Crisis in the Triangle:

Addressing Adolescent Reproductive Health & Violence Prevention in El Salvador, Guatemala and Honduras

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Acronym List

AYSRH	Adolescent and Youth Sexual and Reproductive Health
CARSI	Central America Regional Security Initiative
CCT	Conditional Cash Transfers
CERCA	Community-Embedded Reproductive Health Care for Adolescents
DHS	Demographic Health Survey
EC	Emergency Contraception
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IPV	Interpersonal Violence
LAC	Latin America and the Caribbean
MSF	Medecins Sans Frontieres
MSM	Men who have Sex with Men
PASMO	Pan-American Social Marketing Organization
PSI	Population Services International
RCT	Randomized Control Trial
SIFPO	Support for International Family Planning Organizations
SRH	Sexual and Reproductive Health
SRHC	Sexual and Reproductive Health Care
STI	Sexually Transmitted Infection
UNHCR	UN High Commissioner for Refugees
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

BACKGROUND

The Central American, "Northern Triangle" countries of El Salvador, Guatemala and Honduras face a severe crisis. The confluence of high adolescent fertility rates and widespread violence puts young people at enormous risks, too frequently impeding their potential for healthy and successful futures.

Early marriage, lack of secondary school completion, migration, poverty, socioeconomic and gender inequality, unemployment and weak judicial systems exacerbate these issues[1]. Too often, disparate groups responding to different stakeholders address these inter-related issues of health and violence separately, yet the inextricable link between adolescent and youth sexual and reproductive health (AYSRH) and the perpetration of violence warrants interventions that address the underlying factors cutting across both sectors. If delivered effectively, these interventions could have transformative impacts on the lives and opportunities of youth across the region.

With support from the United States Agency for International Development (USAID), through the Support for International Family Planning Organizations (SIFPO) project, Population Services International (PSI) and local network member Pan-American Social Marketing Organization in Honduras (PASMO/Honduras) undertook an analysis to:

1. Draw attention to the intersecting risk factors for, and consequences of, youth violence and poor AYSRH in El Salvador, Guatemala and Honduras.
2. Present best practices and lessons learned from programs in the region that work on SRH and violence prevention among young people.
3. Catalyze change by motivating donors, policy makers and program planners to design and implement integrated, evidence-based strategies to prevent violence and improve SRH outcomes among the region's young people.

METHODOLOGY

An extensive literature review of peer-reviewed articles, grey literature, impact studies and systematic reviews from the fields of AYSRH and youth violence were examined along with information collected through in-depth interviews conducted with organizations and donors. However, little information was found on the intersections of the two areas and on impactful programming specific to Central America.

Therefore, due to the lack of evidence base, a best practices survey using convenience sampling was carried out to identify practices, challenges and lessons learned with organizations and donors implementing relevant projects in the three countries.

RESULTS

Poor AYSRH and youth violence share a number of underlying risk factors that often overlap and reinforce one another, exacerbating the potential negative outcomes for young people. These risk factors –poverty, disconnection from school, gang membership, family disruption, parental conflict, substance abuse, community social disorganization, social exclusion, gender inequality, lack of social protection and poor education policies, among others–are cross-cutting; affecting individuals, their families and communities, their institutions, and their societies. This means that interventions have to work across all of these spheres of influence to have impact.

Young people's health, safety and happiness are fluid, rather than compartmentalized. This means that successful interventions are holistic and meet young people where they are in terms of their individual needs and stages of development. These interventions recognize that young people are not a homogenous group – strong evidence and audience segmentation are needed to determine the right interventions for the right audiences at the right time and in the right place. Lastly, these interventions work across health, education and citizen security sectors, leveraging various entry-points to reach young people, with the dual focus of reducing risk and promoting protective factors that lead to healthier decision-making. Even though it is very clear from the research that addressing sexual and reproductive health and interpersonal violence together mitigates the risk factors for both, the literature lacks a strong evidence base for the effects of intersectional interventions on interpersonal violence (IPV) and AYSRH indicators.

RECOMMENDATIONS

While the problems are complex, their solutions are underpinned by a simple and straightforward ethos; young people should be able to grow up in:

a. enabling law and policy contexts that allow them to live lives free of violence;
b. an environment that promotes their rights, dignity and ability to access information and services that equip them to make informed choices about sex, marriage and reproduction; supportive families and communities.

Meaningful engagement of young people in the design, delivery and evaluation of these interventions is critical to ensuring a supportive environment.

Programs for young people should integrate one or more of the following interventions:

1. Home visits to first-time parents to educate them about newborn care, delaying a second birth, positive and violence-free parenting, and healthy relationships;
2. Programs to keep girls in school (including flexible scheduling for young mothers);
3. Programs that connect girls and boys with adult mentors;
4. Programs that integrate workforce development and vocational skills for boys with activities focused on transforming gender norms and redefining masculinity, creating male champions for gender equality and female empowerment;
5. Mass and social media campaigns to transform negative gender norms and spur community-wide movements to end violence and sexual coercion;
6. Youth-friendly health services and community-based sexual education programs offered in youth centers and clinics that integrate key violence prevention components such as 'safe-scaping' for girl participants;
7. Efforts to integrate gender-based violence support services within sexual and reproductive health services and sexual and reproductive services within gender-based violence support services;
8. Programs that promote multiple protective factors e.g. life-skills, self-esteem building and social networks;
9. Programs that focus on supporting youth with goal-setting and developing action plans;
10. Programs that focus on preventing child abuse and neglect;
11. Programs that advocate for the effective implementation of laws and policies that punish perpetration of violence, coerced sex, and forced and child marriage;
12. Programs that work with law enforcement officers as allies, rather than just punishers.

CONCLUSION

With the largest youth population in history, it is critical to bring together and evaluate the most promising practices from health, violence prevention, protection and education, to develop – in partnership with young people–programs, evidence based research and opportunities that will transform the Northern Triangle countries into safe and healthy places for young people to thrive.

Terms used in this report

CHILDREN, ADOLESCENTS, YOUTH AND YOUNG PEOPLE

The terms used to refer to people between the ages of 0-24 years vary depending on the source and context.

The World Health Organization (WHO) defines children as 0-18, adolescents as 10-19, youth as 15-24, and young people as 10-24[1]. However, these definitions often change depending on the country, donor and social sector (e.g. health vs. education). This report is written about young people 10-24 years old and will use the term adolescent and youth sexual and reproductive health (AYSRH) to refer to the sexual and reproductive health (SRH) of this age group.

INTERPERSONAL VIOLENCE

The WHO World Report on Violence defines interpersonal violence as: "violence between individuals" and encompasses:

1) family/intimate partner violence, which includes child maltreatment and elder abuse; and

2) community violence, which includes violence perpetrated by acquaintances and strangers; assault by strangers; violence related to property crimes; and violence in workplaces and institutions. This report discusses various sub-types of violence such as child maltreatment, intimate partner violence (IPV), sexual violence and youth violence (which includes physical violence, gang related violence, physical assault and even homicide) and also addresses interpersonal violence as a whole.

Introduction

This report examines the linkages between interpersonal violence and its effects on young people, and on adolescent and youth sexual reproductive health (AYSRH) in El Salvador, Guatemala and Honduras. The report details shared causes and consequences of youth violence and poor AYSRH outcomes, and ultimately documents recommendations from evidence and practice for addressing those challenges.

The purpose of this report is three-fold:

1. Draw attention to the intersecting risk factors for, and consequences of, youth violence and poor AYSRH in El Salvador, Guatemala and Honduras;
2. Present best practices and lessons learned from programs in the region that work on SRH and violence prevention among young people;
3. Catalyze change by motivating donors, NGOs, policy makers and program planners to design and implement integrated, evidence-based strategies to prevent violence and poor SRH outcomes among the region's young people.

BACKGROUND

There is an urgent need to identify solutions that will directly address poor AYSRH and youth violence in Central America's Northern Triangle. El Salvador, Guatemala and Honduras face overlapping development challenges and share a number of underlying risk factors which reinforce one another and exacerbate negative outcomes for young people.

SEXUAL AND REPRODUCTIVE HEALTH AND ITS LINKS TO VIOLENCE

ADOLESCENT PREGNANCY AND CHILD-BEARING

Children of adolescent mothers display increased rates of violence perpetration, often due to the intersecting risk factors of poverty and gender inequality[2],[3]. Adolescent pregnancy is associated with high levels of maternal death, early neonatal death, postpartum hemorrhage, low birth-weight, and preterm delivery[4]. Complications from pregnancy and childbirth (which are leading causes of death among adolescent girls in low and middle income countries)[5] can also lead to neurological damage and psychological or personality disorders in children, which in turn are associated with their perpetration of violence as youth[6].

Adolescent pregnancy in Latin America occurs most often among poor families and tends to perpetuate poverty; it is associated with fewer years of schooling and fewer hours of employment for girls[7]. A study from Honduras found that vulnerability to unintended pregnancy and STIs is associated with a lack of employment and education opportunities among adolescents which is further compounded by the limited availability of information and education on sexual and reproductive health at the primary school level[8].

Children of adolescent parents are also more likely to suffer from neglect and malnutrition due to poor social and economic status, though factors such as the mother's level of education, her family support and financial support of a male partner can moderate these effects[5]. These varied and overlapping risk factors put children of adolescent parents at greater risk for child abuse and neglect, both of which are linked to violent behavior among youth later in life[9].

Given the close links between adolescent unintended pregnancy and future perpetration of violence, the WHO endorses the prevention of unintended pregnancy as a primary prevention strategy for preventing youth violence[10].

STIGMA & SRH ACCESS

Pervasive stigmatizing of sexual behavior among young people in Central America creates enormous barriers, leading to poor AYSRH outcomes. The stigma surrounding premarital sex dissuades many young unmarried women from seeking sexual health services, for fear of chastisement or punishment by health providers[11],[8]. Young women who experience physical or sexual abuse may also be reluctant to seek SRH services in Central America because of the stigma and shame and victim-blaming associated with that violence[8].

Social, cultural and religious norms make contraception difficult for young people to access, while gender and power norms often make the negotiation around condoms or other contraceptives used by young women challenging[8]. Evidence also suggests that male partners of women who experience IPV and unintended pregnancy are likely to assert control over their reproductive choices; women experiencing IPV report that fear of violence is a barrier to contraceptive use and condom negotiation[12]. Access to both emergency contraception and safe abortion services are also key interventions for young women who face intimate partner violence (IPV) and/or are victims of sexual violence, as global evidence links intimate partner violence to unintended pregnancy[13], [12]. Given this context, evidence also shows that there is a significant association between IPV and abortion, and that rates of abortion are higher among women who experience IPV than among those who do not [14],[15].

All modern methods of contraception are available in the three Northern Triangle countries across the commercial, social marketing, and/or public sector; however, female condoms and progestin-only oral contraception are not included on the National Essential Medicines List in El Salvador or Guatemala and emergency contraception is illegal in Honduras[16]. Emergency contraception is, however, available in El Salvador and Guatemala but can only be purchased with a prescription. With regards to youth preference for contraceptive choice, injectables are the leading method across all three countries for the 15-19 and 20-24 year age group of women married or in union; and for all of those unmarried, sexually active women the 15-19 year age group preferred using male condoms and the 20-24 year group preferred either condoms or injectables across all three countries.

STIS AND HIV

In Latin America, the HIV epidemic is concentrated among key populations including men who have sex with men (MSM), transgender women, female sex workers and people who inject drugs. Young people in the region make up a significant proportion of the population and youth who are key populations are at heightened risk for acquiring HIV and other STIs[17]. High-risk behavior (with sex and drugs) within these populations often begins during adolescence, and, globally, large proportions of key populations are younger than 25 years old[18]. HIV prevalence decreased by nearly 20% among young people between 2001 and 2011 in Latin America and the Caribbean (LAC,) with a 33% decline among young men[19].

However, comprehensive knowledge of HIV remains low, especially among vulnerable young women in Central America[20,21]. In Guatemala, comprehensive knowledge of HIV is higher among women in urban areas than in rural areas (32% vs. 14%) and only 5% of the poorest women possess a comprehensive knowledge of HIV[20]. Young people's treatment-seeking behavior for STIs in Central America is also low; one study found that youth sought medical attention for STI symptoms in only 55% of cases[22].

EARLY MARRIAGE

Worldwide, most girls who are married before age 18 are poor, have lower levels of education and live in rural areas[23]. Research shows that early marriage is an impediment to the development of healthy and productive lives, threatens girls' wellbeing and also puts young women at risk for adolescent pregnancy[23]. The practice of early marriage is much more prevalent in Northern Triangle countries than the rest of LAC. Guatemala and Honduras have rates of child marriage at 30% and 34% respectively (LAC average is 12%)—the latter being among the 30 countries worldwide with the highest rates of child marriage[23].

Unmet need for contraception among married adolescents in these two countries is estimated at 25.8% and 29.1% respectively[24]. This unmet need is also influenced by gender inequality and reproductive coercion: among married Guatemalan women aged 15-19, 63% report needing to ask their husband for permission to use contraception[20].

SCHOOL COMPLETION AND UNEMPLOYMENT

Both adolescent pregnancy and adolescent violence perpetration share risk factors associated with a lack of school completion and lack of viable employment. Studies show that adolescent pregnancy in the region is associated with fewer years of schooling and fewer hours of employment[7]. In Honduras, evidence shows that vulnerability to unintended pregnancy and STIs are associated with a lack of employment and education opportunities among adolescents[8]. Though significant progress has been made toward universal primary education enrollment in the Northern Triangle countries during the last two decades, significant numbers of secondary school age young people do not attend school and boys are particularly at risk[25]. Global studies also show that low levels of school attendance and unemployment are associated with the perpetration of violence[26]. In El Salvador, poor academic performance and school expulsion were found to be significant risk factors for violence and delinquency among high risk adolescent females and males[27].

Table 1: Social Determinants of Poor AYSRH Outcomes in Northern Triangle Countries

Country	Percentage of women who use modern contraceptive methods (ages 15-19)	Early marriage (before age 18) (2012)	Upper secondary school gross enrollment rate (2013, 2014)	Comprehensive knowledge of HIV (ages 15-24)
HONDURAS Female	54% (2011)	39%	70% (2014)	33% (2012)
Male			53% (2014)	35% (2012)
GUATEMALA Female	31% (2014)	30%	56% (2014)	22% (2009)
Male			55% (2014)	24% (2009)
EL SALVADOR Female	59% (2009)	25%	56% (2013)	31% (2014)
Male			54% (2013)	no data

Sources: UNFPA 2012 "Marrying Too Young"; UN statistics division MDG Database 2009, 2012, 2014; UNESCO Institute for statistics (UIS) 2013, 2014; Ministerio de Salud El Salvador et al., Encuesta Nacional de Salud Familiar: FESAL-2008 (2009); Ministerio de Salud Honduras et al., Encuesta Nacional de Demografia y Salud: ENDESA 2011 (2012); Ministerio de Salud Guatemala et al., Encuesta Nacional de Salud Materno Infantil: ENSMI 2014 (2015).

VIOLENCE IN THE NORTHERN TRIANGLE

Young men ages 15-29 in Central America are killed at four times the global average for that group; one in every 360 young men falls victim to homicide every year, making it the age group with the second highest homicide victimization rate in the region[28].

GANGS AND ORGANIZED CRIME

A significant proportion of homicides in the region are linked to local and transnational organized crime and gangs. Organized crime has taken hold in the region, which has been a geographic "choke point" between coca-producing countries in South America and US consumers of illegal drugs, with links to drug cartels based in Mexico. Central America is no longer just a transit point for drugs, it has also become a processing site for and a consumer of cocaine and synthetic drugs[29].

Local gangs (known as pandillas or maras) proliferated in the aftermath of Central American conflicts, and subsequent waves of deportation from the United States. Maras contribute to much of the region's insecurity and common crime, especially in the low-income urban neighborhoods where PSI, PASMO and USAID have worked. The largest of these gangs are also transnational in the region, and have increased in size due to mass deportation from the US. El Salvador, Guatemala and Honduras have received the highest numbers of US deportations (after Mexico) for the last several years[29]. Maras and pandillas are known to recruit boys (often by force) as young as age nine. Estimates of total gang membership vary: between 54,000-85,000 gang members are thought to be active in the Northern Triangle countries[29].

Gangs in the region are linked to violence against young women and sexual violence in particular, which has direct impacts on AYSRH. In Honduras, one study found that women associated with gangs or partnered with gang members are frequently the victims of threats and physical and sexual violence by third parties. The same study showed that women who are linked directly to gangs experience sexual violence as part of initiation rituals, loyalty tests and as punishment. Media coverage from El Salvador cites similar acts of violence against women.

WEAK POLICE FORCES AND JUDICIAL INSTITUTIONS

Weak state institutions also play a role in exacerbating crime and violence. Police forces and justice agencies in the region have limited resources and suffer from corruption and coercion and are not well trusted by the public, all of which contributes to rampant impunity of perpetrators and collaborators[30]. These institutional shortcomings result in low sentencing rates for crime. For example, in 2013 the rate of impunity for femicide in El Salvador and Honduras was estimated at 77%[31].

CRIME AND VIOLENCE POLICIES

In the early 2000's, in a rush to respond to popular pressure to address the issue of crime, governments in the region instituted heavy-handed, zero-tolerance anti-gang policies known as *mano dura*[29].

Large numbers of young people were incarcerated; for "appearing" to be in a gang (having visible tattoos), gang association and gang-related crimes. Legislation outlawing gang membership was accompanied by increased militarization of public spaces and more frequent police round-ups. These policies had little effect on gang crime but exacerbated prison overcrowding and increased inter-gang violence within prisons[30]. There are also credible reports of extrajudicial youth killings (including of young people living on the streets) by vigilante groups that have continued since mano dura was implemented[29].

Over time, the *mano dura* policies have been largely discredited as a flawed strategy in the region[32]. Honduras and Guatemala continue with a hardline approach, however, deploying military forces to carry out policing functions. Global evidence demonstrates that a criminal justice approach to preventive violence (which attempts to deter violence by individuals through the threat of punishment) is not sufficient for the primary prevention of interpersonal violence at the level of the general population[33]. For example, when Los Angeles, California battled gangs and high rates of violence in the late 1980's and early 1990's, with a "tough-on crime" approach called "Operation Hammer" that prioritized mass arrests through sweeps of violent communities, gang-related violence did not decrease[34]. Due in part to the failures of mano dura, recent shifts in El Salvador include prevention-focused approaches. An ambitious five-year plan released in 2015 called "Safe El Salvador" requests 74 percent of that estimated $2 billion project go to primary and secondary violence prevention initiatives such as parks, sports facilities, education and training programs in the countries' 50 most violent municipalities. Though the project has not yet been fully funded, it is the most comprehensive plan to date in the country to advocate for violence prevention[35].

A similar shift has begun in terms of policy creation to address attention for victims of gender-based violence that are integrated in nature (tertiary prevention); however policies the primary prevention of GBV and sexual violence are lacking in the region.

Gang truces are another recent occurrence in the region but show mixed results[28]. For a few years, a gang truce brokered in El Salvador was accompanied by a 40% decline in the homicide rate between 2012 and 2015. However, the truce collapsed in 2015 and the country now faces a skyrocketing murder rate, with a 57% increase in 2014, now surpassing that of Honduras with an expected 92 homicides per 100,000 inhabitants in 2015[36]. Honduran gangs were never able to arrive at an agreement for a brokered truce in the country and according to the United Nations Office on Drugs and Crime, this may be attributable to differences within the gangs themselves to be able to reach a truce agreement or ensure compliance [28].

GENDER-BASED VIOLENCE

Gender-based violence is also a significant contributor to rates of interpersonal violence in the region. In Honduras and Guatemala, nearly 30% of women reported ever experiencing physical violence and El Salvador and Guatemala have the second and third highest rates of femicide or gender-motivated killing of women, in the world (accounting for an estimated 10% of all homicides in Guatemala)[37].

In line with global trends, evidence shows that IPV is closely linked to reproductive health indicators in the region. One recent study demonstrated that women who had experienced IPV in the previous 12 months were also more likely to report a younger age at first pregnancy, higher number of live births, and higher rates of unintended pregnancy[38]. Evidence from El Salvador also shows that among adolescent girls there is a significant correlation between sexual coercion, IPV and prohibition from using contraception in an abusive relationship resulting in increased risk of adolescent pregnancy[39]. These patterns, as mentioned, are due to evidence that fear of violence in a relationship impedes contraceptive use. Women who experience IPV are often prohibited by their male partners from using contraception or making decisions regarding their reproductive health[12].

Harmful social and gender norms perpetuate gender inequality, shrouding GBV in a veil of silence. Demographic Health Surveys (DHS) in the region have shown that large proportions of women (up to 75% of women in rural Guatemala) agree that women should obey their husbands even if they disagree with them; the surveys also show that women generally do not believe that outsiders should intervene to help a women who is being abused by her husband[38],[20]. A generational shift may be occurring however, in terms of GBV norms and the acceptability of violence in the home. A recent study in Honduras showed that nearly all young people (100%) and pre-adolescents (70%) reported believing that partner violence is not acceptable and 93% of pre-adolescents considered it important to report cases of violence[40].

Table 2: Women Experiencing Physical Violence and Intimate Partner Violence

Country and year	Percentage of women who responded to the survey having ever experienced physical violence	Percentage of women who responded to the survey having experienced intimate partner violence in the last 12 months
El Salvador (2008)	24.2%	26.3%
Honduras (2011)	27%	22%
Guatemala (2014)	24.5%	21.6%

Sources: Ministerio de Salud El Salvador et al., Encuesta Nacional de Salud Familiar: FESAL-2008 (2009); Ministerio de Salud Honduras et al., Encuesta Nacional de Demografia y Salud: ENDESA 2011 (2012); Ministerio de Salud Guatemala et al., Encuesta Nacional de Salud Materno Infantil: ENSMI 2014 (2015).

SEXUAL VIOLENCE

Rates of formal complaints of sexual violence in Central America -- while assumed to be underreported -- are high compared with other parts of Latin America[41]. According to the Statistical Observatory in Honduras, in 2012 more than 16 thousand reports of violence against women were made to the public prosecutor's office and 20% of the cases were filed as sexual violence[41]. Studies show that sexual violence influences young women's decisions to migrate; according to a report by UNHCR, 58% of young women from El Salvador, Guatemala and Honduras cite the threat of sexual violence and interpersonal violence as their reason for fleeing Central America[42]. Data available from El Salvador and Guatemala show that 33% and 38% of adolescent girls ages 15-19, respectively, report ever experiencing physical, sexual or emotional violence at the hands of a husband or partner[43]. DHS data from the Northern Triangle show epidemic rates of intimate partner violence in the region – close to a quarter of all women in El Salvador and Honduras reported IPV and injury within the last year and a majority of Guatemalan women, a staggering 69.5%, report IPV and injury in the last 12 months[42].

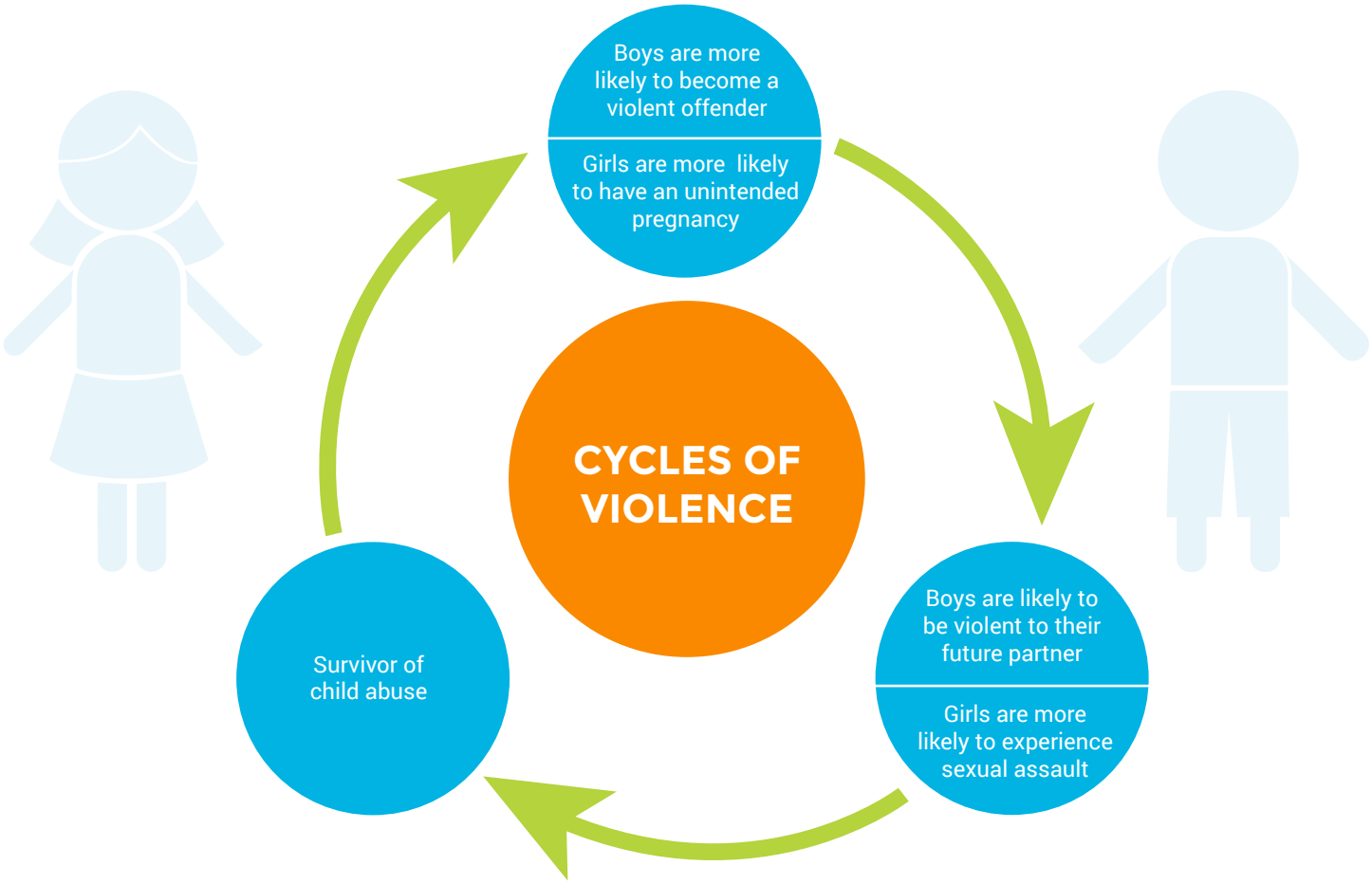
Survivors of sexual violence in the region are often very young. Data from a 2013 Medecins Sans Frontieres (MSF) clinic in Honduras indicate that, out of 2,832 rape investigations carried out by the Public Ministry of Honduras, the majority of cases were girls aged 10 to 14[44]. Another study from El Salvador found that 20.6% of female public school students reported forced sexual intercourse[3]. This information corroborates other sources documenting that the average age of a child experiencing sexual violence in Central America is 10.5 years[45]. Adolescents in the region also report that young women who refuse sex are at increased risk of violence; 76.1% of young women between the ages of 15 -19 years and 57.4% between the ages of 10-14 years old in El Salvador report that refusal to have sex contributes to violent behavior[46].

Intra-familial Violence and Child Maltreatment

CYCLES OF VIOLENCE: THE CONSEQUENCES OF CHILD ABUSE AND VIOLENCE IN CHILDHOOD

Global studies on child abuse demonstrate: a survivor of child abuse is 30% more likely to become a violent offender; abused boys are 17% more likely to be violent to their future partner; girls who are survivors of sexual violence are 2.9 times more likely to have an unintended pregnancy; girls are twice as likely to experience sexual assault after the age of 16 if raped during childhood; 1 in 3 child abusers were themselves abused during childhood and 17% of adult rape survivors were sexually abused as children.

Adapted from UNICEF "Children in Danger: Act to End Violence Against Children" 2014; UNAIDS, Together for Girls Stakeholder Report 2010-2012.



Child maltreatment and exposure to violence can have significant negative consequences for child development and future health and safety. Child maltreatment can damage brain formation and impede brain function, impacting cognitive, language, and socio-emotional development[18] as well as mental health[47]. Health effects for young people who have experienced abuse include depression, anxiety, eating disorders, and suicide attempts[48]. When children grow up in environments where they do not feel safe, their brain cells form different connections to better recognize and respond to threats[49]. This can lead to a hypersensitive sense of threat and a more violent "fight or flight" response than for those who grow up in safe, stable, and nurturing environments[49].

As in other parts of the world, girls in Latin America who are subject to child sexual abuse are found to be more vulnerable to subsequent non-consensual sex, increased risk of unsafe sex and poor mental health[43]. In El Salvador, women who were sexually or physically abused as children had a 42 – 48% higher risk of adolescent pregnancy than those who had not been abused. Estimates of the prevalence of child sexual abuse in Central America are between 5% - 8%[50],[39].

Estimates for physical abuse as punishment during childhood are as high as 35% among women and 46% among men in Guatemala; the figures are similar for El Salvador with 42% and 62% of women and men respectively[50]. Underreporting the experience of abuse is a great challenge, especially in the case of sexual abuse. Some research demonstrates that between 30 – 80% of survivors do not disclose experiences of childhood sexual abuse until adulthood while many others never report their experiences[43].

Table 3: Adolescent fertility and homicide rates in the Northern Triangle

Country	Proportion of the total population that is 10-24 years old (2013).[1]	GINI coefficient (measure of income inequality).[2]	Adolescent fertility rates (ages 15 -19) per 1,000 (2014).[3]	Homicide rates per 100,000 (2013).[4]	Homicides attributed to gangs/ organized crime (percent of total).[5]
El Salvador	32%	41.8 (2012)	65.6	41.2[6]	16.8% (2012)
Guatemala	33%	52.4 (2011)	81.4	39.9	No data
Honduras	32%	57.4 (2011)	65.7	68 (2014)[7]	34.8% (2010)
LAC Region	27%	50 (2012)	64.6	23.4	30% (2012)[8]
Global	26%	52 (2010)[10]	50[11]	6.2	No data

[1] Population Reference Bureau: Database. Available at: http://www.prb.org/DataFinder/Topic/Rankings.aspx?ind=19
[2] World Bank: GINI estimate. Available at http://data.worldbank.org/indicator/SI.POV.GINI
[3] UN data. World Development Indicators 2014. Available at http://data.un.org.
[4] UNODC: Global Study on Homicide 2013.
[5] UNODC: Statistics database. Available at: https://data.unodc.org
[6] It should be noted that rates are from official UN data from the 2013 Global Study on Homicide; El Salvador has since experienced a dramatic rise in homicides; media reports cite a rate of 104/100,000 for 2015 - the highest in the world.
[7] Instituto Universitario en Democracia Paz y Seguridad (IUDPAS) 2014
[8] UNODC; "Global Study on Homicide" 2013
[9] Census.gov; International Database http://www.census.gov/population/international/data/idb/informationGateway.php
[10] Branko Milanovic, Worlds Apart: Measuring International and Global Inequality (Princeton: Princeton University Press, 2005), 180–81.
[11] Kaiser Family Foundation. Global Health Facts. Adolescent Fertility Rate. Available at: http://kff.org/global-indicator/adolescent-fertility-rate/

Methods

This report presents a synthesis of evidence – both published and anecdotal – from the fields of AYSRH and youth violence, amassed through:

1. An extensive literature review of both violence prevention literature and AYSRH literature, primarily in Latin America and where possible, the Northern Triangle countries. Over 50 peer reviewed articles (including 12 systematic reviews) and 35 studies in the grey literature were reviewed.
2. A best practices survey using convenience sampling of AYSRH and violence prevention programs in the Northern Triangle Countries (n=26) was carried out in order to identify practices, challenges and lessons learned from relevant projects in the countries of interest.
3. Key informant interviews with youth leaders and government officials in Honduras, Guatemala and El Salvador.

A small number of impact evaluations of youth violence prevention programs (with violence or violence related outcomes) have been carried out in Latin America and the Caribbean-- four countries account for the majority of impact evaluations generating best practices in violence prevention: Brazil, Chile, Colombia and Jamaica[32]. The only impact evaluation identified for the countries of focus in Northern Triangle was an evaluation of USAID's Crime and Violence Approach in Central America with a focus on El Salvador, Guatemala, Honduras and Panama. In addition, there are currently several large randomized control trials planned for Central American and Caribbean countries, which will yield valuable evidence in the next few years[32]. A need for impact evaluations in the LAC region that identify factors linked to reduced crime and violence (instead of just measuring rates over time) has been noted in the literature. Given the limited literature from the region on violence prevention interventions, additional studies from the US and other regions were included as part of this review. This report presents evidence-based interventions from both fields of youth violence prevention and AYSRH. Promising practices from the work conducted by organizations in the region are included in the review (and are noted as promising practices). Direct quotes from in-depth interviews with these organizations are also shared.

AN EVIDENCE-BASED APPROACH

Tackling youth violence and poor AYSRH takes a dedicated and complex approach that brings together leading evidence and a collective will to foster change in the Northern Triangle countries. An evidence-based approach has three main pillars:

1. Operates across the different levels of the social ecology and addresses the interconnectedness of barriers and solutions at those levels;
2. Uses multi-component and cross-sectoral interventions to reach young people; and
3. Properly segments and involves youth. This report highlights global evidence on risk and protective factors from AYSRH and violence prevention due to an overall gap in the literature that directly identifies relationships between shared risk and protective factors. More research is needed in the region to document the impact of programs that intervene on both health areas.

THE SOCIO-ECOLOGICAL MODEL: SHARED RISK AND PROTECTIVE FACTORS

This report uses the socio-ecological model to frame strategies for violence prevention and positive AYSRH outcomes that;

1. respond to the complex interplay between risk factors,
2. develop protective factors, and
3. build on the strengths of young people across ecological levels. The socio-ecological model used in this report considers four levels, including the individual, interpersonal (or relationship), community (which includes institutions such as schools and health services) and societal factors [51]. Evidence shows that no single risk factor alone can explain why some people or groups are at higher risk of interpersonal violence and/or poor AYSRH, while others are more protected [52]. The risk itself stems across the four levels, interacting with and reinforcing one another. As a result, prevention strategies must be equally crosscutting and complex in order to be effective.

Table 4: Socio-ecological model of shared risk and protective factors for AYSRH and violence

Ecological level	Risk factors	Protective factors	Program approaches
Individual	• Disconnect from school • Substance use and abuse • Experiences with child or other adversities • History of violent behavior • Hopelessness • Gang membership • Limited access to comprehensive SRH information and services	• Life-skills • Self-esteem and locus of control • Links to social networks • Positive adult mentors • Academic skills • Engagement in after-school activities	• Building life skills, self-esteem and links to social networks • Building non-violent problem solving skills • Intensive counseling • Mentoring programs • Goal and action-oriented programs • Providing incentives to stay in school • Increasing access to SRH information and services
Interpersonal	• Lack of parental supervision of children • Parental conflict in early childhood • Family disruption (divorce, migration) • Experience of intrafamilial violence, IPV in intimate relationships (and witnessing IPV among parents) • Insecure attachment between caregiver and child/infant • Adolescent child-bearing • Disconnect from parents • Household substance abuse	• Greater parental/guardian/ caregiver supervision and monitoring • Preschool education and enrichment • Early stimulation and learning • Close relationship with a caregiver during infancy • Strong communication about SRH between parents/guardian and/or caregiver	• Pro-social opportunities • Sports programs for girls and boys • Positive parenting education • Home visitation of young parents of infants/young children • Engagement of men to examine and question gender norms • Building supportive partners for contraception and other SRH services. • Promoting parent-child communication about SRH
Community and Institutional	• Community social disorganization (violence, poverty, substance use) • Concentration of disadvantage in poor, urban settings • Social exclusion including ethnic discrimination and gender exclusion including sexual minorities • Cultures that lack non-violent alternatives to resolve conflict • Harmful gender norms and other cultural norms • Health providers and services that are not friendly to young people • Schools that do not accommodate the needs of marginalized young people, including adolescent parents	• High quality education • Affiliation with religious groups • Involvement with community and/or recreational centers • Provision of comprehensive evidence-based sexuality education linked to contraceptive provision • Community norms that do not tolerate coerced sex, child marriage, or GBV • Youth friendly health services for adolescents at primary health care level	• Increasing school attendance for adolescent girls and mothers (flexible schedules, child care support etc.) • Cooperative learning and student/ family engagement • Positive community engagement/ skill building (recreation, employment) • Building physical and social capital • Programs/policies that prevent child abuse and maltreatment • Schemes to reduce financial barriers for use of contraception • Building community support for • Increasing access to youth friendly health services • Involving youth, parents, and community influencers in the design and delivery of programs
Societal	• Decline in the enforcement of law and order • Lack of social protection • Low confidence in the police • Lack of economic safety net • Poor education and AYSRH policies	• Universal secondary school • Favorable policies that support AYSRH education, contraceptive provision and access to safe abortion services for young people	• Professionalizing police and military forces • Effectively enforcing laws to punish the perpetration of violence and coerced sex and child marriage • Enforcement of laws and policies for AYSRH and violence prevention

Table adapted from: WHO Violence Prevention Report 2004; World Bank: Youth at Risk 2008;Chandra-Mouli et al 2013; Kirby et al 2007, Best Practices cited throughout report.

CROSS-CUTTING INTERVENTIONS

MULTI-COMPONENT INTERVENTIONS

Recent evidence shows that a multi-component approach may have greater effect on behavior change, particularly when addressing AYSRH in developing countries. The evidence recommends using a range of channels to reach young people across multiple spheres of the ecological model[53], [54]. This evidence follows from the increasing recognition that SRH behaviors of young people are influenced by their context and by a range of factors operating and interacting at multiple levels[53]. Common features of successful multi-component interventions include community-based activities, the creation of enabling environments (that promote protective factors and remove structural barriers including harmful government policies) by working with health care service providers, engaging community leaders and involving parents to challenge dominant norms and support positive attitudes around sexual health[54]. These findings, which emphasize comprehensive approaches, are similar to the best practices model used in HIV with combination prevention, which demonstrates that successful programs require a combination of evidence-based mutually reinforcing interventions.

A recent systematic review of interventions to reduce adolescent childbearing in middle-and-low-income countries found that more than half of all interventions that have positive effects on behavior and health outcomes used multiple strategies such as communications and health services and counseling[55]. Further evidence from several meta-analyses of AYSRH peer education programs show similar evidence: peer education alone does not have an impact on sexual behaviors nor on improving health in isolation [56, 57], but can be effective when integrated into more holistic interventions that include referrals to experts, services, and further sensitization[58].

The community-embedded reproductive health care for adolescents (CERCA) program is currently being evaluated in three Latin American cities: Cochabamba, Bolivia; Cuena, Ecuador; and Managua, Nicaragua. The study in Nicaragua is designed as a randomized, controlled trial and aims to determine whether a comprehensive strategy consisting of community-embedded interventions will yield improvements in AYSRH. The interventions target adolescents, parents and adult family members, health providers, local authorities (such as religious leaders and school principals) and community members. The study will gather information on communication about sexuality, sexual and reproductive health information-seeking, access to sexual and reproductive health care and safe sexual relationships[59].

There is also a global push to promote cross-sectoral interventions for young people. Recognizing that young people have a diverse set of needs and that those needs intersect, these programs address young people's life transitions (learning, employment, health, family, citizenship) and are designed to build youth's assets and capacities around common factors (e.g. education, health, economic empowerment, security), leading to overlapping positive outcomes across multiple domains[59], [54].

SEGMENTING AND INVOLVING YOUTH

Young people are not a homogeneous group; they differ in a multitude of ways. Demographically, their differences in age, sex, education level, income, marital status, parity status, race and ethnicity, among others, may warrant very different types of programming. Beyond demographics, their differences in attitudes, motivations, opportunities, self-efficacy (also known as psychographics) will lead to very different needs and different methods of reaching them. Effective interventions show a nuanced understanding of their young audience and use a range of data points, stemming particularly from qualitative research, to segment audiences and tailor intervention approaches. Interventions that do not 19 segment well, or attempt to reach too wide an audience (e.g. youth 15-24) are not found to be effective [58].

Furthermore, young people's engagement is essential. Providing opportunities[58] for young people to share their voices and meaningfully contribute to program design, advocacy efforts, community-led initiatives- helps prepare them for adulthood and prepare adults to listen to and work with them[60]. Studies show that youth-driven programs promote a higher degree of ownership and empowerment than adult driven programs, and show significant effects in terms of leadership and planning skills[60].

Findings

This research identified many successful interventions (detailed below) that have positive outcomes on violence prevention and adolescent and youth sexual and reproductive health. However, there was a lack of evidence in the literature on programs directly addressing both issues together; more research and evaluation is needed in the region to demonstrate relationships and impact of addressing violence prevention and AYSRH simultaneously.

INDIVIDUAL LEVEL INTERVENTIONS

Individual level interventions for reducing violence and sexual risk taking often include those that build life, vocational and social skills; support academic achievement and staying in school; provide pro-social afterschool activities; and support workforce development and youth employment.

> "The problem we have [with teen pregnancy] is not new. The point is to see how we can address this issue with action plans. [Jovenes Contra la Violencia] is working with some of the outreach centers where we have partnerships in nonformal education projects serving youth who have left school and are unemployed. They are given life skills or technical skills suited to the developmental level of the group. Indeed, [we look at] how a young person, through his or her "life plan" can incorporate family planning. We direct them so they can see how decisions and sexual activities will affect them from an early age". In-depth interview with youth leader from Guatemala based ***Jovenes Contra la Violencia*** (JVC).

LIFE-SKILLS, VOCATIONAL TRAINING AND SOCIAL DEVELOPMENT PROGRAMS

A social development program run by the YMCA in Kingston, Jamaica demonstrated effects on violence prevention, as an indirect impact. Designed for adolescent boys (ages 14-16) who were not in school because of academic or social problems (often aggressive or defiant behavior), the program offered comprehensive services including remedial education, vocational training, social/life skills, recreation and positive behavior management. Participants attended the program daily in lieu of school until they attained proficiency for grade nine and then returned to regular schools. An evaluation of the program found reduced self-reports of aggressive behavior as compared with controls[61].

The USAID *Alerta Joven* program in the Dominican Republic incorporates multiple components, including vocational training. This program targets 85,000 youth ages 11-24 over the course of five years and is primarily aimed at violence prevention. The program includes components that address sexual health, sex education, violence prevention and vocational training and uses a variety of methods, including sports-based programs for young men at risk of violence, social clubs that offer activities, technical courses and vocational training. Micro-loans are also offered for young people wanting to start their own businesses. One of the key strategies that makes the program a success is the development of relationships with local businesses that become interested in the mission of training and hiring young people[62].

WORKFORCE DEVELOPMENT AND EMPLOYMENT PROGRAMS

"A Ganar" (meaning "to win" in Spanish), is a job training program for at-risk youth that addresses youth unemployment in 19 LAC countries by using sport-based and classroom activities to develop job skills, link with mentors, and promote positive engagement in their communities[63]. The program is implemented in high crime areas in Guatemala and Honduras, and includes a four-phase integrated job training program that combines sports-based activities, classroom instruction, vocational training, internships and various other activities to help participants find jobs, start businesses or return to formal schooling. USAID is currently funding a five-year impact evaluation of the program in Honduras as a randomized control trial (RCT) to be completed in 2016[63]. Results from previous evaluations of *A Ganar* in other LAC countries demonstrated that 63% of participants graduate from the program and over 75% of graduates obtain formal employment, return to school, or start a business within one year[63].

SCHOOL-BASED PROGRAMS

The Seattle Social Development Project is a social-development program implemented in elementary schools in Seattle that includes a parenting component, and teacher training in the use of a cognitive, emotional and social skills training curriculum. The program is being evaluated by a long-term randomized control trial. Evaluation results to date, show reductions in student reports of violent delinquency six years after the intervention (48% compared with 60% in the control group)[64]. Youth in the program also report lower levels of heavy drinking, a reduction in sexual partners and a lower incidence of teenage pregnancy at follow-up (at age 18)[64].

"Aulas en Paz" ("Classrooms in Peace") is a multi-component school-based program from Colombia that aims to reduce aggressive behaviors and promotes pro-social relationships and citizenship skills in children. Components include workshops with parents and booster sessions with

students who show aggressive behaviors (in addition to the classroom sessions for all students). Evaluation results demonstrate that the program is associated with fewer aggressive behaviors and more pro-social behaviors in the intervention group students than in controls[65].

Evidence from Chile has also shown that an extended school day can have a positive effect on reducing youth violence and teen pregnancy in low-income neighborhoods. Researchers used a natural experiment timed with a national change in school policy to extend the school day. The study found that access to full day schools reduced teenage pregnancy among poor families and in urban areas and also had effects on reduced youth crime[66].

AFTER-SCHOOL PROGRAMS

Supervised after-school programs in youth-friendly spaces show promising evidence for reducing both violence and risky sexual behaviors. The isolated construction of community centers or outreach centers does not affect youth risk behavior, however, supervised youth activities can have an important positive impact on young people, including improved school performance (or return to school) and reductions in sexual risk taking and violence[58]. Studies from the US show that most risky behavior by young people occurs in the after-school hours (between 3 p.m. and 5 p.m.)[67] and that the provision of after-school activities with an academic focus can improve self-esteem and bonding to school and peers, promote positive social behaviors, improve academic achievement, and significantly reduce risk behaviors[68].

Brazil's Open Schools program known as *Abrindo Espaços* provides a range of academic, athletic, health, cultural, and employment-related activities for young people during after school hours and on weekends. This program also integrates HIV and STI prevention into its offerings. The programs, now running in 4,000 locations in Brazil, use schools and other public spaces and are largely staffed by dedicated volunteers and other young people who, in exchange for their commitment to the program, receive tuition waivers at private universities throughout the state[32]. A study of more than 400 schools found that rates of violence among young people in participating schools were lower than control groups, with increasing impact over time. Reduced rates of sexual aggression, suicide and substance abuse were also noted [69].

EDUCATIONAL ATTAINMENT

Educational equivalency programs are considered a promising practice from the region that encourages youth who have dropped out of school to return. A program in the Dominican Republic, provided through the Ministry of Education offers alternative options for out-of-school youth to continue schooling through a nationwide network of schools. The program includes training in life skills and the opportunity for students to receive formal diplomas EBA (for 8th grade equivalence) and PREPARA (for secondary education) upon completion[69]. Key factors for success in these programs include a practical curriculum, flexible time schedule, life skills training as a core part of the curriculum and methods of instruction that are appropriate to young people[69].

Incentives are another tool used to help young people complete education, which has a direct effect on SRH outcomes. One type of incentive intervention is conditional cash transfers (CCT) – money given directly to a pregnancy and child marriage in some settings [70] [71]. However, the effects of CCTs are mixed for young women, and the quality of the program (including stipulations for receiving the funds) is key to ensuring positive outcomes. A cluster randomized control trial evaluating CCT programs in Honduras (the PRAF program), Mexico (PROGRESA program) and Nicaragua (RPS) showed some increased school attendance but no significant effects on fertility among women under age 20 [72]. Studies from other regions have demonstrated that other kinds of economic incentives aimed at keeping girls in school can also have positive effects. For example, one study in western Kenya demonstrated that reducing the cost of education by providing free uniforms reduced pregnancy and early child marriage[73].

RELATIONSHIP LEVEL INTERVENTIONS

The protective power of positive relationships is underscored by evidence that people who live in communities with high levels of violence can be "protected" from the effects of this violence– they are less likely to perpetrate violence or engage in risk behaviors like substance use if they have non-violent, supportive relationships with family, friends, and other groups, including through schools or faith organizations[74],[75]. Relationship level interventions focusing on reducing violence and sexual risk-taking behavior often include early childhood interventions, home visit programs, parental training and family therapy, and mentoring programs. Social support and friendship are also key for girls experiencing violence. This support can reduce a girls' susceptibility to violence but can also be a vehicle to increase knowledge about rights, develop specific safety plans, and provide safe spaces in which they can discuss the sensitive and threatening elements in their lives[53].

EARLY CHILDHOOD EDUCATION PROGRAMS

Evidence from high income countries shows that interventions reaching children in early childhood can have significant effects on reducing violence and adolescent pregnancy later in life[99]. Studies from the US demonstrate that children enrolled in day-care can reduce aggressive behavior and increase educational attainment in the short term [76]. Evidence from two rigorously evaluated early childhood programs in the US suggest the interventions are associated with a reduction in violence: 1) The Chicago Child-Parent Centers and 2) the Perry Preschool interventions. Both programs seek to increase opportunities for academic success among children from economically disadvantaged families: parent-child and other family and school protective factors are promoted as a means to buffer

the potential effects of neighborhood risk factors[77]. The Chicago Child-Parent Centers study demonstrated significant reductions in juvenile arrests for violent crimes for those receiving up to 2 years of preschool services and tracked to age 18[77], however the significance of the effect was not found in follow-up studies at age 24 [78].

A randomized control trial of the Perry Preschool program found long-term positive effects on children exposed to 1-2 years of daily instruction. Follow-up at age 40 found that 32% of the intervention group were ever arrested for a violent crime as compared with 48% of controls and 2% of those exposed were ever arrested for a violent felony compared to 12% of the controls. The Perry Preschool program also showed a 50% reduction in adolescent pregnancies among the preschool group versus controls at follow up (at age 27)[79]. Similarly, a randomized controlled trial of the Early Head Start program (for children aged 0–3 years) found that, compared to children in the control group, participating children were rated by their parents as having lower levels of aggressive behavior at age three[80].

HOME VISIT PROGRAMS

Nurse home-visits to at-risk families in the US have shown numerous long-term benefits for children and families including reduced rates of child abuse and neglect, fewer unintended pregnancies and improved pregnancy spacing for young mothers. A well-known model is the Nurse-Family Partnership, a program that delivers prenatal care, parental education and a maternal skills course to low-income, first time mothers in the U.S.[81]. Results from a randomized control trial show that the home visitation program is associated with a reduction in the number of subsequent pregnancies, welfare enrollment, and child abuse and neglect for up to 15 years after the birth of the first child [82]. There is also strong evidence that the program impacts children of the mothers enrolled in the program. Children at follow-up were found to have fewer behavioral problems, expressed less aggression and were less likely to experience teenage pregnancy[83].

PARENT TRAINING/FAMILY THERAPY INTERVENTIONS

Being connected to a parent or caregiver and having high-quality family interactions, connectedness and satisfaction with relationships is highly protective for both AYSRH and violence prevention[33],[84]. Greater parental supervision and monitoring is also an important shared protective factor. Within this realm, parental communication about sexual health with their children is also key. Encouragement to delay sexual initiation until after age 18 is protective, as is parental acceptance and support of contraceptive use for sexually active adolescents and communication about sex, condoms and contraception before adolescents begin sexual activity [84]. Parental support for the delay of early marriage, and for spacing second births, is another significant protective factor for adolescent pregnancy and gender-based violence[85].

Qualitative information from the organizations surveyed for this report supports the idea of involving parents in programs from the beginning, and recognizes this as a key driver of success.

> "Another important issue we address is with parents. Often it is just the father or the mother -- in the majority of cases, single mothers – we look at the ways we can support the […] role of parents in the education of the children regarding sexual health. This is also a way of breaking the cycle into which boys and girls have fallen. [We look at] how children and youth approach their personal development and how they can create better conditions for their children." (Interview with Jovenes Contra la Violencia Program Manager).

Although many parenting programs do not specifically aim to prevent violence, the WHO notes that programs working to strengthen parent-child relationships through play and praise and provision of effective, age-appropriate positive discipline show associations with reduced youth violence later in life[86]. A systematic review of random controlled studies shows parenting programs are effective in changing parenting practices for adolescent mothers and improving behavior outcomes for their children [87].

Well-known, evidence-based parenting interventions that have shown strong results include the *Incredible Years* and the *Triple P* program. The *Incredible Years* is an evidence-based teacher/parent training program to prevent child behavioral problems.

The intervention was implemented in high-income countries but also tested in pre-schools in Jamaica; showing a reduction in behavioral problems and reductions in teacher and parent-reported behavioral difficulties of children ages 3-6[88]. The *Triple P* Parenting program is a multilevel parenting and family support intervention implemented in high-income countries. The program is a rigorously evaluated family behavioral intervention reduces problematic parenting practices, increases cooperation, reduces conflicts among children and also improves behavior at school[89].

MENTORING PROGRAMS

Based on the known protective factor of having a caring adult in a young person's life, community-based mentoring programs in the US have also demonstrated possible effects on violence prevention. The successful *Big Brothers/Big Sisters* program involves one-on-one mentoring of youth connected to adult volunteers (volunteers meet three times/month for at least one year) and was shown to reduce the number of self-reported minor assaults committed by youth (measured over the past year) of participants in the program as compared with controls[90].

Mentoring programs have also shown to have effects on risky sexual behaviors; some of the key components identified for success include screening and training mentors and ongoing monitoring of the mentoring relationship[69]. Training of mentors may be especially important as ongoing training for mentors during the relationship with youth (not just pre-relationship training has been shown to increase the impact of successful programs[91].

COMMUNITY AND INSTITUTIONAL LEVEL INTERVENTIONS

Community level interventions include programs that promote comprehensive sexuality education; address community violence prevention and interruption; reduce inequitable gender norms and GBV; and utilize behavior change communication such as media campaigns.

COMPREHENSIVE SEXUALITY EDUCATION

Comprehensive sex education that is gender-responsive, evidence-informed and culturally sensitive can be a critical component of HIV prevention and provision of AYSRH. Results from multiple systematic reviews and meta-analysis demonstrate that school-based sex-education in low-income countries is an effective strategy for reducing sexual risk behaviors among adolescents[93], [94]. Effective school-based interventions have been found to increase knowledge and self-efficacy related to refusing sex or negotiating condom use, reduce the number of reported sexual partners and prolong sexual debut[93], [95]. The most effective interventions have one characteristic in common: community-based components that extended beyond school-based sex education involving resources and activities outside the school environment.

Key community-based components include: training healthcare staff to offer youth-friendly services, distributing condoms, and involving parents, teachers, and community members in intervention development [93].

[12] Comprehensive sex education refers to interventions that provide information on abstinence as well as information on how to engage in safer sex and prevent pregnancies and STIs. Comprehensive approaches have proven over the last two decades of research to be the most effective in delaying the onset of first sex and in ensuring that young people protect themselves when they become sexually active 92. Alford SB, E. Davis, L. Hauser, D. Gonzales, T.: Science and Success 3rd Ed.: Sex education and other programs that work to prevent teen pregnancy, HIV and sexually transmitted infections. *Advocates for Youth 2008*.

COMMUNITY-BASED SEX EDUCATION

Given the high rates of children of secondary school age who are out of school in El Salvador, Guatemala and Honduras, community-based sex education interventions are important vehicles to reach vulnerable youth. Several studies in other regions have demonstrated that such programs can be effective in increasing contraception use, especially when the intervention includes multiple components, including peer education, communications, access to SRHC services and youth counseling[96], [97].

Location of the intervention is also important to consider when doing community-based sex education and consulting youth to determine appropriate accessibility and safety is key to choosing the best possible location within a local context. Programs are currently implementing sex education in a variety of community settings including outreach centers, churches, and community centers among others. Research from Sub-Saharan Africa shows that implementing community-based sex education at outreach centers is not effective as they primarily serve young men and the drop-in nature of the centers do not allow for the necessary time to reach youth audiences with messages[58]. The perception by youth that program implementation locations are a safe place (especially for young women and girls) is essential when planning community-based programs.

COMMUNITY VIOLENCE PREVENTION AND INTERRUPTION

The *Cure Violence* pilot program in Trinidad and Tobago and Honduras is a good example of a U.S. program that has been adapted to middle and lower income country contexts. A current study under way in Honduras will provide insight about the program's transferability to the region. However, the U.S. programs show strong evidence in favor of the model, which is a public health approach that prevents the escalation of violence through the deployment of "violence interrupters". The model employs well-respected individuals from the at-risk community to mediate conflicts and diffuse violent incidents. Evaluation of the program in U.S. cities (Chicago, Baltimore and New York) show significant reductions in shootings and homicides in the intervention communities. For example, in Chicago, seven communities experienced from 41% to 73% reductions in shootings[98].

Municipal authorities in Medellin, Colombia developed a large-scale infrastructure project to address community violence. Cable-propelled transit (gondolas) were built to link mountain villages to the urban center along with infrastructural improvements in the neighborhoods including additional lighting for public spaces; pedestrian bridges and paths; "library parks"; and buildings for schools, recreational centers and spaces to promote micro-enterprise businesses. More police patrols were also added and a police station was located next to the gondola station. A longitudinal study of intervention and control neighborhoods in Medellin found that there was a 66% decline in the homicide rate in the intervention neighborhoods as compared to the control neighborhoods, and residents reported 75% less violence in the intervention neighborhoods[99].

A recent multi-site cluster randomized impact evaluation was carried out in El Salvador, Guatemala and Honduras and Panama in order to evaluate the USAID's community-based crime and violence programs under CARSI (Central America Regional Security Initiative) in the region. Traditionally, USAID has supported population-level violence prevention programs in communities at risk for crime and violence through a variety of strategies including:

1. Projects for improving the community environment such as better street lighting and upgraded infrastructure in public spaces,
2. Support of community-level programs for at-risk youth including outreach centers,
3. Public health interventions (including AYSRH),
4. Workforce development programs and
5. Community policing programs[100]. The study collected data on crime and violence perceptions as compared with perceptions in control neighborhoods. According to the study, the CARSI programs have resulted in a statistically significant reduction in reported cases of robberies, sale of illegal drugs, extortion and murders in all four countries [100].

ADDRESSING GENDER INEQUALITY AND GBV

Promundo Brazil's *Program H*, funded by USAID, focused on promoting healthy relationships and HIV/STI prevention among motivated young men in Brazil and Chile by questioning traditional gender norms and behavior, including violence against women, and addressing the perpetuation of gender norms through societal messaging. *Program H* (H stands for homens, Portuguese for men) consisted of two main components. First, a field-tested curriculum that included a manual and an educational video for promoting attitude and behavior change among men, and, secondly, a lifestyle social marketing campaign for promoting changes in community or social norms about what it means to be a man. Comparing baseline and post-intervention results gathered at the intervention sites reveals that a significantly smaller proportion of respondents support traditional gender norms over time. At six months, overall scale scores significantly improved. The majority of individual items significantly improved as well, and these positive changes were maintained at the one-year follow-up in both intervention sites[101]. Impact evaluations in a variety of countries, including Brazil and Chile, found improved attitudes among program participants towards women, and an association of more "equitable" attitudes with less reported partner violence and higher reported contraceptive use[102].

The Chilean program was implemented by the Ministry of Health and targeted young men ages 15-19 focusing on gender-based violence prevention through social and educational workshops. The results of the evaluation showed that young men exposed to the workshop rejected violent attitudes and were less likely to be accepting of violence when compared to controls; young men also reported increased condom use[103].

> *"We look at how we can generate responsibility in men so that sexism starts to change, because it is sexist to say that you just have to address this issue with women. We look at men who are taught not to respect, to be responsible, and if they have a child or begin to be parents at an early age, to take up that role and be fully accountable for what they are involved in -- not just women. We cannot leave one group aside." Interview with Jovenes Contra La Violencia, Program Manager Guatemala*

Safe Dates is a U.S. program that uses a 10-session teacher-led curriculum to reduce dating violence in schools by addressing norms about dating violence, reducing gender stereotyping, increasing communication and conflict management skills and encouraging youth to look out for the safety of friends. A random control trial of the program in 14 public schools found that youth receiving the *Safe Dates* intervention reported both experiencing and perpetrating less physical and sexual dating violence four years after the program as compared to controls. Participants were also found to be less accepting of dating violence [104].

Male peer group interventions also show significant effects on social norms. An evaluation of *Men of Strength* clubs in middle school and high schools in the U.S. demonstrate a shift in attitudes and beliefs among program participants when surveyed a year later. The young men who participated in the clubs were more likely to disagree with statements that support pro-harassment beliefs and more likely to intervene in situations when a girl is being touched inappropriately by male peers. Young men were also more likely to intervene when a male peer was being verbally harassed or threatened with physical violence by another male peer [105].

A school-based program from Canada which includes 21 sessions on dating violence and healthy relationships, delivered in the school classroom by teachers in single-sex groups found significant differences between intervention and control groups, with boys in the treatment group reporting significantly less physical dating violence[106].

MEDIA CAMPAIGNS

A highly successful multi-media societal mass media campaign in Central America, *Somos Diferentes, Somos Iguales* in Nicaragua, aimed at young people, used edutainment programs (featuring the *Sexto Sentido* soap opera) to communicate messages about HIV prevention. A two-year longitudinal study found effects on violence, with young people "greatly exposed" to the program 33% more likely than those "less exposed" to know of a domestic violence support center in their area and 48% more likely to have attended one in the last six months[101].

YOUTH-FRIENDLY, ACCESSIBLE HEALTH CARE[13]

Studies from low-and middle-income countries show that offering quality, youth-friendly clinic services combined with youth counseling (along with free services such as contraception) have significant positive effects on contraception and condom use [107]. A systematic review identifying key constructs of youth-friendly care found that eight domains are important: accessibility of health care (including cost, location and hours of operation), staff attitude, communication (including clarity and amount of information and the quality of clinician's listening skills), medical competency, guideline-driven care, age appropriate environments, youth involvement in health care, and health outcomes[108].

The progress made by youth-friendly programs examined in the survey conducted through this research demonstrate the importance of designing effective youth-friendly interventions. Reorienting health services to adolescents and youth in accordance with the principles and guidelines within regulatory and legal frameworks may still be in its beginning stages, but it shows immense promise as an effective solution. According to implementing organizations, services should continue to focus on the provision of comprehensive care to youth and adolescents, removing barriers and placing greater emphasis on the development of human resources (training) and the quality of care.

In terms of cost accessibility, several studies show that increasing access to clinical services for low-income youth can have an impact on condom and contraceptive use and accessing post-abortion care [11]. A study in Nicaragua demonstrates this potential[109]. The pilot program gave vouchers to poor, underserved youth in Managua that allowed for free access to health centers offering SRH services.

The pilot program gave vouchers to poor, underserved youth in Managua that allowed for free access to health centers offering SRH services. Results showed that the youth who received vouchers reported a significantly higher use of sexual and reproductive health care compared with non-

receivers (34% vs. 19%). At schools, sexually active youth who were given vouchers also reported significantly higher use of contraceptives than those without vouchers (48% vs. 33%) and in neighborhoods, condom use at last sexual activity was significantly greater among those with vouchers than among those without[109].

CLINIC IPV SCREENING AND COUNSELING

The implementation of harm reduction strategies to minimize the risk for unintended pregnancy in the context of sexual violence or coercion, such as offering contraceptive methods that are difficult for a male partner to detect or block such as injectables or intrauterine devices, is an important strategy to assist women in reducing the impact of coercion [110]. However, although IPV screening and counseling have been implemented in a variety of countries, no evidence to date has demonstrated a significant reduction in risk for unintended pregnancy or other adverse reproductive health outcomes[110]. According to Silverman, programs need "not only identify women and girls affected by IPV but also identify and target the specific behavioral mechanisms underlying the associations of IPV with poor reproductive outcomes, i.e., those behaviors directly related to women and girls' lack of 'reproductive control'[110]. This means that women who experience IPV often do not have the power to make decisions about family planning due to violence and coercion.

POLICY AND SOCIETAL LEVEL INTERVENTIONS

The policy landscape in the Northern Triangle countries in recent years demonstrates an increasing recognition of the importance of sex education, youth-friendly health services and violence prevention policies creating a more enabling environment for young people to access services. All three countries are signatories to human rights agreements that oblige States to ensure access to comprehensive health services for survivors of violence and national policies reflect these obligations. Furthermore, Northern Triangle countries incorporated violence against women into national legislation including the criminalization of sexual violence and femicide, strengthening sanctions against perpetrators [111]. Guatemala and Honduras recently developed specific protocols for providing integrated health services to victims of sexual violence. Despite these positive developments, challenges remain in the implementation of these new policies, particularly around limited access to quality AYSRH services and inconsistent enforcement of violence prevention policies and laws. Specialists interviewed as part of this report agree that enforcement of laws and policies should be more consistent. Though strong laws exist which criminalize femicide and violence against women, reporting remains low and few cases are ever actually pursued or prosecuted.

NATIONAL YOUTH POLICIES

All three countries have current national youth policies covering a variety of issues from access to education, health promotion, culture and sports, youth participation and violence prevention[112],[113],[114]. Over-arching, high-level youth councils exist and are funded in all three countries. In Honduras, the National Youth Institute reports to the President and provides inter-sectoral coordination, monitoring and evaluation[113]. In Guatemala, the National Youth Council (CONJUVE) is the governing body that coordinates youth affairs across government and with other national and international agencies [114]. In El Salvador, the National Institute of Youth coordinates youth affairs on a national level [112]. Despite advancements in improving youth policies and the establishment of high-level committees in the three countries, bottlenecks remain in the application of policy and challenges with under-trained human resources in the health and education sectors persist.

NATIONAL SEX EDUCATION POLICIES

> *"We have made some recommendations for public policy for the prevention of youth violence at the national level in Guatemala and the regional level. A strong component of our recommendations is to include SRH in education planning. We realized that many of the risk factors or common denominators for violence include young people starting in their roles as parents at an early age. So, formal education and informal education should address these issues in spaces that reach youth. It's one of our recommendations at the national level and regional level." -Youth Against Violence in Central America, Jovenes Contra La Violencia Centroamerica*

All three countries signed the 2008 Ministerial Declaration "Preventing with Education" in Mexico City, wherein governments committed to enacting sexual education in schools and to reducing the gap in SRH service coverage for young people. In Guatemala, the Ministry of Health, Education and Social Welfare is responsible for this law (Decreto 87-2005). In El Salvador, the general youth law (Ley General de Juventud) passed in 2012, recognizes and guarantees the right to comprehensive sexual education and holds the government accountable for its provision. In Honduras, the Ministry of Health has implemented a National Strategy for Pregnancy Prevention in Adolescents (ENEPREAH); the Secretary of Education heads efforts to train teachers using guides called "Caring for my Health and Life" [115]. Advances made in each country toward implementation are detailed in table 5.

REPRODUCTIVE HEALTH POLICIES

Policies that increase access to contraception make it easier for young people to engage in safe and healthy behaviors and can provide survivors of sexual violence an opportunity to prevent an unintended pregnancy[116]. EC is currently legal in

[13] See Annex 1 PSI Guide to Youth-friendly health care

Table 5: Advances in Sex Education in Schools (Ministerial Declaration)

Country	Law or National Plan enacted to carry out the Ministerial Declaration objectives	Ministry of Health and Ministry of Education have specific budgets for the implementation of the Ministerial Declaration	Ministry of Health goal for coverage of AYSRH services for all adolescents and youth by 2015*	Ministry of Education: goal for increasing number of schools under MOE jurisdiction with institutionalized comprehensive sexual education by 2015*
El Salvador	Yes	Yes (Education) No (Health)	75%	52%
Guatemala	Yes	No	73%	54%
Honduras	Yes	No	66%	40%

both El Salvador and Guatemala, although only available with a prescription. Even though it is legal, access to EC among adolescents continues to be limited particularly because of confidentiality concerns, embarrassment and stigma, and lack of transportation to a health care provider or pharmacy. Global policy experts, such as the World Health Organization recommend the widespread availability of emergency contraception to offer women an opportunity to prevent pregnancy after unprotected sex or sexual violence[110].

LAWS PROHIBITING VIOLENCE AGAINST WOMEN AND CHILDREN

All three countries have made advances in establishing laws that criminalize violence against women. The "Special Integrated Law for a Life Free of Violence against Women in El Salvador" was adopted in 2012. The legislation includes steps for identifying and preventing violence, including femicide and establishes measures to protect and assist survivors and families of victims. In Guatemala, advances have been made to repeal regressive laws and increase legal protections for women who are survivors of violence. Article 200 of the Penal Code, established during the armed conflict, granted impunity to perpetrators of sexual violence and kidnapping of women and girls over 12 years old as long as the perpetrator subsequently married the survivors. The law was repealed in 2009 to provide for the penalization of sexual intercourse with a child under the age of 14[117]. The recently created cabinet for women has also drafted plans to prevent violence against women and girls, including a process to file complaints and referrals for pregnant girls under 14 years of age to receive comprehensive care for them and their children. The plans also include the implementation of a protocol for the identification, care and referral of cases of violence against girls in the national education system. A sexual violence protocol is being implemented in national hospitals, including the creation of committees to report cases, and protocols to assist survivors of trafficking have also been created[118]. Moreover, all three countries have established ministries of women's affairs to address violence against women and to promote women's rights.

These ministries or commissions are responsible for implementing national plans and programs that address violence against women and coordinating the work of multiple sectors such as justice, education and health. The political strength of these institutions is the key to policy effectiveness.

In effort to reduce impunity for sexual violence cases, forensic medical institutes in El Salvador, Guatemala and Honduras were established as a component of an integrated sexual violence security model developed by governments and supported by different international organizations [119]. Steps to address impunity and limited access to justice for women and indigenous people also include the government's accession to the Rome Statute of the International Criminal Court (recognizing genocide, crimes against humanity and war crimes as international crimes). Constitutional proposals have also been made to restructure the justice and security systems, improve coordination systems between enforcement agencies and to create specialized tribunals against femicide at the department level. However, progress in legislation still lacks implementation in Guatemala. In 2011, 705 cases of femicide alone were reported to the Presidential Commission on Femicide. However, by 2012 only 150 sentences were issued out of 424 cases of gender-based violence filed by women and girls[118].

Grouping violence against children with IPV may be counterproductive as it positions violence against children as part of domestic violence, requiring that reporting happen through adults in the family. This runs the risk of perpetuating violence and even reinforcing it[45]. Currently, corporal punishment for children is illegal in Honduras but legal in El Salvador and Guatemala, leaving children inadequately protected from violence in the home[43]. While strides have been made in the region, hurdles remain, such as insufficient political will to improve funding for implementation of policies and programs, deficient human resources and lack of coordination among local, national and regional strategies.

FUNDING LANDSCAPE FOR AYSRH AND VIOLENCE PREVENTION IN THE REGION

Multi-lateral and bilateral funding fall into two broad categories:

1. Family planning and reproductive health, which excludes HIV funding; and
2. Conflict, peace and security, which encompasses various security activities including security sector reform, violence prevention and counterterrorism [120].

Across all types of donors, trends in the past few years show that funding for the conflict, peace and security sector is growing in the region.

Guatemala has received the largest investments for conflict, peace and security across the three countries. In 2012, Guatemala received $13.2M for conflict, peace and security programs compared to $28M for population policy and reproductive health. Honduras has recently received an investment of $4.74M for peace, conflict and security while receiving $25M for population policy and reproductive health in 2012. Comparatively, in the same year (2012), El Salvador received more balanced disbursements of development assistance with $9.1M for conflict, peace and security and $11.5M for population policy and reproductive health.

The U.S. Government-funded Central America Regional Security Initiative (CARSI) program has provided over $1 billion in assistance since its inception in 2008 with five main goals:

1. Create safe streets for the citizens of the region;
2. Disrupt the movement of criminals and contraband to, within, and between the nations of Central America;
3. Support the development of strong, capable, and accountable Central American governments;
4. Re-establish effective state presence, services and security in communities at risk; and
5. Foster enhanced levels of coordination and cooperation between the nations of the region, other international partners, and donors to combat regional security threats.

The initiative also recognizes that strong programs must address the root causes of criminal activity: a lack of access to basic services such as health care, high youth unemployment, insufficient educational opportunities, overburdened and inefficient justice systems, and increased levels of stress on families[121]. One example of USAID support under CARSI programming that seeks to address both AYSRH and violence prevention in high-crime and violence neighborhoods is the *Healthy Youth Program (Jovenes Saludables)* in Honduras.

This program is a 4.5 program (2012-2017) funded under a 50/50 cost share with Population Services International and the Pan American Social Marketing Organization (PASMO). This sex education and violence prevention program is currently implemented in seven municipalities. The project focuses on reducing teenage pregnancy though sex education in both schools and community spaces (reaching both in and out-of-school youth) including community centers, outreach centers, churches and public spaces. All target locations are in zones that experience high levels of violence.

Conclusion

Poor AYSRH and youth violence share a number of underlying risk factors that often overlap and reinforce one another, exacerbating the potential negative outcomes for young people. Through a comprehensive desk review, this report highlights lessons learned and best practices globally and compiles the most promising program interventions into recommendations. However, there is a definite lack of information and literature on specifically addressing the intersections of violence and AYSRH and evidence base to prove the level of impact such interventions could achieve. These recommendations provide opportunities for the design and implementation of programming to address shared risk factors throughout the life cycle and build protective factors that can have cumulative effects across multiple behaviors. In the Northern Triangle region it is particularly important to consider the role of protective factors which can have a positive impact even when risk factors remain. Programs should consider holistic, multicomponent programs that focus on a variety of protective factors that affect both violence and AYSRH outcomes. This may be especially important because risk factors (such as poverty and community-level violence) will be difficult to impact in the short term.

With increased support through both national commitment and international development assistance in the Northern Triangle; program development can consider best practice interventions such as:

- Home visits to first-time parents to educate them about newborn care, delaying a second birth, positive and violence-free parenting, and healthy relationships;
- Programs to keep girls in school (including flexible scheduling for young mothers);
- Programs that connect girls and boys with adult mentors;
- Integrating workforce development and vocational skills programming for boys with activities focused on transforming gender norms and redefining masculinity, creating male champions for gender equality and female empowerment;
- Mass and social media campaigns to transform negative gender norms and spur community-wide movements to end violence and sexual coercion;
- Bringing youth-friendly health services and information to community-based programs focused on violence prevention;
- Integrating gender-based violence support services within sexual and reproductive health services and sexual and reproductive services with gender-based violence support services;
- Programs that promote protective factors e.g. life-skills, self-esteem and social networks;
- Programs that focus on supporting youth with goal-setting and developing action plans;
- Programs that focus on preventing child abuse and neglect;
- Programs that advocate for the effective implementation of laws and policies that punish perpetration of violence, coerced sex, and forced and child marriage.
- Programs that work with law enforcement officers as allies, rather than just punishers.

Finally, the use of formative, operations, and outcome research should be pursued to ensure that programs are reaching vulnerable youth with effective programming. Continuing to build this body of knowledge will greatly support AYSRH and violence prevention programs to serve those most in need.

The Healthy Youth Program (Jovenes Saludables) in Honduras – promising practice

OVERVIEW

The Healthy Youth Program (Jóvenes Saludables) is part of USAID's Central American Regional Security Initiative (CARSI) under the violence prevention initiatives in high-crime and violence neighborhoods in Honduras. It is a three-year program (2012-2015) funded through a 50/50 cost share with the Pan American Social Marketing Organization (PASMO). This sex education and violence prevention program is currently implemented in 7 municipalities: Tegucigalpa, Comayagüela, San Pedro Sula, Choloma, Villanueva, La Lima, La Ceiba and Tela. The project focuses on reducing teenage pregnancy though sex education in both schools and community spaces (reaching both in and out-of-school youth) including community centers, outreach centers, churches and public spaces. All target locations are in zones that experience high levels of violence.

TARGET POPULATION

The program targets young Ladino and Garifuna people between 10 and 24 years of urban and peri-urban areas of Honduras. The selection of intervention areas and the target population was made according to levels of poverty and exclusion, availability of social opportunities and access to information and services on sexual and reproductive health.

The program conducts a number of interventions with different target groups, including: training teachers to carry out sex-education classes, getting parental buy-in, training youth as change agents, and engaging with the Ministry of Health to strengthen youth-friendly health services. Activities also include a variety of methods to prevent gender-based violence by examining social roles including masculine identity, power relations, stereotypes and sexual rights. Techniques include engaging young people in hands-on workshops, presenting short theater presentations, holding group conversations and showing videos that help initiate discussions and promote reflection.

RELEVANCE

The project was designed using official data on adolescent pregnancy from the Honduras National Program to Prevent Adolescent Pregnancy (ENAPRAH) and from regional studies on the impact of comprehensive sexuality education and empowerment of adolescents and young people on issues of sexual and reproductive health and rights.

A dearth of data on sexual behavior, teenage pregnancy prevention and attitudes and opinions of youth was identified during the program design and planning stage. A qualitative study was carried out with youth in proposed intervention zones to fill this information gap.

INTEGRATION STRATEGIES

The integration of the two health areas (AYSRH and violence prevention) is achieved primarily though the integration of pregnancy prevention and gender-based violence prevention. The project also works on the assumption that adolescent pregnancy prevention targeting youth in high-risks zone is a primary prevention strategy for prevention of interpersonal violence.

RESULTS

- 1,214 teachers have been trained to deliver sex education modules through the curriculum “Caring for my Health and my Life”;
- 54 education centers in the seven municipalities are executing comprehensive sex education;
- 45,656 youth have been reached with 33,665 completing the behavior change and communication intervention including at least three topics such as pregnancy prevention, self-esteem, gender equity and gender based violence;

KEY LEARNINGS

- One of the biggest program accomplishments is reaching in-school youth with comprehensive sex education (in partnership with teachers) in 46 educational centers which shows great promise for expansion (and the institutionalization) of teaching comprehensive sex education in schools.
- The out-of-school youth population has been hard to identify and challenging to address.
- Access to and scheduling of activities in the project zones is limited due to the high levels of violence in the sectors.
- Addressing themes related to gender equity and gender-based violence with the out-of-school population has been challenging due to the pressure and threats from local gang members who are against addressing these issues with youth who participate in project workshops.

Population Council, Abriendo Oportunidades Guatemala and Belize – promising practice

OVERVIEW

Since 2004, the *Opening Opportunities (Abriendo Oportunidades)* program has focused on the core goal of interrupting the cycle of poverty and helping young rural Guatemalan girls and young women from Mayan communities reach their maximum potential.

The objectives of the project are: to expand the skills of girls, adolescent and young women so that they can make positive decisions for their health and well-being; develop positive role models for girls in the communities; guarantee safe spaces within the communities for the target population; and prevent gender-based violence in the communities. The program develops mentors/young leaders who carry out activities as credible voices from the target communities. The objectives of the program include:

- Delaying the age of first marriage
- Delaying the first pregnancy
- Promoting education (returning to studies or staying in school)
- Reducing vulnerability to violence (and developing plans to deal with cases of violence)
- Developing skills from an early age that improve prospects for economic activities, access to social services and health services

TARGET POPULATION

Rural girls and adolescents of Mayan descent are divided into two cohorts (ages 8-12; 13-18). Currently the population includes seven different Mayan ethnic groups: (K'iche', Kaqchikel, Tzutuhil, Mam, Q'eqchi', Poqomchi' and Chorti). The program focuses on longer-term engagement with the target population, working with girls and adolescents for at least 18-24 months. The participants and graduates of the program go on to become leaders and change agents in their families, communities and in the workplace.

RELEVANCE

Mayan girls are among the most disadvantaged groups in Guatemala. They are poorly educated, tend to marry at a young age, bear children early and frequently, are socially marginalized and suffer from chronic poverty. The relevance of "Abriendo Oportunidades" is based on various studies that showed a "silent demand" for adolescents and young Mayan women to have access to positive role models in the community, better self-esteem and confidence to learn new skills.

INTEGRATED STRATEGIES

The program works on preventing pregnancy in adolescents and young women by linking it to the prevention of gender-based violence. One of the key activities includes "safescaping" in order to understand where, when and with whom they feel safe and unsafe; and jointly developing strategies to mitigate risk in rural communities of high social vulnerability and levels of violence. The emphasis of the program is currently on the prevention of violence against girls and young women by connecting the issue with the postponement of unions and first pregnancy, with a special focus on SRH rights, gender, training young leaders to address violence at the community level and helping girls and young women to stay safe and know how to respond to violence. Additionally, the White Ribbon Campaign targeted young men and boys for as a strategy to prevent violence. This campaign involved dialogue sessions conducted at the community and institutional levels with three different sessions on gender, SRH, and violence. The objective of this program component is to develop young men as allies and health promotors for the prevention of violence against girls and young women.

RESULTS

- 100% of girl leader participants (lideresas) have finished sixth grade, as compared with 82% at the national level;
- 97% of the girl leaders did not give birth to children during the program cycle;
- 94% of girl leaders report experiencing greater autonomy and feel more comfortable expressing their opinions due to program participation;
- 88% of girl leaders opened a bank account;
- 44% of girl leaders obtained paid employment by the end of the program;

KEY LEARNINGS

- The program should work with community leaders from the beginning.
- The curriculum/guide should be adapted to the context of the target population.
- Carry out strict monitoring of participation and focus on implementing quality activities.
- Involve parents, including home visits to meet with parents or guardians to resolve questions or misgivings they might have.
- Length of the program must adapt to the girls' learning (18-24 months at least).
- The youth mentors are the primary role models, they speak the language, and should be from the same region.
- Mentors need to be close to the age of the participants.
- A public space where all girls feel safe should be identified for program activities.
- It is important to provide a stipend for the mentors as an incentive and form of motivation. Mentors cannot be expected to work solely as volunteers.

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