IPPF
Western Hemisphere Region

From choice, a world of possibilities

Beyond Barriers:

Recommendations for Adolescent Sexual and Reproductive Health Policies and Programs in Belize, Guatemala, and Honduras

About Us

The International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) believes that every individual is entitled to quality health care and a life free of violence and discrimination. We reach young people and poor communities with free or subsidized sexual and reproductive health services in a region characterized by high rates of adolescent pregnancy and extreme income inequality.

In 2012, we provided nearly 33 million services—such as contraception and gynecological consultations—in nearly every country in the Americas and Caribbean. Our network of advocates, health providers, health educators, and volunteers not only provide essential care; we also work to secure government funding and policies in order to improve the lives of millions. Last year alone, we helped secure 37 national policies and legislation in support of sexual and reproductive rights in Latin America and the Caribbean.

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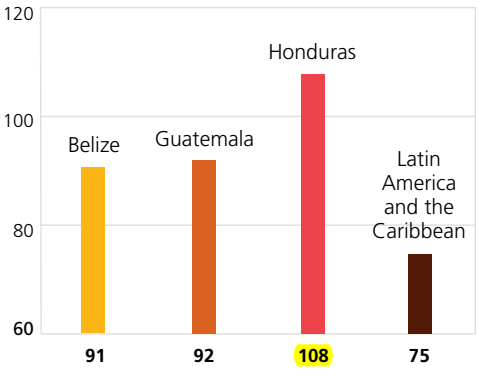
Introduction

Despite decades of international and local support to improve adolescent sexual and reproductive health (ASRH) in Latin America and the Caribbean (LAC), the data show it remains a critical issue for the region.

Condom use and contraceptive prevalence rates remain low,[1] and Central America has among the highest adolescent fertility rates globally,[2] making it a crucial region of focus for adolescent sexual and reproductive health service delivery and advocacy. Youth are not receiving the comprehensive clinical services that they need during this pivotal time period in physical and emotional development.

Adolescent Birth Rate
(per 1000 15-19 year olds) 2009



Source: UNICEF.org/publications/files/SOWC_2011_Main_Report_EN_ 02242011.pdf

This matters, because the decisions and actions that take place during the period, such as engaging in unsafe or risky sexual behaviors, have long-lasting health, educational, and social outcomes for adolescents and their communities.[3,4] Youth have the right to access the services and education necessary to ensure that they lead healthy sexual and reproductive lives now and in the future. Providing youth-friendly sexual and reproductive health services, and promoting youth-friendly laws and policies, is crucial for development in Central America, where half of the population is under 20 years old.[5,6]

With the generous support of the Summit Foundation and other international donors, the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) provides technical and financial support for adolescent sexual and reproductive health programs in Belize, Guatemala, and Honduras.

This paper explores the adolescent health context, seeking to synthesize and summarize the latest thinking about what barriers exist to providing youth with sexual and reproductive health clinical and educational services. These recommendations are meant to start a conversation with programmatic practitioners, decision-makers, and other interested stakeholders to improve youth-serving programs and enhance advocacy efforts.

Methodology

Countrywide indicators and policy information were gathered through a literature review using peer-reviewed journal articles as well as grey literature produced by the following organizations: Alan Guttmacher Institute, International Planned Parenthood Federation, Pan American Health Organization, Population Council, Population Reference Bureau, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Fund for Children, World Bank, and World Health Organization. Information from our Member Associations—BFLA (Belize), APROFAM (Guatemala), and ASHONPLAFA (Honduras)—was provided from the staff of each organization.

The current health challenges of these countries, combined with political support to improve ASRH, make Belize, Guatemala, and Honduras primed to receive technical assistance in the delivery of youth-friendly SRH services.

Common Challenges: Belize, Guatemala, and Honduras

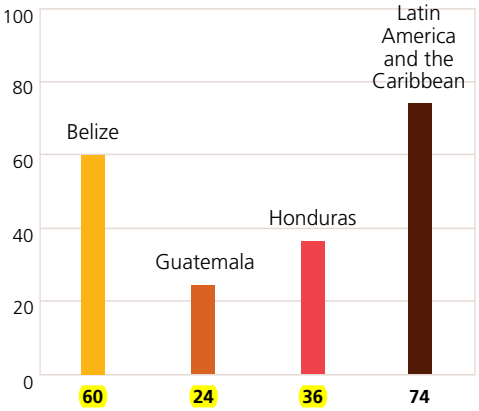
Belize, Guatemala, and Honduras are priority countries within Central America for adolescent sexual and reproductive health interventions. These three countries are among the most impoverished in Latin America and the Caribbean, with 12-18% of the population in each country living on less than $1.25 a day.[7,8] Further, Belize, Guatemala, and Honduras have the highest percentages of youth under the age of 15 in LAC[9] (37%, 42%, 38% respectively), in addition to large populations of vulnerable and marginalized communities, making access to sexual and reproductive health services, especially youth-oriented services, difficult.[10,11]

These three countries have among the highest adolescent fertility rates in Central America[12] among 15-19 year olds,[13] and a high unmet need for contraceptives.[14] All three countries also have high rates of marriage and sexual intercourse among adolescents,[15-17] and limited comprehensive knowledge about HIV/AIDS among this age group.[18] Finally, abortion and abortion-related services are difficult to access in all three countries. Although Belize provides some legal exceptions, the conservative cultural and religious climates prevent individuals from easily accessing the service.[19,20]

A large urban/rural divide affects Belize, Guatemala, and Honduras with respect to school enrollment, and lack of access to education. Both of these correlate with reduced access to sexual and reproductive health services and negative health outcomes.[21-23] An ethnic divide also exists in Belize[24] and Guatemala,[25] with indigenous populations facing challenges such as low rates of school attendance, high rates of teen pregnancy,[26] higher rates of concentrated poverty and lower levels of educational attainment.[27,28] Gender inequality and violence is also high in all three countries. Women comprise the majority of victims of violence in these countries, and violence is generally accepted among both men and women.[29-31] Pregnant adolescent women in Belize, Guatemala, and Honduras face barriers in accessing education, as they are frequently expelled from school even in the presence of legal protections.[32,33]

In addition to facing common challenges, Belize, Guatemala, and Honduras operate adolescent sexual and reproductive health programs within very conservative political and religious climates. But despite this difficult climate for adolescent health, government officials from all three countries signed the Ministerial Declaration, promising to dramatically increase the number of young people that have access to comprehensive sexuality education and sexual and reproductive health services by 2015.[34] The current health challenges of these countries, combined with political support to improve ASRH, make Belize, Guatemala, and Honduras primed to receive technical assistance in the delivery of youth-friendly SRH services.

Secondary School Attendance
(women, net) 2005-2009



Source: UNICEF.org/publications/files/SOWC_2011_Main_Report_EN_ 02242011.pdf

Honduras

Adolescent Sexual and Reproductive Health

Honduras has one of the largest adolescent populations in Central America (23%) combined with a high adolescent birth rate, a high number of HIV infections among youth, lack of HIV knowledge, and limited access to contraceptive methods among adolescents.[35] Birth and marriage rates vary greatly among Honduran adolescents depending on years of schooling and geographic location.[36] In Honduras, there are 108 births per 1,000 girls 15-19 years of age, one of the highest adolescent birth rates in LAC.[37]

The percentage of adolescents giving birth is higher among women with low levels of education, women of low socioeconomic status, and women living in rural areas.[38] An overwhelming majority of adults had their first sexual experience before 20 years of age (79% of men, 67% of women), but not necessarily within a marital union.[39] Adolescent marriage among females is common; 54% of women married before age 20.[40] These percentages increase among women with less education (69%) and those who live in rural areas (62%) and decrease among women with more years of schooling (33%) and who live in urban areas (47%).[41] Among married adolescents 15-24 years of age, over half who do not have a child wish to delay their first pregnancy,[42] but less than half of sexually active adolescents (47%) are using a modern contraceptive method.

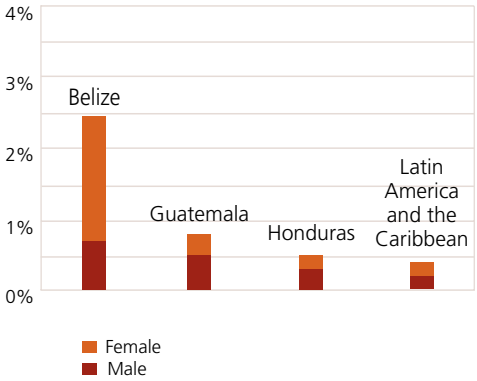
Furthermore, 38% report dissatisfaction with modern methods,[43] highlighting a need and demand for increased contraceptive services among adolescents.

Honduran youth have limited knowledge around comprehensive HIV/AIDS issues. When asked about methods to prevent HIV transmission, just over half of young men and women (66% and 52% respectively) answered "condoms."[44] This is not surprising, considering less than a third of adolescent men and women (29%) reported comprehensive HIV knowledge,[45] and only one-sixth of young men consider themselves at risk for contracting HIV.[46]

Socio-Political Context for Adolescent Sexual and Reproductive Health in Honduras

The conservative legal climate prevents young people from accessing comprehensive sexual and reproductive health services. Abortion and emergency contraception are illegal in all cases, which includes saving the life of the mother.[47] While there is no specific data on clandestine abortion rates among young people, evidence shows that close to half of abortions that occur in Latin America and the Caribbean are obtained by adolescents and women between 15 and 24.[48] With respect to HIV, Honduras passed a law in 1999 making it mandatory for people who are aware of their HIV status to inform their spouse or partner, with exposure and transmission subject to prosecution.[49] Within this climate there are a number of stakeholders committed to improving adolescent sexual and reproductive health, but ASHONPLAFA remains the most important distributor of contraceptives in the country.[50]

HIV Prevalence
(% of 15-24 year olds) 2009



Source: UNICEF.org/publications/files/SOWC_2011_Main_Report_EN_ 02242011.pdf

Vulnerable Young People in Honduras

Adolescents as a whole are a vulnerable population, especially when it comes to accessing services and education; however, there are regions of Honduras where adolescents are especially vulnerable to negative health outcomes. Adolescents living in the western regions of Honduras (Copán, Lempira, Intibuca, Santa Barbara, La Paz, Yoro, and Comayagua) and those in the regions of Colón and El Paraíso face lower rates of school enrollment, knowledge of HIV, access to contraceptive methods, and higher rates of early marriage and violence. Over 20% of girls and boys ages 7-17 living in Copán, Intibuca, and Lempira are not in school. And, almost 20% of girls ages 10-14 living in the regions of Valle and Santa Barbara are not in school and are not living with a parent, increasing their vulnerability to negative health outcomes.[51]

These regions also have some of the lowest rates of knowledge of HIV prevention methods among 15-24 year olds in the country. Yoro has the highest rates of early marriage with almost 20% of girls marrying by age 15. Females aged 15-24 who are not married and living in La Paz are at the greatest risk of not using a contraceptive method, with close to two-thirds of the population having never used any form of contraception. And in Olancho, 32% of women ages 15-24 think that violence against women is completely justified under certain conditions.[52] These statistics are just a snapshot of the current situation for young people in Honduras, but they allow service providers to go beyond the urban vs. rural dichotomy when considering program design, outreach, and advocacy efforts.

Guatemala

Adolescent Sexual and Reproductive Health

Guatemala has one of the largest adolescent populations in all of Latin America and the Caribbean, with young people ages 15-19 accounting for 24% of the national population, which faces high rates of adolescent pregnancy, marriage, unmet contraceptive need, violence, and low rates of contraceptive usage.[53] Similar to the educational, economic and ASRH disparities between urban and rural populations in Honduras, Guatemala experiences these same inequalities in addition to inequalities between indigenous and non-indigenous populations.[54] Mayans are the largest indigenous group in Guatemala,[55] followed by the Garífuna and Ximena; together, these indigenous populations account for over half of the national population. The overwhelming majority of the indigenous population (75%) lives in poverty.[56] Ethnicity is correlated with significantly lower levels of educational attainment and health outcomes.[57]

The majority of young people in Guatemala (83% men and 58% women) had sex before age 20, and while the preponderance of sexually active women ages 15-24 (95%) are married or in some type of consensual union, this is true for only 46% of sexually active young men.[58] Guatemala has the third highest adolescent fertility rate in Central America with an average of 92 births per 1,000 adolescent girls ages 15-19,[59] with a greater proportion of births occurring among indigenous women as well as those with a lower socioeconomic status and lower educational attainment.[60]

The majority of sexually active youth ages 15-24 (married or not) indicated that they do not wish to have a child in the next two years, yet only 25% of married women between ages 15 and 24 are currently using modern contraception. This percentage drops to 10% among indigenous women. Fifty-three percent of youth ages 15-24 have an unmet need for a modern contraceptive method; unmet need increases to 64% among women of lower socioeconomic status.[61]

In addition to a need for increased contraceptive services, there is also a need for increased comprehensive sexuality education. Only 24% of young men and 20% of young women ages 15-19 have comprehensive HIV knowledge.[62] Not surprisingly, when asked about ways to prevent HIV transmission, less than 50% of adolescent women and men responded "condoms" without prompting.[63] Increasing HIV knowledge among young people is crucial, especially since one-third of HIV infections are predicted to occur during adolescence.[64]

Adolescent-specific indicators with respect to maternal mortality, violence, and abortion are not available, yet reporting for women and girls provides us with some context with which to understand the data. Forty-five percent of women and girls reported experiencing some type of violence.[65] Guatemala has the second highest maternal mortality ratio in Central America[66] and abortion is one of the leading causes of maternal death.[67] Though this information does not provide age-specific data on adolescent health, research shows that girls face increased vulnerability to violence and are two times as likely to die in childbirth compared to women in their 20s.[68]

Socio-Political Context for Adolescent Sexual and Reproductive Health in Guatemala

The conservative legal climate combined with harsh topography creates a difficult landscape for the delivery of youth-friendly sexual and reproductive health services.[69] Abortion is also illegal in Guatemala; however, unlike in Honduras, there is a specific provision in the law to allow abortion in cases to save a mother's life.[70] Unfortunately, this exception does not provide for the abortion coverage that Guatemalan women need, as 27,000 women are hospitalized each year due to abortion-related complications.[71,72] Abortion is the third leading cause of maternal death in Guatemala.[73] In 2000, the Government of Guatemala launched a program to train community health workers to provide oral contraceptives, injectables, and condoms to the rural and mostly indigenous population. The program showed a substantial increase in new contraceptive users, and the women who received the service overwhelmingly reported high levels of satisfaction. The providers reported an unwillingness to distribute contraceptives to adolescents and unmarried women without partner consent, indicating that not all vulnerable populations were reached through the program.

Vulnerable Young People in Guatemala

Rural and indigenous adolescents throughout Guatemala face disproportionate negative sexual and reproductive health outcomes relative to their urban and non-indigenous counterparts.[74,75] National studies paint a more in-depth picture of the region where the most vulnerable adolescents live.

The central regions of Alta Verapaz, Quiche and Solola have the greatest percentage of indigenous people (75-97%) and the highest rates of illiteracy among 15-24 year olds (18-27%). The northwestern region of Huehuetenango has the greatest percentage of females ages 7-18 who are not in school (37-43%), followed closely by the regions of Alta Verapaz, Quiche, Baja Verapaz, Solala, Suchitepequez, and Jalapa, where a third of females are not in school. Child marriage rates are highest in the regions of Petén, Izabal, Chiquimula, Santa Rosa, and Retalhuleu. About a third of females (26-33%) living in Chimaltenango, Santa Rosa, Retalhuleu, Izabal, and Zacapa had sex before age 15, and nationally, 58% of 15-19 year old females have been pregnant or had a child. Also, while adolescent females (15-24) are aware of methods to reduce the risk of HIV/AIDS, condom use at the time of last intercourse was less than 10% for currently married and never-married 15-24 year olds.[76]

Belize

Adolescent Sexual and Reproductive Health

Like Honduras and Guatemala, Belize has a high proportion of adolescents as part of the national population, with youth ages 10-19 composing 23% of the total.[77] Belize's adolescent fertility rate is comparable to that of Guatemala, with 91 births per 1,000 among adolescents between 15 and 19 years old.[78] However, it differs drastically from its neighboring Central American countries with respect to HIV/AIDS prevalence.[79]

Belize has not only the highest HIV prevalence rate (1.4)[80] in Central America, but one of the highest in Latin America, placing it on par with most Caribbean and Sub Saharan African countries.[81]

Early sexual initiation among adolescents is not as prevalent as in Honduras and Guatemala with only 8% of young women and men having had sexual intercourse before age 15, but safer sex knowledge and practices are equally low. Only half of young adults 15-24 years old could correctly identify ways to prevent HIV transmission and reject major misconceptions.

Men and women ages 20-24 years old were almost twice as likely as men and women 15-19 years old and 25-49 years old to have multiple sex partners.[82]

And while a majority of adolescent men ages 15-24 (70-80%)[83] report consistent condom use with multiple partners and with non-regular partners (60-70%),[84] only 58% of females 15-19 years old report consistent condom use with multiple partners and 42% with non-regular partners. Improving safer sex practice among adolescents is crucial to preventing new HIV infections; 7% of total new HIV infections occurred among adolescents 10-19 years old[85] and most people living with HIV/AIDS are 20-29 years old,[86] indicating that a large number of infections occur during adolescence in Belize.

Improving access to contraceptive services and decreasing violence are also key health concerns for Belize. From 2001-2005, 18% of all live births occurred among adolescent women 15-19 years old, and the leading cause of hospitalization for this cohort was pregnancy-related complications.[87]

Though there is no adolescent-specific information around contraceptive use or unmet need at the national level, there is a 15-16% unmet need for contraceptives around spacing and limiting births among all women of reproductive age.[88]

Socio-Political Context for Adolescent Sexual and Reproductive Health in Belize

Belize has one of the most liberal abortion laws of the three countries, allowing abortion to save the life or preserve the health of the woman, in cases of fetal impairment, and for economic or social reasons. Yet in practice the provisions are limited and conservative in nature. Abortion is considered an offense under the Criminal Code and there is a maximum penalty of 14 years imprisonment for carrying out an abortion. Abortions are allowed after recommendations from two medical providers detailing physical or mental health risk to mothers, existing children, or physical and/or mental abnormalities in the fetus.[89] The only available data about abortion-related complications, from Karl Heusner Memorial Hospital, shows that 70% of gynecology/obstetrics admissions were due to unsafe abortions.

Belize is the only one of the three countries that allows adolescents to consent to HIV testing; adolescents can receive an HIV test at age 16.[90] The sexual consent laws vary by age, but do provide some legal protections for very young adolescents. Sex with a female minor under the age of 14 is always considered a felony, and sex with females between ages 14 and 16, a misdemeanor.[91] Marriage is also legal at age 14, but requires parental consent up until age 18 for women.[92,93]

Vulnerable Young People in Belize

Similar to Guatemala and Honduras, health and education discrepancies exist between urban and rural adolescents. Education is compulsory for children five to 14 years old and there are high rates of attendance up to age 14 by male and female urban and rural adolescents. After age 14, school enrollment of rural youth drops to almost half that of urban youth. Ethnic disparities exist within the urban/rural disparity. Mayans and Mestizos reported the lowest rates of school attendance for adolescents ages 15-19.

Adolescent pregnancy is also common in Belize and is most prevalent in the district of Stann Creek, where 16.4% of females give birth before age 15 and 43% before age 18. In all of the districts, urban or rural, at least a third of women give birth before age 18 and the total fertility rate is 2.8 births per woman placing young women at risk for pregnancy-related complications including death.

Overall, adolescents ages 10-24 are accessing health services, with 58-62% of females reporting having received a service and 42-51% of men, but this percentage drops significantly, 8-26% for women and 4-28% for men when asked about sexual and reproductive health services.

Barriers to Adolescent Sexual and Reproductive Health Services for Belize, Guatemala, and Honduras

The conservative political climate presents a barrier to services in all three countries. In Honduras and Guatemala, HIV testing requires parental consent among adolescents, limiting the number of youth who may feel comfortable accessing these services. Also, the strong ties to the faith-based communities in these countries hinder comprehensive sexuality education both in and out of schools. Without a comprehensive knowledge of what adolescent sexual and reproductive health is and specific knowledge on HIV, sexually transmitted diseases (STIs), and pregnancy, youth will not understand the benefits to accessing these services. And finally, because abortion is severely restricted in all three countries, young women cannot easily access abortion-related counseling and services in a safe and confidential manner.

In addition to barriers from the socio-political climate, there are also logistical barriers. Transportation and distance to and from clinics may prevent youth from accessing services. Cost of services is another barrier, especially for young women who are less likely to have control over their own finances. Research also consistently shows that lack of youth-friendly spaces, hours, and staff are all barriers to access.[94] Additionally, without consistently capturing data around adolescent sexual and reproductive health indicators, it is impossible to understand what the trends are and which subpopulations are most impacted.

Cultural and regional barriers should also be investigated; data from all three countries shows health and education disparities between urban and rural youth and indigenous versus non-indigenous youth. It is clear that there are barriers facing adolescents from specific regions and of specific ethnicities, but very little information answers why these disparities exist.

General Recommendations

The following recommendations are meant to foster dialogue among stakeholders, both government and civil society, in order to identify joint actions to further adolescent sexual and reproductive health in Latin America and the Caribbean.

1 Improve systematic reporting and collection of adolescent sexual and reproductive health indicators for youth ages 10-24 to allow for disaggregation.

Assessment of adolescent sexual and reproductive health in the region faces a major hurdle from a data perspective. There is a significant lack of ASRH indicators available, and the few indicators that are presently well-measured are often assigned different thresholds and age categories. More systematic reporting is needed at the local and national level as well as further research on how to measure neglected aspects of adolescent health including mental health, health system functioning, and risk and protective factors in adolescents in immediate social contexts. In order to ensure comparability, consensus is needed on the most valid definitions of indicators.[95] At IPPF/WHR, these efforts have been underway for several years in terms of capturing service data, and our regional Member Associations have made significant progress in collecting and using this data, but national health systems must follow suit.

2 Increase young people's access to contraceptive options, including emergency contraception.

Young people face a number of barriers when accessing contraceptives and condoms, including, but not limited to: cost, transportation, distance, and parental consent. Efforts must be made to identify these barriers at national and regional levels in order to improve sexual and reproductive health service delivery. Programs should also be friendly to vulnerable adolescents such as adolescents with disabilities, lesbian, gay, bisexual, and transgender youth, very young adolescents (10-13 years old), rural and indigenous youth, and homeless and street youth. Vulnerable adolescents should be actively recruited and included in programming and outreach efforts, including the distribution of condoms and contraceptives where legal norms allow. Stakeholders must work to increase the availability of a wide range of affordable short-term and long-acting reversible contraceptive methods by addressing barriers such as high taxes or import fees. Government and civil society must work to bring down the high and rising cost of contraceptives, which disproportionately affects adolescents' access, and emergency contraception must be more accessible for young people in order to prevent unintended pregnancy among young women. In addition, it is important to increase providers' ability and willingness to counsel on a wider range of methods. A concrete step that can be taken is to provide updated training and sensitization to address provider misconceptions about adolescents' use of different birth control methods. Service providing organizations, including government health services, can also engage in health promotion to raise awareness of different contraceptive options and to reduce myths and misconceptions of adolescent (and adult) users.

3 Promote systematic advocacy on adolescent sexual and reproductive health issues.

The conservative political climate prevents the development of comprehensive youth-friendly services. In addition to advocating for government support of these services, civil society must also advocate to eliminate policies requiring parental consent for testing for HIV and STIs, prohibiting abortion-related services and policies that allow for the expulsion of pregnant adolescents from schools. IPPF/WHR recommends that stakeholders continue to support civil advocacy organizations such as the Mesoamerican Coalition for Sexuality Education in coordinating civil efforts to meet the targets laid out in the Ministerial Declaration by 2015, and that funding be dedicated for continued evaluation of the implementation the document's goals.

In the coming months, IPPF/WHR Member Associations and the Summit Foundation will invite partners to contribute to strengthening these recommendations and tailoring them to local contexts.

4 Increase young people's access to comprehensive sexuality education.

Comprehensive sexuality education has the power to improve young people's knowledge and understanding of sexual and reproductive health and gender equality, while also empowering young people to become advocates for their own health and the health of their peers. Increasing this kind of education will also improve young people's knowledge of HIV/AIDS, pregnancy, contraceptive methods, and where to access sexual and reproductive health services. Comprehensive sexuality education, following a gender- and rights-based model, also empowers young people to be active in changing harmful social norms that affect their health.

5 Strengthen relationships between adolescent sexual and reproductive health organizations and parents and community and religious leaders.

Support for adolescent sexual and reproductive health is needed from parents and community leaders, especially in countries where young people rely on parental consent in order to receive services. Education, outreach, and awareness-raising are necessary to create more allies among parents and leaders in the community and in faith based organizations. In Costa Rica in 2012, for example, a new national sexuality policy guaranteeing education for young people was developed by the Costa Rican government with technical assistance from IPPF/WHR's Member Association Asociación Demográfica Costariccense (ADC) and the Costa Rican Coalition for comprehensive sexuality education. The Costa Rican courts offered parents an opt-out option, however. ADC and the Coalition launched a sensitization campaign that was informally supported by the Ministry of Public Education, targeting parents and guardians on the importance of sexuality education for their children, in order to increase demand for education among children and adolescents. The campaign was hugely successful, and as a result, few parents have asked for their children to opt out of the program. This type of investment is necessary for long-term societal support of adolescent sexual and reproductive health.

6 Improve financial sustainability.

Obtaining funding for adolescent sexual and reproductive health programs in Latin America and the Caribbean is becoming increasingly difficult. As an increasing number of Latin American countries rise to middle-income status, foreign aid and traditional donor interest in these countries continues to decline. Examining the region's averages masks enormous disparities in wealth and access to health care. The exit of foreign aid has left many without access to services and at the mercy health systems that remain weak and inadequate. In fact, Latin America has one of the highest out-of-pocket costs for health care in the world. This leaves those without the ability to pay unable to access services of any kind. Without donors' commitments to sustain the progress made, the region is at risk of sliding back into the spiral of poverty, the unmet needs, and political instability it faced prior years.

Efforts should be made at a national and local level to identify alternative funding streams in order to strengthen sustainability. In particular, in fulfilling their commitments through the Ministerial Declaration and national policies, governments must back policies with budgetary commitments to support adolescent sexual and reproductive health educational and clinical services.

Conclusion

While there have been documented successes in the last few years of improved adolescent sexual and reproductive health in Central America, many barriers to access still exist, especially for the most vulnerable populations. Data is lacking or unreliable for many important indicators. This lack of data inhibits accurate program design and limits the knowledge that public health officials have about the issues facing the region. Additionally, the data that does exist is often national-level data that hides pockets of tremendous poverty, high adolescent pregnancy rates, early marriage, and HIV prevalence. Through the dedication of our partners and Member Associations, IPPF/WHR has striven to promote awareness of and create transparency around issues of adolescent sexual and reproductive health. IPPF/WHR believes that this recommendations paper will fuel conversations with key stakeholders designed to forge ahead to the next level in terms of service provision, comprehensive sexuality education, and the advocacy needed to improve the adolescent sexual and reproductive health in the region.

Notes and References

1 Denno, D., Chandra-Mouli, V., & Osman, M. (2012). Reaching youth with out-of-facility HIV and reproductive health services: a systematic review. *Journal of Adolescent Health, 51,* 106-121.

2 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

3 Denno, D., Chandra-Mouli, V., & Osman, M. (2012). Reaching youth with out-of-facility HIV and reproductive health services: a systematic review. *Journal of Adolescent Health, 51,* 106-121.

4 Remez, L., Prada, E., Singh, S., Bixby, L., & Bankole, A. (2008). *Ensuring a healthier tomorrow in Central America: protecting the sexual and reproductive health of today's youth,* New York: Guttmacher Institute.

5 Population Reference Bureau. (2010). *World population data sheet.* Washington, DC.

6 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

7 The World Bank. (2013). *Poverty & Equity Data Dashboard.* Retrieved from http://data.worldbank.org/topic/poverty.

8 12% of the population in Belize (1999), 14% of the population in Guatemala (2006), 18% of the population in Honduras (2009).

9 Population Reference Bureau. (2010). *World population data sheet.* Washington, DC.

10 Remez, L., Prada, E., Singh, S., Bixby, L., & Bankole, A. (2008). *Ensuring a healthier tomorrow in Central America: protecting the sexual and reproductive health of today's youth,* New York: Guttmacher Institute.

11 Samandari, G. & Speizer, I. (2010). Adolescent Sexual Behavior and Reproductive Outcomes in Central America: Trends over the Past Two Decades. *International Perspectives on Sexual and Reproductive Health 36(1),* 26-35.

12 Nicaragua remains the highest in the region with 109 adolescent births per 1,000 adolescents aged 15-19 from 2000-2010.

13 UNICEF. (2012). *Table 11: Adolescents*. The State of the World's Children.

14 United Nations, Department of Economic and Social Affairs, Population Division (2012). *World Contraceptive Use.* Retrieved from: http://www.un.org/esa/population/publications/WCU2012/MainFrame.html.

15 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Honduras 2005.* New York.

16 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Guatemala 2002/06.* New York.

17 Joint UN Programme of Adolescent Girls. (2012). *Belize coverage exercise study: assessing the status to build a portfolio of targeted interventions for vulnerable girls.*

18 UNICEF. (2012). Table 11: Adolescents. The State of the World's Children.

19 Remez, L., Prada, E., Singh, S., Bixby, L., & Bankole, A. (2008). *Ensuring a healthier tomorrow in Central America: protecting the sexual and reproductive health of today's youth,* New York: Guttmacher Institute.

20 Global AIDS Country Progress Report, Belize. (2012). Reporting period: January 2010 – December 2011.

21 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Honduras 2005.* New York.

22 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Guatemala 2002/06.* New York.

23 Joint UN Programme of Adolescent Girls. (2012). *Belize coverage exercise study: assessing the status to build a portfolio of targeted interventions for vulnerable girls.*

24 Joint UN Programme of Adolescent Girls. (2012). *Belize coverage exercise study: assessing the status to build a portfolio of targeted interventions for vulnerable girls.*

25 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

26 Joint UN Programme of Adolescent Girls. (2012). *Belize coverage exercise study: assessing the status to build a portfolio of targeted interventions for vulnerable girls.*

27 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

28 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

29 Prairie Women's Health Center of Excellence. (2010). A Gender-Based Analysis of HIV/AIDS in Belize. Belize, Ministry of Health and PAHO.

30 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Honduras 2005.* New York.

31 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Guatemala 2002/06.* New York.

32 Remez, L., Prada, E., Singh, S., Bixby, L., & Bankole, A. (2008). *Ensuring a healthier tomorrow in Central America: protecting the sexual and reproductive health of today's youth,* New York: Guttmacher Institute.

33 Joint UN Programme of Adolescent Girls. (2012). *Belize coverage exercise study: assessing the status to build a portfolio of targeted interventions for vulnerable girls.*

34 Mesoamerican Coalition. (2011). Evaluación de la implementación de la Declaración Ministerial 'Prevenir con Educación.' Mexico, Red Democracia y Sexualidad.

35 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

36 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

37 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

38 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

39 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

40 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

41 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

42 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

43 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

44 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

45 UNAIDS Info Database, 2011.

46 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud hondureña.* New York.

47 Center for Reproductive Rights. (2013). *The world's abortion laws map 2013 update.* New York, New York.

48 Remez, L., Prada, E., Singh, S., Bixby, L., & Bankole, A. (2008). *Ensuring a healthier tomorrow in Central America: protecting the sexual and reproductive health of today's youth,* New York: Guttmacher Institute.

49 Nam AIDSmap. (2013). *HIV & the criminal law.* Retrieved from: http://www.aidsmap.com/law-country/Central-America/page/1445017/.

50 IPPF/WHR Redbook on Honduras 2013 (internal document).

51 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Honduras 2005.* New York.

52 Females aged 15-24 who answered yes to any of the following five questions: if wife goes out without telling husband, if wife neglects kids, if wife argues with husband, if wife refuses to have sex, if wife burns the food.

53 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

54 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

55 Minority Rights Group International, *World Directory of Minorities and Indigenous Peoples – Guatemala: Maya,* July 2008, Retrieved from: http://www.refworld.org/docid/49749d163c.html.

56 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

57 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

58 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

59 UNICEF. (2012). *Table 11: Adolescents*. The State of the World's Children.

60 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

61 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

Notes and References (continued)

62 UNICEF. (2012). *Table 11: Adolescents.* The State of the World's Children.

63 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

64 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

65 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

66 UNICEF. *At a glance: Guatemala.* Retrieved from: http://www.unicef.org/infobycountry/guatemala_statistics.html.

67 Singh, S., Prada, E., and Kestler, E. (2006). Induced abortion and unintended pregnancy in Guatemala. *International Family Planning Perspectives 32(3)*, 136-145.

68 Advocates for Youth. (2007). *Adolescent maternal mortality: an overlooked crisis.* Washington, DC: Kathryn Graczyk.

69 World Health Organization. (2009). *Social Science Policy Brief: community-based providers in rural Guatemala can provide injectable contraceptive DMPA safely.* Switzerland. Retrieved from http://whqlibdoc.who.int/hq/2009/WHO_RHR_09.11_eng.pdf.

70 Center for Reproductive Rights. (2013). *The world's abortion laws map 2013 update.* New York, New York.

71 Figueroa, W. et al. (2006). *Early childbearing in Guatemala: a continuing challenge, In Brief,* New York: Guttmacher Institute.

72 This number reflects both spontaneous and induced abortions.

73 Singh, S., Prada, E., and Kestler, E. (2006). Induced abortion and unintended pregnancy in Guatemala. *International Family Planning Perspectives 32(3)*, 136-145.

74 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

75 Guttmacher Institute. (2008). *Datos sobre la salud sexual y reproductiva de la juventud guatemalteca.* New York.

76 Population Council. (2009). *The adolescent experience in-depth: using data to identify and reach the most vulnerable young people: Guatemala 2002/06.* New York.

77 UNICEF. (2012). *Table 11: Adolescents*. The State of the World's Children.

78 UNICEF. (2012). *Table 11: Adolescents*. The State of the World's Children.

79 Buszin, J., Nieto-Andrade, B., Rivas, J., & Longfield, K. (2012). Multiple partnerships and risk for HIV among the Garifuna minority population in Belize. *Health, 4(8),* 474 – 482.

80 UNAIDS. (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

81 Buszin, J., Nieto-Andrade, B., Rivas, J., & Longfield, K. (2012). Multiple partnerships and risk for HIV among the Garifuna minority population in Belize. *Health, 4(8)*, 474 – 482.

82 UNAIDS. (2010). Global Report: UNAIDS report on the global AIDS epidemic 2010. Retrieved from: http://www.unaids.org/documents/20101123_globalreport_em.pdf

83 Consistent condom use with multiple partners: 80.8% among men 15-19; 70.4% among men 20-24.

84 Consistent condom use with non-regular partners: 69.2% among men 15-19; 59.3% among men 20-24.

85 Pan American Health Organization. (2009). Belize country cooperation strategy: 2008-2011.

86 WHO. (2005). Belize: summary country profile for HIV/AIDS treatment scale-up.

87 Pan American Health Organization. (2009). Belize country cooperation strategy: 2008-2011.

88 UNFPA, 2010.

89 Global AIDS Country Progress Report, Belize. (2012). Reporting period: January 2010 – December 2011.(51)

90 Plus TV, 2013.

91 Belize. 2000. Criminal Code Chapter 101: Revised Edition 2000. Retrieved from: http://www.oas.org/juridico/mla/en/blz/en_blz-int-text-cc.pdf.

92 Pan American Health Organization. (2012). *Health in the Americas.* Washington, DC.

93 Pan American Health Organization. (2012). Antiretroviral Treatment in the Spotlight: A Public Health Analysis in Latin America and the Caribbean. Washington, DC.

94 Denno, D., Chandra-Mouli, V., & Osman, M. (2012). Reaching youth with out-of-facility HIV and reproductive health services: a systematic review. *Journal of Adolescent Health, 51,* 106-121.

95 *The Lancet,* Volume 379, Issue 9826, page 1672, 28 April, 2012.

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