Senderowitz, 2000; Focus on Young Adults, 2001). Furthermore, peer education has helped to increase youth involvement and active participation in programs. According to this observation, peer educators have reported behavior changes due to their involvement in programs. Two examples from the Region are cited: the Jamaica Red Cross Project where peer educators reported significant gains in knowledge about HIV transmission, and many peer educators also intended to delay their first or subsequent sexual encounter and to use condoms when sexually active. AIDSCAP (AIDS prevention projects) found that 95% of peer educators had made changes in their own life and behavior (Senderowitz, 2000). The disadvantage of peer programs is that there are high turnover rates of youth participation. It is, however, important to weigh the benefits of youth involvement in attracting hard-to-reach youth, and the skills, knowledge and experience gained by youth participating in the program that remain with them forever.

Studies show that peer education programs have a much greater effect on the peer educators themselves than on their intended target audience

▷▷▷Workplace Programs[46]

Because many youth have jobs, interventions in the workplace are an important mechanism for delivering programs to a large number of youth. Working youth often have different needs than those who attend school. The type of workplace program varies from garment factory workers, to truck drivers, and even to workers in the informal work sector, with programs in the marketplace and for commercial sex workers. For the formal work sector, providing services and education at these sites is advantageous to employers as it promotes a healthier workforce, with fewer absences, greater on-the-job efficiency and fewer disability and long term illnesses. Workplace programs also promote the image of the company. The informal work sector tends to attract younger workers and more transient populations that could be at higher risk for reproductive illness (truck drivers and commercial sex workers). Although information on workplace programs is limited, evidence indicates these programs have the potential to reach out-of-school and high-risk youth.

▷▷▷Life Skills and Skills-Based Health Education Programs[47]

Skills-based health education is a combination of learning experiences that aim to develop knowledge, attitudes and especially skills, which are needed to take positive actions to maintain healthy behaviors and to change unhealthy behaviors and conditions. There is growing recognition and evidence that as young people grow up, developing psychosocial and interpersonal skills can protect them from health threats, build competencies to adopt positive behaviors and foster healthy relationships. Skills development is more likely to result in the desired healthy behavior when practicing the skill is tied to the content of a specific health behavior or health decision. The most effective method of skills development is to involve people in learning through active, participatory learning experiences rather than passive ones. Active learning methods, along with other

[46] Senderowitz and Stevens, 2001.
[47] Based on Skills for Health: Skills-based Health Education, Including Life Skills; an Important Component of a Child-Friendly/Health-Promoting School. UNICEF/WHO/World Bank/UNFPA, 2002.

factors, were effective in reaching students and leading to positive behavioral results. Box 3 summarizes some characteristics of effective sexual education programs in the U.S.

Box 3
Characteristics of Effective Sexuality Education[48]

- **Start Early:** The adolescent years are often too late! Once behavior sets in, it is far more difficult to change.
- **Aim to reduce one or more sexual behaviors**: Effective programs clearly focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STI infection. Programs must provide an unambiguous message and continually reinforce a clear stance on desired behaviors.
- **Base programs on theoretical approaches**: Successful programs are based on adolescent development theories proven to be effective in influencing other health-related risk behavior. This includes going beyond cognitive development by understanding social influences, changing individual values and building life skills.
- **Promote clear and consistent messages that reinforce a stance on behaviors**: Effective programs do not simply lay out the pros and cons of different sexual choices and let the students decide which is right. Rather, information and facts, activities, values and skills are directed towards convincing students that avoiding sex, using condoms or other forms of contraception are the right choices.
- **Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding it**: Increasing knowledge should not be the primary goal of sexuality education programs; instead, effective programs provide basic information for students to assess risk. Such programs do not provide unnecessary detail but simply emphasize the basic facts needed to make decisions.
- **Address social pressures on sexual behaviors**: Effective program curricula discuss situations that might lead to sex, social barriers to using contraception, and explore how to handle such situations.
- **Provide examples and practice communication, negotiation and refusal skills**: Effective programs provide information about skills, model effective use of skills and provide skill rehearsal and practice (role-playing, etc.) on how to overcome situations.
- **Employ a variety of participatory teaching methods**: Effective programs have instructors who reach students through active learning methods of instruction, rather than didactic instruction. This includes small group discussions, games, simulations, role-playing, dramatizations, rehearsals, etc.
- **Incorporate behavioral goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of the student**: Programs for youth who are not sexually active should use methods that are different from youth who are sexually active, or considered high-risk.
- **Include sufficient time**: Many programs require long-term investments rather than brief episodic responses to problems.
- **Select teachers or peers who believe in the program**: Effective programs select teachers and peers that demonstrate commitment to the program and believe in program goals.

[48] Adapted from Kirby, 1999; Dryfoos, 1998, chapter 8; and Schorr, 1998a.

▷Future Challenges

The previous section highlighted the trends in evaluation of youth programs. It is not the aim of the paper to provide specific programmatic recommendations, as each country has its own priorities and experiences. However, PAHO highlights challenges the Region faces that can serve as recommendations, keeping the Region on the cutting edge of adolescent sexual health and development. The main challenges for the next decade are described below.

▷▷Paradigm Shift for Policy Makers and Youth-Serving Professionals

The first challenge is to accept a paradigm shift whereby adolescent sexual health is considered an indispensable component of health and education and considered an important investment for the Region. In order to improve adolescent sexual health and development, a paradigm shift is necessary whereby policy makers embrace and promote certain principles. Leadership is key to ensure that young people have access to information, education, services and environments that will lead to their sexual health and development.

Box 4 **Paradigm Shift for Policy Makers[49]**
• Adolescents must be valued and respected and considered agents for social change and development.
• Adolescence is a time of opportunities to develop positive lifetime behaviors and skills, rather than a period of turbulence.
• Sexual development is an essential part of adolescence and the majority of adolescents engage in sexual behaviors as part of their overall development.
• Public policies must be consistent with research about adolescent development, adolescent sexuality and program effectiveness.
• Research and effective program interventions are required for youth outside of the school system.
• Parents and families must be integral members of efforts to improve adolescent sexual health, even while adolescents develop greater autonomy and independence.
• Adolescent development is contingent upon high quality education and employment opportunities for all young people.
• There is a need for comprehensive sexuality education, which includes human development, relationships, personal skills, sexual behavior, sexual health, sexuality and culture.
• Adolescents require a full range of confidential sexual and reproductive health services tailored for them.
• Cultural messages should support adolescent and adult sexual health and responsible sexual relationships.
• Research is required on adolescent sexuality and sexual behaviors in the Region.
• Funds should serve to coordinate holistic adolescent programs.

[49] Adapted from *The National Commission on Adolescent Sexual Health*. Haffner, 1995.

Box 4 Paradigm Shift for Policy Makers
• Programs must respond to the diverse sexual health needs and wants of adolescents, including the needs of indigenous, disenfranchised, disabled and gay and lesbian adolescents.
• Greater youth involvement in program planning and implementation is paramount to program success.
• Program plans should match the available human and financial resources available.

▷▷Promote Supportive and Safe Environments

The importance of environment has been outlined in the framework. Youth policies must address determinants of health and ensure a safe and supportive environment. Before implementing a program, policy-makers must take into consideration the cultural, family and community environment in which youth live.

- **Support social youth policies that address determinants of health**: These determinants include income, education, labor, services, etc.

- **Recognize and include adolescent sexuality in National Adolescent Health Policies and Programs**: Integrate concepts of adolescent sexual health into existing health plans. Create intersectorial groups so that adolescent health is addressed in a holistic manner. Work towards a legislative environment conducive to adolescent sexual development, which includes legislation and policies that specifically address the sexual health of youth.

- **Replace restrictive policies, laws and regulations with ones that encourage adolescents and youth to increase their access to services and increase opportunities to succeed**. For example, it is important to work towards outlawing abuse, prohibiting early marriages, increasing the minimum age of marriage and implementing laws to ensure secondary education for girls and boys.

- **Develop policies and legislation to strengthen, support and preserve families:** Policies and legislation should recognize the importance of families in the adolescent development process and ensure that measures are taken within programs to foster this concept.

- **Recognize and promote the social and economic conditions of families**: Policy-makers must recognize the links between poverty, educational opportunities and human development. As the framework indicates, the social and economic conditions of a family are critical factors in determining an environment conducive to adolescent growth.

- **Encourage understanding, prevent discrimination and promote gender equity:** Advocate for specific anti-discrimination policies to ensure that marginalized populations have equal access to opportunities and services. Policies and legislation should work to reduce exposure to unhealthy conditions, racial and ethnic discrimination, gender inequities and risk behaviors, including violence.

▷▷Develop and Implement Plans of Action and Programs

There are several guidelines to follow when developing plans of action and programs:

- **Develop plans of action that address adolescent sexual health and development:** Once policies are established, a multisectoral approach to put the policy into practice through plans of action is important to address youth more effectively. Plans of action should support development, promote health and prevent health problems and provide care as an important aspect of ensuring the healthy development of young people.

- **Consider the heterogeneous nature of adolescents**: Design programs according to adolescent stages of development, sex and marital status. Programs should also consider the differences in culture, values and beliefs of adolescents.

- **Implement strategies to overcome adolescent barriers to access**: Adolescents face a variety of barriers to care. One strategy for overcoming adolescents' concerns regarding accessing care is through intensive outreach efforts. Outreach must also be linked to a health system. Peer education programs are often a useful outreach strategy that help adolescents overcome barriers to care.

- **Improve legal and financial access to comprehensive health services.** Assure the legal right to health care and confidentiality. Reduce legal barriers to adolescent health services and parental consent for services. Provide adolescent-focused and adolescent-acceptable health services.

- **Implement programs that promote gender equality and equity:** Sexual health and development of youth cannot be accomplished without considering gender. Gender inequality increases the vulnerability of girls and young women to coerced sexual intercourse, unwanted pregnancy and HIV/AIDS and other STIs. Ensure programs for males adolescents in sexuality, reproductive health and contraception, and raise their consciousness that sexual responsibility must be shared by both partners.

- **Establish mechanisms for sexuality education in schools, health centers and with community youth groups:** Sexuality education should include reproduction, life skills development and negotiation skills to promote abstinence and delayed onset of sexual activity and to promote dual contraceptive use for sexually active youth. Ensure a quality sexuality education curriculum that provides youth with a set of skills that enable them to understand, appreciate and negotiate their sexual health needs.

▷▷Health Services for Adolescents and Youth

Adolescent health services require a systemic approach in order to:

- **Ensure high quality, "youth-friendly"[50] health care for adolescents**: As the framework suggests, adolescents need holistic, multi-faceted, developmentally appropriate services. There is a growing need for health providers, health care organizations and communities to provide young people with affordable, sensitive, private and confidential health care services.

[50] The Focus on Young Adults Project defines the following characteristics as "youth-friendly": offering a wide range of private, confidential and affordable services for youth with hours convenient (and defined by) youth; having staff trained to respect and meet adolescent needs, youth participation; and providing attractive and comfortable spaces for youth.

- **Provide services that focus on adolescents' needs**: Make health care delivery more personal and engaging for adolescents and provide them with services that meet their needs. Youth services must be confidential, private, affordable, convenient and appropriate, and staff must be non-judgmental towards youth and their desires and concerns.

- **Provide a Comprehensive package of services:** A comprehensive package of health services would include (or be linked through referral services) mental health counseling, livelihood skills development and support services for marginalized youth. Sexual and reproductive health services would include family planning, pregnancy testing, STI screening, diagnosis and treatment and prenatal care. Services need to be tailored according to adolescent stages of development.

  Included in services is the need to provide accurate information about human sexuality, including growth and development, human reproduction, anatomy, physiology, family life, pregnancy, childbirth, parenthood, gender roles, sexual behavior, sexual response, sexual orientation, contraception, sexual abuse and coercion, HIV/AIDS and other sexually transmitted diseases, exploration of cultural beliefs and values regarding sexuality (National Guidelines Task Force, 1996; Aggleton, 2002).

- **Establish school-based health clinics (SBCs) and/or school-linked health centers:** School-based and school-linked services are identified as a means to overcome common barriers to the integration of education, health and social service systems. School-based centers do not necessarily have to be school operated, but should link the students and community to a health center. They can be operated by community agencies, with community leaders and health professionals to provide services. Both the community and the school need to feel ownership of the health facility.

- **Recognize the role of males in sexual health programs**: Programs are increasingly recognizing the important role of males in both the primary prevention of adolescent pregnancy and in support (both financial and emotional) of pregnant and parenting females. In addition, with increased concern about sexually transmitted infections (STIs) and HIV, a stronger focus on the male partner and promotion of condom use is imperative to adequately prevent reproductive infections

▷▷Encourage Youth Involvement

Youth involvement requires a shift in what adults think and do about youth participation and empowerment. The challenge is to:

- **Involve adolescents directly in the planning and delivery of health services and interventions**: The growing trend in adolescent projects shows that involving youth has beneficial effects. Youth participation is the key to ensuring that services are "youth friendly" and appropriate in meeting their needs. Youth should be involved in helping to identify needs, set goals and design services and activities that will be attractive and accessible to youth. Involving young people as program leaders, educators and counselors can yield better outcomes than adult professionals. Additionally, training and experience as peer educators enhance skills, self-esteem and leadership potential among those involved.

- **Actively engage adolescents in their everyday settings**: Adolescents are often disengaged from the community institutions that surround them, although connectedness to community and schools are considered protective factors. Schools should promote school connectedness and an environment that enhances youth participation in their schools and communities. Schools and communities can identify appropriate opportunities for adolescents to engage in community service. In order to engage youth, programs can recruit youth to serve on advisory boards, hold

youth forums, summits or town hall meetings where youth can express their concerns and ideas, and use youth groups to provide guidance on program development

▷▷Encourage Family and Community Involvement

Parents need to be encouraged to talk to their children about sex. It is first important for parents to be clear about their own sexual values and attitudes before communicating with their children so they may explore their feelings and develop their own values. It is best to talk with children early, often and specifically about sex. Adolescents have many questions about sex and they often say that they would most like to hear from their parents, therefore encouraging honest, open and respectful two-way conversations about sex, love, and relationships.

- **Increase the role of schools in improving adolescent health:** Schools play a critical role in the lives of adolescents. Schools can promote and link health and education goals and have the potential to facilitate access to health services. Policies are needed to integrate health and educational objectives and resources are required to enhance the ability of schools to provide on-site services or access to off-site services.

- **Encourage youth and community participation in sexuality education programs:** Increase the role of teachers, community and religious leaders and youth themselves in sexuality education programs to promote community involvement and explore and discuss values surrounding sexuality.

- **Link schools with families and with communities:** Schools must be linked with families as well as community organizations, including local government and religious groups. Schools must encourage family involvement and promote the benefits of incorporating sexuality education into the school curriculum.

▷▷Support the Development of Adolescent Skills and Competencies

These skills must be developed in order to:

- **Promote adolescent transitions into adulthood**: Adolescents have few opportunities to interact in meaningful ways with adults or with societal institutions in a positive and productive context. Adolescents need to form meaningful connections to the institutions with which they will interact as adults. The lack of these experiences can contribute to an increasingly disengaged adolescent population.

- **Establish employment opportunities and build bridges between school and/or community and work:** Providing career and employment opportunities for young people while in school will increase future opportunities for them to participate in the labor market in a meaningful way as adults. This requires partnerships between government and all levels of business and community alliances, and the inclusion of young women in micro-enterprise, savings and credit programs that have proven successful for women's groups. It also includes vocational skills training and internship opportunities for young people to gain meaningful work experience and explore career opportunities. Establishing creative links between formal education and skills and competency training to prepare youth to integrate and contribute to the work force is also important.

- **Maximize opportunities for adolescents to engage and maintain healthy behaviors:** Community programs can expand the opportunities for youth to acquire personal and social assets and to experience the broad range of features of positive developmental settings. Providing adolescents with opportunities and access to education and skills training to meet developmental needs is an important means of reducing risk behaviors. Skills should be reinforced through schools, family, media and communities. Programs should also create opportunities for adolescents to become involved and participate in their communities.

▷▷Capacity Building and Human Resource Development

This is a challenge for Latin America and the Caribbean, and includes a full spectrum of disciplines and professions.

- **Build capacity by training in adolescent sexual and reproductive health**: Increasing access and improving quality of health services has human resource implications. Few professionals are trained in adolescent sexual and reproductive health, particularly adolescent sexuality. Increased training will not only improve the quality of "youth-friendly" services, but also increase the number of professionals who are able to work with youth.

- **Train human resources in adolescent sexuality:** There are many opportunities for building capacity in the Region, at the pre-service and in-service levels, so that health providers, policy planners and program managers have training on working with youth. Sexuality educators must receive specialized training in human sexuality, including the philosophy and methodology of sexuality education. Distance education modules via the Internet or CD-ROM are an emerging strategy for training large numbers of youth-serving professionals, without disrupting their work.

- **Sensitization training for health professionals**: In addition to the more technical, medical side of adolescent health, sensitization training would enable health professionals to work with youth in a non-judgmental way. It should also explore values with youth-serving health professionals on issues of sexuality, and encourage acceptance of the needs and desires of diverse adolescent cultures.

▷▷Involve Media and Social Communication

Important societal attitudinal shifts are needed to encourage adolescents to adopt and maintain healthy lifestyles.

- **Promote positive adolescent health:** Efforts that emphasize positive aspects of adolescence are required, and the necessity of assuring a skills-based approach to ensure the adoption of positive health behaviors. The view of adolescence has shifted from a period dominated by turbulence to one in which opportunities to develop lifelong behaviors and skills can be maximized. As a result, positive aspects of adolescent health and behavior have gained greater attention in program development and policy efforts, although changing behaviors which are perceived to be negative or risky continue to receive focus.

- **Create adolescent-positive societal norms and commitment to health issues**: Mobilize all sectors of society in supporting adolescent health promotion and a healthy sexuality. Develop a strong advocacy case on behalf of adolescents and the promotion of adolescents as agents of change. Encourage adolescents' and youth's ability to adapt and maintain health-enhancing lifestyles and to access health-related services.

- **Create a supportive media and business environment for promoting adolescent health:** Changing business practices that are perceived as harmful to adolescents is strongly recommended. These recommendations include regulating program content and amount of advertising in television, preventing distribution of harmful advertising of tobacco, alcohol and other harmful substances, increasing the portrayals of equity in gender and promoting health-enhancing sexual and reproductive behaviors.

▷▷Support Research and Evaluation

Successful research and evaluation requires several steps:

- **Ensure the evaluation of programs:** Few adolescent programs have been evaluated, particularly national sexuality education programs and policies from the Region. In order to adapt, replicate and scale up culturally appropriate adolescent sexual health programs, it is imperative to monitor and evaluate such programs consistently. Policy-makers and service providers want to know the impact of programs on youth behaviors, the cost-effectiveness of programs and the "how-to" of developing successful programs. All of these are dependent on the monitoring and evaluation of existing programs.

- **Evaluate youth developmental assets:** Develop and operationalize indicators that reflect a broader approach to sexual health and development. Use indicators that measure youth developmental assets (rather than risks) that contribute to healthy sexual development.

- **Evaluate existing programs to measure successes in achieving positive sexual health outcomes:** The Region has very few evaluations that demonstrate impact of programs and policies. Resources should go towards evaluating the impact on health of development approaches, community-based interventions and policies.

- **Conduct research that reflects the diversity of adolescents**: There is little data on youth age categories and even fewer that break down adolescent age groups into early, middle or late adolescence. Epidemiological surveillance should disaggregate youth age groups in order to gain a clearer understanding of the different developmental phases during adolescence and their effects on health behaviors. Similarly, research on culture-specific traits within adolescent groups should be conducted.

- **Encourage increased evaluation**: Service providers are often reluctant to invest in evaluation of programs, due to the perceived costs and investments in human resources. However, several evaluation methodologies exist that lessen the financial and human resource burden, yet provide useful information to program staff. Coordination of evaluation efforts is necessary to decrease the financial burden of evaluation activities

▷▷Build Partnerships and Collaboration

Strategic alliances are needed to accomplish this paradigm shift.

- **Improve collaborative relationships:** With health sector reform serving to re-define priority areas for investment, it is important to ensure that adolescent sexual health and development is included in government priorities. One mechanism to keep adolescent sexual health from waning is to ensure partnerships with other sectors. An integrated government approach will serve to avoid duplication and improve comprehensiveness.

- **Improve government-level collaboration:** Assure an active partnership and visibility with the varying government ministries. The multisectoral approach to adolescent sexual health and development will require close collaboration and partnerships with various government ministries and departments such as the Ministries of Health, Education, Youth, Sports, Women's Affairs and Social Affairs.

- **Improve public-private collaboration:** Establish formal links between government and private sector; promote NGO collaboration. Promote collaboration and partnerships with private industry, which can serve to cut costs and has the potential to play an important role. Businesses with direct interests in reproductive health and the provision of supplies can work with governments to eliminate access barriers to services and information.

- **Improve community-level collaboration:** Expand inter-agency efforts aimed at increasing improved service coordination at the community level, which includes the religious community, teachers and parents. Community involvement is important to ensuring the success of programs.

▷Glossary

Abuse: The physical, emotional and/or sexual maltreatment of another person. Abuse often results in permanent physical injury, psychiatric injury, mental impairment or death (Francoeur, 1991).

Child abuse is the result of multiple and complex factors involving a stressful environment, marital strife or other crises, inadequate emotional and physical support within the family and the lack of adequate stress-coping skills of the parents. Unless treated, child abuse can lead to a repetition of the abuse when the abused child becomes a parent.

Adolescence: Adolescence can be conceptualized by dividing the process into three psychosocial developmental phases. It is important to recognize that these ages are not fixed and can overlap among different adolescents. In addition, they can vary across cultures, rural/urban lifestyles and race.

- preadolescence: before age 10
- early adolescence: age 10-13
- middle adolescence: age 14-17
- late adolescence age: 17-21 (Neinstein, 2002)

Cognitive Growth/Development: Involves changes in an individual's thought, intelligence and language.

Connectedness: A term developed to describe the notion of closeness of a young person to a parent. It is believed that connectedness with at least one parent is a protective factor in a youth's healthy development.

Constructive and Destructive Deviance: According to behavioral theory there are two categories of risk behavior in adolescence. The first category of risk is constructive deviance, practiced by those adolescents who are striving for independence and whose behaviors reflect a premature attempt to get involved in adult lifestyles. The second category is destructive deviance, practiced by adolescents who are alienated from society and committed to an unconventional lifestyle. Early onset of risk behaviors (such as illicit drug use and delinquent behaviors) is generally predictive of destructive deviance (Juszczak and Sadler, 1999).

Culture: Culture is defined as the behavior, patterns, beliefs and all other products of a particular group of people that are passed on from generation to generation.

Demographic Gift: The demographic gift describes a situation whereby a country or region is experiencing decreasing fertility rates and is characterized by a large cohort of economically "dependent" youths. According to this analysis, as youth reach working age and enter into the labor market, there will be an increased ratio of working to non-working age populations, which are potential indicators for future economic growth.

Development: The pattern of change that begins at conception and continues through the life cycle. Most development involves growth, although it also includes decay (as in death and dying). ***Human Development*** includes the physical, social and emotional processes of maturation across the life span.

Gender: Gender is the sum of cultural values, attitudes, roles, practices and characteristics based on sex. Gender, as it has existed historically, cross-culturally and in contemporary societies, reflects and perpetuates particular power relations between men and women (PAHO/ WAS, 2000).

Gender Equity: Refers to concepts of gender, and a power structure that permeates human relations and often affords or limits opportunities based on one's gender.

Gender Identity: Defines the degree to which each person identifies as male, female, or some combination. It is the internal framework, constructed over time, which enables an individual to organize

a self-concept and to perform socially in regards to his/her perceived sex and gender. Gender identity determines the way individuals experience their gender and contributes to an individual's sense of sameness, uniqueness and belonging (PAHO/WAS, 2000).

Ectropy of the Cervix: An eversion (or turning inside out) of the uterine cervix**.**

Empathy: The capacity to put oneself in someone else's place in order to better understand his/her emotions and feelings; the intellectual identification of oneself with another. As part of the development process, the adolescent moves from an egocentric phase to a phase where he/she is able to empathize with others.

Eroticism: Eroticism is the human capacity to experience subjective responses that elicit physical phenomena perceived as sexual desire, sexual arousal and orgasm, and usually identified with sexual pleasure. Eroticism is constructed both at individual and societal levels with symbolic and concrete meanings that link it to other human dimensions (PAHO/WAS, 2000).

Health Risk Behaviors: Those behaviors that predispose to negative health outcomes (for example, unprotected intercourse is a health risk behavior that predisposes to STIs and unintended pregnancy, which are negative health outcomes.

Holistic: A holistic approach refers to programs that focus on prevention of problems and promotion of health and development of youth, within the context of their families, their communities and their environments, rather than looking at a single-focus problem approach, such as pregnancy or drug prevention. Long-term holistic programs start at an early age and work towards preventing risk factors and promoting behaviors constructive to youth development.

Life Skills: 1) Social and interpersonal skills (including communication, refusal skills, assertiveness and empathy; 2) cognitive skills (including decision making, critical thinking and self evaluation); and 3) emotional coping skills (including stress management and increasing an internal locus of control) (Mangrulkar et. al, 2001). Life skills enhance the cognitive development of young people to increase their ability for adaptive and positive behavior (Francoeur, 1991).

Love/Affection: The personal experience and manifest expression of being attached, committed and bonded to another person, group of persons (one's kin) or an ideal. The essence of love is to connect or relate to someone or something external to oneself (Francoeur, 1991).

Machismo: Concept and cultural rules associated with masculinity. Machismo stresses male physical aggressiveness, high risk taking, breaking the rules, casual and uninvolved sexual relations and represents a stereotype with deep-rooted value judgments and cultural assumptions (Francoeur, 1991).

Monitoring and Evaluation: Monitoring is defined as the continuous follow-up of activities to ensure that they are proceeding according to plan. **Evaluation** analyzes the overall effectiveness of a program in achieving its desired objectives.

Moral Development: The rules and values about what people should do in their interactions with other people. Moral judgment involves making decisions about which actions are right and which are wrong. Moral character involves having the strength of your convictions, persisting and overcoming distractions and obstacles (Santrock, 1998; Kohlberg, 1987).

Peer Education: Peer education is a strategy that trains and employs young people to educate and mentor other youth of similar background, place of residence, occupation or interest area. Peer educators are typically the same age or slightly older than the group with whom they are working. Peer activities are not confined to schools but can take place during informal time spent among young people (Birdthistle and Vince-Whitman, 1997).

Positive Development: The engagement in pro-social behaviors and the avoidance of health-compromising and future-jeopardizing behaviors. Other elements of positive development include a sense of industry and competency, a feeling of connectedness to others and society, a belief in control over one's fate and a stable identify (Blum, 1999).

Protective Factors: Factors (individual, family, environmental) that reduce negative health outcomes.

Psychosocial Development: Involves changes in an individual's relationships with other people, in emotions, personality and the roles of social development.

Puberty: Period of life when sexual development and growth occur.

Resilience: Refers to a dynamic process encompassing positive adaptation within the context of significant adversity. Implicit within this notion are two critical conditions: 1) Exposure to significant threat or severe adversity; and 2) the achievement of positive adaptation despite major assaults on the developmental process (Luthar, 2000).

Risk Factors: Factors that increase the likelihood of experiencing negative health outcomes.

Reproductive Health: A general state of physical, mental and social well being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so (UNPOPIN, 1994).

Self-Esteem: The global evaluative dimension of the self, also referred to as self-worth or self-image.

Responsible Sexual Behaviors: Responsible sexual behavior is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure and wellness. The person exhibiting responsible sexual behavior does not intend to cause harm, and refrains from exploitation, harassment, manipulation and discrimination. A community promotes responsible sexual behaviors by providing the knowledge, resources and rights individuals need to engage in these practices (PAHO/WAS, 2000).

Sex: Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males (PAHO/WAS, 2000).

Sexual Health: Sexual health is the ongoing process of physical, psychological and sociocultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld (PAHO/WAS, 2000).

Sexuality: Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. While sexuality can include all of these aspects, not all of these dimensions need to be experienced or expressed. However, in sum, our sexuality is experienced and expressed in all that we are, what we feel, think and do (PAHO/WAS, 2000).

Sexual Abuse: The psychological exploitation of or infliction of unwanted sexual contact on a person for the purpose of one's own sexual excitement and gratification. Physical sexual abuse involves hands-on touching in a sexual way. The range of abusive behaviors may include sexualized hugging or kissing, touching or fondling erogenous areas or the genitalia, oral and anal sex and sexual intercourse. Covert

sexual abuse may be verbal, involving inappropriate sexual talk with children or strangers, or a boundary violation, in which the privacy of a child or unwilling adult is violated (Francoeur, 1991).

Sexual Activity: Sexual activity is a behavioral expression of one's sexuality where the erotic component of sexuality is most evident. Sexual activity is characterized by behaviors that seek eroticism and is synonymous to sexual behavior (PAHO/WAS, 2000).

Sexual Orientation: Sexual orientation is the organization of an individual's eroticism and/or emotional attachment with reference to the sex and gender of the partner involved in sexual activity. Sexual orientation may be manifested in any one or a combination of sexual behavior, thoughts, fantasies or desires (PAHO/WAS, 2000).

Sexual Practice: Sexual practice is a pattern of sexual activity that is exhibited by an individual or a community with enough consistency to be expected as a behavior (PAHO/WAS, 2000).

Safer Sex: Safer sex is a term used to specify sexual practices and sexual behaviors that reduce the risk of contracting and transmitting sexually transmitted infections, especially HIV (PAHO/WAS, 2000).

Sexual Identity: Sexual identity is the overall sexual self identity that includes how the individual identifies as male, female, masculine, feminine or some combination, and the individual's sexual orientation. It is the internal framework, constructed over time, that allows an individual to organize a self-concept based upon his/her sex, gender and sexual orientation, and to perform socially in regards to his/her perceived sexual capabilities (PAHO/WAS, 2000).

Sexually Healthy Adult: Sexually healthy adults appreciate their body, take responsibility for their behaviors, communicate with both sexes in respectful ways, and express love and intimacy consistent with their own values.

Sexual Rights: The rights of individuals to have the information, education, skills, support and services they need to make responsible decisions about their sexuality consistent with their own values. These include the right to bodily integrity, voluntary sexual relationships, a full range of voluntary accessible sexual and reproductive health services, and the ability to express one's sexual orientation without violence or discrimination.

Skills-based Health Education: Skills-based health education is a combination of learning experiences that aim to develop knowledge, attitudes and especially skills, including life skills, which are needed to take positive actions to maintain healthy behaviors and environments, and to change unhealthy behaviors and conditions to promote health and safety and prevent disease (UNICEF/WHO, 2002).

Social Development: The provision of resources (financial, educational, environmental) necessary to support healthy human development.

Social Capital: Environmental resources that are people-specific (e.g. family stability) and support human development. Factors are also protective in that they reduce the likelihood of health risk behaviors. These factors are sometimes viewed as assets or strengths. Others refer to them as components of resilience.

Spirituality: Spirituality, beyond religious affiliation, plays an important role in most societies, particularly in the development of norms and behavioral expectations. In fact, in many cases it dictates acceptable behavior and is reinforced by the family and ethnic or cultural group.

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▷Appendix

International Planned Parenthood Federation (IPPF) Youth Manifesto[51]
IPPF Youth Manifesto is a youth-developed strategy and plan of action for young people written by youth representatives, under the age of 25, active in sexual and reproductive health programs in their countries. The Youth Manifesto represents the voices of youth from around the world--an expression of youth empowerment and participation. The Youth Manifesto fed into the ICPD+5 International Forum.
Goal 1
Young people must have information and education on sexuality and the best possible sexual and reproductive health services. This includes the right to:
• *Choose from a full range of contraceptive methods, including abstinence and the latest advances.*
• *Sexual and reproductive health services that are confidential, accessible, free from judgment and offer a complete range of services*
• *Services that meet the different needs of **all** young people, married or unmarried, whatever their gender, ability, beliefs and sexual lifestyle. This includes addressing the additional needs of young people living with HIV/AIDS, survivors of sexual abuse and young sexual offenders.*
• *Sexual and reproductive health education that is accurate, reliable and responsive to the physical and emotional needs of young people of all ages and sexual lifestyles.*
Goal 2
Young people must be able to be active citizens in their society:
• *Young people must have real decision-making power.*
• *Young people must receive practical skills and knowledge so they can participate to the best of their ability in society.*
• *The contribution of young people and the way that they present themselves must be valued and recognized.*
• *Youth groups must have direct access to funds and support.*
• *Governments and policy makers must be urged to take action to support and promote youth participation in society.*
Goal 3:
Young people must be able to have love, intimacy and confidence in relationships and all aspects of sexuality:
• *Young people must be supported by laws that allow them to act freely in the way they choose to live their lives.*
• *Obstacles that make young people uncomfortable about themselves, their bodies and their relationships must be removed.*
• *Young people must be encouraged to know their own sexual rights and to respect the rights of others.*
• *Young people's sexuality should have a positive image in society.*
• *Society must recognize the right of all young people to develop and express their sexuality according to their values.*

[51] IPPF. Report of the IPPF Youth Parliament: Prague, Czech Republic. November 27, 1998. Outcomes from this report were fed into the ICPD + 5 Youth Forum , held in The Hague, Netherlands, February 6-7, 1999.