

Empowerment of Adolescent Girls

A Key Process for Achieving the
Millennium Development Goals



**Pan American
Health
Organization**

*Regional Office of the
World Health Organization*

 **Sida**


ROYAL NORWEGIAN EMBASSY

 **caacid**

Empowerment of Adolescent Girls

A Key Process for Achieving the
Millennium Development Goals



**PAHO Headquarters Library, Washington, DC
Cataloging-in-Publication Data**

© 2010 by the Pan American Health Organization

ISBN 978 92 7 53 279 75

Title: EMPOWERMENT OF ADOLESCENT GIRLS: A KEY PROCESS FOR ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

1. ADOLESCENT HEALTH
2. ADOLESCENT DEVELOPMENT
3. EMPOWERMENT OF ADOLESCENT GIRLS
4. PERSONAL AUTONOMY
5. GENDER IDENTITY
6. GENDER ROLES
7. EVALUATION
NLM WS 462

This publication was produced by the Family and Community Health Area (FCH) of the Pan American Health Organization/World Health Organization (PAHO/WHO). Support for publication was provided by Grant No. 163136 from the Swedish International Development Cooperation Agency (SIDA), Grant No. 230120 from the Spanish Agency for International Development Cooperation (AECID), and Grant No. 251035 from the Norwegian Agency for Development Cooperation (NORAD). The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of SIDA, AECID, or NORAD.

This report is available on the website of the Family and Community Health Area and can be accessed through www.paho.org. For any inquiries with respect to this document, please contact maddalem@paho.org.

Collaborators:

First and second editions:
Schutt-Aine, Jessie
Maddaleno, Matilde
Nunes Sorenson, Ewa
De la Rosa, Liliana

Third edition:
Corona, Esther
Paredes Drouet, Carla M.
Arango, María Clara

Acknowledgements:

The authors wish to thank Marijke Velzeboer, Alejandro Morlachetti, and Chessa Lutter for their support and participation in developing this document.

Empowerment of adolescent girls: a key process for achieving the Millennium Development Goals
Pan American Health Organization, 2010

Technical and financial support:

Swedish International Development Cooperation Agency (SIDA)
Norwegian Agency for Development Cooperation (NORAD)
Spanish Agency for International Development Cooperation (AECID)

Design and layout: ULTRAdesigns

CONTENTS

Abbreviations and acronyms	5
Foreword	7
Executive summary	9
1. Introduction	17
2. Seven arguments for the empowerment of adolescent girls	19
3. Fundamental concepts in gender equity and empowerment	23
3.1 What is gender equity?	23
3.1.1 Sex and gender	23
3.1.2 Equality, equity, inequity, and empowerment	23
3.1.3 Equity in health	24
3.1.4 Gender inequity in health	24
3.2 Empowerment and disempowerment	25
3.2.1 Empowerment as freedom and autonomy	25
3.2.2 Elements of empowerment with respect to adolescent girls	25
3.2.3 Levels at which empowerment occurs	27
3.2.4 Factors favoring the empowerment of adolescent girls	27
3.2.5 Stages of development of adolescent girls, empowerment, and disempowerment	31
3.2.6 Gender-based violence and disempowerment	33
3.3 Barriers to reaching the most vulnerable adolescent girls	34
3.3.1 Marginality and social exclusion of adolescent girls	34
3.3.2 Adolescent girls belonging to sexual minorities	35
3.3.3 Adolescent girls with HIV/AIDS and STIs, and those at high risk of contracting HIV/AIDS	35
3.3.4 Adolescent girls subject to commercial sexual exploitation	36
4. Monitoring and evaluation of processes for empowerment of adolescent girls	39
4.1 Concepts	39
4.2 Why evaluate programs for empowerment of adolescent girls?	39
4.3 Variables for measuring empowerment of adolescent girls	40

5. Empowerment of adolescent girls as a basic right.	45
5.1. Convention on the Rights of the Child (CRC)	45
5.2. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	46
5.3. Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará)	47
5.4. Ibero-American Convention on the Rights of Youth (CIDJ)	47
6. Empowerment, gender equity, and achievement of the Millennium Development Goals . .	49
6.1. MDG 1: Eradicate extreme poverty and hunger	49
6.2. MDG 2: Achieve universal primary education	51
6.3. MDG 3: Promote gender equality and empower women	53
6.4. MDG 4: Reduce child mortality	55
6.5. MDG 5: Improve maternal health	56
6.6. MDG 6: Combat HIV/AIDS, malaria and other diseases	59
6.7. ODM 7: MDG 7: Ensure environmental sustainability	61
6.8. MDG 8: Develop a Global Partnership for Development	65
7. Recommendations for the empowerment of adolescent girls and examples of good practices	71
MDG 1: Eradicate extreme poverty and hunger	71
MDG 2: Achieve universal primary education	73
MDG 3: Promote gender equality and empower women	75
MDG 4: Reduce child mortality	77
MDG 5: Improve maternal health	78
MDG 6: Combat HIV/AIDS, malaria and other diseases	80
MDG 7: Ensure environmental sustainability	83
MDG 8: Develop a Global Partnership for Development	84
8. Conclusions and lessons learned.	87
Works consulted	89
Annexes	97
References	111

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDJ	Ibero-American Convention on the Rights of Youth
CISALVA	Institute for Peace Promotion and Injury/Violence Prevention
CRC	Convention on the Rights of the Child
ECC	Eastern Caribbean countries
ECLAC	Economic Commission for Latin America and the Caribbean
FAO	United Nations Food and Agriculture Organization
GHESKIO	Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
ICT	Information and communication technologies
IEC	Information, education, and communication
ILO	International Labour Organization
IMAN	Integrated management of adolescent needs
IMCI	Integrated management of childhood illness
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IWHC	International Women's Health Coalition
LAC	Latin America and the Caribbean
MDG	Millennium Development Goal
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PC	Population Council
PIEMA	Interagency Program for Empowerment of Adolescent Girls (El Salvador)
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WFP	United Nations World Food Programme
WHO	World Health Organization



FOREWORD

In recent years, increasing attention to the empowerment of adolescent girls in Latin America and the Caribbean has led to broader interest in this issue and to cooperative interventions in the international, national, and local arenas. These initiatives have arisen mainly from efforts to promote gender equity, reflecting countries' obligations to ensure that adolescent girls enjoy the full measure of human rights to which they are entitled. More recently, limited but relevant evidence suggests that investments in adolescent girls have the potential to help break the intergenerational cycle of poverty.⁽¹⁾

Nonetheless, adolescent girls¹ in the Region as a group remain disempowered and vulnerable. ⁽²⁾ This situation has a direct impact on their health and well-being, especially their sexual and reproductive health. However, adolescent girls' empowerment is seldom considered when government policies are formulated and implemented. Relevant data are scattered and are seldom disaggregated by age and sex, which obscures the problem and makes it difficult to see the complete picture. Lack of data also limits the possibilities for monitoring the situation of empowerment and taking it into account when

making decisions and carrying out actions to meet girls' needs.²

This report presents persuasive arguments and practical recommendations for putting adolescent girls at the center of human development policies. It is aligned with the United Nations Millennium Development Goals (MDGs). The report is also framed within the context of the Regional Strategy for Improving Adolescent and Youth Health (CD48/R5) and the Plan of Action on Adolescent and Youth Health for 2010–2018 (CD49/12) developed by the Pan American Health Organization/World Health Organization.⁽³⁾ Its application will make a key contribution to the process of promoting empowerment of adolescent girls and young women and ensuring that government health systems work toward this end. This framework calls for integrating and coordinating empowerment efforts with those of other international institutions and government sectors, nongovernmental organizations, and adolescent girls and young women themselves. It pays special attention to the most vulnerable adolescent girls³ and seeks to respond to the disparities in health status between and within the countries of the Region.

¹ PAHO and WHO define "adolescence" as the period from 10 through 19 years, and "youth" as the period from 15 through 24 years. Therefore, the term "adolescent girls" refers to girls 10–19 years of age. This distinction has been made because there is a consensus that interventions, to be effective, cannot treat adolescents and young adults as one homogeneous group. Adolescence can be further divided into preadolescence, early adolescence, middle adolescence, and late adolescence.

² The preparation of this document encountered this difficulty on many occasions.

³ See section 3.4.

This report is intended for visionary leaders responsible for shaping social policies and for decision makers concerned with the comprehensive health and development of adolescent girls. PAHO/WHO encourages them to review the experiences set forth in this document and offers support in

implementing its recommendations. Progress toward the empowerment of adolescent girls is an important step toward achievement of the MDGs and a better quality of life for all people in the Region.

Mirta Roses Periago
Director, PAHO/WHO
August, 2009

EXECUTIVE SUMMARY

The empowerment of adolescent girls⁴ is indispensable if the countries of the Region are to achieve the Millennium Development Goals (MDGs).⁵ Efforts toward this end should be made on various fronts and should aim at coordinated actions that have lasting and substantial effects on the health and well-being of this population, which is very diverse yet uniform with respect to its vulnerability.

Adolescent girls in Latin America and the Caribbean (LAC) find themselves in a situation of disempowerment and social vulnerability. (4) This has a direct impact on their health and well-being, especially on their sexual and reproductive health. However, the issue of girls' empowerment is seldom considered in formulating and implementing government policies.

The Pan American Health Organization has framed the present report, "Empowerment of Adolescent Girls: A Key Process for Achieving the Millennium Development Goals," within the context of the Regional Strategy for Im-

proving Adolescent and Youth Health (CD48/R5) and the Plan of Action on Adolescent and Youth Health for 2010–2018⁶ (CD49/12).(5) The report explains why it is important to invest in adolescent girls and their empowerment. It offers a set of recommendations aligned with the MDGs, along with examples of how these recommendations can be put into practice.

The document takes up the concept of empowerment from two basic perspectives: on the one hand, the social reproduction of gender inequality, and on the other hand, the disempowering factors that impinge upon the individual growth and development of adolescent girls, as well as the social dimensions of these processes. Based on this understanding of the problem, the report offers support to social policy makers and to decision makers concerned with the comprehensive health and development of adolescent girls in order to help them incorporate or strengthen actions that lead to empowerment.

⁴ PAHO and WHO define "adolescence" as the period from 10 through 19 years, and "youth" as the period from 15 through 24 years. Therefore, the term "adolescent girls" refers to girls 10–19 years of age. This distinction has been made because there is a consensus that interventions, to be effective, cannot treat adolescents and young adults as one homogeneous group. Adolescence can be further divided into preadolescence, early adolescence, middle adolescence, and late adolescence.

⁵ The Millennium Declaration, signed by more than 150 world leaders, identifies gender equity and the empowerment of women as conditions for reducing poverty and improving health and well-being. United Nations General Assembly Resolution 2, Session 55, "United Nations Millennium Declaration," September 8, 2000.

⁶ The Strategy and Plan of Action can be found at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=770&Itemid=733&lang=en and http://new.paho.org/hq/index.php?option=com_content&task=view&id=1640&Itemid=1425&lang=en

Why is the empowerment of adolescent girls fundamental for human development? This report makes several arguments in response to this overarching question:

1. Empowerment of adolescent girls is a matter of social justice and recognition of their rights. Adolescent girls have rights, and it is the obligation of states to recognize and guarantee that girls, like all human beings, can exercise and enjoy their rights to the fullest. Cultural, ethnic, racial, social, educational, economic, gender, and age discrimination that adolescent girls face represents a direct violation of their rights, affects their health and well-being, restricts the development of their human potential, and hinders their social participation. Although it is evident that many adolescent girls are in situations of vulnerability, approaches to achieving their empowerment and improving their health should treat them as human beings and not as victims. Actions designed to empower adolescent girls have a regulatory framework that is embodied in international human rights treaties that are legally binding on the signatory countries and in political commitments that establish specific guidelines for complying with these treaties signed by the participant countries—for example, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Cairo and Beijing Platforms for Action and their five- and ten-year review conferences, the Convention of Belém do Pará, the Ibero-American Convention on Young People's Rights, and so on. The signatory governments commit themselves to respect, protect, and ensure the rights of adolescent girls and to promote gender equity in formulating their policies and programs.

2. Empowerment of adolescent girls is the entry point for promoting civic participation.

Empowerment of adolescent girls promotes and recognizes the strengths, interests, abilities, and rights of adolescent girls to contribute to their individual development and that of their families and societies. It positions adolescent girls as central actors in their own lives and offers real opportunities for them to participate in the decisions that affect them as individuals and as a group, in the present and the future. Programs and policies that affect adolescent girls should ensure their participation in planning, implementation, and evaluation processes, whether on their own initiative or as part of a partnership of adults and young people, to ensure that the policies and programs reflect their interests and meet their needs. Moreover, empowered adolescent girls will become adult women who are involved in different spheres of decision making at the national and local levels and who contribute toward the achievement of gender parity in representation.⁷ Empowerment of adolescent girls and promotion of their civic participation are fundamental processes for the building of democracy and for the improvement of their health and development.

3. Empowerment makes it possible for adolescent girls to take control over their own lives.

An empowered adolescent girl has the capacity to consider options and to make and carry out decisions. This is both a process and a result, and it is both collective and individual. Empowerment of women is essential for the achievement of gender equality. Other people cannot give power to adolescent girls; only adolescent girls can empower themselves. However, institutions can support empower-

⁷ See ECLAC 2005, p. 134.

ment processes, both for individuals and for groups.(6)

4. Adolescence is an ideal phase of life for reshaping gender roles and restoring a sense of empowerment. Adolescent girls are still in a process of physical, intellectual, emotional, and moral development, making this a productive time for critical deconstruction of social practices and scripts that perpetuate gender inequity. Girls tend to experience these developmental changes some years earlier than boys do, and the changes manifest differently in the two sexes. For example, levels of stress in girls tend to increase as they make the transition from preadolescence (9–12 years) to early adolescence (12–14 years), the stage at which gender differences become more evident; thus this transition is a period of particular vulnerability for adolescent girls.(7) As a result, it is important to invest in girls at an early age in order to take advantage of the sense of empowerment that, according to several studies,⁸ exists during preadolescence.(8) If adolescent girls lose their “voice,” their sense of their own personality, their self-esteem, and their empowerment, their health and development can be seriously compromised.(9)

5. Empowerment of adolescent girls helps break the cycle of poverty. In LAC, 39 percent of the population 15–24 years of age lives in poverty.(10) More than any other group, it is adolescent girls who will have the greatest capacity to reinvest in their families, communities, and societies. Countries that take action to ensure the health, education, and empowerment of girls can look forward to healthy and productive families, communities, and societies. Social investment in this group protects investments made in childhood, facilitates productivity and economic growth,

and safeguards the health of the future adult population.(11)

6. Empowerment of adolescent girls can contribute to reducing high rates of fertility and of sexually transmitted infections (STIs), including HIV/AIDS, in the Region. In LAC, the cohort of male and female youth between 10 and 24 years of age represents 30 percent of the total population.(12) Worldwide, LAC stands out for its high levels of adolescent reproduction, and it is the region of the world with the highest proportion of births to teenage mothers as a share of total births.(13) Furthermore, 20 percent of the HIV cases diagnosed and reported in LAC in 2006 were among young people aged 15 to 24.(14) An empowered adolescent girl has greater possibilities of controlling her own fertility and reducing her chances of contracting an STI by delaying the beginning of sexual relations, avoiding risky behaviors, and negotiating the use of a condom.

7. Empowerment of adolescent girls is indispensable for achievement of the Millennium Development Goals. Investing in gender equity and in the autonomy and empowerment of adolescent girls is fundamental for achieving the eight Millennium Development Goals. The majority of the goals are interrelated and are aimed at improving the health and development of women. As a result, it will be difficult to make progress on some of the MDGs without advancing on others as well.

An essential characteristic of the Millennium Development Goals is that they refer to targets with measurable indicators and a specific time frame. Empowerment of adolescent girls should be addressed mainly in the areas of the MDGs that relate to improvement of women’s

⁸ See J. M. Taylor, C. Gilligan, and A. M. Sullivan.

health, nutrition, education, gender equity, dignified work, and access to basic vital resources and new technologies.

The eight MDGs address essential aspects of the well-being of women. They represent an agreed set of basic development goals related to poverty, education, gender, infant mortality, maternal health, epidemic diseases, environmental sustainability, and financing of development. Toward this end, the following recommendations are made for incorporating the empowerment of adolescent girls into efforts to achieve the MDGs:

MDG 1: Eradicate extreme poverty and hunger

1. Broaden the definition of poverty, particularly when referring to adolescent girls, to include not only the lack of economic resources but also the lack of other assets such as power, opportunities, capability, and security.
2. Integrate the dimension of gender in a meaningful way in the design and application of public policies and programs, especially those dealing with food and nutrition. Strategies that emphasize integrated actions in nutrition, health, and education, recognizing the key role of women in the day-to-day support of families, have proven especially beneficial for women, for example with respect to the treatment of anemia.

MDG 2: Achieve universal primary education

1. Prioritize universal access through intersectoral work in education and health, recognizing their close interrelationship. Access to education is directly related to reduction in fertility rates and use of family planning methods.⁽¹⁵⁾ Adolescent girls with seven or more years of schooling have more knowledge about sexual and reproductive health, HIV, and STIs.⁽¹⁶⁾ They tend to

delay marriage, have fewer children, and have healthier pregnancies and safer births. Their children have better chances of surviving delivery, the first months of life, and the critical first five years, laying the groundwork for healthy and productive lives.⁽¹⁷⁾ Moreover, adolescent girls with poor health and/or poor levels of nutrition perform less well academically, on average, than girls with good health and nutrition.⁽¹⁸⁾

2. Target interventions to adolescent girls in excluded population groups and geographic areas. Local measures should be adopted to respond to their particular circumstances, reduce the costs and improve the quality of education, address the concerns of parents about the role and safety of adolescent girls who attend school, and offer incentives and/or benefits to compensate for the opportunity cost to the family when an adolescent girl enrolls in school rather than contributing to family income.
3. Provide universal access to early and comprehensive sexuality education in schools. This education should not center only on abstinence, since that approach has not been shown to have a significant impact on the age of first sexual relations.⁽¹⁹⁾ Rather, education should give girls and young women information about their bodies, their health, and self-care, and about their civil rights. It should teach them about communication and decision making and help them learn how to establish equality in their relationships, enforce the right to consent in sexual relations and in marriage, and put an end to sexual violence and coercion.

MDG 3: Promote gender equality and empower women

1. Take various measures to protect the store of human capital that the population of adolescent girls represents. Promote adolescent girls' empowerment and their participation in civil society, especially with respect to those who are more vulnerable⁹ because of their socioeconomic status or ethnic group, and whom conventional strategies may fail to reach.
2. Establish effective legal protections to ensure that achievement of sex parity in secondary and tertiary education in the Region results in substantial integration of women into the workforce with equitable wages. In addition, seek to ensure that vocational guidance activities offer career choices to women, including in fields traditionally considered masculine.
3. Promote actions and services of information, education, and communication (IEC), with the participation of male adolescents and young men, that can help protect the integrity of adolescent girls and change the cultural norms, attitudes, and beliefs that underlie abusive practices.¹⁰
4. Promulgate laws and policies of zero tolerance of abuse and violence against women, and promote a culture that encourages the reporting of assaults.

MDG 4: Reduce child mortality

1. Address neonatal health by taking a comprehensive approach to the health of adolescent girls, mothers, newborns, and children. Ensure continuous skilled care that encompasses health promotion for

adolescent girls, prevention of early pregnancy in adolescents, and care during pregnancy, childbirth, the puerperium, and the postnatal period. Children born to adolescent mothers have 1.5 times higher probability of dying before their first birthday than those born to older mothers.⁽²⁰⁾ Early pregnancy in adolescence is associated with low birthweight and prematurity, a higher infant mortality rate, and greater physical and mental morbidity, with a greater risk of illness, malnourishment, neglect and abuse.⁽²¹⁾

2. Pass legislation that strengthens health systems with a view to achieving universal access to care. Registry of mothers and newborns should be made compulsory, and free access to a basic set of quality health services should be guaranteed to mothers, newborns, and children. Community participation should be promoted, and the needs of the most impoverished and excluded populations given priority.
3. Support programs aimed specifically at young men, with a view to changing social standards that exclude them from care of newborns and parenting of children. These programs should also encourage young men to take responsibility for their own sexual behavior and its consequences, and promote young men's integration into the workforce.

MDG 5: Improve maternal health

1. Promote universal access to sexual and reproductive health for adolescent girls.¹¹ Reduce rates of abortion and unwanted pregnancy in adolescents, delay first preg-

⁹ See section 3.4.

¹⁰ See Promundo's Program H at <http://www.promundo.org.br/en/activities/activities-posts/program-h/>.

¹¹ See Target 5B (universal access to reproductive health) under the expanded MDG indicators from 2007 (paragraph 24, A/61/1, http://mdgs.un.org/unsd/mdg/resources/Static/Products/Sgreports/61_1/a_61_1_e.pdf). <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/Officialist.htm>.

- nancies, and space subsequent pregnancies by increasing access to health services, contraceptive methods, and prenatal care.
2. Provide adequate resources, both human and financial, so that adolescent girls can have access to safe pregnancies and safe deliveries attended by skilled personnel.
 3. Improve the collection, reporting, availability, and use of relevant data in implementing programs and policies, making decisions, and taking effective actions with respect to adolescent health and sexual/reproductive health.
 4. Advocate the empowerment of adolescent girls, and their families and communities, with a view to improving their self-care, strengthening their capacity to avoid unprotected or forced sexual relations, and increasing their access to and utilization of quality specialized care. Also crucial is support for necessary transportation to health centers, especially in cases of obstetric emergency, to ensure access to medical care. Adapting health services to cultural patterns will encourage safe motherhood among the most vulnerable adolescents and youth.
2. Ensure that adolescents with STIs and HIV have access to comprehensive health services, including health education, counseling, medication, and support for adherence to treatment.
 3. Promote voluntary testing among adolescents and young adults, particularly the key populations of vulnerable adolescents¹² and those at greater risk for HIV/AIDS,¹³ and offer appropriate health care and counseling services.
 4. Identify and reduce the barriers to access that can prevent adolescent girls from utilizing sexual and reproductive health services, especially stigma and discrimination against the most vulnerable and disempowered girls.
 5. Advocate for and prioritize work with groups of vulnerable adolescents and those at higher risk of HIV/AIDS, involving them in the design of services appropriate to their needs. These may include capacity-building programs to reduce risky behaviors and promote positive behaviors such as use of condoms, reduction of the number of sexual partners, and use of sterilized syringes and equipment.(22)

MDG 6: Combat HIV/AIDS, malaria and other diseases

1. Promote systematic collection of data on the situation of HIV in adolescent girls and on its social determinants, breaking down the information by age, sex, ethnic group, and socioeconomic level.

MDG 7: Ensure environmental sustainability

1. Align and integrate environmental sustainability with a gender approach that recognizes that women play an essential role in the development of sustainable and ecological patterns of production and consump-

¹² Populations and groups vulnerable to HIV are those which, for biological or social reasons, lack the control necessary to avoid exposure and consequently cannot prevent the infection. Examples of biological reasons for vulnerability include immaturity of the vaginal mucous membrane, the presence of another STI, and injuries to the vaginal or anorectal mucous membrane. Social factors include gender roles (male control of sexual relations), educational status, access to information, transactional sex, kidnapping, and rape.

¹³ Populations and groups at risk are those which, because of their activities, occupations, or practices, have greater probability of exposure to an agent that causes injury or disease (for example, HIV), and therefore greater probability of contracting the disease, than do other populations or groups. Populations at greater risk for HIV include men who have sex with men, sex workers, and injecting drug users. Ver por ejemplo la Iniciativa de mujeres adolescentes del Banco Mundial: "The adolescent girls initiative: an alliance for economic empowerment"

- tion and in the management of natural resources.
2. Provide knowledge, develop skills, and promote values for empowering adolescent girls and promoting their participation in shaping a culture of environmental stewardship and sustainable development.
 3. Introduce environmental sustainability into all sectoral strategies for development, involving women and recognizing their knowledge of sustainable resource management.
2. Ensure that access to education for women is accompanied by equitable opportunities for employment, promoting programs of economic empowerment that benefit adolescent girls in all sectors (urban, rural, indigenous).
 3. Recognize information and communication technologies as a tool for the comprehensive development of adolescent girls, and adopt policies aimed at promoting and expanding girls' use of technology, taking advantage of their capacities and potential.

MDG 8: Develop a Global Partnership for Development

1. Improve collaborative relationships within the health sector and with other sectors and strategic partners through preparation and implementation of interinstitutional and intersectoral work plans that uphold constitutional principles and are based on a human rights perspective, with defined budgets, areas of responsibility, and deadlines.

The document presents specific recommendations for the achievement of the MDGs along with examples of best practices, exemplary projects, monitoring and evaluation methods, and actions that demonstrate that it is indeed possible to make the empowerment of adolescent girls a reality in Latin America and the Caribbean.



As psychologist Carol Gilligan has observed, based on her research with adolescent girls in the United States, girls up to 8 years old have “voice” and can say openly what they think and feel. That voice is silenced as girls reach adolescence . . .



1

Introduction

There is no real consensus on a definition of empowerment of adolescent girls, nor is there agreement about the best ways to measure this process. This has made it difficult to determine the scope and long-term results of empowerment interventions and to monitor and evaluate their effectiveness. For this reason, such programs tend to be short-term, and decisions on their renewal or expansion depend on unstable budgetary resources. Some organizations have started by considering empowerment in terms of the economic empowerment of adolescent girls.¹⁴ It is now essential to continue and expand these efforts by introducing a comprehensive human development perspective.

International development priorities until 2015 are summed up in the eight Millennium Development Goals.¹⁵ These priorities are not new; in fact, they were identified with a view to fulfilling pending commitments established in the Beijing Platform for Action, in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and in other international human rights in-

struments adopted in recent decades. The essential characteristic of the MDGs is that they refer to targets with measurable indicators and a specific time frame. Empowerment of adolescent girls should be addressed mainly in the areas of the MDGs that relate to improvement of women's health, nutrition, education, gender equity, dignified work, and access to basic vital resources and new technologies. Progress on any one of the MDGs has effects on the other MDGs; thus, progress on the MDGs, singularly or as a group, has a positive impact on empowerment of adolescent girls. This in turn contributes directly to achievement of the MDGs.⁽²³⁾

This document has two objectives:

- » To assist in reaching a consensus on basic definitions, including a definition of empowerment¹⁶ that centers on the healthy development and well-being of adolescent girls. The report takes up the concept of empowerment from two perspectives: on one hand, the social reproduction of gender inequality, and on

¹⁴ An example is the World Bank's initiative on adolescent girls, known as "The Adolescent Girls Initiative: An Alliance for Economic Empowerment."

¹⁵ In the Millennium Summit in 2000, U.N. Member States adopted the "Millennium Declaration" and made a commitment to a new global partnership to reduce levels of extreme poverty. They established a series of time-defined goals, known as the Millennium Development Goals or MDGs, to be achieved by the year 2015.

¹⁶ The use of the term "empoderamiento" in Spanish has been criticized because of its English origin, resulting in a search for alternative concepts and terms. Among the most common equivalents are "potenciación" y "poderío." Nevertheless, whichever term is chosen, the concept is one of "gaining power." In addition, in this document the term "autonomía," used in MDG 4, is used to convey the concept of empowerment.

the other hand, the disempowering factors that impinge upon the individual growth and development of adolescent girls, as well as the social dimensions of these processes. The concept of empowerment of adolescent girls is also applied to analysis of the MDGs, emphasizing the importance of incorporating empowerment processes in order to achieve the goals; and

- » To support those responsible for shaping social policies and making decisions that affect the comprehensive health and development of adolescent girls, encouraging them to adopt or strengthen actions that favor girls' empowerment. The study analyzes indicators of progress toward the MDGs, reviews examples of good

practices, and proposes recommendations for decision makers who are in a position to promote empowerment programs that support growth and development.

From a conceptual standpoint, the aim is to help create a framework for theoretical and methodological reflection on ways of ensuring the healthy development of adolescent girls, their social inclusion, and the generation of sustainable processes based on their capabilities and needs that can contribute to achievement of the MDGs. Specialists on this issue from the Region of Latin America and the Caribbean have contributed to this evidence-based effort.¹⁷

¹⁷ Preparation of this document involved staff members of PAHO/WHO, UNICEF, UNFPA, IWHC, IPPF, PC, personnel from ministries of health, and senior regional and national authorities, as well as youth leaders, academics, and NGO experts. The following countries were represented at the Meeting on Empowerment of Adolescent Girls in Guatemala, March 6–8, 2008: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Peru. Furthermore, this effort has actively linked two PAHO units—the Newborn, Child, and Youth Health unit of the Family and Community Health Area (FCH/CH), and the unit on Gender Equity (AD/GE)—setting a precedent for collaboration and collective building of concepts and strategies for action.

2

Seven arguments for the empowerment of adolescent girls

Why empower adolescent girls? In response to this question frequently posed by decision makers, we offer the following arguments:

1. Empowerment of adolescent girls is a matter of social justice and recognition of their rights.

Adolescent girls have rights, and it is the obligation of states to recognize and guarantee that girls, like all human beings, can exercise and enjoy their rights to the fullest. Cultural, ethnic, racial, social, educational, economic, gender, and age discrimination that adolescent girls face represents a direct violation of their rights, affects their health and well-being, restricts the development of their human potential, and hinders their social participation. Although it is evident that many adolescent girls are in situations of vulnerability, approaches to achieving their empowerment and improving their health should treat them as human beings and not as victims. Actions designed to empower adolescent girls have a regulatory framework that is embodied in international human rights treaties that are legally binding on the signatory countries and in political commitments that establish specific guidelines for complying with these treaties signed by the participant countries—for example, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Cairo and Beijing Platforms for Action and their five- and ten-year review conferences, the

Convention of Belém do Pará, the Ibero-American Convention on Young People's Rights, and so on. The signatory governments commit themselves to respect, protect, and ensure the rights of adolescent girls and to promote gender equity in formulating their policies and programs.

2. Empowerment of adolescent girls is the entry point for promoting civic participation.

Empowerment of adolescent girls promotes and recognizes the strengths, interests, abilities, and rights of adolescent girls to contribute to their individual development and that of their families and societies. It positions adolescent girls as central actors in their own lives and offers real opportunities for them to participate in the decisions that affect them as individuals and as a group, in the present and the future. Programs and policies that affect adolescent girls should ensure their participation in planning, implementation, and evaluation processes, whether on their own initiative or as part of a partnership of adults and young people, to ensure that the policies and programs reflect their interests and meet their needs. Moreover, empowered adolescent girls will become adult women who are involved in different spheres of decision making at the national and local levels and who contribute toward the achievement of gender parity in representation.¹⁸ Empowerment of adolescent

¹⁸ See ECLAC 2005, p. 134.



girls and promotion of their civic participation are fundamental processes for the building of democracy and for the improvement of their health and development.

3. Empowerment makes it possible for adolescent girls to take control over their own lives.

An empowered adolescent girl has the capacity to consider options and to make and carry out decisions. This is both a process and a result, and it is both collective and individual. Empowerment of women is essential for the achievement of gender equality. Other people cannot give power to adolescent girls; only adolescent girls can empower themselves. However, institutions can support empowerment processes, both for individuals and for groups.(24)

4. Adolescence is an ideal phase of life for reshaping gender roles and restoring a sense of empowerment. Adolescent girls are still in a process of physical, intellectual, emotional, and moral development, making this a productive time for critical deconstruction of social practices and scripts that perpetuate gender inequity. Girls tend to experience these developmental changes some years earlier than boys do, and the changes manifest differently in the two sexes. For example, levels of stress in girls tend to increase as they make the transition from preadolescence (9–12 years) to early adolescence (12–14 years), the stage at which gender differences become more evident; thus this transition is a period of particular vulnerability for adolescent girls.(25) As a result, it is important to invest in girls at an early age in order to take advantage of the sense of empowerment that, according to several studies,¹⁹ exists during preadolescence.(26) If adolescent girls lose their “voice,” their sense of their own personality, their self-esteem, and their empowerment, their health and development can be seriously compromised.(27)

5. Empowerment of adolescent girls helps break the cycle of poverty.

In LAC, 39 percent of the population 15–24 years of age lives in poverty.(28) More than any other group, it is adolescent girls who will have the greatest capacity to reinvest in their families, communities, and societies. Countries that take action to ensure the health, education, and empowerment of girls can look forward to healthy and productive families, communities, and societies. Social investment in this group protects investments made in childhood,

¹⁹ See J. M. Taylor, C. Gilligan, and A. M. Sullivan.

facilitates productivity and economic growth, and safeguards the health of the future adult population.(29)

6. Empowerment of adolescent girls can contribute to reducing high rates of fertility and of sexually transmitted infections (STIs), including HIV/AIDS, in the Region. In LAC, the cohort of male and female youth between 10 and 24 years of age represents 30 percent of the total population.(30) Worldwide, LAC stands out for its high levels of adolescent reproduction, and it is the region of the world with the highest proportion of births to teenage mothers as a share of total births.(31) Furthermore, 20 percent of the HIV cases diagnosed and reported in LAC in 2006 were among young people aged 15 to 24.(32) An empowered adolescent girl has greater possibilities of controlling her own fertility and reducing her chances of contracting an STI

by delaying the beginning of sexual relations, avoiding risky behaviors, and negotiating the use of a condom.

7. Empowerment of adolescent girls is indispensable for achievement of the Millennium Development Goals. Investing in gender equity and in the autonomy and empowerment of adolescent girls is fundamental for achieving the eight Millennium Development Goals. The majority of the goals are interrelated and are aimed at improving the health and development of women. As a result, it will be difficult to make progress on some of the MDGs without advancing on others as well. Empowerment of adolescent girls provides a framework within which actions can be introduced on several fronts in a structured way. In 2015, only the countries that have taken empowerment of adolescent girls seriously will have achieved the MDGs.





Gender equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results.

3

Fundamental concepts in gender equity and empowerment

3.1. WHAT IS GENDER EQUITY?

3.1.1. Sex and gender

People sometimes ask whether gender is equivalent to sex, or assume that gender is only an issue for women. To clarify: sex refers to the biological differences between men and women, while gender refers to the social meaning attributed to those biological differences.

As far as the notion that gender is a matter of concern only to women, gender should be understood as a *relational* concept, referring to, among other things, the distribution of power between women and men.⁽³³⁾

3.1.2. Equality, equity, inequity, and empowerment

The terms equality and equity are often used interchangeably, but equality refers to the concept of equivalence, while equity implies impartial, fair, or just treatment. Therefore, not every inequality is considered an inequity. While equality is an empirical concept, equity represents an ethical imperative that is associated with the principles of social justice and human rights.

PAHO policy (2005)⁽³⁴⁾ establishes the following definitions:

Gender equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy,

SEX	GENDER
Biological, anatomical, physiological, and chromosomal characteristics and differences that define human beings as women or men.	Set of ideas, beliefs, and attributions that are socially and culturally constructed based on sexual differentiation and underlie the concepts of femininity and masculinity. Gender constructs influence the behavior, functions, opportunities, and valuations of men and women and the relationships between them.
A person is born with sex characteristics.	Gender depends on sociocultural constructions that are learned and can be modified.

contribute to health development, and benefit from the results.

Gender equity means fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men. The concept recognizes that women and men have different needs, access to, and control over resources, and that these differences should be addressed in a manner that rectifies the imbalance between the sexes. Related to this approach is the concept of diversity, which recognizes the heterogeneity of male and female groups. In addressing the issue of gender and health, differences with respect to age, socioeconomic status, education, ethnicity, culture, sexual orientation, disability, and geographic location should be taken into ac-

count.(35) Gender equity by no means implies a single model for all cultures, but it reflects the concern that women and men should have the same opportunities and make vital decisions in partnership.(36)

Gender inequity refers to inequalities that are unnecessary, avoidable, and unjust.(37) These in turn are linked with variables such as age and race. In the case of adolescent girls, both age inequity and gender inequity come into play; other elements of exclusion, such as ethnicity and poverty, may impose further disadvantages. Empowerment of adolescent girls is essential for achievement of gender equity, since it is through empowerment that adolescent girls gain the capacity to consider options, make decisions, and put their decisions into practice.

3.1.3. Equity in health

When discussing equity in health, we must distinguish between health status and health care. *Health status* refers to a person's physical, psychological, and social well-being, while *health care* is only one of many determinants of health status. Health care refers to certain characteristics of health services, such as accessibility, use, quality, resource distribution, and financing.(38)

In operational terms, equity in health means minimizing *avoidable* disparities between groups with different levels of social privilege.

Equity in health status implies achievement of the highest attainable well-being in specific contexts, while equity in health care implies that *resources* and *services* are allocated and received according to need, and that payment for them is made according to economic capacity.



3.1.4. Gender inequity in health

Gender inequity is reflected in health risks, access to services, and control over resources. It also results in asymmetries in the ways in which men and women contribute to the health of their families and their communities, and in the ways that this contribution is remunerated. Gender dynamics in health have long been overlooked, despite their considerable importance.

Gender-based inequality and discrimination constitute an obstacle to women's health. In the particular case of adolescent girls, this makes them more vulnerable to unwanted and unprotected sexual relations, to inadequate nutrition, and to physical and psychological abuse, and it also limits their access to health care.

3.2. EMPOWERMENT AND DISEMPOWERMENT

3.2.1. Empowerment as freedom and autonomy

The concept of empowerment is defined as “the expansion of freedom of choice and action. It means increasing one’s authority and control over the resources and decisions that affect one’s life.”⁽³⁹⁾ Associated with the concept of empowerment are such concepts as social inclusion, autonomy, visibility, mobility, *agency* (that is, the capacity to make use of available assets), and *self-efficacy* (that is, confidence in one’s individual competencies).

The empowerment of women responds to the need to foster changes in the asymmetries of power between genders.²⁰ In this process, women increase their capacity to shape their own lives and their environment, strengthen their self-awareness, become aware of their rights and the political and sociocultural context in which they live, recognize the mental and economic obstacles that hinder change, and engage in critical reflection in order to carry out transformative action.

In the case of adolescent girls, subject experts from WHO/PAHO, UNICEF, and UNFPA²¹ agreed to define empowerment as *the personal, social, and political process that generates and strengthens the capacities of adolescent girls and their organizations to fully exercise their rights with a sense of co-responsibility. This empowerment is expressed through the ability, authority, and agency to make informed decisions and implement changes that affect*

their lives and the lives of other adolescents, young people, and adults.

Through empowerment, adolescent girls acquire three types of power: social, political, and psychological. The first concerns information, knowledge, and access to social networks and other resources. With the second, they gain access to the democratic decision-making processes that affect them, becoming able to make choices in everyday life about their bodies and their lives: for example, when and how to bear children, get married, and choose a partner. The third means becoming aware of the power that they have, both individually and collectively.

3.2.2. Elements of empowerment with respect to adolescent girls

Following are some elements that characterize the particular process of empowerment of adolescent girls, supported by empirical analysis of experiences in the Region. These elements constitute the basis for the identification of variables that can be used to measure and evaluate empowerment processes among adolescent girls.²²

- » **Empowerment is variable.** Girls may feel empowered at any given point during their adolescence; however, this situation can change as they move into subsequent stages of development.

During preadolescence (9–12 years), girls often succeed in constructing a sense of identity and self-esteem, with the desire and capacity to act and choose freely. In some cases, however, when they reach early adolescence (12–14 years) or middle

²⁰ Gramsci, Freire, Foucault, and other authors define power as access to, use of, and control of physical and ideological resources in a social relationship.

²¹ Meeting on Empowerment of Adolescent Girls, Guatemala City, Guatemala, March 6–8, 2008.

²² See Section 4, “Monitoring and Evaluation of Processes of Empowerment of Adolescent Girls.”

adolescence (14–16 years), they feel family and/or social pressure to conform to traditional gender roles, which causes them to lose their self-assurance and feel disempowered.⁽⁴⁰⁾

- » **Empowerment means the capacity to make one's voice heard, to participate, and to make choices.** It implies psychological well-being and includes elements such as self-esteem, free choice, and free expression. For adolescent girls, it means having a voice and being able to count on an enabling environment and real opportunities for participation and involvement in decisions that affect them. Empowerment provides girls with the tools and capacity to identify options and act on these options, to confront the difficulties of daily life with courage and decisiveness, and to persist in the search for constructive solutions.

This is the case for adolescent girls who participate in and/or lead activities of their peers, community organizations, or organizations seeking to improve goods and services that benefit them. It also applies to adolescent girls who defy customs of early marriage or unmarried union in order to continue their education, and who manage to express their preferences and win support from their families in pursuing this path.

- » **Empowerment is multidimensional.** Among adolescent girls, it is manifested in different spheres of life (school, home, community) and includes convictions, ideals, aspirations, and commitments. Perceptions of empowerment by adolescent girls can vary depending on the context. An adolescent girl may feel empowered with her close friends or with her father or mother, yet at the same time feel disempowered in

the school or community, where she lacks support networks.

- » **Empowerment is a process.** It follows a sequence that goes from recognition of a disadvantage toward removal of that disadvantage, passing through phases of reflection and then recognition—or development—of the ability to influence one's life and environment. When adolescent girls understand that there are cultural reasons for the disadvantageous position that women in their families and communities have occupied, that this situation can be changed, and that they have the right to make this change, this understanding can create new expectations for their own lives and guide their efforts to meet their expectations.

Adolescent girls who have participated in empowerment processes in rural or indigenous communities, for example, experience a transition between the traditional values that sustain gender inequity and new visions that offer them the possibility of constructing more just and egalitarian relations.

- » **Empowerment is contextual.** Empowerment is related to the role of each adolescent girl within a particular context. It is the process through which girls gain awareness of themselves and what is happening in their environment, acquire skills and capacities, and solve problems by using or generating resources for themselves and their communities. Geographic mobility, that is, a move from one place to another, can offer adolescent girls an opportunity to play roles different from their customary ones and thus promote their empowerment.²³ Empowerment is defined culturally

²³ Testimonies of indigenous adolescent girls at the Meeting on Empowerment of Adolescent Girls, Guatemala City, Guatemala, March 6–8, 2008.

and contextually. What it means for an indigenous adolescent in Guatemala may be different from what it means for a Garifuna adolescent in Belize or an urban adolescent in Buenos Aires.

- » **Empowerment is multifactorial.** It encompasses the areas of interpersonal relations and institutional and cultural transformation, and it implies changes in individual and/or collective consciousness. An adolescent girl who attends school and, in addition to learning subjects useful for living, has teachers who encourage her participation and who involve the community in maintaining school facilities and ensuring the security of the students, has a greater chance of staying in school and meeting her educational goals.
- » **Empowerment is a way to improve sexual and reproductive health.** Empowerment of adolescent girls promotes attitudes of independence, responsibility, and risk avoidance, which in turn encourages them to care for their own health, sexuality, and reproductive lives. With regard to sexual and reproductive health, empowerment puts the adolescent girl in touch with her own body as a terrain in which she exercises power and controls her relationships to others.⁽⁴¹⁾

In education about sexual and reproductive health, for example, adolescent girls acquire information that enables them to engage in a process of reflection, to recognize that they have rights, to value their own abilities, and to use their decision-making capacity. Their empowerment fosters their ability to take care of themselves and to choose sexual practices that are pleasurable and safe. It enables them to control decision making about whether or not to have sexual relations and whether or not to bear children (and when).

- » **Empowerment is a basic element of human development.** Throughout the course of adolescence, empowerment gains importance as it becomes an essential strategy for creating and consolidating the processes of independence, development, and personal and collective growth. In the case of adolescent girls, empowerment allows them to assume control over their bodies and formulate clear plans and aspirations for their lives. It enables them to move from a culture of defenselessness toward autonomy and self-direction.⁽⁴²⁾

Empowerment means promoting the entire spectrum of a person's abilities and human potential and dismantling negative social constructs. In this way, people whose social, economic, or cultural status puts them at a disadvantage come to see themselves as having the capacity and the right to take action and to exert influence on their lives and environments.

3.2.3. Levels at which empowerment occurs

In light of the considerations set forth above, we propose an ecological approach to the empowerment of adolescents that includes the five levels shown in Table 1. It should be taken into account that change in any one area—whether individual, psychological, interpersonal, community, sociocultural, political, or legal—that excludes the other areas may limit the scope of empowerment.⁽⁴³⁾

3.2.4. Factors favoring the empowerment of adolescent girls

The ecological model identifies a set of actions that promote the empowerment of adolescent girls. While not exhaustive, this list serves as a reference that can guide the processes of identifying needs and making decisions in relation to this age group.

TABLE 1. The ecological model and empowerment of adolescent girls

At the individual level, an empowered adolescent girl has developed a positive self-image, is sure of herself, and values her capacities. On that basis, she sets the terms of her relationships to others and to her environment.

At the interpersonal and family level, an empowered adolescent girl develops her social skills, first through interaction with her family members and subsequently in the wider environment of the school and the community. Through the ensemble of these interactions, she strengthens her identity and self-esteem.

At the social and community level, empowered adolescent girls seek to participate in and become productive members of their communities. They need income and educational and work opportunities that help them develop a sense of responsibility. Communities, in turn, should provide conditions in which this participation can take place, to the benefit of both the individual and the collectivity. Access to health services enables adolescent girls to obtain information that helps them enjoy healthy lives and healthy sexuality, which in turn facilitates their contributions to society.

At the political level, empowered adolescent girls gradually gain the capacity to participate in decision making regarding health, community life, and development in general. They become recognized as important assets for their communities and for their country's future.

At the legal level, empowered adolescent girls know and defend their rights, including inheritance rights; they struggle for better and wider economic, educational, and health opportunities; and they denounce discrimination and abuse of women and advocate for laws to eradicate gender violence and promote human rights.

At the individual level

- » **Create safe spaces for adolescent girls that enable** them to establish interpersonal relationships, express their views, and increase their mobility and social presence.
- » **Help adolescent girls manage their emotions** and develop their abilities to express their feelings, resolve conflicts, strengthen internal defenses, and develop negotiation skills. An essential factor is internal control—that is, a girl's level of sensitivity and consciousness about what happens to her, and her awareness of her responsibility to make decisions about her own life rather than becoming a victim of external forces.
- » **Provide private, accessible counseling services** with counselors who promote healthy sexuality, self-esteem, and avoidance of risky behaviors. It has been shown that programs focused only on the transfer of information are not effective, as giving someone information about healthy behaviors does not guarantee that she will adopt them. Even with information, a lack of skills and capacity may leave girls vulnerable to coercive forces or peer pressure that threaten their well-being.
- » **Promote a positive body image by providing opportunities for girls to enjoy sports or other forms of physical exercise.** Sports promote self-reliance, self-defense skills, and fearless acceptance of changing bodies.
- » **Promote healthy growth and physical development**, guaranteeing access to services of primary health care and sexual and reproductive health care from preadolescence onward. Promote the

development of healthy eating habits, encourage exercise and physical activity, and work to deepen girls' knowledge of the changes that occur in puberty.

- » **Develop leadership and teamwork skills in adolescent girls** by fostering their self-confidence, self-awareness, expression of individual personality, decision-making skills, and competence, and by helping them forge partnerships and networks.
- » **Promote skills that girls can use to access resources** they need to support themselves, obtain scholarships, participate in competitions, and contribute to their own well-being.
- » **Educate adolescent girls and expand their knowledge.** It is important to increase the knowledge, education, and school attainment of young women, as well as their information about sexual and reproductive health, rights and choices, and services available.

At the family and community level

- » **Foster a good relationship with a significant adult figure** to help improve an adolescent girl's self-esteem, promote her self-respect and self-confidence, and avoid, insofar as possible, risky behaviors.
- » **Foster and support same-sex friendships** that promote confidence and camaraderie among adolescent girls and in this way strengthen their emotional and psychological well-being.
- » **Urge families to support their adolescent girls** as they go through the changes that occur at this stage of life. It is important for family members to be well informed and to avoid perpetuating myths and fears about the body, sexuality, and passivity. Open and



honest communication helps adolescent girls understand that decisions they make in the domestic arena can influence their empowerment and well-being.²⁴

- » **Listen to adolescent girls;** it is important that their voices are heard and their opinions taken into account. Encourage young women to express themselves and to engage in dialogue.
- » **Raise awareness among adolescent boys and adult men** who interact with adolescent girls, encouraging them to change social patterns that pose obstacles to the development and well-being of adolescent girls and adult women.
- » **Permit greater participation and mobility,** encouraging adolescent girls to take part in community development activities and in other activities related to civic responsibilities.

²⁴ An example is the PAHO Familias Fuertes (Strong Families) program. See http://www.paho.org/spanish/ad/fch/ca/sa-familias_fuertes.htm.

At the sociocultural level

- » **Create opportunities for social inclusion of adolescent girls** that make it possible for them to participate in recreational, educational, sporting, cultural, community, and productive activities appropriate for their age group.
- » **Use communications media** to prevent gender violence and improve the image of women and adolescent girls. Media campaigns should seek to eliminate stereotypes of beauty and perfection and advance equitable gender roles.²⁵
- » **Raise awareness in schools and in the community** about effects of gender discrimination, and encourage educators and authorities not to permit such situations. Carry out interventions with the community and with regulatory agencies to promote their understanding of the dynamic of empowerment of adolescent girls and its links with their health and development, in a specific cultural framework.

At the political and legislative level²⁶

- » **Guarantee education, including sexuality education, for adolescent girls**, ensuring the availability and accessibility of schools. Create incentives for the education of adolescent girls and young women, particularly the most vulnerable, by reducing school fees or the cost of school supplies, for example. Follow up commitments made under the Mexico City Ministerial Declaration⁽⁴⁴⁾ to promote sexuality education.
- » **Protect adolescent girls from early marriage** through policies and laws that discourage or prohibit this practice.
- » **Guarantee rights to sexual and reproductive health**, offering high-quality and easily accessible health services for adolescent girls, including family planning methods. Review and adapt legislation on sexual and reproductive health and the rights of adolescents.
- » **Guarantee the property and inheritance rights** of adult women and adolescent girls, revising and enforcing laws to this effect. Remedying the injustice that impedes women's property ownership and inheritance will have significant implications for the solution of related problems such as poverty and violence.
- » **Eliminate gender-based inequality in the workplace**. Reduce female participation in informal work; eliminate labor exploitation and pay disparities based on gender, for example in the maquiladora assembly plants⁽⁴⁵⁾; and reduce occupational segregation. Incentives should be provided to employers to eliminate disparities between the sexes and to give professional opportunities to young women.
- » **Increase the proportion of women** in national legislatures and local governmental bodies. Seek to ensure that all those who occupy positions of power act with an awareness of gender equity and work to protect the interests and empowerment of women.
- » **Combat violence against adolescent girls and adult women**, removing this issue from the private arena and recognizing it as a public health problem. Improve

²⁵ An example is the public education campaign "Girl Power," sponsored by the U.S. Department of Health and Human Services. See <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0038/Default.asp>.

²⁶ The Millennium Declaration proposed a set of strategic priorities for governments aimed at strengthening the autonomy of women and adolescent girls. Among other things, it recommends a legal framework and political commitment to address gender inequalities and promote the empowerment of adolescent girls.

health systems and train health providers to identify women who suffer abuse and provide them guidance and referrals in addition to necessary medical care. Work for the passage of legislation that defines violence against women as a crime, even when it occurs within marriage or cohabiting unions. Make use of the communications media to encourage reporting of such cases and to promote changes that discourage gender violence.

3.2.5. Stages of development of adolescent girls, empowerment, and disempowerment

When an adolescent girl finds herself devalued and subordinated, uneducated and at risk, and suffocated by the social standards she has internalized, she is in a situation of disempowerment. That is, she lacks the power she is entitled to, held back by the multiple psychological, cultural, economic, social, legal, and other obstacles that she faces.

In Latin America and the Caribbean, adolescent girls become disempowered when the groups they are part of exclude them because they are considered difficult and rebellious; when the society regards them as problems, as in the case of young women who live on the street, become pregnant, or break the law; when they engage in risky behaviors such as leaving school, becoming mothers at a young age, being unemployed, or being addicted to drugs, situations that affect 25–32 percent of youth of both sexes from 12 to 24 years old, according to the World Bank⁽⁴⁶⁾; when ethnic disadvantages are added to those of gender⁽⁴⁷⁾; when girls grow up in societies that discriminate by discouraging their capacity and desire for participation; and finally, when complications of pregnancy, childbirth, and

the puerperium, including abortion, are the leading cause of death among them.⁽⁴⁸⁾

During adolescence, girls go through several stages of significant physical, neurological, cognitive, sexual, emotional, and social changes.⁽⁴⁹⁾ When these changes are superimposed on gender roles that reinforce disempowerment, this places young women in a situation of greater vulnerability than men.⁽⁵⁰⁾

According to the classification used by PAHO, the stages of adolescent development include preadolescence (9–12 years), early adolescence (12–14 years), middle adolescence (14–16 years), and late adolescence (16–18 years).⁽⁵¹⁾ Girls tend to experience these developmental changes some years earlier than boys do, and the changes manifest differently in the two sexes. Several studies²⁷ show that adolescent girls are more likely than boys to experience anxiety and interpersonal pressure, especially in the context of close relationships, with girls more concerned about negative opinions from their friends and more vulnerable to pressures within the family and peer group.⁽⁵²⁾ Adolescent girls often feel more empathy and take on roles that require them to support others, which can increase their own stress. Levels of stress tend to increase from preadolescence through early adolescence, the stage at which gender differences become more evident, which suggests that this transition represents a period of particular vulnerability for adolescent girls.⁽⁵³⁾

The transition from childhood to adulthood should be explored more thoroughly from the perspective of girls, since there has been little study of how girls perceive their developmental changes and how these changes influence their well-being. A girl typically enters pre-

²⁷ See Almeida and Kessler (1998), Kaplan (2004), and Rudolph (2002) in *Youth: Choices and Change* (PAHO, 2005).



adolescence with a strong sense of her own personality. The psychologist Carol Gilligan, who carried out several years of research on adolescent girls in the United States, has observed that girls up to about 8 years old have “voice” and can say openly what they are thinking and feeling. They are connected with their families, which shape their values. They are flexible and can communicate what they think and feel. Girls of this age are physically active, play by the rules, and can show aggressive tendencies. They can distinguish false relationships from real ones and they have a strong sense of their own identity and personality. This “voice” is fundamental for their sense of empowerment and healthy for their development.(54)

As a girl enters early adolescence, her perception of safety and self-esteem changes and she begins to lose her voice. Her breasts begin to develop and her hips widen. The appearance of these secondary sexual characteristics is ac-

companied by increases in height and weight, which often leads a girl to be dissatisfied with her body image.(55)

During early and middle adolescence, girls experience the second period of rapid growth and development in their lives (the first having come in the first year of life). This time they are old enough to be aware of the development (or lack of development) that occurs during puberty.(56) This has significant implications for adolescent girls and their empowerment or lack of empowerment.

Menarche, in particular, has concrete social and cultural implications. In some cultures, the family prepares the adolescent girl for marriage; in other cultures, protection and restriction of girls is redoubled, especially with regard to contact with men. In either case, adolescent girls gradually lose the right to control their own lives and bodies: “they are ‘owned’ by their father until they are married and then by their husband.”(57)

Once she reaches sexual and reproductive maturity, the adolescent girl is assigned still more tasks and responsibilities in the home, based on gender roles, which are not remunerated economically or compensated in other ways.(58) Adolescent girls are given fewer rights and opportunities in comparison with their brothers and other male adolescents of the same age.

This disempowerment tends to be accompanied by family and social pressures that encourage girls to drop out of school and adopt submissive roles, with consequent repression of their decision-making capacity. This is particularly critical among indigenous groups:

“In puberty, young women find that negative social standards on sexuality are strengthened,

while their own desires are subordinated to those of others. Many drop out of school in this stage, while the domestic workload of young women increases disproportionately, even as they feel the need for an income and withdraw from public space. In this scenario, adolescent girls face risks different from those facing men, such as the lack of peer support, the beginning of unwanted or unprotected sexual relations, early marriage, and consequent responsibility for children.”(59)

Disempowerment may be reflected in objective reality, as noted above, as well as in the subjectivity of adolescent girls. In this case, girls’ self-esteem²⁸ is affected in contexts where they are devalued and made to feel worthless, inhibiting their internal capacity to legitimize their own desires, needs, and aspirations. Similarly, empowerment, understood as the capacity to carry out actions and make decisions, is restricted by the requirement that a young woman obtain consent from a male authority figure—such as a father or brother, even a younger brother—for anything she wishes to do. Adolescent girls are often treated as inferiors and taught that they come last. Pressure to adapt to traditional gender roles significantly affects their identity and self-esteem.(60) They are looking for a model of femininity to imitate, and they want to be accepted in their social context. Their susceptibility to social influences and expectations leads them to doubt their independence and to refrain from voicing their feelings with their peers and their families. Often cultural and social norms on gender restrict their access to basic information, prescribe an unequal and more passive role in sexual decision making,

undermine their autonomy, and expose many of them to sexual coercion.(61)

Facilitating empowerment does not resolve conflicts that come from learned inequity, but empowerment makes it possible to understand these conflicts, talk about them, and expose them. This is an essential step toward bringing about change at the level of the individual and the environment. Empowerment implies gaining power in two ways: by understanding the dynamics of domination, and by refusing to accept internalized subjugation.

3.2.6. Gender-based violence and disempowerment

The problem of disempowerment due to gender-based violence, which is a violation of the rights of women, deserves special mention. (62) On the one hand, disempowered adolescent girls are more susceptible to violence; on the other hand, violence disempowers adolescent girls. This problem affects women around the world, irrespective of social class, religion, or ethnicity. In addition, the norms and values that put women in a subordinate position in relation to men serve to maintain, reinforce, and perpetuate this kind of violence.

The World Bank(63) estimates that rape and domestic violence account for 5 percent of years of health life lost by women of reproductive age in developing countries undergoing demographic transition. Worldwide, the health burden due to gender-based violence suffered by women 15–44 years old is comparable to that associated with other risk factors and diseases that are already high priorities on the global agenda, including HIV, tuberculosis, puerperal sepsis, cancer, and cardiovascular disease.(64)

²⁸ Self-esteem refers to a person’s own evaluation of herself, that is, an internal personal perception based on thoughts, emotions, feelings, and experiences that develop over the course of a person’s life.

Both gender and age discrimination contribute to violence against adolescent girls. Disempowered adolescent girls are particularly vulnerable to violence at the hands of adults who may abuse their greater physical strength, authority, economic capacity, or social position—as well as bonds of trust, in cases of physical and sexual abuse in the home or school.⁽⁶⁵⁾ Sexual violence has physical consequences for adolescents, including genital, anal, oral, and urinary tract injuries and/or infections, and unwanted pregnancies. Many women who become pregnant as a result of rape attempt to terminate the pregnancy using dangerous procedures, without the support of their families, which causes serious damage to their physical and emotional integrity.

With respect to psychological health, gender-based violence diminishes a woman's capacity to exercise reproductive and sexual autonomy. It leads to feelings of self-denigration, self-destructive thoughts or actions, and psychosexual disorders and post-traumatic stress; these in turn can trigger other problems such as substance abuse. In addition to the human costs, violence against women hinders their participation in public life, reduces their productivity, drives up costs for medical care and other services, and undermines the economic welfare of societies.

It seems, according to García-Moreno, that “the major risk factor for domestic violence against women is precisely the fact of being a woman.”⁽⁶⁶⁾ For this reason, while teenagers and young adults must be empowered to face situations of violence, protection will be limited as long as gender violence remains rooted in deeply entrenched social norms. Effective efforts to reduce such violence will require combined actions in the legal, judicial, law enforcement, education, and health sectors, among others.

3.3. BARRIERS TO REACHING THE MOST VULNERABLE ADOLESCENT GIRLS

One of the most difficult challenges in trying to empower adolescent girls is reaching the most vulnerable girls in society, those who are members of marginalized and socially excluded groups. They include sexual minorities; adolescent girls with HIV or STIs; those at high risk of contracting HIV (injecting drug users who use unsterilized equipment, and sex workers, including those who are victims of human trafficking for sexual exploitation and those who have unprotected sex); adolescent girls with disabilities; migrants and the displaced, among others.

3.3.1. Marginality and social exclusion of adolescent girls

Younger adolescents often become inaccessible when they leave school. School dropouts tend to live in shantytowns ringing the cities or in rural villages. They come mainly from the poorest population and are often members of indigenous ethnic groups. In addition to the geographic, cultural, and linguistic barriers facing these girls, there exists little social and economic infrastructure to support them. Many lack support networks or safe public places to meet. Lack of institutional support for adolescent girls is a barrier that disempowers them in terms of their access to and participation in the labor market, social security, and health services. Thus, adolescent girls who drop out of school and are immersed in a situation of poverty are more likely to become sexually active at a young age, without using birth control or other protection. It is these girls who have the highest rates of unwanted pregnancy; they and their children are exposed to health risks, neglect, abandonment, and abuse.⁽⁶⁷⁾ This set of productive and reproductive disadvantages contributes to keeping adolescent girls in



poverty.

3.3.2. Adolescent girls belonging to sexual minorities

In LAC, as in most of the world, adolescents are expected to follow certain sexual rules based on heterosexual behavior. These rules exclude those adolescent girls who feel sexually attracted to persons of the same sex, and this exclusion in turn affects their health and well-being. In a health survey conducted in the Caribbean, more than 10 percent of adolescents reported being unsure of their sexual orientation (11.7 percent of females and 13.3 percent of males).⁽⁶⁸⁾ However, this issue is seldom addressed and discussed.

This exclusion also applies to bisexual and transgender adolescents. These sexual minorities feel the weight of social disapproval, and they must confront stressful and exhausting physical, psychological, and social challenges. These do nothing to empower them or help them resolve their doubts about sexual identity.

The discrimination and isolation suffered by

adolescent girls who are sexual minorities interferes with the development of their individual, family, and social skills and capacities. Nonetheless, social struggles against homophobia and transphobia do not always take this age group into consideration.

Efforts to improve the sexual and reproductive health of young people require an understanding of their sexual orientation. For example, lesbian and transgender teens may be reluctant to go to health clinics because they often experience lack of support and stigmatization in these settings.

3.3.3. Adolescent girls with HIV/AIDS and STIs, and those at high risk of contracting HIV/AIDS

Around the world, women are at five times greater risk of contracting sexually transmitted infections than men. The prevalence of STIs in adolescent girls is an indicator of high-risk behaviors and lack of condom use.⁽⁶⁹⁾ Having one or more STIs is associated with

two to nine times greater risk of becoming infected with HIV.(70)

The social discrimination and powerlessness that adolescent girls endure makes them more vulnerable to contracting STIs and HIV. Adolescent girls may be forced to engage in unprotected sexual relations, often by their partner or an older relative. A study in the United States found that in a group of adolescent girls diagnosed with HIV or STIs, more than half were victims of intimate partner violence, both physical and sexual.(71)

Culturally transmitted gender roles foster power imbalances that increase risks for young women, who often do not know how to prevent disease and/or lack the ability to discuss HIV with their partners and negotiate the use of condoms. The discriminatory and stigmatizing society in which adolescent girls with HIV/AIDS live can inhibit them from seeking counseling and treatment. And when they do, follow-up often is affected by the discriminatory and inappropriate treatment they receive from health personnel. In addition, some adolescents who are unaware of their HIV status refrain from getting tested because they fear discrimination.

Particular attention should be paid to adolescent girls at high risk of contracting HIV/AIDS. They include, among others, injecting drug users who use unsterilized equipment, as well as sex workers, including victims of sex trafficking and those who have unprotected sex. In Honduras, a survey(72) of 70 women aged 15 to 24 who are commercial sex workers revealed that only 32 percent had completed primary education and only 2 percent finished high school. Of the sex

workers surveyed, only 84 percent used a condom in their last sexual contact with a client, and less than 50 percent reported that their own partner used a condom when having sex. This is a worrisome situation, because while 91 percent of commercial sex workers in the survey reported that they had taken an HIV test in the preceding year, only 60 percent had adequate knowledge of how to prevent the infection.(73)

3.3.4. Adolescent girls subject to commercial sexual exploitation²⁹

Among the most disempowered adolescent girls are those who, for various reasons, are subject to commercial sexual exploitation. Since the sexual exploitation of adolescent girls is a crime, its prevalence in the Region is difficult to quantify. It is believed that a substantial number of adolescent girls are in this situation, but it is difficult to find them because the networks of exploitation keep them hidden (at least from those who would offer them another way of life), and accomplices in some sectors of society sometimes participate in covering up the crimes.

Sexual exploitation of adolescent girls is a “multi-causal phenomenon that develops in areas where power is unequal and is based on gender and age.”(74) Manipulative exploiters prey on the most ignorant and helpless adolescents, many of whom are illiterate and poor. “An unjust socioeconomic structure with obvious disparities in the distribution of wealth, urban sprawl, few job options, and growing consumer needs make the poorest social sectors, and especially poor adolescent girls, vulnerable to sexual exploitation.”(75) While poverty is not the only explanation for this phenomenon, it provides the crucial

²⁹ Commercial sexual exploitation of children means the use of minors for commercial activities such as sexual relations, sex shows, or production of pornography.

catalyst that draws together many types of disadvantage.

Any intervention with this group of adolescent girls presents a challenge because of the violent way in which their rights are violated and the severe consequences for their development. Dealing with this issue requires a comprehensive strategy aimed at empowerment and at prevention and eradication of these exploitative practices. The welfare and rights of the victims, and of adolescent girls at risk of becoming victims, should be paramount at all times.

Once adolescent girls are immersed in this lifestyle of exploitation and abuse, their reintegration into a life of dignity becomes difficult. Because of their vulnerability and confusion, they will need to participate fully in recovery processes to restore their self-esteem and promote empowerment. Given these difficulties, it is extremely important to stress preventive actions and address the structural factors that make adolescents vulnerable to sexual exploitation.



Evaluation helps improve national programs for empowerment of adolescent girls, facilitates going to scale, and generates knowledge that is useful for replicating these programs in other countries.



4

Monitoring and evaluation of processes for empowerment of adolescent girls

4.1. CONCEPTS

The terms follow-up, monitoring, and evaluation are often used interchangeably, but there are important differences between them. Follow-up or monitoring of a program generally refers to the participatory process for regularly reviewing the status of a program by comparing the actual implementation of activities with the work plan to see whether the activities are being undertaken within the specified time frame, whether budgeted funds are being spent according to plan, whether any changes are needed in the management or implementation of activities, and whether the work plan should be modified.

Evaluation, on the other hand, aims to measure progress toward achievement of the program's objectives and, ultimately, its impact—that is, the extent to which anticipated long-term changes have taken place. This process involves both measuring the extent of the changes that have occurred and studying the extent to which these can be attributed to program activities.

Although there are differences between monitoring and evaluation, the two processes operate together to achieve the same goal, that is, to produce information that can be used to improve the implementation of a program

and achieve its short-term objectives and long-term results. Neither process can substitute for the other.

When a monitoring and evaluation plan is developed, the key actors in the program should be involved from the beginning. Monitoring and evaluation, far from marking the close of the process, should be an integral part of the planning and implementation of a project or program. The results of monitoring and evaluation are needed at various points during the cycle of planning and implementing program activities.

4.2. WHY EVALUATE PROGRAMS FOR EMPOWERMENT OF ADOLESCENT GIRLS?

The primary reason for evaluating a program is to improve it and to make it possible to scale up the interventions. The time and energy invested in an evaluation will be wasted if the results are not used to develop better plans for the future, identify changes that need to be made, share experiences with other programs that can benefit from them, identify strengths and weaknesses and areas that need improvement, and see where the program is heading—and if that is the direction laid out by the plan, identify the best ways to support the program.



Since the empowerment of adolescent girls is a relatively new subject, much remains unknown about how best to evaluate the processes of change. Even measuring the empowerment of women in general remains difficult, as most empirical studies fail to operationalize the concept of agency or empowerment or effectively measure these processes.⁽⁷⁶⁾ This section uses the conceptual framework developed in section 3.2 of this document to identify indicators of empowerment of adolescent girls, which can be used to determine whether an intervention to empower adolescent girls has resulted in gains or created additional risks.

Because there is a possibility that a poorly planned intervention may expose adolescent girls to greater risk or inflict unintentional damage, every program must take responsibility

for evaluating and monitoring its activities. For example, what happens if a training session to change prejudices and misconceptions about rape ends up reinforcing them instead?

Monitoring and evaluation is not a luxury, but rather the only way to ensure that strategies work and to promote evidence-based interventions.

4.3. VARIABLES FOR MEASURING EMPOWERMENT OF ADOLESCENT GIRLS

With a view to strengthening programs and projects for the empowerment of adolescent girls and improving program evaluation, a group of experts participated in a meeting on the Empowerment of Adolescent Girls and Young Women, held in Guatemala in March 2008.³⁰ Drawing on the conceptual framework described in section 3.2 of this report, they identified certain variables which, along with the impact indicators for the MDGs, should be considered in measuring the level of empowerment of adolescent girls. These variables are interrelated, so it is not possible to speak of comprehensive empowerment when only some of them are present. Tables 2 through 5 present the variables divided into two groups, internal/individual and external. Tables 2 and 3 pertain to early adolescence, and tables 4 and 5 to middle/late adolescence.³¹

Dimensions of the concept of empowerment in the population of adolescent girls 15–19 years of age include the variables shown in tables 4 and 5.

³⁰ This meeting brought together representatives of government agencies, international organizations, and academic institutions, including the ministries or departments of public health of Costa Rica, El Salvador, Guatemala, and Honduras; the ministries of public education of El Salvador and Guatemala; the Presidential Secretariat of Planning and Programming of Guatemala; the PAHO/WHO offices in El Salvador, Guatemala, Honduras, Nicaragua, Panama; PAHO Brazil; PAHO/WDC and PAHO/ECC; and nongovernmental organizations such as UNFPA Guatemala, Population Council, IPPF/WHR, Instituto CISALVA at Universidad del Valle in Colombia, and Instituto Promundo.

³¹ See section 3.2.5

Table 2. Internal or individual variables for measuring empowerment processes in the adolescent girl 10–14 years old

Variable	Definition
Ability to express her interests in an autonomous manner	She expresses her opinions even to people who may disagree.
Ability to negotiate her ideas based on information	She has access to information, expresses her ideas, and negotiates agreements, avoiding or managing conflict.
Recognition of her own abilities	She can describe and evaluate her own abilities.
Self-care	She understands her body and the bodily changes she is experiencing. She plans her time to include self-care practices that include, among others, adequate rest, a good diet that is nutritionally appropriate for her age, proper hygiene, and physical exercise.
Capacity for self-criticism	She can recognize her limitations and mistakes.
Ability to analyze simple problems (appropriate to her age) and make decisions	She can evaluate problems that concern her (personal problems and those in her environment) and make decisions.
Ability to participate in organizations of her peers	She is involved in peer groups or organizations.
Recognition of herself as a person who has rights	She is aware of the rights that protect her.

Table 3. External variables for measuring empowerment processes in the adolescent girl 10–14 years old

Variables	Definición
Social participation	She is aware of the authorities who represent her, and expresses her opinions on how to improve her community.
Cultural identity	She is aware of the history, values, and expectations of the social group in which she is growing up.
Access to education	She attends school and has time available to devote to her studies.
Social leadership and influence	She is recognized for her contribution to the group, and develops skills to advance her interests.
Access to justice	She is aware of the legal framework that protects her and of the agencies responsible for seeing that her rights are respected.

Annex 3 provides three additional scales and indexes for measuring the empowerment of adolescent girls:

Table 4. Internal or individual variables for measuring empowerment processes in the adolescent girl 15–19 years old

Variables	Definición
Ability to express her interests in an autonomous manner	She expresses her opinions even to people who may disagree.
Ability to negotiate her ideas based on information	She has access to information, expresses her ideas, and negotiates agreements, avoiding or managing conflict.
Recognition of her own abilities	She can describe and evaluate her own abilities.
Self-care	She understands her body and the bodily changes she is experiencing. She plans her time to include self-care practices that include, among others, adequate rest, a good diet that is nutritionally appropriate for her age, proper hygiene, and physical exercise. She is in charge of her sexual life.
Capacity for self-criticism	She can recognize her limitations and mistakes.
Ability to analyze problems and make decisions	She can evaluate problems that concern her (personal problems and those in her environment) and make decisions.
Ability to participate in organizations of her peers	She is involved in peer groups or organizations.
Understanding of her rights	She is aware of the legal framework that protects her rights.

Table 5. External variables for measuring empowerment processes in the adolescent girl 15–19 years old

Variables	Definición
Social participation	She is aware of the authorities who represent her, and expresses her opinions on how to improve her community.
Cultural identity	She is aware of the history, values, and expectations of the social group in which she is growing up.
Access to education	She attends school and has time available to devote to her studies.
Social leadership and influence	She wins elections to represent her team and has the skills needed to exercise leadership.


Continues

Table 5. External variables for measuring empowerment processes in the adolescent girl 15–19 years old (cont.)

Variables	Definición
Access to justice	She is aware of the legal framework that protects her and of the agencies responsible for seeing that her rights are respected.
Occupational skills	She develops skills that will help her, later on, to generate income.
Political leadership and participation, and participation in management of public goods and services	She promotes organizations, leads actions, and participates in efforts to improve public goods and services that benefit her.
Ability to define her future occupational interests	She defines her intellectual and artistic interests and has general ideas about the occupation she would like to pursue.

- i. Gender-Equitable Scale for Women - Promundo (31 items, $\alpha=0.86$)
 - ii. Personal Competence in Interpersonal Relations Index (14 items)
 - iii. Qualitative instrument for evaluation of early results of the Interagency Program for Empowerment of Adolescent Girls (PIEMA), El Salvador, 2007(77)
- Adolescent girls are subjects and holders of rights. It is the obligation of states to recognize and ensure that they, like all human beings,



A close-up photograph of a young woman with long, dark, wavy hair. She is smiling warmly at the camera, showing her teeth. She is holding a large white flower, possibly a lily, near her face. The background is a soft-focus green with some white flowers. She is wearing a red top. The overall mood is positive and natural.

Empowerment is the personal, social, and political process that creates and strengthens the capacities of adolescent girls and their organizations to fully exercise their rights with a sense of shared responsibility.

5

Empowerment of adolescent girls as a basic right

can fully enjoy and exercise all their rights, including measures for special protection corresponding to their capacities.³² Although many adolescent girls are in situations of vulnerability, efforts to promote their empowerment and improve their health must treat them as human beings, not as victims.

Measures aimed at empowerment of adolescent girls and young women have a regulatory framework underpinned by international human rights treaties that are legally binding for signatory countries and by political commitments (e.g., conferences and declarations) that establish specific guidelines for States Parties in their compliance with these treaties. These governments are committed to respect, protect, and ensure implementation of the rights of adolescent girls and to promote gender equity when formulating their policies and programs. Among the most relevant treaties are the following:

5.1. CONVENTION ON THE RIGHTS OF THE CHILD (CRC)³³

The CRC defines a child as anyone under 18 years of age, citing the common needs of childhood. Consequently, adolescent girls are entitled to all the rights and special protection measures provided in this Convention, with practical implications for their health and development (Art. 24).³⁴ Parents,³⁵ schools, and communities play fundamental roles in this process and are required to provide direction and guidance to adolescent girls in the exercise of their rights; to provide them genuine opportunities to express their views freely and to give their views due weight, in accordance with their age and maturity; and to provide a safe environment conducive to their development (Arts. 5, 12). Also, health workers are required to ensure the confidentiality of medical information on adolescents by disseminating the information only with the patient's consent or according

³² The Convention on the Rights of the Child affirms that persons under 18 years old enjoy certain specific additional rights by virtue of their age. See <http://www2.ohchr.org/english/law/crc.htm>.

³³ The Convention entered into force on September 2, 1990. The LAC countries that have ratified it include Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

³⁴ The International Covenant on Economic, Social and Cultural Rights is considered the key instrument for protection of the right to health, recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Art. 12). See Annex 1 of this report for a list of international human rights treaties that recognize the right to health.

³⁵ Or any other persons legally responsible for the child.



to the same confidentiality requirements that apply to adults (Art. 16).

The general comment on adolescent health and development in the context of the CRC³⁶ explicitly mentions, in light of Articles 3, 7, and 24, the right of adolescent girls to access sexual and reproductive information, including information about family planning and contraceptives, the dangers of early pregnancy, prevention of HIV/AIDS, and prevention and treatment of sexually transmitted diseases. It calls on States Parties to ensure that adolescents have access to appropriate information, regardless of their marital status and whether their parents or guardians consent.

5.2. CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION

AGAINST WOMEN (CEDAW)³⁷

CEDAW is often described as the international bill of rights for women and girls. It is guided by two fundamental principles: substantive equality and non-discrimination. Discrimination against women is understood to mean any distinction, exclusion, or restriction made on the basis of sex that has the effect or purpose of impairing or nullifying women's recognition, enjoyment, or exercise of their rights, irrespective of their marital status (Art. 1). CEDAW affirms that access to health care, including reproductive health care, is a basic right (Art. 12). It emphasizes that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education, and means to enable them to exercise these rights (Art. 16, Art. 10). The CEDAW general recommendation on women's health³⁸ calls upon States Parties to "ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality."

CEDAW is the only human rights treaty that affirms the reproductive rights of women and characterizes culture and tradition as influential forces shaping gender roles and family relations. Several global conferences of the United Nations have also considered these goals and have developed additional relevant action programs. They include, most notably, the World Conference on Human Rights in 1993; the International Conference on Population and Development, held in Cairo in

³⁶ Committee on the Rights of the Child, General Comment No. 4 (2003), "Adolescent health and development in the context of the Convention on the Rights of the Child," http://www2.ohchr.org/english/bodies/crc/docs/gC4_en.doc.

³⁷ CEDAW entered into force on September 3, 1981. The list of countries that have ratified it is available at <http://www.un.org/womenwatch/daw/cedaw/states.htm>.

³⁸ CEDAW General Recommendation No. 24, 1999, Par. 8.

1994 (and its +5 and +10 review conferences); the Fourth World Conference on Women, held in 1995 in Beijing (and its +5 and +10 review conferences); and most recently, the Tenth Regional Conference on Women in Latin America and the Caribbean, held in 2007, which produced the Quito Consensus (see Annex 2).

5.3. INTER-AMERICAN CONVENTION ON THE PREVENTION, PUNISHMENT AND ERADICATION OF VIOLENCE AGAINST WOMEN (“CONVENTION OF BELÉM DO PARÁ”)³⁹

In addition to participating in the treaties mentioned above, the Region of the Americas is the only region in the world with a specific convention to prevent, punish, and eradicate violence against women. This Convention recognizes that the elimination of violence against women is a prerequisite for their individual and social development and their full and equal participation in all spheres of life. The Convention defines violence against women as any act or conduct, based on gender, which causes death or physical, sexual, or psychological harm or suffering to women, whether in the public or the private sphere (Art. 1). It specifically mentions that violence against women can occur within the family and the community, including the workplace, educational institutions, health facilities, or any other place (Art. 2). States Parties to this Convention are obliged to take account of the vulnerability of women to violence that may occur because they are adolescents, or

pregnant, or socioeconomically disadvantaged, or because of their race or ethnic background, among other factors (Art. 9). The Convention establishes an agenda for national action to end such discrimination (Art. 7) and allows the individual presentation of petitions or complaints of violation of Article 7 before the Inter-American Commission on Human Rights (Art. 12).

5.4. IBERO-AMERICAN CONVENTION ON THE RIGHTS OF YOUTH (CIDJ)⁴⁰

The CIDJ explicitly recognizes people 15–24 years of age as subjects and holders of rights, without prejudice to the rights that also benefit minors under the Convention on the Rights of the Child. The CIDJ recognizes that young people make up a social sector with unique psychosocial, physical, and identity characteristics that require special attention, because youth is a period of life in which the individual’s personality, body of knowledge, personal security, and vision of the future are formed and consolidated. In Article 23, the CIDJ explicitly mentions the right to sex education, to be taught at all educational levels, in order to encourage responsible conduct in the exercise of sexuality that favors its full acceptance and helps prevent sexually transmitted diseases, HIV/AIDS, unwanted pregnancies, and sexual violence and abuse. The document also affirms the important role of the family in the sexual education of youth.

The empowerment of women is a right, not merely a goal. It is a critical component of efforts to achieve the eight MDGs.⁽⁷⁸⁾ Most

³⁹ The Convention entered into force on March 5, 1995. The list of countries that have ratified it is available at <http://www.oas.org/juridico/spanish/firmas/a-61.html>.

⁴⁰ The Convention entered into force on March 1, 2008. To date, it has been ratified by seven countries: Bolivia, Costa Rica, Dominican Republic, Ecuador, Honduras, Spain, and Uruguay. <http://convencion.oij.org/aplicacion.php>.



6

Empowerment, gender equity, and achievement of the Millennium Development Goals⁴¹

of these goals relate in some way to improving the health of women, referring to issues such as malnutrition, anemia, gender violence, fertility, early and unwanted pregnancy, unsafe abortions, maternal mortality, STDs, HIV, and other diseases. Significant progress toward the proposed goals will require investment in the population of women who are most vulnerable to these problems, that is, adolescent girls who are poor.

The Region of the Americas has advanced toward meeting the MDGs, but the LAC countries are still lagging on reaching key targets such as reducing by half the proportion of people in extreme poverty, reducing maternal mortality, halting the spread of HIV, and reversing environmental degradation.⁽⁷⁹⁾

Socioeconomic inequities that exist in the Region, which affect ethnic and indigenous groups most severely, contribute decisively to this delay.⁽⁸⁰⁾ Moreover, the lack of a focus on gender and human rights in the development of some policies and programs in place has prevented an effective response to the problems of adolescent girls and adult

women. Without empowerment of women and girls, they lack the capacity to demand their rights and become active agents of their own development.⁽⁸¹⁾

Below is a review of each of the MDGs, with particular attention to the progress achieved to date and the situation of adolescent girls in relation to these advances.⁴² Mention is made also of some experiences and lessons learned in the Region on the empowerment of women and adolescent girls in particular.

6.1. MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

What this MDG means for adolescent girls

Limitations imposed by poverty and hunger threaten to severely curtail the potential of the 30 million adolescent girls in the Region.

⁴¹ Following the Millennium Declaration, the Millennium Project was developed in 2002 to lay out a concrete action plan to achieve the MDGs, and subsequently the 2005 World Summit was held. The MDGs are a test of political will to establish stronger partnerships; they commit countries to initiate new actions and join forces in the fight against poverty, illiteracy, hunger, lack of education, gender inequality, infant and maternal mortality, disease, and environmental degradation. The eighth goal, reaffirmed in Monterrey and Johannesburg, calls on rich countries to take steps to relieve debt, increase aid, and allow poorer countries access to their markets and technology.

⁴² Only the targets related to the subject of this document will be considered.

(82) The majority of adolescent girls in LAC live in social and material conditions that are deficient in terms of access to income, housing, services, and social inclusion. ECLAC points out that if adolescence consolidates skills developed in previous stages of life, it is in these years that young people may be condemned to a dim future, especially if childhood was marred by nutritional, family, and educational deficiencies. A poor youth is likely to have been a poor child, and he or she has a high probability of becoming a poor adult. In this sense, youth *transmit* poverty from one generation to another.(83)

If the Region of Latin America and the Caribbean is to be enriched by the contributions, creativity, and energy of adolescent girls, it will be necessary to encourage their participation and promote their prosperity as well as that of their communities. The empowerment of adolescent girls living in poverty, extreme poverty, and vulnerability can reverse the damage caused by childhoods that lacked opportunities for comprehensive human development.

Is it possible to achieve this goal?

The prospects for halving poverty by 2015 in LAC are not encouraging.(84) Even though four countries (Chile, Brazil, Mexico, and Ecuador) reached the target by 2006, progress in the remaining countries—including Bolivia, Guatemala, Honduras, Nicaragua, and Paraguay, which have some of the highest poverty rates in the Region—has not been sufficient.(85)

The Region is characterized by sharp inequalities between social groups, rooted in history and in socioeconomic structures. This inequality is hidden when one measures

compliance with the goal for the Region as a whole, and differential poverty rates by sex, education, area of residence (rural or urban), ethnicity, and race also go unnoticed. It is noteworthy that Afro-descendant and indigenous women are most affected by poverty and destitution in the Region.(86) In Brazil, for example, 22 percent of black women are poor, compared with 8 percent of white women.(87)

Although there is a relatively strong correlation between extreme poverty, undernourishment, and undernutrition, and hunger is usually associated with extreme poverty(88), the fact is that the Region is on track to meet the target on hunger. However, ECLAC warns that even if the target is met, given the anticipated increase in population, Latin America and the Caribbean will still have more than 40 million undernourished inhabitants in 2015.⁴³(89)

MDG 1 uses underweight as the indicator of malnutrition for estimating the prevalence of hunger. Given the limitations of this indicator, PAHO believes that growth retardation, or stunting, is a more useful indicator for probing the cumulative and permanent effects of malnutrition. If stunting is used as the indicator, **the likelihood of meeting the target is low.**(90) Moreover, stunting directly affects the probability of achieving the MDG 4 in the Region, given that it represents one of the main risk factors for child mortality.

⁴³ This finding is particularly important because the countries with the highest rates of undernutrition and extreme poverty are the ones projected to post the highest rates of population growth in the coming decade.

Data on the current status of adolescent girls

Poverty

- Poor households in all countries have the highest fertility rates; thus they have the largest number of children and adolescents, which are the groups most affected by poverty.(91)
- In Latin America, according to 2002 figures, there are 15 million homeless adolescents between 13 and 19 years of age.(92)
- Among young women, the poverty rate exceeds 37 percent, while among young men it is 33.5 percent, a slightly lower level of destitution.(93)
- In urban areas of the Region, nearly 43 percent of women over 15 years of age lack their own incomes, compared with only 22 percent of men.(94)
- In rural areas, 70 percent of the people with no income are women over 15 years of age.(95)
- These last two facts point to the lack of economic autonomy that affects women because of their inability to generate income and make decisions on expenditures.(96)

Hunger and undernutrition

- Anemia is the main nutritional problem among females 10–19 years of age.(97)
- Anemia in adolescent girls ranges from 7 percent in El Salvador to 30 percent in Bolivia and 45 percent in Haiti.(98)
- Anemia in adolescent girls and young women may have negative effects on their cognitive development and physical growth. If an adolescent becomes pregnant, anemia increases maternal morbidity and mortality, increases the incidence of problems in the newborn (e.g., low birthweight and prematurity), and has a negative impact on the infant's body iron stores.(99)
- Short stature in adolescent mothers is a risk factor for labor and delivery. Where adequate health care at delivery is lacking, it contributes to maternal and neonatal mortality.(100)
- In several countries, girls are more likely to die from undernutrition than boys. For example, in Ecuador in 2000, for every 69 boys aged 1–4 years who died due to undernutrition, 91 girls died from the same cause. In Peru in 2000, the ratio was 99 boys to 110 girls. In El Salvador in 1999, the ratio was 12 to 12. In Uruguay, in 2000, 4 male children for every 7 female children died due to nutritional deficiencies.(101)

6.2. MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

What this MDG means for adolescent girls

Investing in the education of girl children and adolescent girls unquestionably contributes to empowerment and yields a double dividend: benefits to the girls themselves and intergenerational benefits to the children of the future. Educated girls have a better chance to develop fully

as individuals, to participate in community and social life, and to raise healthy sons and daughters who are active participants in their environment, happy during childhood and socially and economically productive as adults.(102)

Educating women means saving the lives of many children. The longer an adolescent girl attends school, the greater the chance that she will become a healthy and well-nourished mother with economic capabilities, who has the resources to ensure the health and education of her children. An additional year of education can boost the income of an adolescent girl

between 10 and 20 percent.⁽¹⁰³⁾

Education is central to the comprehensive development of adolescent girls, not only because it is a fundamental human right, but also because it contributes to productive development, promotes intergenerational equity, and equips adolescents to pursue diverse life ambitions, exercise their citizenship in a democratic framework, and work for peace.⁽¹⁰⁴⁾

Eliminating gender disparities in access to and completion of primary education is a key factor in ensuring that adolescent girls acquire the skills they need to participate in civic and political life, to find employment or generate income, and to make decisions that affect their life and health. Girl children and adolescent girls who are in school are less likely to be subject to labor exploitation, less vulnerable to abuse, sexual coercion, and violence, and more able to take responsibility for their sexual and reproductive lives. It is more likely that they will participate in the development of their communities. ECLAC states, “Education today favors well-being in the future. It not only leads to income gains, but also helps develop the skills and capacities that people need to exercise new forms of citizenship and live together harmoniously in a multicultural society.”⁽¹⁰⁵⁾

Is it possible to achieve this goal?

By the early 1990s, Latin America and the Caribbean had achieved relatively high levels of primary education coverage, with net enrollment ratios above 90 percent in many

countries. The Region has continued to make rapid progress since then. These advances have been particularly significant in countries that have expanded their primary education coverage to over 95 percent. However, a number of Latin American countries recorded a drop in net enrollment ratios between the start of the 1990s and the start of the 2000s, and in some others the rate is still below 90 percent. Data available for the Caribbean indicate that insufficient progress has been made in this subregion, although most of the Caribbean countries have high net enrollment ratios of over 95 percent in primary education.⁽¹⁰⁶⁾

Nevertheless, a review based on an indicator that more accurately reflects the extent to which this MDG is being achieved—the percentage of children who actually complete primary school—shows that **progress has been insufficient and that the Region as a whole is not on track to achieve universal primary education by 2015**. According to ECLAC, “In fact, if current trends continue, none of the Latin American and Caribbean countries for which information was available will meet the target in 2015, not even the ones that made slightly more headway than the rest, such as Bolivia and Mexico. Unless the trends of the last decade improve, in 2015 over 6 percent of the children in the Region will not complete primary schooling, although this average masks large differences among the countries.”^{(107)⁴⁴}

6.3. MDG 3: PROMOTE GENDER

⁴⁴ In 10 of the 18 countries considered (Argentina, Chile, Colombia, Costa Rica, Ecuador, Mexico, Panama, Peru, Uruguay, and the Bolivarian Republic of Venezuela), this percentage will be less than or close to 5 percent; in four of them (Bolivia, Brazil, Dominican Republic, and Paraguay), it will be between 7 percent and 12 percent; and in the other four (El Salvador, Guatemala, Honduras, and Nicaragua), a very high percentage (18 to 31 percent) of children will not complete primary schooling.

Data on the current status of adolescent girls

Primary school completion

- Despite the global increase in enrollment, disparities persist between countries as well as between rural and urban areas within countries.
- Girls most at risk of not going to school are those who are from poor families, indigenous, disabled, displaced, living in rural or marginal urban areas, and/or daughters of mothers who did not themselves attend school.(108) Being a girl increases the probability of dropping out of school.(109)
- Young women from poor rural households are at a disadvantage in school access in comparison with their poor urban peers, trailing by almost 6.5 percentage points, while the disparity with non-poor urban women is as much as 24 percentage points.(110)
- Girls who drop out of school early do not benefit from other programs that are run through the schools, such as feeding and nutrition programs, well-child checkups, income transfer to households, and others.
- Among the factors that contribute to the dropout rate are child labor, long distances that students must walk to school, lack of teachers, social conflicts, and emergency situations, as well as the costs of school fees, uniforms, food, textbooks, and teaching materials that are borne by families. All these factors have a more adverse impact on girls.(111)
- Among the factors that contribute directly to dropout rates among girl children and adolescent girls are lack of safe transportation, dangerous school environments, the unwillingness of parents to invest in or take an interest in girls' education, discriminatory social and cultural practices such as keeping girls at home to contribute to family income or care for younger siblings, restrictions on freedom of movement and freedom of expression of girls and women, lack of efforts to retain and reintegrate adolescents who become pregnant and give birth, and so on.(112)
- Problems with girls' schooling also have to do with the content of education. Problems include the absence of continuing and comprehensive processes of consciousness raising and capacity building on gender for male and female teachers; lack of educational models that are culturally appropriate and respectful of diversity; lack of sexuality education; limited attention to the special educational needs of girls, threats to the emotional security of girls; and curriculums insensitive to the issue of inequity. All conspire directly against the right to education.(113)
- Dropping out of school has a particularly severe economic impact on women. Sex-disaggregated data show that dropping out leads to greater loss of earnings for women than for men.(114)

EQUALITY AND EMPOWER WOMEN

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

What this goal means for adolescent girls

Both empowerment and advances in gender equity are essential to eliminate discrimination against adolescent girls, which has such deep roots in the countries of the Region that it

has come to be widely accepted. Many people simply do not see it as a problem that women may be subordinate in families and society, have fewer rights, earn lower pay for equal work, and suffer abuse by men, even though all of these situations in some way jeopardize women's health and well-being.

Women, especially adolescent girls, face a variety of health problems that ultimately derive from the notion that they are "the second sex." An article in the British

journal *The Lancet* notes: “Long-term and sustained improvements in women’s health require rectification of the inequalities and disadvantages that women and girls face in education and economic opportunity.”(115) A person who is female, young, and poor is also more vulnerable in terms of health.

In the case of adolescent girls, the close relationship between education, empowerment, and health outcomes is very clear:

- » Adolescent girls and young women with seven or more years of schooling tend to marry five years later than women with fewer years of schooling or no schooling at all. In addition, they have between two and four fewer children, as well as healthier pregnancies and safer births. Their children are more likely to survive childbirth, the first months of life, and the critical first five years, creating the foundation for a healthy and beneficial life.(116)
- » Schooling also has a positive effect on the protection of adolescent girls from HIV. Young women with more education are more knowledgeable about HIV, know more about how to avoid it, and are better able to change behaviors that put them at risk of contracting it.(117)
- » Women with formal education make greater use of contraceptive methods to delay pregnancy or space births at healthy intervals. This in turn reduces the incidence of children born with low birthweight as well as rates of infant mortality and child malnutrition.(118)
- » Adolescent girls in poor health and/or who suffer from malnutrition or eating disorders

are less likely to attend school; when they do attend, their performance is lower than that of girls who enjoy good health.(119)

The ability to control their own fertility is absolutely fundamental to the empowerment and autonomy of adolescent girls. “When a woman can plan her family, she can plan the rest of her life,” says Thoraya A. Obaid, executive director of UNFPA. “When she is healthy, she can be more productive. And when her reproductive rights are protected, she has freedom to participate more fully and equally in society. Reproductive rights are essential to women’s advancement.”(120)

In addition to the positive effects on health, the empowerment that adolescent girls gain from higher levels of education allows them greater social mobility and access to wider social networks, better opportunities for economic independence, a broader and more critical attitude toward the media, knowledge of their rights and a greater willingness to insist on them, and a lower risk of gender-based violence (or at least awareness of the injustice it represents).(121)

In many cases, empowerment processes are thwarted by gender-based violence⁴⁵ against adolescent girls by their family members or partners. This situation undermines their integrity and their opportunities to participate in decisions that affect their lives and their sexual and reproductive health. To the extent that the problem of gender-based violence is gaining visibility, it will be possible to estimate its size, explore its causes and consequences, and take actions in various fields to eradicate it.

⁴⁵ According to ECLAC, official indicators are insufficient to allow a comprehensive assessment of progress and challenges with regard to gender equality and the empowerment of women. Therefore, ECLAC has proposed some additional indicators, complementary to the official ones, that are adapted to the Region’s realities with respect to sexual and reproductive rights, domestic inequalities, and violence against women in LAC.

Is it possible to achieve this goal?⁴⁶

The overall figures show that countries in the Region are succeeding in eliminating disparities between the sexes at all levels of education, with rates that favor women in higher education. It is in the field of education that women have made the greatest achievements in gender equity in the Region. Equity of access to primary education was achieved in the 1990s, with the net enrollment ratios of girls and boys equalized in most countries. In secondary and tertiary education, women outperformed males in enrollment. However, there are still pending issues, mainly concerning disparities linked to socioeconomic status, ethnic/racial group, and area of residence.(122)

Information from the early 2000s shows that, in secondary education, girls' net enrolment ratios are higher than boys' in all countries of the Region except Anguilla, Guatemala, and Peru. With respect to tertiary education, although relatively little information is available, it seems that Mexico is the only country that has not yet reached the MDG target of eliminating gender disparities.(123)

However, this broad participation of women in the educational system has not brought about a sufficient reduction in the wage gap. This is in part because the adolescent girls who enter tertiary education, either university or technical school, are still concentrated in fields that are traditionally considered "feminine" and are therefore devalued. It is also because the educational advances of women have not been accompanied by major changes in the redistribution of family responsibilities, so women retain the primary responsibility for unpaid household work.(124)



These factors lessen the impact of education of adolescent girls. It is not enough to ensure girls' access to education; it is also essential to restructure their educational participation for their own benefit and that of society.

6.4. MDG 4: REDUCE CHILD MORTALITY

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

What this goal means for adolescent girls

The survival and health of newborns are closely related to the survival and well-being of their mothers, particularly in the case of adolescent mothers. Early pregnancy is associated with increased neonatal mortality, low birthweight and prematurity, a higher infant mortality rate, and greater physical and

⁴⁶ The Millennium Declaration establishes the goal of gender equality and empowerment of women in terms of indicators related to education, work, and political participation.

mental morbidity, with higher risk of illness, malnutrition, neglect and abuse.(137) Other risk factors for infant mortality include a pregnancy that closely follows the preceding one, higher birth order of the newborn, and poor access to services of sanitation, family planning, and skilled birth assistance. Also, the educational level of the mother continues to have a significant impact on levels of infant mortality.(138)

Adolescent mothers in general are less well equipped than older mothers to help their children survive and thrive.(139) Older mothers are more likely to have developed skills for care and feeding of their children and to have support networks that help them meet their maternal responsibilities.

These findings lend weight to the arguments for delaying the first pregnancy, spacing the second, and promoting adolescent health and access to quality services. Adolescent pregnancy contributes to intergenerational transmission of poverty, as the children of adolescent mothers are at greater risk of being poor and have twice the risk of malnutrition.(140)

Is it possible to achieve this goal?

In the years 1990–2003, representing about half the period allowed for achieving the MDGs, LAC recorded the fastest decline in infant mortality of any world region. In 2003 the Region recorded the lowest infant mortality in the developing world.

However, regional infant mortality averages mask wide disparities between countries. While five countries had levels of infant mortality below 9.2 in 2003, that same year 12 other countries had infant mortality levels higher than the regional average of 25.6 per 1,000. The most serious case is that of Haiti,

with a rate of over 60 per 1,000.(141)

Taken as a whole, the evidence makes clear that **further efforts will be needed to attain the goal of a two-thirds reduction**. It must also be recognized that, given the gaps between countries, specific measures will have to be taken to reduce the main determinants of mortality in each situation.(142)

The countries of Latin America and the Caribbean are characterized by high levels of social inequality. Child mortality is no exception, since historically the most excluded and vulnerable groups have had higher mortality rates. Indigenous children in both rural and urban areas are at greater risk of dying before their first birthday than non-indigenous rural children. Likewise, in the late 1990s child mortality was higher in the lowest income quintiles.(143)

6.5. MDG 5: IMPROVE MATERNAL HEALTH

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

What this MDG means for adolescent girls

Maternal mortality is a phenomenon closely linked to the rights of women and to poverty, given that it is a summary indicator of gender inequities.(148) Data on maternal mortality in the Region show that societies have failed women, particularly adolescent girls, in the poorest countries.

Pregnancy and abortion are among the leading causes of death for adolescent girls in the Region.(149) An adolescent mother's risk of death from obstetric causes is twice that of a woman over 24 years of age, and girls under 15 have a risk three times as high. For every adolescent who dies in childbirth, many more

Data on the current status of adolescent girls

Gender equity in education

- Between 1990 and 2005, school attendance increased from 84 percent to 94 percent for adolescents 12–14 years old, from 61 percent to 76 percent for those 15–17 years old, and from 28 percent to 35 percent for those 18 years old.
- However, disparities persist among adolescents and young people in the lower socioeconomic strata, who are more likely to fall behind in their schooling and more likely to drop out.⁽¹²⁵⁾ It is estimated that in the poorest countries and in rural areas, 40 percent of girls have dropped out of school by age 15.⁽¹²⁶⁾
- The national aggregates for the gender parity index show no large differences in access to primary schooling in Latin America and the Caribbean.⁽¹²⁷⁾ However, survival rates to grade five⁴⁷ are significantly lower than access rates. In LAC, only 10 countries and territories (of those examined) have a survival rate to grade five of over 90 percent.⁽¹²⁸⁾ To a large extent, this reflects relatively high rates of grade repetition in the early years of primary education, which leads to dropping out. In this respect, inequities are again apparent, since it is typically girls from the poorest groups who fall furthest behind and are more likely to drop out.⁽¹²⁹⁾
- Even though many girls are reaching secondary or tertiary education levels, unemployment rates for young people 15–24 years of age are higher for women than for men. In a comparative study conducted between 1990 and 2000, in nine of 10 LAC countries with available data, young women had higher rates of unemployment in 2000 than in 1990.⁽¹³⁰⁾

Barriers to gender equity: Violence against adolescent girls

- In Mexico, according to 2007 data, 15 percent of young men and women 15–24 years old have experienced at least one incident of physical violence in a dating relationship. These incidents are more likely to occur in urban areas. In 61 percent of cases, this violence is directed against the woman. According to the same study, 16.5 percent of girls have been subjected to sexual violence by an intimate partner; the proportion is similar among young people in urban and rural areas.⁽¹³¹⁾
- In Peru, in 2000, 40 percent of young women reported that their first sexual relations took place under pressure or coercion.⁽¹³²⁾ Similarly, in the Caribbean, also in 2000, of the 30 percent of adolescents who said they were having sex, half said their first sexual relations were forced.⁽¹³³⁾
- Between 2000 and 2004, among women aged 15–19 years who had ever been married or in an unmarried union, those reporting episodes of sexual violence ranged from 15 percent in Haiti to 11 percent in Bolivia, 10 percent in Paraguay, and 7 percent in Colombia.⁽¹³⁴⁾
- In the same period, also among women 15–19 years of age, those who had been subject to physical violence were 43 percent in Bolivia, 38 percent in Colombia, 31 percent in Peru, and 18 percent in Haiti and Paraguay.⁽¹³⁵⁾
- In Costa Rica, in 1999, 95 percent of pregnancies in girls aged 15 or younger were due to incest.⁽¹³⁶⁾

suffer injuries, infections, STIs, infertility, and prolonged disabilities, such as obstetric fistula.⁽¹⁵⁰⁾ Pregnant adolescent girls are less likely to complete their schooling, more likely to

work in the informal sector, and more likely to be poor; their children suffer more health risks. In Latin America and the Caribbean, 45 percent of the recorded deaths from unsafe

⁴⁷ This measures the proportion of the cohort of first-grade entrants who go on to enroll in fifth grade; it is calculated on the basis of certain assumptions that make it possible to reconstruct the path taken by this cohort.

abortions were among women younger than 24 years of age.(151)

The absence of effective health policies focused on sexual and reproductive health contributes directly to maternal mortality.(152) Delivery care by skilled personnel is essential, as it helps avoid birth complications; birth attendants may also refer women to other services, such as family planning and treatment for STIs.⁴⁸ It is estimated that preventing unintended pregnancies through access to family planning could reduce maternal deaths by 20 to 35 percent, as well as complications during pregnancy and childbirth, and unsafe abortions. The unmet need for contraception among adolescents in the Region is 2.5 times greater than among adult women(153) and comes to approximately 40 percent of cases.(154)

Gender inequality puts adolescent girls at greater risk of maternal mortality and other reproductive health problems. Denial of the right to freely decide whether or not to have children, fear of male violence, sociocultural

pressures for motherhood, even on adolescents, and the lack of sex education policies and services are all causes associated with maternal mortality that should be addressed openly.

Is it possible to achieve this goal?

Available estimates indicate that maternal mortality has remained at about 190 deaths per 100,000 live births in Latin America and the Caribbean during the past decade. Because the total number of births has not changed significantly since then, the number of women dying from causes related to pregnancy and childbirth in the Region is estimated to have remained at about 22,000 a year.(155)

Although the figures are imprecise, the relative stagnation of the maternal mortality ratio is troubling, as it indicates that the Region is not nearly on track to meet the target of reducing maternal mortality by three-quarters by 2015. (156)

Only a small group of countries (Uruguay,

Data on the current status of adolescent girls

Infant Mortality

- ▶ Children of adolescent mothers are 1.5 times more likely to die before their first birthday than those with older mothers.(144)
- ▶ Early pregnancy in adolescence is associated with low birthweight and prematurity, a higher rate of infant mortality, increased physical and mental morbidity, and increased risk of illness, malnutrition, neglect and abuse.(145)
- ▶ In LAC, it is estimated that 18 percent of births are to women under 20 years of age, and that 30 percent to 40 percent of these pregnancies are unwanted.(146)
- ▶ When a mother dies in childbirth, only one-third of the infants who survive the birth are alive and healthy a year later. This pattern holds true in all locations.(147) This also has an impact on other girls or women in a family, because the oldest girl is pressured to leave school and take care of the household if her mother dies in childbirth.

⁴⁸ The proportion of births attended by skilled health personnel is one of the indicators established to monitor compliance with target 6 of the MDGs, on maternal mortality.

Chile, Cuba, St. Lucia, Argentina, Brazil, and Costa Rica) have levels below 50 deaths per 100,000 live births. Rates in the remainder range from 60 to a high of 520 maternal deaths per 100,000 births in Haiti.

Even though 82 percent of births in Latin America are attended by trained personnel, it should be noted that the decline in maternal mortality also depends on other socioeconomic and environmental factors. For example, in Guyana and Paraguay, coverage of skilled care during childbirth was over 85 percent in 2000, yet the maternal mortality ratio exceeded 130 per 100,000.(157)

Access to reproductive health services is subject to severe inequalities and difficulties, especially among the rural and indigenous populations, both of which have a high incidence of maternal mortality. This is due to the lack of emergency services and care, particularly in the case of obstetric emergencies, as well as communication difficulties, such as remoteness from health centers, and a lack of information about the services that are available. Consequently, measures to improve access and reduce inequalities can make a substantial contribution to meeting this goal.

6.6. MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.

What this MDG means for adolescent girls

Two trends that can be seen in the HIV epidemic affect adolescent girls in the Region. First, there is a “rejuvenation” of the epidemic, given that half of all new cases of HIV infection have occurred in the population aged 15–24; this marks a change from the tendency seen in the first half of the 1990s, when cases were

concentrated among people aged 30–39.(165) Second, there are increasing rates of infection in women.

Adolescent girls are currently among the most vulnerable groups in the Region, particularly in the Caribbean.(166) They are more prone to risky sexual behavior than adult women and have less bargaining power, and they are more likely than boys to have forced or unprotected sex. In Jamaica, pregnant young women have an HIV incidence rate almost double that of older women.(167) In the Caribbean, young women represent more than two-thirds (69 percent) of all young people living with HIV/AIDS.(168)

Gender inequity and lack of empowerment are key forces driving the epidemic.(169) The greater vulnerability of women and girls to HIV is determined by a culture that limits their access to goods and services and prevents them from making autonomous and informed decisions about their sexual and reproductive life. In many cases it is their partners, husbands, or family members who decide when, how, and how frequently they have sexual relations. This makes it difficult for women to take preventive or protective measures to avoid infection and sexual abuse.

The risk of HIV infection in adolescent girls is intensified because physiologically they are two to four times more susceptible to infection transmission.(170) Adolescent girls have a delicate, immature vaginal mucosal surface where microscopic lesions can occur. Young women and adolescents, whose reproductive system is not fully developed, are more susceptible to infection by HIV and STIs. The risk of HIV infection increases in women with an untreated STI.(171)

Adolescent girls often lack access to

Data on the current status of adolescent girls

Maternal mortality

- The most frequent causes of hospitalization in young women were obstetric problems (27 percent and 31 percent in the Caribbean and Central America respectively).*(158)*
- An estimated 30 percent of maternal deaths occur in women younger than 24. The figure was as high as 50 percent in a maternal mortality study done in El Salvador in 2006.*(159)*
- Maternal deaths due to complications from unsafe abortions in the Region are subject to widespread underreporting, and are estimated to be far more than the 11 percent shown by official statistics.*(160)*
- In some countries of Central America, approximately 50 percent of women aged 15–24 years have had sex by 15 years of age. The percentage is higher in rural areas and among the less educated.*(161)*
- In 2006, the unmet need for contraception among young women was 48 percent in Honduras, 38 percent in Guatemala, and 36 percent in Nicaragua.*(162)*
- In more than five countries in the Region, fertility rates in adolescents aged 15–19 are over 100 live births per 1,000; 12 countries have fertility rates higher than the regional average of 76 per 1,000.*(163)*
- Fertility rates among adolescents are greater than 100 live births per 1,000 in Honduras, Nicaragua, Guatemala, El Salvador, and the Dominican Republic.*(164)*

appropriate health services and qualified health workers, and the most vulnerable and disempowered young women face stigma and discrimination; both contribute to spreading the HIV epidemic. In the words of Jean Pape,⁴⁹ in Haiti, “most health centers send 13- to 25-year-old patients to either adult or pediatric clinics, not recognizing the special needs of this population. Targeted interventions for HIV-infected adolescents and youth are needed.”*(172)*

Lack of access to high-quality sexuality education for adolescent girls increases the prevalence of risky behaviors associated with STIs and limits their ability to discuss HIV with a partner, require condom use, or negotiate the terms of sexual relations. This increases the risk of HIV infection. “Primary education has a substantial positive effect on

knowledge of HIV prevention and condom use, but secondary education has an even greater effect. Girls who attend secondary school are far more likely to understand the costs of risky behaviour and even to know effective refusal tactics in difficult sexual situations.”*(173)*

Is it possible to achieve this goal?

Latin America and the Caribbean saw significant increases in the total number of people with HIV between 2002 and 2004. It is estimated that, as of 2004, a total of 2.4 million people were infected in the Region, 21 percent of them living in the Caribbean. It is calculated that the number of people living with HIV/AIDS rose by 200,000 in Latin America over the same period; the figure for the Caribbean is 20,000.*(174)*

According to ECLAC, “in just a few years,

⁴⁹ Founder of the Haitian Study Group for Kaposi’s Sarcoma and Opportunistic Infections (GHESKIO), established in May 1982. For more information see <http://www.haitimedical.com/gheskio>.

the AIDS epidemic has swept away decades of investment in public health. . . . Recovering from this is going to be a formidable challenge [requiring] extraordinary measures, especially as regards prevention and treatment.”(175)

Without considering national averages, even in countries with low prevalence there are specific population groups that contain subpopulations with high prevalence levels. Adolescents (10–19 years) at greatest risk of HIV are injecting drug users who use unsterilized equipment; men who have unprotected sex with men; sex workers, including those involved in human trafficking for sexual exploitation and those having unprotected sex; and men who have unprotected sex with sex workers.(176)

It is asymmetries of power that determine the increased social vulnerability of women and help explain changes in the male-female ratio. For example, in the Caribbean around 1985 there were four men with AIDS for every woman with the disease (a 4:1 ratio). The average ratio has dropped to 2:1 among adolescents and youth (2007) in Barbados, the Bahamas, and Jamaica, among other countries. In Cuba the ratio among youth is almost 1:1. In the Dominican Republic, Haiti, and Trinidad and Tobago, the estimated number of women (15–24 years) living with HIV is larger than the number of men.(177)

The HIV epidemic is one of the most daunting challenges currently facing countries in the Region. An adequate strategy must be comprehensive and consider not only the need to expand prevention, treatment, and care, but also the rights of people with HIV.

6.7. MDG 7: ENSURE ENVIRONMENTAL

SUSTAINABILITY

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water.

Target 11: By 2020, have achieved a significant improvement in the lives of at least 100 million slum dwellers.

What this MDG means for adolescent girls

Everyone has a right to enjoy sufficient and safe water that is physically accessible, as well as sanitation services that make it possible to live with dignity and that ensure sustainable development. This right also involves access to a variety of other rights that are directly or indirectly related to water and sanitation, such as the right to a healthy environment, health, and adequate nutrition. In this context, the right to a healthy environment⁵⁰ for children and adolescents implies their access to quality basic services and an environment that protects health and encourages full development of their capacities.(186)

Limited access to water and sanitation affects the young population 0–18 years of age more severely than it affects adults. Children and adolescents in rural areas are more affected than those in urban areas; low-income groups more than those with higher income; and indigenous and Afro-descendant minorities more than the rest of the population in the same age group.(187)

These deprivations set in motion a chain of negative consequences. A higher incidence of infections and diarrhea increases child mortality and also childhood malnutrition, which causes a decline in cognitive abilities,

⁵⁰ The healthy environment is an integral concept that recognizes home, school, and community as key areas where people spend an important part of their childhood and adolescence and acquire the knowledge and values that are crucial for life.

which in turn leads to academic failure and decreased productivity throughout life.

In most developing countries, women are in charge of managing water in households and communities. They are responsible for finding water sources, assessing their hygienic quality, and calculating the amount needed. Water is crucial for maintaining healthy homes: it is needed not only for drinking but for washing, preparing, and cooking food, for washing clothes, for farming and animal husbandry, for home construction and repair, and for many other domestic tasks that are the responsibility of women. Around the world, all the unpaid, unrecognized, and undervalued but extremely essential services that women provide for their families and communities depend on their ability to obtain water. Limitations on this

access have a negative impact on the health, safety, and personal development of women and their families and communities. (188)

The UN special rapporteur on the right to water, in his 2001 report, affirms: “The right to water, together with the right to food, is the true essence of the right to life.” (188)

Just as water is the essence of life, having access to sanitation and hygiene involves coverage of universal basic needs, which for many women is a luxury. The impacts and benefits of this coverage are immediate at the household and community levels. Nonetheless, sanitation and hygiene are often ignored as critical elements that allow families to carry out their daily activities within a healthy environment. (189)

Data on the current status of adolescent girls

HIV/AIDS

- ▶ It is estimated that in 2007, nearly 40 percent of new HIV infections in the global population over 15 years of age were in adolescents and young adults.(178)
- ▶ In 2006, 20 percent of HIV cases diagnosed and reported in LAC were in young people 15–24 years of age.(179)
- ▶ In Latin America in 2008, estimates of young people aged 15–24 years living with HIV were 0.2 percent for women and 0.7 percent for men.(180)
- ▶ In the Caribbean, AIDS is already among the top five causes of death among young people.(181)
- ▶ It is estimated that between a quarter and half of adolescents 15–19 years old in Guatemala, Peru, Haiti, and Brazil do not know that a person with HIV may not show symptoms of AIDS for some time after contracting the virus.(182)
- ▶ Adolescent girls and young women (15–24 years) in Haiti, Bolivia, Trinidad and Tobago, and Guyana show a gap between “knowing that AIDS exists” (90 percent) and correctly identifying the principal ways to protect themselves (just over 20 percent).(183)
- ▶ STIs affect one in five teens each year; the most common infections are chlamydia, gonorrhea, syphilis, and trichomoniasis.(184)
- ▶ Condom use remains limited, even in risky relationships. In four countries for which data are available, the percentage of women of childbearing age who have used a condom in high-risk sexual relationships ranges from 16 percent to 25 percent. In the case of men, information is available only for the Dominican Republic and Haiti. In the latter country, condom use in high-risk relationships is a mere 27 percent, while the figure for the Dominican Republic is 51 percent.(185)



Recently, *The Lancet* described climate change as the greatest global health threat of the twenty-first century.⁽¹⁹⁰⁾ These changes affect men and women differently; women are more vulnerable, as they constitute the majority of the world's poor and thus depend disproportionately on natural resources that are threatened by climate change. Climate change will unquestionably affect agricultural activities that are frequently the responsibility of women, as well as the availability of water and fuel. Girl children and adolescent girls could, for example, be particularly affected, since a major reason for girls' not attending school or dropping out of school is to collect firewood and water.⁽¹⁹¹⁾

Is it possible to achieve this goal?

Most of the LAC countries are well positioned to meet the target for expanding the coverage of drinking water services in urban areas. Some countries are even ahead of the target.

For most, the maintenance, between 2005 and 2015, of annual rates of expansion of coverage similar to the ones seen in the 1990s will probably be sufficient to meet the target.

The target for drinking water coverage in rural areas has already been reached by six countries. The other countries have made progress since 1990, although some are still more than 10 percent below the target. In short, the Region needs to increase the coverage of drinking water services by 2.5 percentage points in order to meet the target, with required increases of 1.5 points in urban areas and 10 points in rural areas.⁽¹⁹²⁾

With respect to basic sanitation, the outlook is less promising and varies more widely from country to country. In 2002, sanitation coverage was 84 percent in urban areas and 44 percent in rural areas. Progress over the past decade has been much slower than it would have been if efforts had been sustained throughout this period. Coverage increased by

only 27 percent in rural areas and 35 percent in urban areas; both percentages are lower than the figures needed to put the Region on track to meet the sanitation target. To meet the target, service coverage needs to rise by 9.5 percentage points: 7.0 points in urban areas and 23.5 points in rural areas.(193)

As the Inter-American Development Bank notes in its report on the Millennium Development Goals, meeting the water and sanitation targets is an important challenge because of their direct implications for the achievement of other health-related MDGs (reducing infant and under-five mortality and improving living conditions in slums, for example).(194)

The percentage of slum dwellers in the total urban population declined from 35.4 percent to 31.9 percent between 1990 and 2001. Over the same period, the urban population increased by about 79 million; thus the

number of slum dwellers rose from about 111 million to about 127 million. In other words, a decrease in percentage terms coincided with an increase in absolute numbers, indicating that the rate at which slums are being improved is too slow to reduce the total number of slum dwellers.

Improving the quality of life for insecure households is an increasing challenge, as slum populations continue to grow. In some countries, they have even grown in relative terms, that is, faster than the rest of the urban population.

6.8. MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target 16: In cooperation with developing countries, develop and implement strategies



Data on the current status of adolescent girls

Drinking water and basic services

- ▶ In rural areas of Latin America, approximately three out of five children and adolescents lack adequate access to safe water and sanitation.(195)
- ▶ In the poorest 20 percent of the Latin American population, lack of adequate access to water, sanitation, or both affects about half of children and adolescents, while in the richest 20 percent it affects about one in five.(196)
- ▶ In seven countries in Latin America, on average 35.6 percent of the population 0–18 years old of indigenous or Afro-descendant origin lacks adequate access to safe water, compared with 22.3 percent of the rest of the population.(197)
- ▶ In the poorest 20 percent of the population, inadequate access to sanitation and drinking water affects 55.4 percent and 48.3 percent of children and adolescents, respectively.(198)

for decent and productive work for youth.

Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

The Region of the Americas is currently experiencing a changing context shaped by demographic transition, globalization, environmental changes, and new communication technologies. This new context requires a new strategic approach to effectively address the health and development needs of adolescent girls. MDG 8 presents the countries of the Region with the challenge of developing this new approach in a comprehensive and coordinated manner.

There has been significant progress in the formation of strategic alliances for the health and development of adolescent girls.(199) However, work remains to be done to transform these alliances into concrete and effective measures, evaluate them, and take them to scale in the Region. In general, policies, programs, and services still deal with the health and development of adolescent girls from a vertical perspective focused on specific problems.

For example, they address HIV infection, pregnancy, alcohol consumption, and gender-based violence as separate issues. Funding sources often reinforce this approach, leading to costly duplication of efforts and limited impact. In turn, processes of development and implementation of interventions exclude participation by adolescent girls and therefore do not take account of their specific needs, which are determined by age, developmental stage, culture, and gender. Moreover, programs have not taken into account the central importance of support from families, schools, and communities in protecting health and education, and their potential to facilitate access to services and become essential spaces for health promotion.

What this MDG means for adolescent girls

Decent and productive work

Employment generation is a key factor in the empowerment of adolescent girls, in overcoming extreme poverty, and in improving health. According to ECLAC, employment is the main mechanism for enabling people to achieve social inclusion, economic independence, and empowerment. Moreover, evidence shows that investments that facilitate



job transition of adolescent girls have the potential to break the intergenerational cycle of poverty.(200)

Actions contributing to the empowerment of adolescent girls in the fields of education, health, and human development in general should enable them to make the passage to adulthood equipped with the skills to function as autonomous, participatory, and creative individuals, able to access, through their work, a sufficient income and a life of dignity.

Moreover, the participation of empowered adolescent girls in the world of work is not only motivated by economic factors; it also responds to profound changes in their perceptions and aspirations regarding their role in society and their priorities in life. Work is seen as a necessity and as a source of independence and self-realization.

However, one of the most pressing challenges facing the Region is that of reducing rates of youth unemployment and ensuring decent working conditions for youths who manage to enter the labor market. On the one hand, poor adolescent girls are severely affected by the problem of unemployment.(201) On the other hand, for many young people who find employment, the reality of the labor market does not meet their expectations or does so only partially. There is a tension between the high value that young women place on work and their actual experiences in their jobs(202), which are often frustrating. Many early work experiences do not meet expectations because of low wages, informal employment, threats of dismissal, abuse, sexual harassment, unpleasant personal relationships, and other factors leading to occupational vulnerability and deterioration in the quality of work.

Moreover, secondary education is often a necessary but not sufficient condition for the successful job placement of adolescent girls. These frustrating experiences have serious implications for the health and development of adolescent girls and deprive society of the opportunity to benefit from the work of young women.

For young people, even those who are excluded, work remains central to their personal development and social participation. Therefore, efforts should be aimed at restoring the possibility of building a good future based on work.

Information and Communication Technology (ICT)(203)

Compared to the total population, young people show greater use of ICT, including cell phones, Internet, and computers, in all countries of the Region with available data. (204) Within the youth population, no large gender differences in the use of ICT are apparent. However, a gender gap exists in the general population, where adult women are disadvantaged compared to adult men. (205)

The more obvious digital divide stems from the socioeconomic status of adolescent girls. The vast majority of Latin American adolescent girls who have access to ICT are literate, have had some education in the use of



Data on the current status of adolescent girls

Employment

- The unemployment rate among young people aged 15–29 in the Region increased from 12 percent in 1995 to 16 percent in 2005 and was more than double the unemployment rate for adults aged 30–64.(211)
- At the beginning of the current decade, the unemployment rate among young women was 20 percent, and for the poorest youth population (both sexes) it was 28 percent.(212)
- Domestic service is the single most important occupation for young women in the Region, with about 11 million of them in this line of work (comprising 90% percent of all people who work in this field). This is especially true of women and girls with lower education and income levels. A large number of domestic workers come from poor rural families and begin working at a very young age. They are thus excluded from education and do not enjoy any protection of their rights. Despite the importance of their labors, domestic servants have the lowest levels of pay and social protection of any employees. In Brazil, for example, there are over six and a half million domestic workers, the majority of them of African descent, with an average income that is less than the minimum wage. Only 26 percent of them have signed employment contracts.(213)
- For 34 percent of young people in Peru, their main fear is the lack of work, and for 46 percent the employment situation presents the principal barrier to entering adult life.(214)
- A qualitative study in urban and rural Peru found that among poor youth, those with the best prospects for social inclusion and development are urban youth 18–24 years of age who are part of a functional family, who have had formal schooling, and who continue on to higher education or want to do so.

ICT⁵¹

- In Brazil, young people aged 15–24 account for 41 percent of Internet users at the national level.(215)
- According to the ILO, women account for a minority of Internet users in both developing and developed countries. For example, only 38 percent of Internet users in Latin America are women.(216)
- The Region is very heterogeneous in access to and adoption of new technologies, with differences both between countries and within countries; these differences are determined by user characteristics such as income, education, geographic location, gender, ethnicity, and age.
- The digital divide by gender widens the gap between men and women in professions and the workplace, affecting wages, employment stability, and professional credibility and recognition.

⁵¹ The lack of diagnostics and data, disaggregated by sex, socioeconomic group, and age group, on access to and use of ICT in all the Latin American countries has been a limiting factor for developing this resource.

ICT, and have the purchasing power, however limited, to pay for an Internet connection at home, at a cybercafé, or on a cell phone. They presumably also have a basic knowledge of English, considering that 80 percent of all online information is in that language.(206)

Thus there is a marked difference between the “techno-rich,” who have access to the infrastructure and education needed to take advantage of technology, and the “techno-poor,” who remain marginalized from the benefits of ICT for economic, educational, cultural, or other reasons.

Greater use of ICT has the potential to encourage and enable poor adolescent girls to take active part in networking and advocacy for their rights; gain access to new jobs and opportunities, including working from home if they so choose; participate in interactive learning initiatives; and receive quality information not available in the traditional media. However, it should be recognized that mere access to ICT does not automatically have a positive impact on the empowerment of adolescent girls. The gender gap in technology use is another of the preexisting conditions that exclude a number of women from the development process.

Is it possible to achieve this goal?

Employment. According to the International Labour Organization (ILO), “women have to overcome many discriminatory obstacles when seeking jobs. Societies cannot afford to ignore the potential of female labor in reducing poverty, and need to search for innovative ways of lowering economic, social and political barriers. Providing women an equal footing in the workplace is not just right, but smart.”(207)

Despite its importance, the problem of employment is not adequately considered in the Millennium Development Goals, since, among other deficiencies, indicators are not specified to cover the wide range of areas related to this topic.(208) The Region has a long way to go before it can achieve full economic integration of women and take advantage of their great potential for development.

ICT. As far as the need to broaden the population’s access to the benefits of ICT, access to telephone and Internet services has grown exponentially over the last decade. However, Latin America and the Caribbean still lags behind the developed countries in this respect. In 2002 the number of fixed-line and cellular telephones in the Region averaged less than one-third of the number in developed regions, proportionally speaking, while the number of personal computers averaged less than one-sixth and the number of Internet connections, just under one-fifth.(209, 210) Despite the efforts made to bridge these gaps and the significant sums invested in the stock of ICT-related capital and technology use, the gap with respect to the developed world remains large.



7 Recommendations for the empowerment of adolescent girls and examples of good practices

The following recommendations and examples of good practices are based a review of the needs of adolescent girls, on lessons learned in implementing interventions for their empowerment in the Region, and on assessment of what remains to be done to ensure their comprehensive development.

MDG 1: Eradicate extreme poverty and hunger

General recommendations

1. Broaden the definition of poverty, particularly when referring to adolescent girls, to include not only the lack of economic resources but also the lack of other assets such as power, opportunities, capability, and security. It has been shown that promoting gender equality and the empowerment of women is essential in order to reduce and eradicate poverty and hunger. Women's equality and participation have a direct impact on economic growth and on the welfare of families and communities.
2. Integrate the dimension of gender in a meaningful way in the design and application of public policies and programs, especially those dealing with food and nutrition. Strategies that emphasize integrated actions in nutrition, health, and education, recognizing the key role of women in the day-to-day support of families, have proven especially beneficial for women.

Specific recommendations

- a. Establish social safety nets and invest in the empowerment of adolescent girls in extreme poverty, giving particular attention to girls from indigenous and Afro-descendant groups. Greater integration of adolescent girls requires, among other measures, direct subsidies and improved access to education, health, justice, and land ownership; elimination of gender-based violence; and strengthening of their organizations.
- b. Involve adolescent girls in actions to combat poverty and hunger by promoting their empowerment and participation, recognizing and promoting formation of their organizations, and establishing mechanisms for joint management of public goods and services.
- c. Prioritize adolescent girls in programs to prevent obesity and anemia and promote physical exercise. This is critical not only for improving the health and survival of current and future generations, but also for escaping poverty.
- d. Prioritize the fortification of staple foods with iron and encourage their consumption. Ensure that distribution of these foods reaches adolescent girls in the poorest households. Likewise, promote programs that encourage dietary changes and provide nutritional education.



- e. Develop comprehensive packages of interventions that link actions in nutrition education/prevention and detection/treatment of anemia with other programs for adolescent girls (sexual and reproductive health, vaccination against human papillomavirus, prevention of HIV) in order to avoid duplication and ensure broader impact.⁵²

Notable examples of good practices:

- » **Conditional cash transfer programs in Brazil and Mexico.** These programs deliver a sum of money on a regular basis to disadvantaged households on condition that the recipients meet certain obligations that favor human development, such as sending their children to school or

participating in health, nutrition, and information programs. Two well-known examples of cash transfer programs are Bolsa Escola in Brazil and Oportunidades in Mexico; in both cases the benefits are given directly to mothers participating in the programs.(217)

An evaluation of the first generation of cash transfer programs found that they are an efficient means of promoting human capital accumulation among poor people. The programs have contributed to higher school enrollment rates, improvements in preventive health care, and increased household consumption. However, despite the promising data, there are concerns regarding the limitations of social service delivery, the need to balance social assistance with the objectives of human capital formation, and the adequacy, effectiveness, and appropriateness of the program in different countries, especially in countries with low incomes and limited capacity.(218)

The Oportunidades program operates nationwide in over 92,000 Mexican communities located in the most marginalized municipalities, both in rural areas and in large cities. A quarter of the national population receives benefits. With respect to education, results in 2008 show that the 5.2 million children and adolescents enrolled in the program are staying in school and have different life expectations than their parents.(219) It should be noted that additional years of secondary education confer even greater benefits for women(220), helping prevent frequent pregnancies and early childbearing, factors

⁵² In February 2009, PAHO/WHO organized a meeting in Mexico City to present a package of adolescent health interventions (related to sexual and reproductive health and prevention of cervical cancer) and discuss ways to implement it in the context of adolescent health services currently provided in the countries. This is available upon request to PAHO at <https://portal.paho.org/sites/fch/Ca/WS/HPV/default.aspx>.

that strongly influence the reproduction of poverty.(221)

- » **“Community Kitchens” in periurban areas of Peru.**(222) This program aimed to improve iron intake in adolescent girls by enriching the menu of the community kitchens, identifying foods that are cheapest and richest in iron. The strategy also included encouraging adolescent girls to understand their nutritional vulnerabilities and improve their diets. The results of an evaluation of the program show that adolescent girls who were beneficiaries increased their knowledge about anemia and improved their iron intake compared with a control group.(223)

MDG 2: Achieve universal primary education

General recommendations

1. Prioritize universal access through intersectoral work in education and health, recognizing their close interrelationship. Access to education is directly related to reduction in fertility rates and use of family planning methods.(224) Adolescent girls with seven or more years of schooling have more knowledge about sexual and reproductive health, HIV, and STIs.(225) They tend to delay marriage, have fewer children, and have healthier pregnancies and safer births. Their children have better chances of surviving delivery, the first months of life, and the critical first five years, laying the groundwork for healthy and productive lives.(226) Moreover, adolescent girls with poor health and/or poor levels of nutrition perform less well academically, on average, than girls with good health and nutrition.(227)
2. Target interventions to adolescent girls in excluded population groups and geographic areas. Local measures should be adopted to

respond to their particular circumstances, reduce the costs and improve the quality of education, address the concerns of parents about the role and safety of adolescent girls who attend school, and offer incentives and/or benefits to compensate for the opportunity cost to the family when an adolescent girl enrolls in school rather than contributing to family income.

3. Provide universal access to early and comprehensive sexuality education in schools. This education should not center only on abstinence, since that approach has not been shown to have a significant impact on the age of first sexual relations.(228) Rather, education should give girls and young women information about their bodies, their health, and self-care, and about their civil rights. It should teach them about communication and decision making and help them learn how to establish equality in their relationships, enforce the right to consent in sexual relations and in marriage, and put an end to sexual violence and coercion.

Specific recommendations

- a. Ensure that access goes hand in hand with quality of education by investing in pedagogical improvement. Design, with the participation of teachers and communities, strategies to make instruction more relevant, to advance empowerment and gender equity, and to help students develop the skills to live in a world undergoing rapid cultural and labor-related transformations.
- b. Help adolescent girls develop a strong sense of their own initiative in the process of learning, of confidence in their ability to learn, and of the critical capacity to understand themselves as actors in the environment in which they live. Also, instill in the students an ethical commitment to

justice and equal opportunities, promoting programs in which adolescent girls mentor younger girls or engage in peer education, and developing attitudes of intra- and inter-generational solidarity, responsibility, and respect for others.

- c. Adapt the curriculum to local contexts and develop curricula in local languages, addressing gender-specific issues and involving women in the design of curriculum content. Consider cultural factors that have an impact on women's access to extracurricular activities.
- d. Ensure that schools are healthy places, not only to guarantee adolescent girls the right to be educated in an environment appropriate to their needs, but also because healthy schools contribute to healthy communities.
- e. Promote participation by parents and the community in the schools and in efforts to promote the healthy growth of adolescent girls. Decisions that adolescent girls make in the family setting may influence their empowerment and well-being. Identify programs that promote open and honest communication between parents and children, along with love and discipline, and that decrease risky behaviors such as unsafe sex and consumption of alcohol and drugs, among others.⁵³

Notable examples of good practices:

- » **Improving quality and equity in education:** The P-900 Program in Chile.⁽²²⁹⁾ The P-900 Program is a strategy for improving educational quality and equity, developed with support of the Chilean Ministry of

Education. It focuses on the 900 schools with the lowest performance in rural and urban areas of the country, as measured by national standardized tests.⁵⁴ From 1990 to 1997 the program involved only primary schools; from 1998 onward, secondary schools were included as well. This is an effort to help the student population at greatest social and educational risk by providing training for teachers and students, teaching resources, and infrastructure. Learning workshops for students take place outside the regular class schedule and are taught both inside and outside the schools. Teacher training workshops take place during normal working hours once a week. The P-900 Program has been of great importance in identifying gaps and barriers to providing high-quality education to students living in difficult conditions, and in promoting the participation of parents and the community.

- » **Ministerial Declaration of the 1st Meeting of Ministers of Health and Education to Stop HIV and STIs in Latin America and the Caribbean:** Prevention through Education. (230)⁵⁵ This high-level declaration calls for improving sex education and increasing access to health services for adolescents. It is important example of the impact of intersectoral work. The declaration recognizes the need for a comprehensive effort to stop HIV/AIDS and reflects the commitment of ministers of health and education in the Region to develop intersectoral strategies based on scientific data on comprehensive sex education and promotion of sexual health. This document includes two targets for the year 2015:

⁵³ See the PAHO program called Strengthening Families: Love and Limits. Information at http://www.paho.org/english/ad/fch/ca/sa-familias_fuertes.htm.

⁵⁴ The Chilean government uses SIMCE: Sistema de Medición de la Calidad de la Educación.

⁵⁵ The Declaration is available at http://data.unaids.org/pub/BaseDocument/2008/20080801_minsterdeclaration_en.pdf.

to reduce by 75 percent the number of schools that do not provide comprehensive sexuality education, and to reduce by 50 percent the number of adolescents and young people who are not covered by health services that provide appropriate sexual and reproductive health care.

MDG 3: Promote gender equality and empower women

General recommendations

1. Take various measures to protect the store of human capital that the population of adolescent girls represents. Promote adolescent girls' empowerment and their participation in civil society, especially with respect to those who are more vulnerable⁵⁶ because of their socioeconomic status or ethnic group, and whom conventional strategies may fail to reach.
2. Establish effective legal protections to ensure that achievement of sex parity in secondary and tertiary education in the Region results in substantial integration of women into the workforce with equitable wages. In addition, seek to ensure that vocational guidance activities offer career choices to women, including in fields traditionally considered masculine.
3. Promote actions and services of information, education, and communication (IEC), with the participation of male adolescents and young men, that can help protect the integrity of adolescent girls and change the cultural norms, attitudes, and beliefs that underlie abusive practices.⁵⁷
4. Promulgate laws and policies of zero tolerance of abuse and violence against

women, and promote a culture that encourages the reporting of assaults.

Specific recommendations

- a. Promote the integration of adolescent girls in the secondary education system by reducing fees, providing scholarships, locating schools near the homes of adolescent girls, and allowing flexible schedules to eliminate discrimination against adolescents who are married or mothers.
- b. Recognize the heterogeneity of the population of adolescent girls and ensure that interventions that affect them address their specific needs according to age, rural or urban residence, marital status, and ethnicity, with empowerment interventions that complement their schooling, enabling them to exert more control over their own bodies, economic and family resources, and life in general.
- c. Ensure that education and information programs on adolescent health are integrated into the curriculum and are age-appropriate, avoiding stereotypes that devalue women.
- d. Offer sex education that is empowering as an integral part of the education of adolescent girls. It should not simply transmit knowledge, but should be a catalyst for changing attitudes that underlie discrimination against women and sexual violence and promoting an inclusive and fair society.

Notable examples of good practices:

- » **Creating Opportunities for Mayan Girls and Young Women in Guatemala.**(231)
This project, sponsored by the Population

⁵⁶ See section 3.4.

⁵⁷ See Promundo's Program H at <http://www.promundo.org.br/en/activities/activities-posts/program-h/>.

Council, benefits indigenous youth in marginalized zones. The objective is to increase options for indigenous youth through multisectoral activities such as creating social networks, providing safe places to meet, teaching new skills, fostering dialogue with peers and adults, and providing positive alternative role models. The program trains indigenous youth as community change agents. Through this intervention, indigenous youth have strengthened their life skills and improved their self-esteem, decision-making capacity, teamwork, and social support.

- » **Interagency Program for Empowerment of Adolescent Girls in El Salvador, 2002–2006 (PIEMA).**(232) This was an initiative launched by the interagency gender group of the United Nations (UNICEF, UNFPA, UNDP, PAHO/WHO, and FAO) to improve the health and development of girls and young women 10–19 years of age. PIEMA took a comprehensive approach to the needs of adolescent girls, making use of the comparative advantage of each agency.⁵⁸ It was implemented in 13 municipalities in rural and periurban areas and involved 5,000 adolescent girls. An evaluation showed that the program was effective in improving adolescent girls' knowledge about sexual and reproductive health, especially transmission of HIV and other STIs; about ways to protect themselves against domestic violence and report occurrences; and about how to access health care services for adolescents. The assessment showed that the beneficiary

adolescent girls had greater participation in grassroots organizations, and it concluded that the program influenced collective empowerment, as measured by collective efficacy and social cohesion.

- » **Program M for young women in Brazil, Mexico, Jamaica, and Nicaragua.**(233) This intervention, developed by Promundo, is part of the initiative called Alianza H.59 It focuses on gender issues, including aspects relevant to masculinity. Its main work is the production, dissemination, and evaluation of educational materials such as manuals and videos. Among the topics covered are gender and power, identity, relationships, body and sexuality, violence, sexual and reproductive rights, maternity and HIV/AIDS, substance abuse, work, and community participation. Program M also carried out a campaign with youth that focused on sexual and reproductive rights, gender equity, and empowerment of women in various social spheres.

These actions were tested with 176 adolescent girls in Brazil, Mexico, Jamaica, and Nicaragua and then evaluated with different instruments, some developed by the project and others adapted from other contexts. The results showed improvements with respect to self confidence and self-knowledge, communication skills, community involvement, recognition of the cycle of violence, and a critical vision of traditional gender norms.(234) These results have led to an adaptation of this program for the school system in Brazil.

⁵⁸ The distribution of responsibilities was as follows: UNICEF, review of legal frameworks favoring or impeding the development of adolescent girls and life skills training for adolescent girls; UNFPA, training for health providers and for adolescent girls in sexual and reproductive health; UNDP, promotion of associations and leadership training for adolescent girls; WHO, training of health providers and dissemination of technical guidelines on quality health care for adolescents; FAO, promotion of productive initiatives and training of adolescent girls in administrative management and teamwork.

⁵⁹ An international cooperative initiative involving NGOs, UN agencies, and the private sector to promote gender equity among young people.

MDG 4: Reduce child mortality**General recommendations**

1. Address neonatal health by taking a comprehensive approach to the health of adolescent girls, mothers, newborns, and children. Ensure continuous skilled care that encompasses health promotion for adolescent girls, prevention of early pregnancy in adolescents, and care during pregnancy, childbirth, the puerperium, and the postnatal period. Children born to adolescent mothers have 1.5 times higher probability of dying before their first birthday than those born to older mothers. (235) Early pregnancy in adolescence is associated with low birthweight and prematurity, a higher infant mortality rate, and greater physical and mental morbidity, with a greater risk of illness, malnourishment, neglect and abuse. (236)
2. Pass legislation that strengthens health systems with a view to achieving universal access to care. Registry of mothers and newborns should be made compulsory, and free access to a basic set of quality health services should be guaranteed to mothers, newborns, and children. Community participation should be promoted, and the needs of the most impoverished and excluded populations given priority.
3. Support programs aimed specifically at young men, with a view to changing social standards that exclude them from care of

newborns and parenting of children. These programs should also encourage young men to take responsibility for their own sexual behavior and its consequences, and promote young men's integration into the workforce.

Specific recommendations

- a. Promote the use of validated tools, such as the IMCI and IMAN strategies developed by PAHO,⁶⁰ to improve the integrated management of childhood illnesses and the quality of health services that address the needs of young people, including adolescent mothers.
- b. Ensure training of health personnel in key human rights issues such as confidentiality, privacy, consent, equal protection of the law, and nondiscrimination in the context of cultural diversity.⁶¹
- c. Promote home visits by health personnel to provide prenatal care and prevent second pregnancies among adolescents.
- d. Promote bonding between adolescent mothers and their children, and help them build networks of support that involve the health services.
- e. Promote actions to include fathers in parenting. Provide education aimed at providing both father and mothers, especially adolescents, with the skills to take part in the care and upbringing of their children.⁶²
- f. Continue efforts to spread the practice of exclusive breastfeeding.

⁶⁰ Integration of Management of Adolescent Needs (IMAN) follows the model established by Integrated Management of Childhood Illness (IMCI). It includes guidelines for the treatment of diseases in adolescence and youth, emphasizing prevention and promotion. This integrated model of care aims to improve the multidisciplinary skills of professionals in the field of adolescent health and youth and to improve clinical practice and treatment in the field of family and community.

⁶¹ These activities for capacity building in human rights are set out in the "Regional Strategy for Improving Adolescent and Youth Health," technical document CD48/8, available at <http://www.paho.org/English/GOV/CD/cd48-08-e.pdf>.

⁶² The PAHO Strengthening Families intervention has been shown to reduce risky behaviors in adolescents and improve communication between adolescents and parents so that together they can make healthy choices. It is adapted from Iowa State University's Strengthening Families Program for Parents and Youth 10–14. See <https://www.extension.iastate.edu/store/ItemDetail.aspx?ProductID=5767&SeriesCode=&CategoryID=&Keyword=sf%200002>.

Notable examples of good practices:

- » **The community component of the PAHO/WHO strategy of Integrated Management of Childhood Illness (IMCI).** This is based on the premise that mothers, families, and communities have the primary responsibility for providing care for their children, and that in most cases they have not actually been involved or consulted in the implementation of programs. Community IMCI mobilizes communities in areas at high risk of infant mortality to inform them of key family practices and invite them to take part in participatory projects that support implementation of these practices. IMCI has been implemented in 17 countries in the Region, with cross-sector partnerships such as health/education. In Chao, Peru, key family practices have been integrated in school curricula. Evaluation of this strategy shows that the participation of mothers has been fundamental to its success.⁽²³⁷⁾
- » **Rural Care Centers for Adolescents (CARA) in Mexico.**⁽²³⁸⁾ These are spaces dedicated exclusively to adolescents and youth, located within rural medical units and rural hospitals run by the Mexican Social Security Institute (IMSS) and Oportunidades. They are designed to create a friendly environment in which young people can meet, participate in educational sessions and activities, and exchange ideas with health personnel. These centers use the Model of Comprehensive Health Care for Rural Adolescents (MAISAR). Although the primary objective is to improve sexual and reproductive health in adolescence, the CARA centers also address preventive health issues and seek to encourage creativity, human development, self-esteem, diversity, development of life skills, and gender equity.
- » **“Where is the man in family health?” A project to improve men’s participation and social support in family health at the community level in rural areas of Guatemala.**⁽²³⁹⁾ This program, implemented by the Population Council in 2003, consisted of identifying strategies to promote gender equity and foster the constructive involvement of Maya men in maternal, child, and reproductive health, enabling them to effectively support their partners and families. It included an intervention to improve the knowledge, skills, and attitudes of men to enable them to respond appropriately on issues related to family health and to participate actively and positively in perinatal care. This involved (a) providing information about such topics as proper care and danger signs during pregnancy, childbirth, and the postpartum period, sexually transmitted infections, birth spacing, and family violence, and (b) fostering preventive practices such as timely medical referral in emergencies, family preparation and planning for childbirth, and emergency plans in case of danger signs in pregnancy, childbirth, and the postpartum period. The project helped men define their specific roles in relation to childbirth and postnatal care, encouraged communication between partners, and promoted spacing of pregnancies.

MDG 5: Improve maternal health

General recommendations

1. Promote universal access to sexual and reproductive health for adolescent girls.⁶³ Reduce rates of abortion and unwanted pregnancy in

⁶³ See target 5B (universal access to reproductive health) under the expanded MDG indicators from 2007 (paragraph 24, A/61/1, http://mdgs.un.org/unsd/mdg/resources/Static/Products/Sgreports/61_1/a_61_1_e.pdf). <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/Officialist.htm>.

- adolescents, delay first pregnancies, and space subsequent pregnancies by increasing access to health services, contraceptive methods, and prenatal care.
2. Provide adequate resources, both human and financial, so that adolescent girls can have access to safe pregnancies and safe deliveries attended by skilled personnel.
 3. Improve the collection, reporting, availability, and use of relevant data in implementing programs and policies, making decisions, and taking effective actions with respect to adolescent health and sexual/reproductive health.
 4. Advocate the empowerment of adolescent girls, and their families and communities, with a view to improving their self-care, strengthening their capacity to avoid unprotected or forced sexual relations, and increasing their access to and utilization of quality specialized care. Also crucial is support for necessary transportation to health centers, especially in cases of obstetric emergency, to ensure access to medical care. Adapting health services to cultural patterns will encourage safe motherhood among the most vulnerable adolescents and youth.
- seek out sexual and reproductive health services.
- c. Remove the stigma associated with adolescent pregnancy, so that when it does occur, adolescents can access health care services in a timely fashion to obtain prenatal care.
 - d. Strengthen health systems. Quality care for adolescent girls should include comprehensive services to promote sexual and reproductive health, prevent risk behaviors, and provide care during pregnancy, childbirth, and the puerperium. Practical and effective services that are low-cost include childbirth in health care facilities with the necessary equipment, medicines, and specialized personnel who attend births 24 hours a day. Also necessary are quality control and transport to emergency obstetric care in case of complications.
 - e. Ensure training of health personnel, including midwives, who can attend safe births in remote areas. In addition to the traditional instruction in sexual and reproductive health, this training should also address other issues of adolescent health and development, such as health problems related to gender inequities. It should include capacity building to enable these health workers to communicate with adolescents, showing empathy, understanding their needs, and not simply seeing them from the perspective of the adult world.
 - f. Develop strategies for updating health personnel on recent research and new technologies that affect the health of young people (e.g., findings on brain development, new vaccines such as the one for human papillomavirus, and new tests for detection of diseases).

Specific recommendations

- a. Train strategic actors (government officials, NGOs, and young people) working on the empowerment and health of adolescent girls, and emphasize that health as a human right is enshrined in human rights instruments of the United Nations and the Organization of American States, particularly the CRC, CEDAW, and the Convention of Belém do Pará.⁶⁴
- b. Orient family planning services to young women in order to encourage them to

⁶⁴ These human rights instruments are mentioned in the “Regional Strategy for Improving Adolescent and Youth Health,” technical document CD48/8, available at <http://www.paho.org/English/GOV/CD/cd48-08-e.pdf>.

Notable examples of good practices:

- » **Municipal Houses for Adolescents and Youth: Empowering communities in Nicaragua.**⁽²⁴⁰⁾ The Municipal Houses for Adolescents program started in 1998 at the initiative of UNFPA and was implemented by the Association of Municipalities of Nicaragua. The houses have the full legal backing of the municipal governments. They educate adolescents and young adults (both male and female) about issues of sexual and reproductive health, gender equity, STIs and HIV, as well as public policies for adolescents.
- » **Maternity Waiting Homes and Culturally Sensitive Vertical Delivery Care in Peru.**⁽²⁴¹⁾ The Maternity Waiting Homes accommodate pregnant women from remote areas where access to medical care is difficult, especially women who have obstetric and social risk factors. The pregnant woman lives in the Maternity Waiting Home, close to a health facility that provides her essential obstetric care, until the obstetric emergency is resolved and she can safely return to her community.

The establishment of the Maternity Waiting Homes depends on mobilization and organization of local resources and individual commitments based on solidarity and social responsibility. Financial resources are also important, but to a lesser extent, and they can be found more easily when all stakeholders in the community share responsibility.

The organization and operation of the Maternity Waiting Homes involves a complex support structure based on the commitment and participation of

individuals, organizations, and agencies within the context of the population, with both an individual and institutional character.

With respect to culturally sensitive health care, these experiences have been successful because they have built bridges between women's expectations and needs for maternal health care and the generally biomedical model of the public health services. Most notably, they have achieved a significant reduction in the geographic and cultural barriers to childbirth care. These experiences must be systematized to identify the achievements and lessons learned and promote their institutionalization through health policies that are national in scope.

MDG 6: Combat HIV/AIDS, malaria and other diseases

General recommendations

1. Promote systematic collection of data on the situation of HIV in adolescent girls and on its social determinants, breaking down the information by age, sex, ethnic group, and socioeconomic level.
2. Ensure that adolescents with STIs and HIV have access to comprehensive health services, including health education, counseling, medication, and support for adherence to treatment.
3. Promote voluntary testing among adolescents and young adults, particularly the key populations of vulnerable adolescents and those at greater risk for HIV/AIDS,⁶⁵ and offer appropriate health care and counseling services.

⁶⁵ Populations and groups vulnerable to HIV are those which, for biological or social reasons, lack the control necessary to avoid exposure and consequently cannot prevent the infection. Examples of biological reasons for vulnerability include immaturity of the vaginal mucous membrane, the presence of another STI, and injuries to the vaginal or anorectal mucous membrane. Social factors include gender roles (male control of sexual relations), educational status, access to information,



4. Identify and reduce the barriers to access that can prevent adolescent girls from utilizing sexual and reproductive health services, especially stigma and discrimination against the most vulnerable and disempowered girls.
5. Advocate for and prioritize work with groups of vulnerable adolescents and those at higher risk of HIV/AIDS, involving them in the design of services appropriate to their needs. These may include capacity-building programs to reduce risky behaviors and promote positive behaviors such as use of condoms, reduction of the number of sexual partners, and use of sterilized syringes and equipment.(242)

Specific recommendations

- a. Improve access to health supplies and services for the prevention, treatment, and care of STIs and HIV through comprehensive packages of interventions that meet the specific needs of adolescent girls. This means having trained health personnel, ensuring confidentiality and privacy, providing affordable and accessible services, and making sure girls are aware that these services exist.(243)
- b. Promote sex education programs that provide adolescent girls with information about HIV/AIDS that is timely and age-appropriate, relates to their sociocultural context, and promotes gender equity. This effort requires the participation of parents, schools, friends, workplaces (including

transactional sex, kidnapping, and rape. Populations and groups at risk for HIV are those which, because of their activities, occupations, or practices, have greater probability of exposure to an agent that causes injury or disease (for example, HIV), and therefore greater probability of contracting the disease, than do other populations or groups. Populations at greater risk for HIV include men who have sex with men, sex workers, and injection drug users.

those for commercial sex workers), and the media.

- c. Provide spaces for developing the skills and capacities of adolescent girls, helping them become able to recognize risky and/or violent sexual behaviors and to discuss and negotiate sex and condom use with their partners and with their parents and other adults.
- d. Support information, education, and communication actions that challenge the systematic discrimination against people with HIV in all areas of public life. This discrimination has its origin in misinformation, ignorance, and prejudice about sexuality and infection.
- e. Promote organizations of adolescents and ensure their participation in the effort to prevent HIV and promote sexual and reproductive rights and the right to nondiscrimination for people with HIV/AIDS.

Notable examples of good practices:

- » **GHESKIO Haiti: Clinic for pregnant adolescents with HIV.**⁶⁶(172) Based on the results of a study of the effects of antiretroviral therapy in young people 13–25 years old, an HIV clinic for adolescents was opened in Port-au-Prince with the support of UNICEF. Three-quarters of its young patients have had unprotected sex, and one-third of the young women are pregnant. The clinic provides comprehensive primary care services and counseling on treatment compliance and safer sex practices. CD4 T-cell counts and monitoring of medication compliance allow for additional counseling



for adolescents who show signs of treatment failure.

Patients are provided with phone cards so they can call the clinic at no cost to ask questions. Meetings of peer counseling groups are held to discuss compliance strategies. The clinic uses a multidisciplinary approach that includes nutritional support, treatment for tuberculosis, and reproductive health services, all available at the clinic for adolescents. Many of the adolescents and youths are orphans and suffer from depression and physical and sexual abuse. Therefore, the clinic offers services to empower adolescents by providing social and psychological support and education in life skills.

⁶⁶ The Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (Groupe Haitien d'Étude du Sarcome de Kaposi et des Infections Opportunistes, GHESKIO) was established in May 1982. It is a reference center for major health problems in Haiti and works in support of the Ministry of Public Health and Population. See <http://www.haitimedical.com/gheskio>.

MDG 7: Ensure environmental sustainability**General recommendations**

1. Align and integrate environmental sustainability with a gender approach that recognizes that women play an essential role in the development of sustainable and ecological patterns of production and consumption and in the management of natural resources.
2. Provide knowledge, develop skills, and promote values for empowering adolescent girls and promoting their participation in shaping a culture of environmental stewardship and sustainable development.
3. Introduce environmental sustainability into all sectoral strategies for development, involving women and recognizing their knowledge of sustainable resource management.

Specific recommendations

- a. Provide conceptual and technical education on sustainable development for the current generation of young people, who in 2015 will be the generation making key decisions on environmental sustainability.
- b. Promote the participation of adolescent girls in decisions affecting their environment and their future.
- c. Treat and prevent parasitic infections and their adverse effects through deworming programs for adolescent girls that incorporate a basic sanitation component (handwashing, using latrines, etc.).

Notable examples of good practices:

- » **PAHO/WHO Health-Promoting Schools Initiative.** This program was launched in 1995 in response to the situation, priorities, and perspectives on school health in the Member States of the Region of the Americas. It is a strategic mechanism for advocacy, coordination, and social, multisectoral, and interagency mobilization of resources for strengthening regional, national, and local capacities for the creation of conditions conducive to learning and human development.

One of the most significant achievements of this initiative is to have helped raise awareness of the comprehensive needs of children and young people of school age, giving them greater visibility in the political, socioeconomic, and public health agendas of the Member States. Similarly, the initiative has promoted a greater understanding in the Region of the unbreakable link between health and education and the potential for schools to play a strategic role in promoting health, sustainable development, and socioeconomic and spiritual growth of peoples.

Within this framework, the Child-Friendly and Healthy Schools Initiative in Nicaragua⁽²⁴⁵⁾ encourages the participation of children, adolescents, parents, and teachers in efforts to improve learning conditions in a healthy and stimulating environment where good nutritional and health habits are practiced.⁶⁷

- » **Eco-Clubs and the UN Tunza Program.** ⁽²⁴⁶⁾ These programs have a presence throughout Latin America. They provide environmental education to improve the

⁶⁷ Agencies participating in the management of this experience include the Ministry of Education, Culture and Sports, the Ministry of Health, the Nicaraguan Water and Sewer Authority, UNICEF, and WFP.

quality of life in the communities of youth who participate, and raise awareness in these communities of problems related to the environment.

Their activities are aimed at strengthening values in young people regarding their responsibility in a world where the natural environment is deteriorating rapidly. The clubs have met with remarkable acceptance. There are now several groups of youths highly aware of their role as protectors of the environment, developing various activities focused on food safety, vector-borne diseases, reforestation, and water quality in their communities.

The program is supervised by volunteers with support from PAHO, government agencies, and NGOs operating in the communities where the clubs are active. Most of the governments in the countries where these clubs have worked have gained respect for the quality and success of their projects, giving them strong credibility.

MDG 8: Develop a global partnership for development

General recommendation

Improve collaborative relationships within the health sector and with other sectors and strategic partners. This will be fundamental for facilitating the empowerment of adolescent girls and advancing toward achievement of MDG 8. This should be done through preparation and implementation of interinstitutional⁶⁸ and intersectoral⁶⁹ work plans that uphold constitutional principles

and are based on a human rights perspective, with defined budgets, areas of responsibility, and deadlines. To maximize the impact of limited resources, this collaboration should:

4. Take into account existing mechanisms for technical, administrative, and financial coordination.
5. Be designed to meet the special needs of the poorest adolescent girls in the least developed countries or those with high impact.⁷⁰
6. Take into account the circumstances in each country as well as national priorities.
7. Build networks to share experiences and spread knowledge in order to increase the global value of activities carried out by national organizations.
8. Increase the decision-making power of adolescent girls in different areas. It is important to recognize their potential, their worth, and their capacity to take charge of themselves, improve their quality of life in a participatory and democratic way, and contribute to collective development. (247) This also means abandoning the stereotypical and reductionist notion of adolescence as a problem, and of adolescents as individuals who suffer from something.

Specific recommendations on work

- a. Ensure that employment programs benefit adolescent girls in all sectors (urban, rural, indigenous).

⁶⁸ Interagency collaboration among United Nations agencies, organs and units of the Organization of American States, government agencies, private organizations, universities, the media, civil society, youth organizations, and communities (including the religious community, teachers, parents and youth themselves).

⁶⁹ Intersectoral strategic plans should integrate at least three key areas that affect the health and development of adolescents, such as health, education, the economy, the environment, etc.).

⁷⁰ PAHO has identified five priority countries for technical cooperation: Bolivia, Guyana, Haiti, Honduras, Nicaragua. It has named six high-impact countries for interventions on adolescents and youth: Argentina, Brazil, Colombia, Mexico, Peru, and Venezuela

- b. Help adolescent girls achieve social inclusion and economic autonomy in order to advance their empowerment, break the intergenerational cycle of poverty, and improve health.
- c. Invest in efforts to facilitate the transition of adolescent girls into the workplace, thus reaping the benefits of investments already made in their education.
- g. Make strategic use of ICT in policies of the social sectors, such as health and education, in order to broaden and deepen the reach of the services and adapt them to each locality.

Notable examples of good practices:

Specific recommendations on ICT

- d. Recognize information and communication technologies as a tool for the comprehensive development of adolescent girls, and adopt policies aimed at promoting and expanding girls' use of ICT, taking advantage of their capacities and potential:
 - Provide computers and Internet connections in schools.
 - Incorporate ICT and language learning in educational curricula to increase productivity and competitiveness.
 - Provide community settings for Internet access or incentives for affordable access in private establishments.
 - Establish partnerships with Internet service providers to reduce costs for poor adolescent girls.
- e. Considering that large sectors of the adolescent population in Latin America live in poverty, assess the proportion of young people who have access to electronic communication technologies and invest in new forms of ICT, such as text messaging, social networking sites, and microblogging services, to increase access to health interventions and services.
- f. Exchange information on best practices in the use of new technologies for social communication and support evaluations
 - » **Youth employment programs in Peru and Colombia.** In Latin America, two youth employment programs that promote equal labor force participation by women and men have been evaluated and found to have a positive impact on the comprehensive development of participating adolescent girls.⁽²⁴⁸⁾ ProJoven in Peru and Youth in Action in Colombia offer training for adolescent girls⁷¹ through courses and work experiences that are tailored to the needs of local companies. In the case of ProJoven, to ensure equal opportunity, subsidies were provided to adolescent mothers. Evaluations of the programs showed an increase in the adolescent girls' employment rates and monthly incomes, which were higher than those of a control group and also higher than those of their male counterparts.⁽²⁴⁹⁾ It should be noted that the effectiveness of these programs was based on the prior existence of employment training centers in medium and large formal sectors. Thus their replication might be feasible in certain other countries of the Region such as Chile, Mexico, or Brazil, but probably less feasible in the poorest countries.
 - » **Teen Health Series Project in the United States.**⁽²⁵⁰⁾ The use of new technologies in health centers offers promising interventions for making sexual and reproductive health

⁷¹ Adolescent girls represent more than 50 percent of the beneficiaries of the programs.

services for adolescents more user-friendly and thus more effective. This method of education and empowerment has been tested at the Jane Fonda Center at Emory University School of Medicine in the United States. Taking advantage of time spent in waiting rooms, PowerPoint presentations are shown to waiting patients, providing clear and direct information that adolescents need to make decisions about sexual and reproductive health. The presentations include references to websites validated by and oriented to adolescents. Evaluation

of this project with 109 adolescent girls showed changes in knowledge, attitudes, and behavior. The probability of using a condom was 61 percent in the group of participants, compared with 42 percent in a control group. The adolescent girls who returned to the clinic between three and six months later frequently reported refusing to have sex without a condom and using up to two methods of protection. By 2008, 19 different presentations had been developed for meeting the needs of adolescents in health services.

8

Conclusions and lessons learned

The empowerment of adolescent girls is central to progress toward gender equity and human development. This report has presented a conceptual framework for defining the empowerment of women during adolescence, which in turn provides the basis for identifying strategies to improve the health and well-being of this group and for selecting variables to measure the empowerment process. The report emphasizes that these variables are interrelated and suggests that it is not possible to speak of comprehensive empowerment when only some of the criteria are met. An analysis of the Millennium Development Goals was used to address the process of empowerment from a holistic and comprehensive perspective, considering the different needs and life situations of adolescent girls, and to present specific recommendations for meeting each of the MDGs.

An analysis of the situation of adolescent girls in Latin America and the experiences presented in this report leads to a number of conclusions:

Different interventions can either facilitate or limit empowerment. Families, community programs, and social policies have specific roles in ensuring that adolescents develop in a healthy way. There is a need to further develop our understanding of the ways in which certain programs and policies disempower adolescents, compromising their basic rights.



The disempowerment of adolescent girls begins with the loss of a sense of connection and of the ability to make their voices heard. This begins a transition in which girls may develop low self-esteem and depression, hindering them from speaking up for their interests and planning their lives. Interventions must be made in preadolescence and early adolescence, when girls still “have a voice.”

The disempowerment of women is one of the objectives of patriarchal socialization,

which in turn ensures the reproduction of this form of social organization. In this context, empowerment must be addressed from a sociocultural perspective that includes collective work with families, communities, and schools.

There is no single, specific approach to the empowerment of adolescent girls. Many of the actions required to advance toward the MDGs, for example by eliminating gender-based violence and ensuring access to education and health, are likely to benefit adolescent girls. To the extent that they do, these become effective approaches for achieving adolescent girls' empowerment and promoting the realization of their human rights.

Coordinated efforts to empower adolescent girls, involving international institutions, government agencies, NGOs, civil society, and adolescents themselves, have the potential to increase efficiency, reduce costs, and make an impact.

Packages of integrated interventions for empowering adolescent girls in the areas of health, education, and work, among others, may be promising in ideal contexts and environments, those with adequate infrastructure, economic opportunities, and implementation capacity. In less than ideal contexts, it may be more feasible to select certain strategic components from the comprehensive package, implementing only those interventions that are most appropriate and viable in a specific context.

Empowerment is important for all adolescent girls, not only those who belong to poor and excluded population groups. However, given the stark disparities in health and development within and between the countries of the Region, it is critical to develop targeted

interventions aimed at those adolescents who are most vulnerable and marginalized and at highest risk of infections such as HIV/AIDS.

Adolescent girls themselves play a key role in the design, implementation, and potential sustainability of interventions, particularly in environments where other resources are limited. The participation of adolescent girls, their families, and their communities as key allies—and not just as the passive beneficiaries of programs—ensures the ownership of intervention processes and promotes transparency and accountability.

A major obstacle in developing this report was the lack of statistical data on the female adolescent population of the Region. To facilitate decision making and effective action in the areas of adolescent health, sexual and reproductive health, and empowerment, it is essential to begin collecting data on age, sex, residence, socioeconomic status, and ethnicity. This should be done both at the local level, with specific geographic populations, and at the national level, through general surveys or censuses.

Decision makers, civil servants, public servants, and parents must invest the time and resources needed to increase the decision-making power of adolescent girls and empower them in different settings, including the family, school, community, and society.

International cooperation agencies and academia have a special responsibility to carry out more rigorous studies of the empowerment of adolescent girls in the Region and to develop methods for measuring the impact and effectiveness of interventions. Initial experiences in this regard suggest that this is a particular challenge that must be addressed.

Works consulted

- Ayala and Ortiz. 2008. Programa Interagen- cial de Empoderamiento de mujeres adoles- centes de El Salvador. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- BBC News. April 8, 2003. "Annan Plea for Girls' Schooling." http://news.bbc.co.uk/2/hi/uk_news/education/2929541.stm.
- Boonstra, H. D. 2007. Young People Need Help in Preventing Pregnancy and HIV: How Will the World Respond? Alan Guttmacher Policy Review. Volume 10, Number 3. <http://www.guttmacher.org/sections/adolescents.php>.
- Breinbauer, C., and Maddaleno, M. 2004. Jóvenes: Opciones y Cambios. PAHO. Wash- ington, DC. <http://www.paho.org/spanish/DD/PIN/ps080731b.htm>.
- Breinbauer, C., and Maddaleno, M. 2005. Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents. Pan American Health Organization.
- Burnett, N. 2007. Educación para todos en 2015 ¿Alcanzaremos la meta? Informe de seguimiento de la Educación para Todos (EPT) en el Mundo. Resumen. In Perfiles Educativos. Year/Vol. XXIX. Number 118. Universidad Nacional Autónoma de México, Mexico City.
- Camacho, Ana Lorena. 2003. Reflexiones pre- liminares en torno al empoderamiento. <http://www.alforja.or.cr/centros/cep/documentos/poderyempoderamiento.pdf>.
- CEPAL. 2008. Progresos en la reducción de la pobreza extrema en america latina. pp. 33 and 108. http://www.eclac.cl/publicaciones/xml/6/33936/PobrezaExtrema_CapituloII.pdf.
- Chaparro, C. M., and Lutter, C. K. n.d. Anemia among Adolescent and Young Adult women in Latin America and the Caribbean: A Cause for Concern. PAHO. http://new.paho.org/hq/index2.php?option=com_docman&task=doc_download&gid=2424&itemid=646.
- CISALVA. 2007. Informe final de evaluación del PIEMA. Universidad del Valle, Cali, Co- lombia. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- Consejo Nacional de Políticas Públicas de la Persona Joven and UNFPA. 2008. Prim- era Encuesta Nacional de Juventud en Cos- ta Rica. http://nacionesunidas.or.cr/index.php?option=com_content&task=view&id=84&Itemid=20.
- Convention on the Rights of the Child. <http://www2.ohchr.org/english/law/crc.htm>.
- COSUDE. 2003. Promover la equidad de gé- nero una clave para reducir la pobreza e in-

- staurar un desarrollo sostenible. p. 6. http://www.deza.admin.ch/ressources/resource_es_23963.pdf.
- Creed-Kanashiro, H. M., Uribe, T. G., Bartolini, R. M., et al. Improving dietary intake to prevent anemia in adolescent girls through community kitchens in a periurban population of Lima, Peru. *J Nutr* 2000;130:459S-461S. <http://jn.nutrition.org/cgi/reprint/130/2/459S>.
- Deere, Carmen Diana, and León, Magdalena. 2003. "The Gender Asset Gap: Land in Latin America." *World Development*, Elsevier, vol. 31(6), pp. 925-947, June.
- ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. <http://www.eclac.org/publicaciones/xml/0/21540/lcg2331.pdf>.
- ECLAC, UNDP, and IPEA. 2003. Meeting the Millennium Poverty Reduction Targets in Latin America. <http://www.cepal.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/5/12555/P12555.xml>.
- ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "Teenage Motherhood in Latin America and the Caribbean: Trends, Problems and Challenges." Number 4, January 2007. Santiago de Chile. <http://www.eclac.org/dds/desafios/default.asp?idioma=IN>.
- ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "The Right of Children and Adolescents to a Healthy Environment: A Diagnosis from Latin America and the Caribbean." Number 5, July 2007. Santiago de Chile. <http://www.eclac.org/dds/desafios/default.asp?idioma=IN>.
- ECLAC and UNICEF. 2008. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "Children and HIV/AIDS in Latin America and the Caribbean." Number 7, July 2008. Santiago de Chile. <http://www.eclac.org/dds/desafios/default.asp?idioma=IN>.
- Emory University School of Medicine. 2009. Jane Fonda Center. Teen Health Series. Atlanta. http://janefondacenter.emory.edu/projects/teen_health_edu.cfm.
- García-Moreno, C. 2000. *Violencia contra la mujer. Género y equidad en la salud*. PAHO, Harvard Center for Population and Development Studies.
- García-Moreno, C. 2004. *Gender-based violence: Prevalence and health consequences*. Workshop on the Development Implications of Gender-Based Violence, World Bank, Washington, DC.
- Global Health Council. 2004. *Commitments: Youth Reproductive Health, the World Bank, and the Millennium Development Goals*. Washington, DC. Global Health Council.
- Gomes, Cristina. 2007. *Análisis de situación de población América Latina y Caribe. Diversidad y desigualdades*. UNFPA. p. 46. <http://lac.unfpa.org/public/pid/2504>.
- Gómez, Elsa. 2001. *Taller Internacional Cuentas Nacionales de Salud y Género*. 18-19 October 2001, Santiago de Chile. PAHO/WHO, Fondo Nacional de Salud (FONASA).
- Heise, Lori L., Pitanguy, J., Germain, A. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank, Washington, DC.

- ILO. 2007. Decent Work and Youth: Latin America. [http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional\[ingles\].pdf](http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional[ingles].pdf).
- ILO. 2008. Global Employment Trends for Women. http://www.ilo.org/global/About_the_ILO/Media_and_public_information/Press_releases/lang--en/WCMS_091102/index.htm.
- Instituto Interamericano del Niño. 2002. La explotación sexual de niños, niñas y adolescentes en América Latina. Montevideo.
- Instituto Mexicano de la Juventud y Secretaría de Educación Pública. 2008. Encuesta Nacional de Violencia en las Relaciones de Noviazgo 2007. Executive summary. Mexico City. http://www.imjuventud.gob.mx/contenidos/programas/encuesta_violencia_2007.pdf.
- Instituto Mexicano del Seguro Social (IMSS)/ Programa Oportunidades, Thais, A. C., UNFPA. 2007. CARA: Ocho años de experiencia con adolescentes rurales e indígenas. Mexico City.
- Instituto Nacional de las Mujeres. 2007. Glosario de género. Mexico City.
- IPPF, UNFPA. 2007. Young Positives, Global Coalition on Women & AIDS. Make It Matter: 10 Key Advocacy Messages to Prevent HIV in Girls and Young Women. http://www.who.int/pmnch/topics/hiv_aids/makeitmatter/en/index.html.
- Katz, E. 2008. Programs Promoting Young Women's Employment: What Works.
- León, Magdalena (ed.). 1998. Poder y empoderamiento de las mujeres. Bogota. Tercer Mundo Editores/Universidad Nacional de Colombia.
- Levaggi, Virgilio. 2008. Día Internacional Juventud femenina latinoamericana. Report. http://portal.oit.or.cr/index.php?option=com_content&task=view&id=297&Itemid=184.
- Levine, R., Lloyd, C., et al. 2008. Girls Count. A Global Investment and Action Agenda. Center for Global Development. http://www.cgdev.org/files/15154_file_GirlsCount.pdf.
- Maddaleno, Matilde. 2008. PAHO. 1 Foro "Inclusión al Desarrollo: Empoderando adolescentes y jóvenes." Lima.
- Maddaleno, M., et al. 2003. Salud y desarrollo de adolescentes y jóvenes en Latinoamérica y El Caribe: desafíos para la próxima década. Salud Pública de México. pp. 136–137. http://www.adolesc.org.mx/saludpublica/45s1_17.pdf.
- Maddaleno, M., and La Rosa, Liliana. 2008. Empoderamiento de las adolescentes, condición para el desarrollo. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- Malhotra, A. 2003. Conceptualizing and Measuring Women's Empowerment as a Variable in International Development. Paper presented at workshop on "Measuring Empowerment: Cross-Disciplinary Perspectives," World Bank, Washington, DC, February 4–5, 2003.
- Morlachetti, Alejandro. 2007. "Políticas de salud sexual y reproductiva dirigidas a adolescentes y jóvenes: un enfoque fundado en los derechos humanos." In Notas de Población No. 85. Economic Commission for Latin America and the Caribbean (ECLAC). p. 85. http://www.eclac.org/cgi-bin/getProd.asp?xml=/celade/agrupadores_xml/aes51.xml.

- Moyano, Martha. 2008. *La Educación de la Sexualidad y la prevención del VIH/SIDA en América Latina y el Caribe. La situación en la región.* UNFPA. Unpublished.
- Munist, M., et al. 1998. *Manual de identificación y promoción de la resiliencia en niños y adolescentes.* PAHO. Washington, DC. <http://www.paho.org/spanish/hpp/hpf/adol/resilman.pdf>.
- Muus, R. E. 1990. *Adolescent Behavior and Society: A Book of Readings.* 4th ed. New York: McGraw Hill.
- Narayan, D. 2005. "Conceptual Framework and Methodological Challenges." In D. Narayan, ed., *Measuring Empowerment: Cross-Disciplinary Perspectives.* Washington, DC: World Bank.
- OECD, 1999. *DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation.* <http://www.oecd.org/dataoecd/56/46/28313843.pdf>.
- Olavarría, José, and Madrid, Sebastián. 2005. *Sexualidad, fecundidad y paternidad en varones adolescentes en América Latina y el Caribe. Equipo de asistencia técnica para América Latina y el Caribe.* http://lac.unfpa.org/webdav/site/lac/shared/DOCUMENTS/2005/sexualidad_paternidad.pdf.
- PAHO. n.d. *Women, Health and Development Program fact sheet. Gender and HIV/AIDS.* <http://www.paho.org/English/ad/ge/GenderandHIVFactSheetI.pdf>.
- PAHO. n.d. *Women, Health and Development Program. Gender Equity in Health.* www.paho.org/english/hdp/hdw/GEHPaper.pdf.
- PAHO. 2001. *Life Skills Approach to Child and Adolescent Healthy Human Development.* <http://www.paho.org/english/hpp/hpf/adol/lifeskills.pdf>.
- PAHO. 2005. *PAHO Gender Equality Policy, 46th Directing Council Resolution, CD46/R16.* <http://www.paho.org/english/gov/cd/CD46.r16-e.pdf>.
- PAHO. 2006. *Community IMCI: Conceptual Framework.* http://www.paho.org/spanish/ad/fch/ca/fs2_english.pdf.
- PAHO. 2006. *Community IMCI: The Engendering of Social Empowerment in Chao, Peru.* http://www.paho.org/spanish/ad/fch/ca/fs1_english.pdf.
- PAHO. 2007. *Health in the Americas. Scientific and Technical Publication No. 622.* Washington, DC. <http://www.paho.org/HIA/index.html>.
- PAHO. 2007. *Proposed Strategic Plan 2008–2012.* p. 51. <http://www.paho.org/french/gov/csp/od328-full-e.pdf>.
- PAHO. 2008. *Ministers of Health Approve Strategy to Improve Health of Adolescents and Young Adults.* http://new.paho.org/hq/index.php?option=com_content&task=view&id=319&Itemid=327.
- PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health. Provisional Agenda Item 4.4 (CD48/8).* <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- Plan International. 2007. *Because I Am a Girl: The State of the World's Girls 2007.* <http://plan-international.org/what-you-can-do/campaigns/because-i-am-a-girl-campaign>.

- Population Council. 2005. M. J. Ruiz. In: Relatoría de la reunión sobre “Estrategias multisectoriales innovadoras para satisfacer las necesidades de las jóvenes indígenas y de otras/os adolescentes vulnerables.” Antigua, Guatemala, 1–2 December 2005. http://hivaidsclearinghouse.unesco.org/search/resources/santiago_relatoriamar3.pdf.
- Promundo. 2008. Programa M. Working with Young Women: Empowerment, Rights, and Health. <http://www.promundo.org.br/wp-content/uploads/2010/03/trabalhando-com-mulheres-jovens-ingles.pdf>.
- Roses, Mirta. Determinantes psicosociales y ambientales en el desarrollo de la juventud iberoamericana. PAHO/WHO.
- Ruiz, M. J. 2008. El proyecto Abriendo Oportunidades para Mujeres Jóvenes Indígenas en Guatemala. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- Santrock, John. 2001. Adolescence. New York: McGraw Hill.
- Save the Children. 2005. State of the World’s Mothers. Westport, CT. http://www.savethechildren.org/publications/mothers/2005/SOWM_2005.pdf.
- Schutt-Aine, J., and Maddaleno, M. 2003. Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications. PAHO, Washington, DC. <http://www.paho.org/english/hpp/hpf/adol/srh.pdf>.
- Sedlacek, G., Duryea, S., Ilahi N., and Sasaki, M. 2005. Child Labor, Schooling, and Poverty in Latin America. Social Protection Discussion Paper. World Bank, Washington, DC.
- Sorensen, Bente. “Medidas para enfrentar la explotación sexual comercial de niños, niñas y adolescentes.” In ILO et al. 2004. Foro Internacional sobre el Combate a la Explotación Sexual Comercial Infantil. Mexico.
- Tanner, J. M. 1990. Sequence, Tempo, and Individual Variation in Growth and Development of Boys and Girls Aged Twelve to Sixteen. Institute of Child Health, London.
- Muus, R. E. 1990. Adolescent Behavior and Society: A Book of Readings. 4th ed. New York: McGraw Hill.
- UN. n.d. La juventud y las Naciones Unidas. <http://www.un.org/esa/socdev/unyin/spanish/wpaygirls.htm>.
- UN. 1993. Declaration on the Elimination of Violence against Women. General Assembly Resolution A/RES/48/104, 20 December 1993. <http://www.un.org/documents/ga/res/48/a48r104.htm>.
- UN. 2002. Doc. E/C.12/2002/11.
- UN. 2003. The Right to Water. E/C.12/2002/11. General Comments. 20/01/2003. <http://www.unhchr.ch/tbs/doc.nsf/0/a5458d1d1bbd713fc1256cc400389e94?Opendocument>.
- UN. 2005. Proyecto del Milenio de las Naciones Unidas, Grupo de Trabajo sobre Educación e Igualdad de Género. <http://www.paho.org/spanish/ad/fch/ca/sa-genero.htm>.
- UN. 2008. End Poverty. Make it Happen. Millennium Development Goals 2015. Fact sheet. <http://www.un.org/millenniumgoals>.
- UN. 2008. The Millennium Development Goals Report. mdgs.un.org/unsd/mdg/resources/Static/Products/Progress2008/mDg_report_2008_En.pdf.

- UN. 2008. Situación y Desafíos de la Juventud en Iberoamérica. Una Contribución del Sistema de Naciones Unidas de El Salvador bajo la supervisión técnica de la CEPAL. <http://www.scribd.com/doc/8004334/Situacion-y-Desafios-de-la-juventud-en-Iberoamerica-CEPal-2008>.
- UN. 2008. World Population Prospects: The 2008 Revision. United Nations Population Division. <http://esa.un.org/unpp/index.asp?panel=2>.
- UNAIDS. 2005. The Global Coalition on Women and AIDS. Educate Girls, Fight AIDS. http://data.unaids.org/GCWA/gcwa_fs_girlseducation_sep05_en.pdf.
- UNAIDS. 2008. Inter-Agency Task Team (IATT) on HIV and Young People. Global Guidance Briefs.
- UNAIDS/WHO. 2008. Report on the Global AIDS Epidemic. July 2008.
- UNDP. 2008. Guía Recursos de Género para el Cambio Climático. México. http://www.undp.org.mx/spip.php?page=publicacion&id_article=350.
- UNDP. 2008. Investing in Women and Girls. Kemal Dervis statement: International Women's Day. <http://content.undp.org/go/newsroom/2008/march/dervis-statement-international-womens-day-20080308.en>.
- UNESCO. 2008. Education for All by 2015. Will We Make It? EFA Global Monitoring Report. Summary. Paris. <http://unesdoc.unesco.org/images/0015/001548/154820e.pdf>.
- UNFPA. 2003. State of World Population 2003. <http://www.unfpa.org/swp/2003>.
- UNFPA. 2005. Salud sexual y reproductiva en el comienzo del siglo XXI en América Latina y el Caribe. <http://lac.unfpa.org/public/cache/offonce/pid/838>.
- UNFPA. 2005. State of World Population 2005. www.unfpa.org/swp/2005/.
- UNFPA. 2005. State of World Population. Chapter 7: Gender-Based Violence: A Price Too High. <http://www.unfpa.org/swp/2005/english/ch7/index.htm>.
- UNFPA. 2007. Análisis de situación de población América Latina y el Caribe. Diversidad y desigualdades. <http://lac.unfpa.org/public/cache/offonce/pid/2504>.
- UNFPA. 2008. Make it Matter. http://www.unfpa.org/upload/lib_pub_file/754_filename_makeitmatter.pdf.
- UNFPA. 2008. Guidance Brief: HIV Interventions for Young People. Inter-Agency Task Team on HIV and Young People. Overview.
- UNICEF. 2003. The State of the World's Children 2003. <http://www.unicef.org/sowc03>.
- UNICEF. 2006. Advocacy Tools and Arguments for Social Development in Adolescents. [http://www.unicef.org/lac/INVERSION_EN_ADOLESCENTES-eng\(4\).pdf](http://www.unicef.org/lac/INVERSION_EN_ADOLESCENTES-eng(4).pdf).
- UNICEF. 2006. The State of the World's Children 2006. <http://www.unicef.org/sowc06>.
- UNICEF. 2008. Positive Adolescent Development in Latin America. Public Policy Issues. http://www.unicef.org/lac/Positive_Adolescent_Development_ING.pdf.

- UNIFEM. 2003. *Mujer, Medio Ambiente, Agua: reflexiones sobre la promoción y protección del derecho de las mujeres al agua*. <http://www.cinu.org.mx/eventos/agua/presUNIFEM.doc>.
- Vilardo, Valeria. 2008. *Mujeres, TIC y transparencia*. Presentation at “III Foro de mujeres contra la Corrupción,” September 29 to October 1, 2008, Buenos Aires. <http://www.artemisanoticias.com.ar/site/notas.asp?id=46&cidnota=6173>.
- Weller, J. 2006. *Inserción laboral de jóvenes: expectativas, demanda laboral y trayectorias*. Boletín redEtis no. 5. Preliminary version presented at the regional workshop “Estrategias educativas y formativas para la inclusión social y productiva,” 14–15 November 2005, Mexico City, organized by redETis (Red latinoamericana sobre educación, trabajo e inserción social), DIE-Cinvestav, Colegio Mexiquense, and the Mexican Secretariat of Education.
- WFP. 2005. *Inventario de los Programas de Alimentación Escolar en América Latina*. Final report. <http://www.fepale.org/lechesalud/documentos/Informe-final-pma.pdf>.
- Whitehead, M. 1990. *The Concepts and Principles of Equity and Health*. Document Eur/ICP/rPD/414. WHO Office for Europe, Copenhagen.
- WHO. 2005. *The World Health Report 2005: Make Every Mother and Child Count*. <http://www.who.int/whr/2005/en/index.html>.
- WHO. 2007. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*. 5th ed. Geneva.



ANNEXES

ANNEX 1. INTERNATIONAL HUMAN RIGHTS TREATIES THAT RECOGNIZE THE RIGHT TO HEALTH

- » International Convention on the Elimination of All Forms of Racial Discrimination, 1965: Art. 5(e)(iv).
- » International Covenant on Economic, Social and Cultural Rights, 1966: Art. 12.
- » Convention on the Elimination of All Forms of Discrimination against Women, 1979: Arts. 11(1)(f), 12, and 14(2)(b).
- » Convention on the Rights of the Child, 1989: Art. 24.
- » International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990: Arts. 28, 43(e), and 45(c).
- » Convention on the Rights of Persons with Disabilities, 2006: Art. 25.

ANNEX 2. STATEMENTS AND CONFERENCES RELATED TO EMPOWERMENT OF ADOLESCENT GIRLS

International Conference on Population and Development (ICPD)

The ICPD (Cairo, 1994) agreed that population and development are intrinsically linked and that the development of nations depends upon actions to promote greater empowerment of women and meet people's needs in education and health, including reproductive health. The conference adopted a Program of Action for the next 20 years. Its specific goals focus on providing universal education and reproductive health care, including family planning, and reducing maternal and infant mortality. The ICPD called for the elimination of violence against women and for steps to ensure women's ability to control their own fertility as key strategies to advance the goals of gender equality. It held an open and unprecedented discussion of adolescent and youth sexuality within the framework of "sexual and reproductive health." The problems of adolescence and youth were also analyzed in the context of gender, family, community, and social structures that give rise to or affect these problems.

Fourth World Conference on Women

At this conference (Beijing, 1995), governments adopted the Beijing Declaration and Platform for Action. The platform is one of the most complete documents relating to the rights of women, incorporating the results of previous treaties and conferences⁷² and reaffirming the definitions agreed in Cairo. It is intended to strengthen legislation protecting women's rights. The statement reaffirms that the human rights of women include their right

to control all aspects of their health, in particular their own fertility, and it calls for reviewing laws that provide penalties for women who have had an abortion. It also calls for measures to remove obstacles to the participation of women in all spheres of public and private life. The conference affirmed the international commitment to equal rights for women and men and identified two strategies to achieve equality: gender integration⁷³ in all processes of decision making and policy implementation, and empowerment of women, understood as affirmation of their capabilities to participate on equal terms in decision-making processes and in the exercise of power.

Beijing +5

In 2000, a five-year review of the Beijing conference measured the progress achieved and results of the implementation of the Platform for Action. The review conference discussed examples of best practices, positive actions, lessons learned, obstacles, and major problems remaining.

Governments in attendance pledged new initiatives and set objectives to ensure compulsory primary education for girls and boys and improve the health of women through increased access to preventive programs.

Quito Consensus: Tenth Regional Conference on Women in Latin America and the Caribbean

In the Quito Consensus (2007), the countries made commitments to ensure parity in women's political participation, achieve equality

⁷² CEDAW, Nairobi 1985, Vienna Declaration.

⁷³ Gender integration (mainstreaming) is a strategic, continuing process in the day-to-day implementation of public policies aimed at achieving true gender equity.

between men and women within the political parties, take measures to ensure that both sexes are fairly engaged in family and work life, equalize the rights of women performing domestic work with those of other workers,

ensure that sexual rights are a precondition in the political life of women and in paid work, recognize unpaid work, and establish comprehensive systems of public social security capable of ensuring the welfare of women.



ANNEX 3. ADDITIONAL SCALES AND INDEXES FOR MEASURING THE EMPOWERMENT OF ADOLESCENT GIRLS

I. Gender-Equitable Scale for Women - Promundo (31 items, alpha=0.86)

Domestic roles and care and attention

1. A woman's most important job is to attend to domestic tasks and cook for her family
2. Only the mother is responsible for changing diapers, bathing, and feeding the baby
3. Only when a woman has a child does she become a real woman

Sexual relationships

1. Men need sex more than women do
2. The man must decide how the couple will have sex
3. You don't talk about sex, you just do it
4. Men are always ready to have sex
5. A man needs other women, even if the relationship with his wife is going well
6. A woman needs a man in order to be happy
7. Masturbation is a "guy thing"
8. A woman cannot refuse to have sex in the heat of the moment

Homophobia and relationships with other women or nonsexual relationships with other men

1. I am disgusted when I see a man acting like a woman
2. I would never have a gay friend
3. I would never have a lesbian friend
4. A woman and a man cannot be "just friends"
5. Women who have sex with other women should be ashamed of themselves

Roles in reproductive health and disease prevention (focus on condom use, monogamy, and reducing number of partners)

1. It would be too bold for a woman to ask her partner to use a condom

2. It is the woman's responsibility to avoid getting pregnant
3. A woman who carries a condom in her purse is "easy"
4. A woman would be out of line to ask her partner to get tested for HIV
5. The woman is the only one responsible for obtaining contraceptives
6. The man should decide whether to use a condom or not

Acceptance of violence

1. If a woman is unfaithful to her partner, the man has the right to beat her
2. There are times when a woman deserves to be beaten
3. A man may beat his wife if she refuses to have sex with him
4. A woman should tolerate violence to keep her family together
5. Violence in a relationship is the couple's problem and should not be discussed with other people
6. A woman cannot do anything to help a friend who lives in a violent relationship

Autonomy in decision making/action/rights

1. It is man who decides whether a woman can go out alone
2. The man should have the final say over household decisions
3. A woman should have the right to work outside the home, even when her husband disagrees

Scoring

- » The choices for responses are: (1) agree, (2) partially agree, and (3) disagree. The values assigned to these choices are: 1, 0.5, and 0, respectively.

- » Respondents who answer fewer than half of the items on the scale should not be included. In cases where respondents answer more than half the items but fail to complete the scale, “do not know” should be used to fill in the blank responses.
- » Scores can be calculated for the scale as a whole and/or for subscales.
- » A score for each respondent can be calculated by adding up the values (1, 0.5, and 0) corresponding to the responses given.
- » Scores for gender equity can be categorized in the following ranges: low (0–5.4), moderate (5.5–6.1), and high (6.2–6.8).

II. Personal Competence in Interpersonal Relations Index (14 items, alpha=0.7)

1. If a friend was beaten by her husband, I could not help her
 2. If my partner beats me, I am able to seek help
 3. I can report my partner if he forces me to have sex
 4. I am not able to organize community groups to solve local problems
 5. I can provide solutions for the lack of recreational areas in my community
 6. I can arrange a meeting with community members to combat violence against women
 7. I can organize a march to demand better health services in my community
 8. I can convince someone outside my community to help solve a local problem
 9. I feel capable of expressing my opinions even though I know others differ with them
 10. I would have sex with someone against my will in order not to lose him
 11. If I am in love, I cannot demand that my partner use a condom the first time we have sex
 12. If neither my partner nor I had a condom, we would have sex without a condom
 13. I am able to carry a condom in my purse without feeling uncomfortable
 14. I do not feel able to comfortably negotiate condom use with my partner
- Scoring
- » The choices for responses are: (1) agree, (2) partially agree, and (3) disagree. The values assigned to these choices are: 1, 0.5, and 0, respectively.
 - » Respondents who answer fewer than half of the items on the scale should not be included. In cases where respondents answer more than half the items but fail to complete the scale, “do not know” should be used to fill in the blank responses.
 - » Scores can be calculated for the scale as a whole and/or for subscales.
 - » A score for each respondent can be calculated by adding up the values (1, 0.5, and 0) corresponding to the responses given.
 - » Scores for personal competence can be categorized in the following ranges: low (0–.08), moderate (0.9–.16), and high (.17–. 19).



III. Evaluation of early results of the Interagency Program for Empowerment of Adolescent Girls (PIEMA)

El Salvador–2007

List of indicators, measurement themes, and questions from the qualitative surveys

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
At the end of the intervention, adolescent girls organized in production projects in the areas of intervention apply management tools	<ul style="list-style-type: none"> ➤ How did the girls come to be part of the production group? What are the characteristics of the production group or project? ➤ What were the steps that allowed them to come together as a group for the development of a production project? ➤ Before forming this group (production project), did they participate in another group in their area (church, youth, community organization, health facility, school)? ➤ What are the differences between that group and the newly formed group? (Ask about training processes.) ➤ Have they managed to maintain the membership of the group? What situations or issues cause people to leave the group? How does the group ensure that if one person leaves, the group's activities continue? ➤ What expectations have been generated around the group? 	ORGANIZATION
	<p>Participating in a group requires that all work for its benefit</p> <ul style="list-style-type: none"> ➤ What do you do for the welfare of your group? ➤ How does the group determine the activities that each person carries out? ➤ Can you carry out activities that initially were not your responsibility? ➤ How are decisions made on the products that the project will produce? Is that done on your own initiative or has the activity been designated? ➤ What needs to be done for the production project to be sustainable? How do you support this? ➤ What are the daily activities carried out by the production project? 	MANAGEMENT

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
At the end of the intervention, in the 13 adolescent girls' organizations, one or more of the members exercise leadership on their production project	<ul style="list-style-type: none"> ➤ Is there a person in the group who decides on activities to be carried out? Does this person determine who performs each activity? Describe the characteristics of this person. ➤ How are decisions made in the group on activities that each member should do? ➤ Do you recognize a leadership core within the group or, alternatively, do all members make the same contribution? ➤ What matters are decided within the group? What matters are decided with persons who are not part of the group? ➤ Does the group decide what activities to carry out or are these defined by other people? 	LEADERSHIP
By the end of the intervention, the life skills initiative has been developed with the adolescent girls in the production projects	<ul style="list-style-type: none"> ➤ When problems have arisen in the group, how were they solved? ➤ How are decisions made in the group with regard to payments for work and activities to be undertaken? ➤ How is the work of each group member evaluated? ➤ How are each member's activities monitored? Who does this monitoring? 	PERSONAL SKILLS
At the end of the intervention, the adolescent girls in the production projects have strengthened their teamwork skills and values	<ul style="list-style-type: none"> ➤ How do you define teamwork? According to this definition, does your group display teamwork? ➤ How does the group define which work should be done in teams? Is there support from others outside the group to complete the work as a team? Have you been trained to work as a team? ➤ What has teamwork allowed or enabled you to do? ➤ What limitations do you find in teamwork? 	TEAMWORK
	<ul style="list-style-type: none"> ➤ How do you define solidarity? What is solidarity? ➤ In your group, how is solidarity shown? ➤ During the time the organization has existed, what situations have occurred where there has been solidarity among group members? ➤ In your family, friends, neighborhood, school, or other places, is there an emphasis on the importance of solidarity? 	SOLIDARITY
	<ul style="list-style-type: none"> ➤ What is the current situation of the production project? ➤ Why do you think the production project is in this situation? ➤ How do you assess the participation of each of the group members in what has been achieved? 	COLLECTIVE EFFICACY

Continues

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
At the end of the intervention, the adolescent girls in the production projects have strengthened their teamwork skills and values	<ul style="list-style-type: none"> ➤ Is the production project recognized in other places? What is the evidence that there is such recognition? ➤ Have you managed to make the production project as successful as you expected? 	COLLECTIVE EFFICACY
	<ul style="list-style-type: none"> ➤ Do the members of the organization have the same information about the production project? ➤ How are the relations between the members of your organization? Do you share other spaces outside the production project? ➤ Do you recognize common goals for the production project? ➤ Within the group, do you have discussions of the pros and cons of different options for the production project? ➤ Have the difficulties and limitations of the production project been discussed within the group? 	COHESION

MODULE 1. Sexual and reproductive health (SRH)

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
By the end of the intervention, girls in the 13 localities have tools to allow them to improve and protect their health, with emphasis on SRH	SRH1. What can a person do to avoid getting a sexually transmitted infection?	ACQUISITION OF SKILLS-KNOWLEDGE
	SRH2. How is the virus that causes AIDS transmitted?	ACQUISITION OF SKILLS-KNOWLEDGE
	SRH3. Here is a list of phrases. Please say whether you AGREE, DISAGREE, ARE NOT SURE, or DO NOT KNOW. (<i>duties and rights</i>)	ATTITUDES
	SRH4. Can a girl get pregnant the first time she has sex?	ACQUISITION OF SKILLS-KNOWLEDGE
	SRH5. Do you think a woman should have her first child when she is an adolescent?	ACQUISITION OF SKILLS-KNOWLEDGE
	SRH6. Why or why not?	

Continues

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
By the end of the intervention, SRH services for adolescent girls are being offered in a local health unit	SRH7. Next I want to ask about the services of the health unit in your area.	INSTITUTIONAL SERVICES
	SRH8. Have you visited a health unit (clinic) in the last six months?	INSTITUTIONAL SERVICES
	SRH9. What was the reason for your last visit to a health unit?	INSTITUTIONAL SERVICES
	SRH10. Who attended you at the health unit?	INSTITUTIONAL SERVICES
	SRH11. Now I am interested in knowing how this person treated you.	INSTITUTIONAL SERVICES

Note: The component of practices was not addressed in the evaluation process and was excluded from the survey in the review with the facilitators on the UN technical team.

MODULE 2. Organization, leadership, and participation

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
At the end of the intervention, in the 13 adolescent girls' organizations, one or more of the members exercise leadership on their production project	ORG1. Do you belong to a group (organization)? ORG2. What group (organization) do you belong to? ORG3. When did you join the group?	PARTICIPATION
	ORG5. What are the reasons that do you not participate in any groups?	PARTICIPATION
CONTROL QUESTION	ORG4. What is the main benefit you seek from participation in this/these group(s)?	
At the end of the intervention, in the 13 adolescent girls' organizations, one or more of the members exercise leadership on their production project	ORG6. Now I want to ask you about some activities that you may or may not have done in the last 12 MONTHS.	LEADERSHIP
By the end of the intervention in the 13 localities, spaces for participation of adolescent girls have been strengthened	ORG7. Now I will ask a series of questions about your local institutions. (<i>making complaints, responses to requests, willingness to work with adolescents, linkages to these activities, ability to participate in making decisions about the family and the community</i>)	PARTICIPATION

Continues

MODULE 3. Gender-based violence

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
By the end of the intervention, adolescent girls in the production projects have strengthened their knowledge and attitudes for mitigating gender-based violence	VIO1. I am going to read a list of situations that could happen at any time. (<i>justifications for beating/attacking others</i>)	PERCEPTION OF VIOLENCE
	VIO2. Have you received information on how to seek protection and report cases of domestic violence?	INSTITUTIONS THAT RESPOND TO CASES
	VIO3. From whom did you receive information?	REPORTING CASES
	VIO4. Which of these institutions do you know offer attention in cases of domestic violence?	INSTITUTIONS THAT RESPOND TO CASES REPORTING CASES
By the end of the intervention, there is at least one girl in each area who has leadership skills and is focused on the prevention of gender-based violence	VIO5. Now I'm going to ask you about things that you may have done in the past 12 MONTHS. (<i>report having been a victim of physical violence, report sexual abuse, report abuse of a friend</i>)	REPORTING CASES
	VIO6. What would you do if you witnessed violence between a couple?	PERCEPTION OF VIOLENCE
By the end of the intervention, adolescent girls in the production projects have strengthened their knowledge and attitudes for mitigating gender-based violence	VIO7. Do you currently have a boyfriend, husband, or partner?	PERCEPTION OF VIOLENCE
	VIO8. How many times have the following situations occurred with your partner?	

MODULE 4. Conflict resolution and assertive communication

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
By the end of the intervention, the life skills initiative has been developed with the adolescent girls in the production projects	CON1. All people face conflicts and have different ways of dealing with them.	CONFLICT RESOLUTION ASSERTIVE COMMUNICATION
	CON2. IN THE LAST 12 MONTHS, as the result of the discussions (conflicts) in your family . . .	CONFLICTS
	CON3. In your opinion, why are there discussions (conflicts) in your family?	CONFLICTS
	CON4. During the past 12 months, when faced with a discussion (conflict) in your family, you . . .	CONFLICT RESOLUTION
	CON5. Sometimes people have problems with acquaintances or strangers, sometimes because they are in a bad mood or for some other reason.	CONFLICTS ASSERTIVE COMMUNICATION
	CON6. I'll read a series of situations that can occur at any time. Please say whether each one has happened to you in the LAST 12 MONTHS. Please answer yes or no.	ASSERTIVE COMMUNICATION

MODULE 5. Personal skills

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
By the end of the intervention, the life skills initiative has been developed with the adolescent girls in the production projects	SKL1. I'm going to read a number of sentences. Thinking of yourself, please tell me if you do this ALWAYS, ALMOST ALWAYS, SOMETIMES, SELDOM, or NEVER.	AUTONOMY SELF-ESTEEM ASSERTIVE COMMUNICATION
	SKL2 and SKL3. I want to ask you about the confidence you have in different institutions in your community.	CONFIDENCE
At the end of the intervention, in the 13 adolescent girls' organizations, one or more of the members exercise leadership on their production project	SKL4. In the past 12 months, have you worked with others to do something for your community? SKL5. What were the three main activities in which you participated?	COHESION SOLIDARITY COLLECTIVE EFFICACY

Continues

INDICATOR	SURVEY QUESTIONS	MEASUREMENT AREA
INCLUDED AS PART OF THE REQUIREMENTS OF ONE OF THE AGENCIES	SKL6. Do you know of institutions working to raise awareness of the rights of children and adolescents?	EXISTENCE OF PARTICIPATION
	SKL7. What institutions do you know that work on the issue of human rights of children and adolescents?	ACQUISITION OF SKILLS AND KNOWLEDGE
	SKL8. Do you know any of the rights of youth and adolescents? SKL9. Mention the rights you know.	ACQUISITION OF SKILLS AND KNOWLEDGE
	SKL10. Do you know any local institutions that offer employment opportunities to adolescents? SKL11. What institutions do you know?	EXISTENCE OF PARTICIPATION

MODULE 6. Recognition of the program

Were there PIEMA program activities in your community?
Did you hear that adolescent girls were called to participate in PIEMA activities?
Were you informed about the objectives of the program and the organizations involved?
Did you participate in the sexual and reproductive health day organized by PIEMA?
Did you participate in training and recreational workshops on family violence organized by PIEMA?
Did you participate in PIEMA training on teamwork, assertive communication, self-esteem, and life planning?
Did you participate in workshops to train “young multipliers” on issues of sexuality and reproduction? (health unit)
Are you part of the multipliers group on issues of sexuality and reproduction?
Did you receive training for forming the production project?
Did participating in the program lead to changes in your life?
Did your family change the image they had of you?
With the program in your community, did you notice any changes in the institutions that work with adolescents?
In terms of the program in your community, were adolescent girls given opportunities for participation?
Since the end of the program, has the organization continued among adolescent girls?
Since the end of the program, have institutions in your community continued their activities?
Since the end of the program, is there recognition of the work done by adolescent girls in your community?



References

- 1 Levine, R., Lloyd, C., et al. 2008. *Girls Count: A Global Investment and Action Agenda*.
- 2 Rudolph 2002, cited in Breinbauer, C., and Maddaleno, M., *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents* (PAHO, 2005). p. 269
- 3 See <http://www.paho.org/english/gov/cd/cd48.r5-e.pdf> for the Regional Strategy.
- 4 Rudolph 2002, cited in Breinbauer, C., and Maddaleno, M., *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents* (PAHO, 2005). p.269
- 5 See <http://www.paho.org/english/gov/cd/cd48.r5-e.pdf> for the Regional Strategy.
- 6 PAHO. 2005. PAHO Gender Equality Policy, 46th Directing Council Resolution, CD46/R16. <http://www.paho.org/english/gov/cd/CD46.r16-e.pdf>.
- 7 Rudolph 2002, cited in Breinbauer, C., and Maddaleno, M., *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents* (PAHO, 2005). p. 269.
- 8 Gilligan, C. In *a Different Voice: Psychological Theory and Women's Development*. Harvard University Press, 1993. Taylor, J. M., Gilligan, C., and Sullivan, A. M. *Between Voice and Silence: Women and Girls, Race and Relationship*. Harvard University Press. Cambridge, Massachusetts. 1995.
- 9 Gilligan, C. In *a Different Voice: Psychological Theory and Women's Development*. Harvard University Press, 1993.
- 10 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*.
- 11 Levine, R., Lloyd, C., et al. 2008. *Girls Count: A Global Investment and Action Agenda*.
- 12 UN. 2008. *World Population Prospects: The 2008 Revision*. United Nations Population Division. <http://esa.un.org/unpp/index.asp?panel=2>.
- 13 ECLAC and UNICEF. 2007. *Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective*. "Teenage Motherhood in Latin America and the Caribbean: Trends, Problems and Challenges." Number 4, January 2007, Santiago de Chile.
- 14 PAHO database of country reports on HIV/AIDS infection, FCH/A Project.
- 15 Subbarao, K., and Raney, Laura. *Social Gains from Female Education: A Cross-National Study*. World Bank Discussion Paper 194.
- 16 UNAIDS. 2005. *The Global Coalition on Women and AIDS. Educate Girls, Fight AIDS*. http://data.unaids.org/GCWA/gcwa_fs_girlseducation_sep05_en.pdf.
- 17 Basic Education Coalition. 2004. *Teach a Child, Transform a Nation*. Washington; and World Bank 2002: *World Development Indicators*. Washington. Cited in Save the Children. 2005. *State of the World's Mothers*. Westport, CT.
- 18 Weili Ding, and Lehrer, Steven, et al. 2006. *The Impact of Poor Health on Education: New Evidence Using Genetic Markers*. <http://www.nber.org/papers/w12304>.

- 19 Schutt-Aine, J., and Maddaleno, M. 2003. Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications. PAHO, Washington, DC. <http://www.paho.org/english/hpp/hpf/adol/srh.pdf>.
- 20 UNFPA. 2005. State of World Population 2005. p. 50. <http://www.unfpa.org/swp/2005/index.htm>.
- 21 WHO. 2000. Child Mortality. The Challenge Now. [http://www.who.int/bulletin/archives/78\(10\)1174.pdf](http://www.who.int/bulletin/archives/78(10)1174.pdf).
- 22 UNAIDS. Inter-Agency Task Team (IATT) on HIV and Young People. Global Guidance Briefs.
- 23 World Bank. 2003. Gender Equality and the Millennium Development Goals.
- 24 PAHO. 2005. PAHO Gender Equality Policy, 46th Directing Council Resolution, CD46/R16. <http://www.paho.org/english/gov/cd/CD46.r16-e.pdf>.
- 25 Rudolph 2002, cited in Breinbauer, C., and Maddaleno, M., Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents (PAHO, 2005). p.269
- 26 Gilligan, C. In a Different Voice: Psychological Theory and Women's Development. Harvard University Press, 1993. Taylor, J. M., Gilligan, C., and Sullivan, A. M. Between Voice and Silence: Women and Girls, Race and Relationship. Harvard University Press. Cambridge, Massachusetts. 1995.
- 27 Gilligan, C. In a Different Voice: Psychological Theory and Women's Development. Harvard University Press, 1993.
- 28 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 29 Levine, R., Lloyd, C., et al. 2008. Girls Count: A Global Investment and Action Agenda.
- 30 UN. 2008. World Population Prospects: The 2008 Revision. United Nations Population Division. <http://esa.un.org/unpp/index.asp?panel=2>.
- 31 ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "Teenage Motherhood in Latin America and the Caribbean: Trends, Problems and Challenges." Number 4, January 2007, Santiago de Chile.
- 32 PAHO database of country reports on HIV/AIDS infection, FCH/A Project.
- 33 PAHO. n.d. Women, Health and Development Program. Gender Equity in Health. www.paho.org/english/hdp/hdw/GEHPaper.pdf.
- 34 PAHO. 2005. PAHO Gender Equality Policy, 46th Directing Council Resolution, CD46/12. <http://www.paho.org/english/gov/cd/CD46.r16-e.pdf>.
- 35 Ibid.
- 36 Organization for Economic Cooperation and Development (OECD), 1999. DAC Guidelines for Gender Equality and Women's Empowerment in Development Cooperation. <http://www.oecd.org/dataoecd/56/46/28313843.pdf>.
- 37 Whitehead, M. 1990. The Concepts and Principles of Equity and Health. Document Eur/ICP/rPD/414. WHO Office for Europe, Copenhagen.
- 38 Gómez, Elsa. 2001. Taller Internacional Cuentas Nacionales de Salud y Género. 18–19 October 2001, Santiago de Chile. PAHO/WHO, Fondo Nacional de Salud (FONASA).
- 39 World Bank. 2006. World Development Report 2006: Equity and Development. Washington, DC.
- 40 Gilligan, C. In a Different Voice: Psychological Theory and Women's Development. Harvard University Press, 1993.

- 41 Narayan, D. 2005. "Conceptual Framework and Methodological Challenges" in D. Narayan (ed.) *Measuring Empowerment: Cross-Disciplinary Perspectives*. World Bank. Washington DC.
- 42 Maddaleno, M., and La Rosa, Liliana. 2008. Empoderamiento de las adolescentes, condición para el desarrollo. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- 43 UN. 2005. Proyecto del Milenio de las Naciones Unidas, Grupo de Trabajo sobre Educación e Igualdad de Género, 2005.
- 44 Ministerial Declaration. 1st Meeting of Ministers of Health and Education to Stop HIV and STIs in Latin America and the Caribbean. Preventing through education. http://www.summit-americas.org/Newsletter/2008/Mini_Health_Education_0808.pdf.
- 45 La discriminación laboral y de edad de las mujeres en las maquilas textiles guatemaltecas. <http://www.business-humanrights.org/Links/Repository/920377>.
- 46 UNICEF. 2008. Op. Cit. p. 2.
- 47 Ibid., p. 4.
- 48 Ibid., p. 5.
- 49 Breinbauer, C., and Maddaleno, M. 2005. *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents*. Pan American Health Organization.
- 50 Santrock, John. 2001. *Adolescence*. Chapter 11: Gender. New York: McGraw Hill.
- 51 Breinbauer, C., and Maddaleno, M. 2005. *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents*. Pan American Health Organization.
- 52 Nolen, et al., cited in Breinbauer, C., and Maddaleno, M. 2005. *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents*. Pan American Health Organization. p. 269
- 53 Rudolph 2002, cited in Breinbauer, C., and Maddaleno, M., *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents (PAHO, 2005)*. p. 269
- 54 Machoian, L. *The Disappearing Girl: Learning the Language of Teenage Depression*. Dutton New York; 2005. Gilligan, C. *In a Different Voice: Psychological Theory and Women's Development*. Harvard University Press, 1993. Brown, L. M. *Girlfighting: Betrayal and Rejection Among Girls*. New York University Press. 2003.
- 55 Breinbauer, C., and Maddaleno, M. 2005. *Youth: Choices and Change: Promoting Healthy Behaviors in Adolescents*. Pan American Health Organization.
- 56 Tanner, J. M. *Sequence, Tempo, and Individual Variation in Growth and Development of Boys and Girls Aged Twelve to Sixteen*. Institute of Child Health, London, England. In Muus, R. E. 1990. *Adolescent Behavior and Society: A Book of Readings*. 4th ed. New York: McGraw Hill.
- 57 Plan International. 2007. *Because I Am a Girl. The State of the World's Girls 2007*.
- 58 Camacho, Ana Lorena. 2003. Reflexiones preliminares en torno al empoderamiento. <http://www.alforja.or.cr/centros/cep/documentos/poderyempoderamiento.pdf>.
- 59 Population Council. 2005. M. J. Ruiz. In: *Relatoría de la reunión sobre "Estrategias multisectoriales innovadoras para satisfacer las necesidades de las jóvenes indígenas y de otras/os adolescentes vulnerables."* Antigua, Guatemala, 1–2 December 2005. http://hivaidsclearinghouse.unesco.org/search/resources/santiago_relatoriamar3.pdf.
- 60 Santrock, John. 2001. *Adolescence*. New York: McGraw Hill.
- 61 PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health (CD48/8)*. p. 8. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.

- 62 Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. “Convention of Belém do Pará.” <http://www.oas.org/juridico/english/sigs/a-61.html>, and UN. 1993. Declaration on the Elimination of Violence against Women. <http://www.un.org/documents/ga/res/48/a48r104.htm>.
- 63 World Bank, 1993. In Heise, Lori L., Pitanguy, J., Germain, A. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank, Washington, DC.
- 64 World Bank, 1993. In Heise, Lori L., Pitanguy, J., Germain, A. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank, Washington, DC.
- 65 Claramunt, María Cecilia. 2000. Abuso sexual en mujeres adolescentes. <http://www.paho.org/spanish/hdp/hdw/gph9.pdf>.
- 66 García-Moreno, C. 2000. *Violencia contra la mujer. Género y equidad en la salud*. PAHO, Harvard Center for Population and Development Studies. p. 18. Boston.
- 67 Gomes, Cristina. 2007. Análisis de situación de población América Latina y Caribe. *Diversidad y desigualdades*. UNFPA. p. 161. <http://lac.unfpa.org/public/pid/2504>.
- 68 *A Portrait of Adolescent Health in the Caribbean, 2000*. WHO Collaborating Center on Adolescent Health, University of Minnesota, Minneapolis. In: PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health (CD48/8)*. p. 9. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 69 Neinstein, Lawrence. *Adolescent Health Care*. 5th ed.
- 70 Plan International. 2007. *Because I Am a Girl: The State of the World’s Girls 2007*
- 71 Decker, Michele, Silverman, Jay, et al. Dating Violence and Sexually Transmitted Disease/ HIV Testing and Diagnosis among Adolescent Females. *Pediatrics* vol. 116 No. 2 August 2005, pp. e272–e276.
- 72 PAHO. 2008. *Estudio de Evaluación de los Servicios de Cobertura de Servicios de Prevención del VIH en adolescentes y jóvenes, Tegucigalpa, Honduras*.
- 73 PAHO. 2008. *Estudio de Evaluación de los Servicios de Cobertura de Servicios de Prevención del VIH en adolescentes y jóvenes, Tegucigalpa, Honduras*.
- 74 Sorensen, Bente, “Medidas para enfrentar la explotación sexual comercial de niños, niñas y adolescentes.” In ILO et al. 2004. *Foro Internacional sobre el Combate a la Explotación Sexual Comercial Infantil*. México, p.13.
- 75 Instituto Interamericano del Niño. 2002. *La explotación sexual de niños, niñas y adolescentes en América Latina*. Montevideo. p. 2.
- 76 Malhotra, A. 2003. *Conceptualizing and Measuring Women’s Empowerment as a Variable in International Development*.
- 77 CISALVA. 2007. *Informe Final de Evaluación del PIEMA*. Universidad del Valle, Cali, Colombia.
- 78 World Bank. 2003. *Gender Equality and the Millennium Development Goals*.
- 79 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*.
- 80 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*.
- 81 UNIFEM. 2008. *Making the MDGs Work for All*. http://www.unifem.org/attachments/products/Making_MDGs_work_for_all_complete.pdf.
- 82 Calculation by M. Ordorica on the basis of data from UN. 2008. *World Population Prospects: The 2008 Revision*. United Nations Population Division. <http://esa.un.org/unpp/>

- index.asp?panel=2. Also see ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 83 ECLAC. 2008. Youth and Social Cohesion in Ibero-America: A Model in the Making. <http://www.eclac.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/0/35370/P35370.xml>.
- 84 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 85 CEPAL. 2008. Progresos en la reducción de la pobreza extrema en america latina. pp. 33 and 108. http://www.eclac.cl/publicaciones/xml/6/33936/PobrezaExtrema_CapituloII.pdf.
- 86 *Ibid.*, p. 133.
- 87 *Ibid.*, p. 133.
- 88 *Ibid.*, p. 61
- 89 *Ibid.*, p. 66.
- 90 PAHO. 2008. Malnutrition in Infants and Young Children in Latin America and the Caribbean: Achieving the Millennium Development Goals. http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=1204&Itemid=.
- 91 World Bank. 2006. Cited in Roses, Mirta, Determinantes psicosociales y ambientales en el desarrollo de la juventud iberoamericana. PAHO/WHO.
- 92 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 93 *Ibid.*
- 94 *Ibid.*
- 95 *Ibid.*
- 96 *Ibid.*
- 97 Chaparro, C. M., Lutter, C. K. n.d. Anemia among Adolescent and Young Adult Women in Latin America and the Caribbean: A Cause for Concern. Washington, DC. Cited in PAHO. 2008. Regional Strategy for Improving Adolescent and Youth Health (CD48/8). p. 10. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 98 *Ibid.*, p. 10.
- 99 Chaparro, C. M., Lutter, C. K. n.d. Anemia among Adolescent and Young Adult Women in Latin America and the Caribbean: A Cause for Concern. PAHO. p. 1. http://new.paho.org/hq/index2.php?option=com_docman&task=doc_download&gid=2424&itemid=646.
- 100 Khan K. S., Wojdyla D., Say L., Gulmezoglu A. M., Van Look P. F. A. WHO Analysis of Causes of Maternal Death: A Systematic Review. *Lancet* 2006;367:1066–1074. Cited in Chaparro, C. M., Lutter, C. K. Anemia among Adolescent and Young Adult Women in Latin America and the Caribbean: A Cause for Concern. PAHO. p. 2. http://new.paho.org/hq/index2.php?option=com_docman&task=doc_download&gid=2424&itemid=646.
- 101 WHO Statistical Information System (WHOSIS). Mortality database. Table 1: “Number of registered deaths.” Ecuador 2000, Peru 2000, El Salvador 1999, México 2001, Uruguay 2000. http://www3.who.int/whosis/mort/table1.cfm?path=whosis,mort,mort_table1&language=english.
- 102 Schmelkes, S. Comentarios en el lanzamiento del Informe Mundial de la Infancia 2006 de UNICEF.
- 103 Plan International. 2007. Because I Am a Girl: The State of the World’s Girls 2007.
- 104 UN. 2008. Situación y Desafíos de la Juventud en Iberoamérica. Una Contribución del Sistema de Naciones Unidas de El Salvador bajo la supervisión técnica de la CEPAL. p. 6.

- 105 UN. 2008. Situación y Desafíos de la Juventud en Iberoamérica. Una Contribución del Sistema de Naciones Unidas de El Salvador bajo la supervisión técnica de la CEPAL. p. 6.
- 106 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 107 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 108 Burnett, N. 2007. Educación para todos en 2015 ¿Alcanzaremos la meta? Informe de seguimiento de la Educación para Todos (EPT) en el Mundo. Resumen. En: Perfiles Educativos. Vol. XXIX. Number 118. Universidad Nacional Autónoma de México, México, D.F. p. 94.
- 109 UNESCO. 2008. Education for All by 2015. Will We Make It? EFA Global Monitoring Report. Summary. Paris.
- 110 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective.
- 111 Save the Children. 2005. State of the World's Mothers. Westport, CT.
- 112 Office of the High Commissioner for Human Rights. 2006. Report of the Special Rapporteur on the right to education, V. Muñoz Villalobos. Girls' Right to Education. http://ap.ohchr.org/documents/dpage_e.aspx?m=99.
- 113 *Ibid.*, p. 21.
- 114 *Ibid.*, p. 119.
- 115 <http://www.thelancet.com/journals/lancet/article/PIIS0140673605178726/fulltext>.
- 116 Basic Education Coalition. 2004. Teach a Child, Transform a Nation. Washington; and World Bank 2002: World Development Indicators. Washington. Cited in Save the Children. 2005. State of the World's Mothers. Westport, CT. p. 11.
- 117 UNAIDS. 2005. The Global Coalition on Women and AIDS. Educate Girls, Fight AIDS. http://data.unaids.org/GCWA/gcwa_fs_girlseducation_sep05_en.pdf.
- 118 World Bank. 2004. Cited in Save the Children. 2005. State of the World's Mothers. Westport, CT. p. 11.
- 119 Weili Ding, and Lehrer, Steven, et al. 2006. The Impact of Poor Health on Education: New Evidence Using Genetic Markers. <http://www.nber.org/papers/w12304>.
- 120 UNFPA. 2003. State of World Population 2003. p. 27. <http://www.unfpa.org/swp/2003>.
- 121 Studies by the Population Council and UNFPA cited in Plan International. 2007. Because I Am a Girl: The State of the World's Girls 2007. p. 45.
- 122 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. pp. 111–115.
- 123 *Ibid.*, p. 116.
- 124 *Ibid.*, p. 113.
- 125 UN. 2008. Situación y Desafíos de la Juventud en Iberoamérica. Una Contribución del Sistema de Naciones Unidas de El Salvador bajo la supervisión técnica de la CEPAL.
- 126 Cynthia Boyd. Cited in Roses, Mirta. Determinantes psicosociales y ambientales en el desarrollo de la juventud iberoamericana. PAHO/WHO. p. 5.
- 127 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 87.
- 128 *Ibid.*, p. 88.
- 129 UN. 2008. Situación y Desafíos de la Juventud en Iberoamérica. Una Contribución del Sistema de Naciones Unidas de El Salvador bajo la supervisión técnica de la CEPAL. p. 8.

- 130 UN. 2005. Proyecto del Milenio de las Naciones Unidas, Grupo de Trabajo sobre Educación e Igualdad de Género, 2005.
- 131 Instituto Mexicano de la Juventud y Secretaría de Educación Pública. 2008. Encuesta Nacional de Violencia en las Relaciones de Noviazgo 2007. Executive summary, pp. 14–15. Mexico City. http://www.imjuventud.gob.mx/contenidos/programas/encuesta_violencia_2007.pdf.
- 132 Cáceres, C. F., Vanoss, M. B., and Hudes, S. 2000. “Sexual Coercion among Youth and Young Adults in Lima, Peru.” *Journal of Adolescent Health*, Nov., 27 (5). Cited in Schutt-Aine, J., and Maddaleno, M. 2003. *Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications*. p. 14. PAHO, Washington, DC.
- 133 WHO Collaborating Center on Adolescent Health, University of Minnesota/Pan American Health Organization. 2000. A Portrait of Adolescent Health in the Caribbean. Cited in Schutt-Aine, J., and Maddaleno, M. 2003. *Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications*. p. 14. PAHO, Washington, DC.
- 134 UNFPA. 2005. Salud sexual y reproductiva en el comienzo del siglo XXI en América Latina y el Caribe. p. 59. <http://lac.unfpa.org/public/cache/offonce/pid/838>.
- 135 *Ibid.*
- 136 PAHO. 1999. Para vivir sin violencia: Dimensiones del problema compromisos de solución. Women, Health and Development Program. Division of Health and Human Development. Cited in Schutt-Aine, J., and Maddaleno, M. 2003. *Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications*. p. 14. PAHO, Washington, DC.
- 137 WHO. 2000. Child Mortality. The Challenge Now. [http://www.who.int/bulletin/archives/78\(10\)1174.pdf](http://www.who.int/bulletin/archives/78(10)1174.pdf).
- 138 *Ibid.*, p. 150.
- 139 WHO. 2005. The World Health Report 2005: Make Every Mother and Child Count.
- 140 Cited in Roses, Mirta, Determinantes psicosociales y ambientales en el desarrollo de la juventud iberoamericana. p.3.
- 141 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. pp. 144–145.
- 142 *Ibid.*, p. 145.
- 143 *Ibid.*, p. 146.
- 144 UNFPA. 2005. State of World Population 2005. p. 50. <http://www.unfpa.org/swp/2005/>.
- 145 WHO. 2000. Child Mortality. The Challenge Now. [http://www.who.int/bulletin/archives/78\(10\)1174.pdf](http://www.who.int/bulletin/archives/78(10)1174.pdf).
- 146 PAHO. 2007. Proposed Strategic Plan 2008–2012. p. 51. <http://www.paho.org/french/gov/csp/od328-full-e.pdf>.
- 147 Plan International. 2007. Because I Am a Girl: The State of the World’s Girls 2007. p. 28.
- 148 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 154.
- 149 World Health Organization. The Global Burden of Disease: 2004 Update. (2008 publication of the set of updated data for 2004). http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html.
- 150 UNFPA. 2005. Op. Cit. p. 171.

- 151 WHO. 2007. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*. 5th edition. Geneva.
- 152 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 154.
- 153 PAHO. 2007. *Health in the Americas*. Scientific and Technical Publication No. 622. pp. 177–181. Washington, DC. <http://www.paho.org/HIA/index.html>.
- 154 PAHO. 2007. *Proposed Strategic Plan 2008–2012*. p. 51. <http://www.paho.org/french/gov/csp/od328-full-e.pdf>.
- 155 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 151.
- 156 *Ibid.*, p. 152.
- 157 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 154.
- 158 PAHO. 2007. *Health in the Americas*. Scientific and Technical Publication No. 622. Washington, DC. Cited in PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health (CD48/8)*. p. 9. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 159 PAHO. 2007. *Health in the Americas*. Scientific and Technical Publication No. 622. pp. 177–181. Washington, DC. <http://www.paho.org/HIA/index.html>.
- 160 PAHO, cited in ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 152.
- 161 United States Centers for Disease Control and Prevention, Division of Reproductive Health; United States Agency for International Development. *Reproductive, Maternal, and Child Health in Central America: Trends and Challenges Facing Women and Children: El Salvador, Guatemala, Honduras, Nicaragua*. Atlanta: CDC/USAID, 2005. Cited in PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health (CD48/8)*. p. 8. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 162 Guttmacher Institute. *Early Childbearing in Nicaragua: A Continuing Challenge*. In Brief, 2006 Series, No. 3, 4, and 5). Cited in PAHO. 2008. *Regional Strategy for Improving Adolescent and Youth Health (CD48/8)*. p. 9. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 163 PAHO. 2007. *Proposed Strategic Plan 2008–2012*. p. 51. <http://www.paho.org/french/gov/csp/od328-full-e.pdf>.
- 164 *Ibid.*
- 165 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 157.
- 166 *Ibid.*, pp. 157–158.
- 167 *Ibid.*, p. 157.
- 168 *Ibid.*, p. 2.
- 169 Global Health Council, 2004. *Commitments: Youth Reproductive health, the World Bank, and the Millennium Development Goals*. Washington, DC.
- 170 UNAIDS. 1999. “AIDS—5 Years Since ICPD.” Cited in PAHO. n.d. *Women, Health and Development Program fact sheet. Gender and HIV/AIDS*. <http://www.paho.org/English/ad/ge/GenderandHIVFactSheetI.pdf>.
- 171 “Women and HIV/AIDS.” WHO fact sheet 242. 2000. Cited in PAHO. n.d. *Women, Health and Development Program fact sheet. Gender and HIV/AIDS*. <http://www.paho.org/English/ad/ge/GenderandHIVFactSheetI.pdf>.

- 172 Cited in ECLAC and UNICEF. 2008. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "Children and HIV/AIDS in Latin America and the Caribbean." Number 7, July 2008, p. 2. Santiago de Chile.
- 173 Grown et al. 2005. Taking action to improve women's health through gender equality and women's empowerment. *The Lancet*, 2005. Cited in Plan International. 2007. *Because I Am a Girl: The State of the World's Girls 2007*. p. 82.
- 174 UNAIDS/WHO, 2004. In ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 155.
- 175 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 155.
- 176 UNAIDS. Inter-Agency Task Team (IATT) on HIV and Young People. *Global Guidance Briefs*. p. 158.
- 177 UNAIDS/WHO, Report on the Global AIDS Epidemic, July 2007.
- 178 UNAIDS. Inter-Agency Task Team (IATT) on HIV and Young People. *Global Guidance Briefs*.
- 179 PAHO database of country reports on HIV/AIDS infection, FCH/A Project.
- 180 UNAIDS/WHO, Report on the Global AIDS Epidemic, July 2008.
- 181 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 157.
- 182 UNFPA/EAT, 2004. Cited in ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 157.
- 183 *Ibid.*, pp. 157–158.
- 184 PAHO. 2008. Regional Strategy for Improving Adolescent and Youth Health (CD48/8). p. 7. <http://www.paho.org/english/gov/cd/cd48-08-e.pdf>.
- 185 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 158.
- 186 ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "The Right of Children and Adolescents to a Healthy Environment: A Diagnosis from Latin America and the Caribbean." Number 5, July 2007, p. 4. Santiago de Chile.
- 187 *Ibid.*, p. 2.
- 188 UNIFEM. 2003. *Mujer, medio ambiente, agua: Reflexiones sobre la promoción y protección del derecho de las mujeres al agua*. www.cinu.org.mx/eventos/agua/presUNIFEM.doc
- 189 ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "The Right of Children and Adolescents to a Healthy Environment: A Diagnosis from Latin America and the Caribbean." Number 5, July 2007, p. 11. Santiago de Chile.
- 190 *The Lancet*. 2009. vol. 373, May 16, 2009. <http://www.thelancet.com>.
- 191 UNDP. 2008. *Guía Recursos de Género para el Cambio Climático*. México. http://www.undp.org.mx/spip.php?page=publicacion&id_article=350.
- 192 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 283.
- 193 ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 285.
- 194 Cited in ECLAC. 2005. *The Millennium Development Goals: A Latin American and Caribbean Perspective*. p. 285.

- 195 ECLAC and UNICEF. 2007. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "The Right of Children and Adolescents to a Healthy Environment: A Diagnosis from Latin America and the Caribbean." Number 5, July 2007, p. 12. Santiago de Chile.
- 196 *Ibid.*, p. 12.
- 197 *Ibid.*, p. 12.
- 198 *Ibid.*, p. 6.
- 199 Grupo de Trabajo Interagencial de las Naciones Unidas sobre las Mujeres Adolescentes, Planificación mundial conjunta para las adolescentes marginalizadas (2009–2011) en desarrollo. Other examples at the global level include "The Girl Fund" and "Adolescent Girls Initiative." <http://www.unfoundation.org/donate/the-girl-fund.html> and <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:21914520~menuPK:336874~pagePK:64020865~piPK:51164185~theSitePK:336868,00.html>.
- 200 Levine, R., Lloyd, C., et al. 2008. Girls Count: A Global Investment and Action Agenda.
- 201 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 218.
- 202 Weller, J. 2006. Inserción laboral de jóvenes: expectativas, demanda laboral y trayectorias. Boletín redEtis no. 5. Preliminary version presented at the regional workshop "Estrategias educativas y formativas para la inclusión social y productiva," 14–15 November 2005, Mexico City, organized by redETis (Red latinoamericana sobre educación, trabajo e inserción social), DIE-Cinvestav, Colegio Mexiquense, and the Mexican Secretariat of Education.
- 203 Vilardo, Valeria. 2008. Mujeres, TIC y transparencia. Presentation at "III Foro de mujeres contra la Corrupción," September 29 to October 1, 2008, Buenos Aires. <http://www.artemisanoticias.com.ar/site/notas.asp?id=46&idnota=6173>.
- 204 Study of 44 countries, including several in the Region of the Americas: Costa Rica, Brazil, Mexico, Chile, Bermuda, Canada, and the United States. ITU. 2008. Use of ITC by the World's Children and Youth. pp. 41–42. http://www.itu.int/ITU-D/ict/material/Youth_2008.pdf.
- 205 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 218.
- 206 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 222.
- 207 Director of the ILO Bureau for Gender Equality.
- 208 ILO. 2007. Decent Work and Youth: Latin America. p. 293. [http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional\[ingles\].pdf](http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional[ingles].pdf).
- 209 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 294.
- 210 In Levaggi, Virgilio. 2008. Día Internacional juventud femenina latinoamericana. Report. http://portal.oit.or.cr/index.php?option=com_content&task=view&id=297&Itemid=184.
- 211 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 218.
- 212 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 218.
- 213 ILO. 2007. Decent Work and Youth: Latin America. pp. 87–89. [http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional\[ingles\].pdf](http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional[ingles].pdf).

- 214 Levaggi, Virgilio. 2008. Día Internacional juventud femenina latinoamericana. Report. http://portal.oit.or.cr/index.php?option=com_content&task=view&id=297 &Itemid=184.
- 215 ILO. 2007. Decent Work and Youth: Latin America. p. 47. [http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional\[ingles\].pdf](http://white.oit.org.pe/tdj/informes/pdfs/tdj_informe_regional[ingles].pdf).
- 216 ILO. 2009. Las tecnologías de la información y la comunicación TIC & género—una brecha digital a superar. <http://www.cinterfor.org.uy/public/spanish/region/ampro/cinterfor/temas/gender/temas/tic/indexa.htm>.
- 217 ECLAC. 2005. The Millennium Development Goals: A Latin American and Caribbean Perspective. p. 106.
- 218 World Bank. 2006. Third International Conference on Conditional Cash Transfers. <http://web.worldbank.org/WBSITE/EXTERNAL/WBI/WBIPROGRAMS/SPLP/0,,contentMDK:20892674~pagePK:64156158~piPK:64152884~theSitePK:461654,00.html>.
- 219 <http://www.presidencia.gob.mx/programas/?contenido=34798>.
- 220 ECLAC. 2002. Social Panorama of Latin America 2001–2002. Santiago, Chile. <http://www.cepal.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/5/11245/P11245.xml>.
- 221 ECLAC. 2002. Social Panorama of Latin America 2001–2002. Santiago, Chile. <http://www.cepal.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/5/11245/P11245.xml>.
- 222 See Creed-Kanashiro, H. M., Uribe, T. G., Bartolini, R. M., et al. Improving dietary intake to prevent anemia in adolescent girls through community kitchens in a periurban population of Lima, Peru. *J Nutr* 2000;130:459S–461S. <http://jn.nutrition.org/cgi/reprint/130/2/459S>.
- 223 *Ibid.*
- 224 Subbarao, K., and Raney, Laura. Social Gains from Female Education: A Cross-National Study. World Bank Discussion Paper 194.
- 225 UNAIDS. 2005. The Global Coalition on Women and AIDS. Educate Girls, Fight AIDS. http://data.unaids.org/GCWA/gcwa_fs_girlseducation_sep05_en.pdf.
- 226 Basic Education Coalition. 2004. Teach a Child, Transform a Nation. Washington; and World Bank 2002: World Development Indicators. Washington. Cited in Save the Children. 2005. State of the World’s Mothers. Westport, CT. p. 11.
- 227 Weili Ding, and Lehrer, Steven, et al. 2006. The Impact of Poor Health on Education: New Evidence Using Genetic Markers. <http://www.nber.org/papers/w12304>.
- 228 Schutt-Aine, J., and Maddaleno, M. 2003. Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications. p. 47. PAHO, Washington, DC. <http://www.paho.org/english/hpp/hpf/adol/srh.pdf>.
- 229 Carlson, Beverly. Achieving Educational Quality: What Schools Teach Us. Learning from Chile’s P900 Primary Schools. Productive Development Series, No. 64. ECLAC. <http://www.eclac.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/4/4634/P4634.xml>.
- 230 http://data.unaids.org/pub/BaseDocument/2008/20080801_minsterdeclaration_en.pdf.
- 231 In Ruiz, M. J. 2008. El proyecto Abriendo Oportunidades para Mujeres Jóvenes Indígenas en Guatemala. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.
- 232 CISALVA. 2007. Informe Final de Evaluación del PIEMA. Universidad del Valle, Cali, Colombia.
- 233 Rocha, B. 2008. Programa M. Trabajando con mujeres jóvenes. <https://portal.paho.org/sites/fch/Ca/WS/empoderamiento/pages/Biblioteca.aspx>.

- 234 Promundo. 2008. Programa M. Working with Young Women: Empowerment, Rights, and Health. p. 137. <http://www.promundo.org.br/wp-content/uploads/2010/03/trabalhando-com-mulheres-jovens-ingles.pdf>.
- 235 UNFPA. 2005. State of World Population 2005. p. 50. <http://www.unfpa.org/swp/2005/>.
- 236 WHO. 2000. Child Mortality. The Challenge Now. [http://www.who.int/bulletin/archives/78\(10\)1174.pdf](http://www.who.int/bulletin/archives/78(10)1174.pdf).
- 237 See: PAHO. Community IMCI. Conceptual Framework. April 2006. http://www.paho.org/spanish/ad/fch/ca/fs2_english.pdf. PAHO. 2006. Community IMCI: The Engendering of Social Empowerment in Chao, Peru. April 2006. http://www.paho.org/spanish/ad/fch/ca/fs1_english.pdf.
- 238 Instituto Mexicano del Seguro Social (IMSS)/Programa Oportunidades, Thais, A. C., UNFPA. 2007. CARA: Ocho años de experiencia con adolescentes rurales e indígenas. Mexico City.
- 239 For more information contact mruiz@popcouncil.org.
- 240 See: <http://orgs.tigweb.org/12089>.
- 241 UNICEF. Maternidad Segura. See http://www.unicef.org/peru/spanish/survival_development.html.
- 242 UNAIDS. Inter-Agency Task Team (IATT) on HIV and Young People. Global Guidance Briefs.
- 243 UNFPA. 2008. Guidance Brief: HIV Interventions for Young People. Inter-Agency Task Team on HIV and Young People. Overview.
- 244 Cited in ECLAC and UNICEF. 2008. Challenges: Newsletter on Progress Towards the Millennium Development Goals from a Child Rights Perspective. "Children and HIV/AIDS in Latin America and the Caribbean." Number 7, July 2008, p. 2. Santiago de Chile.
- 245 See http://www.unicef.org/lac/flash/DW/nicaragua_educacion_09.html.
- 246 See <http://www.unep.org/Tunza/youth/>.
- 247 Krauscopf, 2000. In Morlchetti, Alejandro. n. d. "Políticas de salud sexual y reproductiva dirigidas a adolescentes y jóvenes: un enfoque fundado en los derechos humanos." In Notas de Población No. 85. Economic Commission for Latin America and the Caribbean (ECLAC). p. 85. http://www.eclac.org/cgi-bin/getProd.asp?xml=/celade/agrupadores_xml/aes51.xml.
- 248 Impact evaluation and gender evaluations carried out by the World Bank through the Youth Employment Inventory and the The Adolescent Girls Initiative: An Alliance for Economic Empowerment. Katz, E. 2008. Programs Promoting Young Women's Employment: What Works.
- 249 Katz, E. 2008. Programs Promoting Young Women's Employment: What Works.
- 250 Teen Health Series. 2009. Jane Fonda Center, Emory University School of Medicine, Atlanta, GA. http://janefondacenter.emory.edu/projects/teen_health_edu.cfm.



Pan American Health Organization

Regional Office of the
World Health Organization

525 Twenty-third Street, N.W.
Washington D.C. 20037

www.paho.org

ISBN 978 92 7 53 279 75



9 789275 327975