

102611

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN EL SALVADOR

DISCUSSION PAPER

JUNE 2015

*Rafael Cortez*  
*Karin-Annabela Revuelta*  
*Yolanda Guirola*



**WORLD BANK GROUP**  
Health, Nutrition & Population



**ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH  
IN EL SALVADOR**

**Rafael Cortez  
Karin-Annabela Revuelta  
Yolanda Guirola**

**June 2015**

## Health, Nutrition and Population (HNP) Discussion Paper

This series is produced by the Health, Nutrition, and Population (HNP) Family of the World Bank's Human Development Network (HDN). The aim of this report is to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, its affiliated organizations, or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character.

The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

For information regarding the HNP Discussion Paper Series, please contact Martin Lutalo at [mlutalo@worldbank.org](mailto:mlutalo@worldbank.org) or Erika Yanick at [eyanick@worldbank.org](mailto:eyanick@worldbank.org).

### Rights and Permissions

The material in this work is subject to copyright. Because The World Bank encourages dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given.

Any queries on rights and licenses, including subsidiary rights, should be addressed to the Office of the Publisher, The World Bank, 1818 H Street NW, Washington, DC 20433, USA; fax: 202-522-2422; e-mail: [pubrights@worldbank.org](mailto:pubrights@worldbank.org).

# Health, Nutrition and Population (HNP) Discussion Paper

## Adolescent Sexual and Reproductive Health in El Salvador

Rafael Cortez<sup>a</sup> Karin-Annabela Revuelta<sup>b</sup> Yolanda Guirola<sup>c</sup>

<sup>a</sup> Senior Economist, Health, Nutrition and Population Global Practice, The World Bank, Washington D.C. USA

<sup>b</sup> Senior Researcher, Health Focus GmbH, Postdam, Germany.

<sup>c</sup> Senior Researcher, CEMUJER-Health Focus GmbH, San Salvador, El Salvador.

**Abstract:** The aim of the study is to understand the sexual and reproductive health (SRH) behavior and determinants among adolescents in El Salvador using data from a survey of 1,258 adolescents aged 10-19 and 12 interviews with representatives from the Ministry of Health (MOH), Ministry of Education (MOE), nongovernmental organizations (NGOs) and UN agencies. The study found that adolescents were not educated enough on their sexual and reproductive health rights (SRHR), and have limited use of and access to contraceptives. Alcohol and violence were found to be associated with risky sexual behavior, requiring a multisectoral response from the government and civil society. Adolescents need to receive earlier and more accurate information on their sexual and reproductive health rights (SRHR); and this information should be disseminated in a way that empowers adolescents to make responsible decisions about their sexual reproductive health. The MOE could play a vital role in informing adolescents in this area, and adjust these programs when necessary. Further, the role of parents is critical, as the study found that adolescents are not receiving adequate and enough SRHR information from their parents. In addition, the MOH needs to offer adolescent-friendly health services, which includes trained health personnel. Although adolescents stated that the maternal and child health programs offered were satisfactory and the government has made an effort at educating adolescents on HIV/AIDS, both the promotion of contraceptive methods and monitoring adolescent SRHR remain as key challenges to be addressed by multisectoral interventions.

**Keywords:** Sexual and reproductive health (SRH), risky sexual behavior, adolescent, sexual and reproductive rights, human rights-based approach.

**Disclaimer:** The findings, interpretations and conclusions are those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

**Correspondence Details:** Rafael Cortez, Nutrition, and Population Global Practice (GHNDR), 1818 H Street, NW, Room G7-197, Washington, DC, 20433; telephone: (202) 458-8707; fax: (202) 522-0050; e-mail: [rcortez@worldbank.org](mailto:rcortez@worldbank.org); website: <http://www.worldbank.org/health>.



## Table of Contents

TABLES AND FIGURES.....	vi
Tables	vi
Figures.....	vi
PREFACE .....	vii
ACKNOWLEDGEMENTS .....	viii
ACRONYMS .....	ix
1. INTRODUCTION .....	1
2. BACKGROUND .....	3
3. METHODOLOGY AND CONCEPTUAL FRAMEWORK .....	7
3.1 Methodology .....	7
3.2 Conceptual Framework .....	8
4. RESULTS .....	12
4.1 Socio-Demographic Profile .....	12
4.2 Sexual and Reproductive Health .....	15
4.3. The Government’s Efforts at Guaranteeing Adolescent SRHR .....	35
5. CONCLUSIONS AND RECOMMENDATIONS .....	37
5.1 Conclusions .....	37
5.2 Recommendations .....	39
REFERENCES .....	41
ANNEXES .....	45
Annex I: Design and Instruments of Study .....	45
Annex II: The International Treaties Ratified by El Salvador Include: .....	45

## TABLES AND FIGURES

### Tables

Table 1. Human Rights Principles and El Salvador's Efforts to Meet These Principles.....	11
Table 2. Adolescents' (10-19 years of age) Reasons for Not Wanting to have Sex by Sex (percent).....	20
Table 3. Adolescent (10-19 years) Frequency of Contraceptive Use by Sex (percent). .....	22

### Figures

Figure 1. Percentage of Adolescents (10-19 years of age) Enrolled in School by Sex.....	12
Figure 2. Percentage of Weekly Hours Worked among Adolescents (10-19 years of age) by Sex. ....	13
Figure 3. Household differences by Geographic Location among Adolescents (10-19 years of age) (percent). ....	14
Figure 4. Most Common Sources of SRH Information as Reported by Adolescents (10-19 years of age) (percent). ....	16
Figure 5. Most Common SRH Topics Taught in Schools as Reported by Adolescents (10-19 years of age) (percent).....	16
Figure 6. Knowledge of Adolescent SRHR according to Right as reported by Adolescents (10-19 years of age) (percent).....	17
Figure 7. Adolescents (10-19 years of age) Perceived Support for their Sexuality by Source (percent).....	19
Figure 8. Adolescents' (10-19 years of age) Perceptions of the Purpose of Sex (percent). ....	21
Figure 9. Most Commonly Used Contraception by Method as Reported by Adolescents (10-19 years of age) (percent).....	22
Figure 10. Relationship Status (single, cohabitating or married) of Adolescents (10-19 years of age) (percent). ....	23
Figure 11. Adolescent (10-19 years of age) Perception on the Most Ideal Time for a Woman to Become Pregnant by Sex and Stage of Life (percent). ....	24
Figure 12. Adolescent (10-19 years of age) Perception of Adolescent Father's Responsibilities by Age (percent). ....	25
Figure 13. Adolescent Girls' (10-19 years of age) reported reasons for keeping their baby (percent).....	26
Figure 14. Adolescent (10-19 years of age) Knowledge about STIs by Infection (percent). .....	28
Figure 15. Type of Health System used for SRH Service among Adolescents (10-19 years of age) (percent). ....	29
Figure 16. Adolescents (10-19 years of age) use of SRH services by Service (percent). ....	29
Figure 17. Adolescent (10-19 years of age) use of SRH service by Residence (percent). ....	30
Figure 18. Adolescent's (10-19 years of age) reported Reasons for Violence by Age (percent). ..	31
Figure 19. Main Perpetrators of Abuse as Reported by Adolescents (10-19 years of age) (percent).....	32
Figure 20. Symptoms of Depression reported by Adolescents (10-19 years of age) (percent). ..	33
Figure 21. Groups most Targeted for Discrimination as reported by Adolescents (10-19 years of age) (percent).....	34

## PREFACE

Adolescents and youth play an important role in society and represent the largest cohort in the history of El Salvador. As with many countries in the Region, El Salvador is currently experiencing a demographic window of opportunity, creating a situation that is conducive for economic development and poverty reduction. However, these young people – particularly adolescent girls and young women – continue to face challenges to meeting their sexual and reproductive health (SRH) needs, challenging their ability to contribute to the country's development. Indeed, inadequate access to health information and services, as well as inequitable gender norms, contributes to a lack of knowledge and awareness about puberty, sexuality, and basic human rights. These underlying factors lead to poor SRH outcomes, such as high rates of adolescent pregnancies and sexually transmitted infections (STIs).

Although it has been twenty years since the International Conference on Population and Development (ICPD) first put adolescent sexual and reproductive rights (SRHR) on the political and public agenda, support and protection for adolescent SRH programs and SRHR policies have developed at a slower pace in El Salvador. Furthermore, adolescents and youth lack knowledge about their SRHR. These young people are the next generation of adults and will greatly influence the achievement of the post-2015 agenda; therefore, investments in SRH education, SRHR, and human capital are critical.

Acknowledging this importance, the World Bank with support from the Nordic Trust Fund, is pleased to present *Adolescent Sexual and Reproductive Health in El Salvador*. This report is based on data collected through a quantitative survey and presents the challenges and opportunities that adolescents in El Salvador face in meeting their SRH needs. It also provides multisectoral and integrated policy and program recommendations to improve adolescent SRH. The overarching goal of this report is to contribute to improving the health and wellbeing of young people through development.

Protecting the health and wellbeing of adolescents and youth is a priority for the World Bank. This report is intended for visionary leaders responsible for shaping social policies and for decision makers concerned with the comprehensive health and development of adolescents and youth. It is our hope that, by disseminating more evidence in adolescent SRH status and policies at country level, countries will make advances in improving the SRH of young people and thereby secure the health and well-being of future generations.

## ACKNOWLEDGEMENTS

This report was prepared by World Bank staff and a team of consultants that included Rafael Cortez (senior economist, GHNDR, task team leader), Karin-Annabela Revuelta (senior researcher, Health Focus GmbH), and Yolanda Guirola (National Coordination, CEMUJER-Health Focus GmbH). This report benefited from contributions from the following World Bank staff and consultants: Alba America Guirola (CEMUJER-Health Focus GmbH), Lorena Rivas de Mendoza (research assistant, University of Central America José Simeón Cañas, Gladys Noemy Anaya Rubio (associate researcher, Health Focus GmbH), Amanda Libertad Guirola (consultant, CEMUJER-Health Focus GmbH); Amparo Gordillo-Tobar (senior health economist, GHNDR), Meaghen Quinlan-Davidson (consultant, GHNDR), and Jimena Garrote (counsel, LEGLE). The report is partly based on a background paper commissioned by the World Bank and prepared by Health Focus, which collaborated with the NGO CEMUJER, the University of Central America José Simeón Cañas; and several technical notes from the Ministry of Health (MOH).

This work was funded by the Nordic Trust Fund (TF098378), which was managed by the World Bank

We gratefully acknowledge the MOH partnership with the Bank in holding the International Seminar on *Adolescent and Youth Sexual and Reproductive Health in Latin America: Incorporating the Human Rights Perspective in Public Health Investments* in August of 2012 in San Salvador. Its conclusions and findings were essential for this report. The report also includes feedback and discussions with the El Salvadorian MOH team led by Dr. Maria Isabel Rodriguez (Minister of Health). We would like to give special thanks to Dr. Sofia Villalta (Director, Directorate of Reproductive Health of the MOH), and the MOH officials who offered feedback and continuous operational support that facilitated the data collection and analysis, and technical dialogue at the country level We also wish to thank Barbara Koppel for her editorial work on the original manuscript.

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper.

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CONNA	National Council on Childhood and Adolescence (Spanish: <i>Consejo Nacional de Niñez y Adolescencia</i> )
FESAL	El Salvadorian National Family Health Survey ( <i>Enquesta Nacional de Salud Familiar</i> )
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
ICPD	International Conference on Population and Development
ISDEMU	Salvadorian Institute for the Development of Women ( <i>Instituto Salvadoreño para el Desarrollo de la Mujer</i> )
ISSS	Salvadorian Institute for Social Security ( <i>Instituto Salvadoreño del Seguro Social</i> )
IUD	
LGBT	Intra-Uterine Device Lesbian, Gay, Bisexual and Transgender
LEPINA	Law on the Comprehensive Protection of the Child and Adolescent ( <i>Ley de Protección Integral de la Niñez y Adolescencia</i> )
MDG	Millennium Development Goal
MOE	Ministry of Education ( <i>Ministerio de Educación</i> )
MOH	Ministry of Health ( <i>Ministerio de Salud</i> )
MMR	Maternal Mortality Rate
NTF	Nordic Trust Fund
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization, Regional Office of the World Health Organization
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SRR	Sexual and Reproductive Rights
UN	United Nations
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organization



## 1. INTRODUCTION

**The adolescent and youth population<sup>1</sup> is the largest cohort in the history of the world, representing approximately 26 percent of the global population (United Nations Population Division, 2012).** These young people face health challenges that are closely linked with poverty, marginalization, and discrimination. Indeed, this key stage of life between childhood and adulthood is defined by physical, mental, social, and emotional changes. With the onset of puberty, it is at this time that adolescents and youth begin to define their gender and sexual identities and roles. These changes are shaped by social determinants, as well as sexual and reproductive health (SRH) risk and protective factors. Meeting the SRH needs of these young people is, therefore, important as it affects their health, development, and opportunities for the rest of their lives.

**Today’s adolescents and youth face substantial physical, social, and economic barriers to meeting their SRH potential. Implicit to meeting these needs are human rights; gender equity and equality; and the provision of healthcare, among others. SRH is a right for everyone, including young people.** When adolescents and youth exercise these rights, they are better able to protect themselves against STIs, unplanned pregnancies, and take advantage of educational and other opportunities. In fact, international support for adolescent and youth SRH and rights has been on the political and public agenda for over 20 years. Indeed, in 1994, the International Conference on Population and Development (ICPD) specifically addressed the right of adolescents to reproductive health education, information, and care (UNFPA, 1994).

**Despite this support, however, young people – especially adolescent girls –continue to consistently face high levels of unmet need for contraception, unplanned pregnancies; unsafe abortions; sexually transmitted infections (STIs), including HIV; violence; exploitation; discrimination on the basis of sexual orientation and gender identity; and maternal mortality and morbidity (UNFPA, 2010).** At the global level, for example, adolescent females 10 to 14 years of age are twice as likely to die in childbirth as adult women, and half of all new HIV infections occur in young people between 15 and 24 years of age (Pathfinder International, 2011).

**Many countries are currently experiencing a demographic “window of opportunity” in which there are a larger proportion of working-age persons relative to the dependent population (World Bank, 2006).** This creates a situation that is conducive for development as it increases the possibility of saving and investing in the economy. Investment in the health, education, and the rights of young people and the alignment of policies is, therefore, important as it enables productivity and economic growth. Empowering young people in their health development, including SRH practices and rights, furthermore, provides them the opportunity to enter adulthood with strong capabilities. They’ll also be better equipped to make informed decisions for themselves and their community (World Bank, 2011).

**Acknowledging this importance, and in order to understand how countries are addressing adolescent sexual and reproductive health and rights (SRHR), the World Bank conducted a quantitative study among 1,258 adolescents 10 to 19 years of age as well as 12 semi-**

---

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

**structured stakeholder interviews in El Salvador, using resources provided by the Nordic Trust Fund (NTF).**

The specific objectives of the study included:

- Evaluating associations between adolescent sexual and reproductive health, human rights, and economic development among adolescents and youth;
- Assessing the operational implications of integrating human rights instruments into SRH services, within the context of limited fiscal resources;
- Systematizing and disseminating the results of these activities in order to support a regional and multi-sectorial dialogue on SRHR.

The goals of the study were to promote adolescent-friendly health services; develop pro-adolescent social programs; develop and implement activities that prevent and respond to adolescent fertility; and raise awareness among adolescents and youth about the importance of their rights.

**The findings from this study were presented to MOH officials and stakeholders at an international seminar and workshop on Adolescent and Youth Sexual and Reproductive Health in Latin America: Incorporating the Human Rights Perspective in Public Health Investments.** The meeting was organized in collaboration with the World Bank and the Pan American Health Organization (PAHO) and held in August of 2012 in San Salvador, El Salvador (Annex I and II).

## 2. BACKGROUND

**El Salvador is a lower-middle income country with a gross national income (GNI) per capita of US \$3,720 (World Bank, 2013).** Young people represent approximately 34 percent of the total population in El Salvador (World Bank, 2013). These adolescents and youth face several interrelated-health challenges to meeting their SRH needs and potential. For example, there are more 15-19 year olds living in poverty than older age groups. Poverty rates also tend to be higher in rural areas and among females (CEPAL, 2012).

**The average number of years of schooling in El Salvador is six, however, education is compulsory for 9 years (between 7 and 15 years of age), indicating that the average adolescent drops out of school before this is fulfilled.** As is the case with many countries, adolescent girls are less likely to be enrolled than boys (PAHO, 2012). Education plays an important role in the life of an adolescent girl in El Salvador as the likelihood of having sex or getting pregnant decreases with higher educational attainment (FESAL, 2008; Samandari, 2010; Vala-Haynes, 2013). For example, research has found that 1 out of every 2 adolescent girls without an education will become a mother before turning 18 years of age; this ratio decreases to 1 in 10 with at least 10 years of education (UNFPA, 2013).

**Most adolescents in El Salvador have learned about SRH.** One study found that 4 out of every 5 female adolescents had received information on menstruation; STIs, including HIV; contraception; pregnancy; and sex. Further, approximately 3 out of 4 adolescent girls had received information on body development during puberty and the human reproductive system. These adolescents were most likely to learn about SRH through school. In fact, two thirds of adolescent girls stated that schools were the most common source for disseminating SRH information. However, although 87 percent of girls learned about HIV/AIDs, only 25 percent were able to correctly answer all five questions about HIV transmission. Similar results were found for contraception (FESAL, 2008), raising an issue about the quality of SRH information provided through schools (Ruiz-Canela, 2012).

**Age at sexual debut is young in El Salvador. According to the most recent data available, approximately 26.8 percent of youth have had sex before the age of fifteen (UNAIDS, 2012).** Indeed, the average age of sexual debut among adolescent girls is 16.3 years with boys initiating sex at an earlier age (FESAL, 2008). When comparing age at sexual debut to other Central American countries, Nicaragua has the youngest age at initiation, followed by El Salvador, Honduras, and Guatemala (UNAIDS, 2012).

**Several factors are associated with age at sexual debut including area of residence, social network, and socioeconomic level.** Studies have found that adolescents in urban areas are more likely to have ever had sex than their rural counterparts (Samandari, 2010; FESAL 2008; Ruiz-Canela, 2012; Springer AE, 2006). Furthermore, family and friends influence adolescent age at sexual debut. In fact, siblings and friends that encourage sex are a significant risk factor for earlier age at sexual debut; other risk factors include a lack of parental monitoring or social support (Ruiz-Canela, 2012; Springer AE, 2006). For example, female adolescents who perceive low parental social support are significantly more likely to engage in risky sexual behaviours than those who perceive higher parental social support (Springer A, 2006). In addition, some evidence has found that sexual activity is higher among the poorest adolescents. One study found that adolescents in the highest socioeconomic bracket were less likely to have sex than their less

wealthy counterparts (Samandari, 2010), while another found that premarital sexual activity tended to be higher among the third and fourth wealth quintile in comparison to those in the lowest two quintiles (FESAL, 2008), indicating that further research is needed in this area to elucidate whether an association exists.

**Research has also found that sexual activity increases with age (Ruiz-Canela, 2012; Springer AE, 2006; Osorio, 2012).** For example, among women, 90 percent have had sex by twenty years of age in El Salvador. Of these, 21 percent had sex before turning 15 and 69 percent by late adolescence (FESAL, 2008). Furthermore, 34 percent of adolescent girls 15-19 years of age report being sexually experienced. These numbers were higher among unmarried women than married women (26 percent and 7.5 percent respectively), and have increased since the previous National Household Survey (FESAL 2002-2003) (FESAL, 2008).

**Despite a reported high level of contraceptive knowledge, contraceptive use among young people is low in El Salvador (FESAL, 2008).** In 2012, the Salvadorian Ministry of Health (MINSAL) reported that 18 percent of sexually active females and 28 percent of males used contraceptives at first sex (MINSAL, 2012). This varied with age, area of residence, and marital status. Older adolescents and adolescent girls in urban areas were more likely to use contraception at sexual debut than their younger and rural counterparts, while unmarried adolescents were less likely to use contraception than their married counterparts (31 percent and 20.5 percent respectively) (FESAL, 2008). Notwithstanding, the literature has found that use of contraception increases with age at first sex. Twenty-three percent of adolescent girls who initiated sexual activity before the age of 15 had used contraception at first sexual encounter, while 31 percent used contraception in later adolescence. Studies have also found that use increases with socioeconomic level and education (FESAL, 2008).

**Adolescent fertility is a significant concern in El Salvador with 76 births per 1,000 adolescent females 15-19 years of age, well above the regional average of 69.1 (per 1,000 adolescent women 15-19 years of age) (World Bank, 2013).** In 2011, El Salvador was ranked among the 50 countries with the highest adolescent fertility rates in the world. In fact, seven out of ten sexually active adolescents 15-19 years of age become pregnant each year, of which approximately 47 percent are unplanned and 8.9 percent are repeat pregnancies (PAHO, 2012). Further, approximately 24 percent of adolescents have given birth by their eighteenth birthday (UNFPA, 2013). In 2008, the MOH found that of these adolescent pregnancies, 10.8 percent were among unmarried adolescents and 12.7 percent among married adolescents (FESAL, 2008). In 2012, approximately 25,000 adolescents between 10 and 19 years of age gave birth in a health center, accounting for 23.8 percent of all institutionalized births that year (MINSAL, 2012-2013).

**Despite these statistics, however, the adolescent fertility rate in El Salvador has decreased by 19.3 percent over the last decade.** Further, births to adolescents, as a share of all births in El Salvador, have declined from 30.2 percent in 2005 to 23.8 percent in 2012 (World Bank, 2012). This is an achievement given that adolescent fertility in the Latin American and Caribbean region has been decreasing at a slower rate than total fertility since the 1970s (UNICEF, 2007).

**Adolescent pregnancy does not occur independently but rather as a result of the interaction between reinforcing social and economic factors.** Age at sexual debut has been associated with not only sexual behaviours, such as multiple sexual partners and decreased contraceptive use, but also health and economic outcomes, including an increased risk for STIs; unplanned pregnancies; lower socioeconomic status; intimate partner violence; and school

abandonment (Wellings, 2006). It also alters the odds of young age at first pregnancy, as older age at sexual debut lowers the likelihood of getting pregnant during adolescence (Samandari, 2010; Azevedo, 2013). In addition, the lower the socioeconomic level the greater the likelihood of experiencing an adolescent pregnancy in El Salvador (FESAL, 2008). Other factors that are associated with adolescent pregnancy include lack of adequate SRH knowledge and information, a lack of contraceptive use, and a lack of power to exercise SRH rights.

**Interestingly, studies have found that adolescent mothers who are more educated when they found out they were pregnant were less likely to interrupt their education and more likely to go back to school than less educated mothers.** This indicates that education is not only a protective factor against early pregnancy but also a protective factor against dropping out of school permanently (FESAL, 2008).

**Importantly, adolescent pregnancy entails high medical, social, and economic costs for society while contributing to the intergenerational transmission of poverty.** Young age at first pregnancy impacts a teenager's education and life prospects. It also is associated with female disempowerment; poor prenatal, labour and delivery; and postnatal services (IDB, 2011). Furthermore, it can also lead to maternal morbidity and mortality.

**In 2011, MINSAL reported that 11 percent of all maternal deaths were among adolescents, while PAHO has estimated that as many as 25 to 30 percent of all maternal deaths in El Salvador were among adolescents 15-19 years of age (MINSAL, World Bank, and PAHO 2012).** Overall, adolescents have worse pregnancy outcomes than adult women. Moreover, adolescent mothers under the age of 16 are at a substantially higher risk of maternal morbidity and mortality compared to older adolescents (16-19 years of age) (Conde-Agudelo, 2005).

**Not only does pregnancy put adolescent lives at risk but an attempt to terminate the pregnancy does so as well.** El Salvador is one of five countries with the strictest abortion laws in the Region. In El Salvador, abortion is prohibited under any circumstance, even if a woman's life is at stake. This violates universal human rights laws by limiting a woman's right to life and health, and compromises their life and health even further by making them seek illegal abortions, which are typically unsafe (Lakhani N, 2013). In 2012, MINSAL reported that approximately 26 percent of women hospitalized due to an abortion were adolescents (MINSAL, 2012).

**Furthermore, suicide is one of the main causes of death among pregnant adolescents.** According to MINSAL, suicide is the second cause of death among adolescents between 10 and 19 years of age and is particularly high among pregnant adolescents. It is estimated that it accounts for half of all pregnant adolescent deaths (Azevedo, 2013).

**Within this framework of adolescent and youth SRH, many of the social norms and expectations related to gender roles, marriage, and fertility have remained the same.** These have dictated adolescent male and female behaviour, exposing them to a different set of risks, with a particularly negative impact on adolescent girls and young women. For example, *machismo* (masculinity) and *marianismo* (femininity) impact adolescent boys and girls sexual behaviour, sexual responsibilities, sex education, and access to SRH information and services (PAHO, 2012; Rani, 2003; Remez 2008). One study found that adolescent males were more likely than females to feel pressured to have sex (32 percent of adolescent males in comparison to 20 percent of females) (Osorio, 2012). Adolescent females, on the other hand, were encouraged to have sex with older men for financial benefits. In fact, 13.4 percent of women aged 15-24 who initiated sex between

15 and 19 years of age stated that their partner was their age or younger, in comparison to 30 percent who stated that their first partner was 3-5 years older (Boston University School of Public Health, 2011). This was even higher among those who initiated sex before 15 years of age, with 37 percent reporting that their first partner was 3-5 years older and 23 percent reporting that he was 6 to 9 years older (FESAL, 2008).

**Gender norms and gender inequality also play a role in sexual abuse and violence. Approximately 20 percent of sexually active adolescent girls reported experiencing forced sex.** In fact, they were 4 times more likely to report forced sex than their male counterparts (Springer AE, 2006). According to the Observatory of Gender Violence, adolescent girls between 12 and 18 years of age are also most likely to be victims of sexual violence, followed by women 18-25 years of age (CIDH, 2011). Further, the Salvadorian Institute for the Development of Women (ISDEMU) reported that between 2008 and 2009, those between 10 and 14 years of age were the most likely to be raped (IDESMU, 2010).

**Another consequence of gender inequality is that adolescent fertility is higher among females compared to males.** For example, 24.4 percent of females in El Salvador have given birth while 7 percent of sexually experienced adolescent males have impregnated someone (Springer AE, 2006). In fact, most children of adolescent mothers have adult fathers. In many cases, the father (especially an adolescent father) refuses to accept responsibility. This gender inequality leads to several problems. Firstly, the responsibility falls on the adolescent mother and maternal grandmother. Secondly, the father figure is absent from the household. A father's absence in the household can have serious consequences on the child's development, especially on girls who are more likely to become pregnant at a younger age, thus, continuing the cycle of adolescent motherhood.

**The provision of adolescent-friendly SRH services in El Salvador is needed, as there is a high unmet need.** Indeed, most services are intended for adults, and many doctors and nurses are not trained for sharing information and providing services to youth in a sensitive and engaging way (Rodriguez, 2008). Adolescents and youth in El Salvador, therefore, face several challenges when accessing SRH services, including, among others, a lack of awareness about their SRH rights; a lack of SRH knowledge and information; and a lack of confidentiality and negative attitudes from healthcare providers (Ehrle, 2011).

## 3 METHODOLOGY AND CONCEPTUAL FRAMEWORK

### 3.1 Methodology

**Researchers gathered information through a questionnaire developed by the World Bank and Health Focus GmbH to understand adolescent SRHR in El Salvador.** In addition to collecting demographic information, the questionnaire explored the following topics:

- Adolescent access to SRH information
- Knowledge about SRHR and the exercise of these rights
- Gender and sexuality
- SRH knowledge, attitudes, and practices
- Violence, depression, and discrimination
- SRH services

**A human rights based conceptual framework was developed and guided the content of the questionnaire.** It was built upon a human rights based approach to programming and the goals of the International Conference on Population and Development (ICPD) 1994; the ICPD+5 1999; the ICPD+10 2004; and the 2005 23rd Special Session of the General for the Review and Appraisal of the Beijing Declaration and Platform for Action and the Outcome Document (Beijing+10). It also utilized various conventions and human rights principles that have been ratified by El Salvador.

**A representative sample of adolescents (both sexes) was recruited through a nationwide randomly selected process at the household level from the 14 districts in El Salvador.** The sample size was based on 2008 census estimates with a confidence interval of 95 percent and an error margin of +/- 4 percent. The statistically significant sample was estimated according to the population share in each of the districts, separated by rural and urban areas, gender, and age. An additional 5 percent of the population was added to the sample to anticipate the possibility of invalidity of some questionnaires.

**A pilot study was conducted in order to test the questionnaire and to standardize procedures.** It was conducted in a randomly selected district in which the field team surveyed 30 participants (20 in an urban area and 10 in a rural area). The final version of the questionnaire was adjusted accordingly.

**Participants were approached in their homes by interviewers who had been trained prior to the start of the study.** Interviewers established initial contact with the participants, describing the questionnaire and the purpose of the study while providing them with informed consent. Each participant's consent was obtained prior to the start of the study. They understood that the survey would be anonymous and confidential. They then set a time to come back and conduct the survey. In households that had more than one eligible participant, only one was interviewed. Further, participants were informed that the SRH tools used have already proven valid (e.g., UNFPA, PAHO).

**The data was analyzed using SPSS for Windows, version 14.0.** A *Likert Scale* of 1 to 5 was used for questions that addressed attitudes (for example, strongly agree; agree; neither agree nor disagree; disagree; strongly disagree). Quantitative methods (for example, frequency,

percentages, average) as well as bi- and multi-variable regression analyses were used to analyse closed questions. In order to assess knowledge regarding human rights, sexual rights, reproductive rights, social determinants of SRH, and social interaction, a scale was constructed corresponding to these categories. For the open-ended questions, two analytical techniques were used: content analyses for the system of categories and ethnographic analyses.

**A total of 1,258 participants 10-19 years of age participated in the survey. There were a total of 630 females and 628 males.** Of these, approximately one third (n=439) were 10-14 years of age and two-thirds (n=819) 15-19 years of age. Over half of the participants (56.5 percent) lived in urban areas while 43.5 percent lived in rural areas.

**Stakeholder interviews were also conducted in order to understand the government's efforts at guaranteeing adolescent SRHR.** These interviews were conducted among a randomly selected group of representatives from non-governmental organizations (NGOs), United Nations organizations, the Ministry of Education, and the Ministry of Health. Inclusion criteria for the stakeholder interviews included a minimum of one year of service as well as voluntary participation in the interview. Coordinators and heads of service, as well as SRH health workers were interviewed.

**A total of 12 interviews were conducted.** Two interviews were conducted among representatives from NGOs, 1 from an United Nations organization, 3 from the Ministry of Education, and 6 from the Ministry of Health.

### **3.2 Conceptual Framework**

The conceptual framework that was used in the study was developed to provide overall guidance in the development of the questionnaire and implementing ASRHR in El Salvador. The framework builds on the following: a human rights-based approach (HRBA) to programming; several international conferences on sexual and reproductive health and rights (SRHR); and El Salvador's legal obligations to SRH.

#### ***Human Rights-Based Approach***

**When using an HRBA to develop and implement adolescent SRH programs, it is important to recognize and address the diversity of needs.** Each young person has a unique set of life circumstances and develops at their own pace. For example, sexually and non-sexually active adolescents, young mothers, adolescents with disabilities, young married couples, abused adolescents, adolescents with HIV/AIDS, and poor and marginalized adolescents and youth all have different needs. These needs must, therefore, be approached and addressed in different ways (UNFPA, 1994).

**It also requires viewing adolescents and youth as “right holders”, or individuals who are aware of and able to exercise their rights.** This necessitates that governments be accountable for their actions to prevent and reduce barriers that lead to human rights violations (BMZ, 2008). It also entails employing a holistic approach to adolescents and youth when examining their civil, political, social, economic, and cultural rights (Boesen, 2007). For example, for adolescent SRH, comprehensive gender and socio-culturally sensitive approaches to information and educational

activities and services should be provided in order to encourage healthy and responsible behaviours (UNAIDS, 2012).

**Furthermore, certain principles must be incorporated into adolescent SRH policies and programs, including non-discrimination and equality; participation and empowerment; and transparency and accountability.**

#### **Non-discrimination and Equality**

One of the most important components to realizing a young person's right to health is non-discrimination and equality. This requires that governments respect, protect, and fulfil all human rights (for example, civil, political, social, economic, and cultural) regardless of age, sex, sexual orientation, mental or physical health, ethnic or religious affiliation, and other status<sup>2</sup> (OHCHR, 1976). This also entails analysing the structural and indirect forms of discrimination in terms of public policies (or lack thereof), local power structures, and cultural practices. For example, this includes policies that deny adolescents' access to SRH information and education, or cultural practices that put the parental responsibility on the mother instead of the father (Boesen, 2007).

With equality, governments must prioritize access to quality health services, focusing on the most marginalized and vulnerable groups and the proper allocation of health resources (OHCHR, 1976).

#### **Participation and Empowerment**

Participation and empowerment signify that even the most marginalized and vulnerable groups are able to exercise their rights and participate in the decision-making processes that affect them. This requires governments to implement recommendations from international human rights bodies, suggesting that participation is not only a development tool but also a goal within itself (Boesen, 2007).

#### **Transparency and Accountability**

Transparency and accountability are two critical components of young people's right to health. It is the ability of citizens to monitor policies, and requires governments to analyse the causes of poverty, deprivation, and human rights violations in order to set priorities. These priorities should include expanding young people's choice and increasing their ability to exercise rights, as well as target economic improvement (GTZ, 2009).

Accountability mechanisms can include judicial (for example, public interest litigation); quasi-judicial (for example, reviews by national human rights institutions); administrative (for example, complaint desks at public service offices); political (for example, elected health or education councils); or social (for example, the involvement of civil society in monitoring policies and budgets) (GTZ, 2009).

### ***International Conferences on Sexual and Reproductive Health and Rights***

Several conferences over the last twenty years have been held that have put SRHR on the political and public agenda. Four of these conferences are highlighted below. The documents that have resulted from these conferences are important tools for SRHR advocates and women's rights.

---

<sup>2</sup> 'Other status' indicates that the list of grounds in which discrimination is prohibited is non-exhaustive and subject to expansion.

### ***The International Conference on Population and Development (ICPD) 1994***

**Twenty years ago, ICPD 1994 was held in Cairo (UNFPA, 1994).** It was at this Conference that delegates from 179 countries made significant advances in putting SRH, including adolescent SRHR, on the political and public agenda. These countries agreed that:

**Reproductive rights** are a set of human rights described in international treaties, including the right of individuals and couples to decide on the timing and spacing of pregnancies, to have the information and means to do so, and to be free from coercion, discrimination, and violence. (UNFPA, 1995)

*therefore implies that people are able to have a satisfying and safe life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.* (UNFPA, 1995)

People have the **right to family planning and SRH information** as stated that: *all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.* (UNFPA, 1995)

**The Conference also recognized adolescent vulnerability and the need for reproductive health (RH) education and services,** urging governments to provide private and confidential family planning (FP) information and services to sexually active adolescents, including services for STIs and sexual abuse, as well as information on how to prevent adolescent pregnancies and avoid poor reproductive health outcomes (UNFPA, 1994).

**In the years since ICPD 1994, various meetings and pronouncements have reaffirmed the role of reproductive rights and reproductive health in achieving human rights, reducing poverty, attaining gender equality, building a world free of violence against women and girls, preventing HIV/AIDS, and attaining the Millennium Development Goals (MDGs) (UNFPA, 2008).** At the ICPD+5, delegates reviewed the Plan of Action (POA) and set specific benchmarks for youth obtaining SRH services, including access to male and female condoms (UN, 1999b). However, post-ICPD+5 agreements have omitted any mention of youth access to condoms. At the ICPD+10, delegates from Latin America and the Caribbean (LAC) and Asia-Pacific asked governments to address unsafe abortion through appropriate strategies, as it was and continues to be a major public health concern (Reichenbach and Roseman, 2009). The Beijing+10 went one step further and mentioned sexual rights. This was a major milestone for sexual health and rights given that since 1999 no agreement had been made that unconditionally recognized governments' obligation to provide universal access to confidential SRH services to young people, regardless of age, parental consent, or marital status (Reichenbach and Roseman, 2009).

### ***El Salvador's Ratification of International Treaties and Human Rights Principles***

**The observations and recommendations from the present study were compared to various conventions ratified by El Salvador, including among others, the 1948 Universal Declaration (UN General Assembly, 1948); the 1979 Convention on the Elimination of All Forms of Discrimination (UN General Assembly, 1979); and the 1989 Convention on the**

**Rights of the Child (CRC) (UN General Assembly, 1989).** Further, the study reviewed and utilized human rights principles relevant to adolescent SRHR. Table 1 illustrates examples of El Salvador trying to meet these human rights principles.

Table 1. Human Rights Principles and El Salvador’s Efforts to Meet These Principles.

Human Rights Principles	Example of El Salvador’s Efforts to Meet these Principles
<i>Non-discrimination</i>	<ul style="list-style-type: none"> <li>• Guaranteeing non-discrimination for all before the law</li> <li>• 2009 Special Law on HIV/AIDs that prohibits any discrimination based on sexual orientation and gender identity</li> </ul>
<i>Equality</i>	<ul style="list-style-type: none"> <li>• Guaranteeing equality for all before the law</li> </ul>
<i>Freedom from sexual violence</i>	<ul style="list-style-type: none"> <li>• Passing special measures to protect women and children from sexual violence, including: <ul style="list-style-type: none"> <li>◦ The 2010 Special Comprehensive Law for Women’s Access to life Without Violence (La Asamblea Legislativa, 2010)</li> <li>◦ Establishing ISDEMU</li> <li>◦ Reforming the Penal Code to define sexual harassment</li> <li>◦ Developing the Management Guide on the Comprehensive Care for Women’s Health</li> </ul> </li> </ul>
<i>Life</i>	<ul style="list-style-type: none"> <li>• The government defines life as starting at the moment of conception and penalizes abortion under all circumstances</li> </ul>
<i>Freedom of expression and access to information</i>	<ul style="list-style-type: none"> <li>• The Law on the Comprehensive Protection of the Child and Adolescent (LEPINA) (La Asamblea, 2010)</li> </ul>
<i>Privacy, family, and parental responsibilities</i>	<ul style="list-style-type: none"> <li>• Parents have certain obligations to their children</li> </ul>
<i>Social security</i>	<ul style="list-style-type: none"> <li>• The government gives pregnant women the right to claim child support and health services from the public health system</li> </ul>
<i>Work</i>	<ul style="list-style-type: none"> <li>• Passing several laws to protect pregnant women, ensuring that they have the right to work</li> <li>• Prohibition of child labour, especially if their right to education is compromised due to work</li> </ul>
<i>Adequate standard of living, including special assistance for motherhood</i>	<ul style="list-style-type: none"> <li>• The Constitution requires that minors be protected in such a way that allows them healthy development and growth</li> </ul>
<i>Education</i>	<ul style="list-style-type: none"> <li>• The right to free primary and intermediary education</li> <li>• Requiring schools to ensure that pregnant students stay in the system</li> </ul>
<i>Health</i>	<ul style="list-style-type: none"> <li>• Following international health agendas such as the Millennium Development Goals (MDGS)</li> <li>• Following the 2008 Technical Guide on Family Planning to reduce adolescent pregnancies</li> <li>• Following the 2011-2015 Multisectoral National Strategic Plan for the Prevention, Care, and Control of HIV/AIDS</li> </ul>

**Source:** World Bank Group. Adolescent sexual and reproductive health and rights Survey: El Salvador. Health Focus. 2012. Data collection commissioned by the World Bank. 2012.

## 4. RESULTS

The results of the study are divided into the following sections: the socio-demographic profile of study participants; their sexual and reproductive health; and the government's efforts to ensure adolescent SRHR.

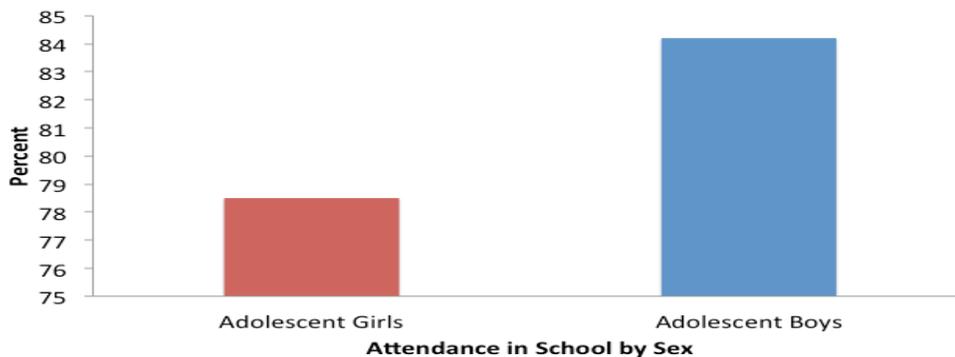
### 4.1 Socio-Demographic Profile

This section presents information on the demographic background within which Salvadorian adolescents live. Importantly, their background and the social, economic, and cultural environment in which they are raised and develop impact their SRH choices. These basic characteristics provide the background for interpreting findings on SRH presented later in the report.

#### *Education*

**According to the study, approximately 81.4 percent of adolescents interviewed were in school at the time of the study, with girls significantly less likely to be enrolled than boys (figure 1).** Further, 39.7 percent of adolescents reported that they had completed 7<sup>th</sup> – 9<sup>th</sup> grade; 20.5 percent of adolescents had received a diploma from a technical/trade school; and 1.6 percent were university students. In addition, approximately 40 percent of adolescents stated that they had not completed 6<sup>th</sup> grade.

**Figure 1. Percentage of Adolescents (10-19 years of age) Enrolled in School by Sex.**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

#### *Family and Household Arrangements*

**Most adolescents were dependent on their parents or another adult in their life.** Households ranged from living with parents (both or either), grandparents, siblings, partners, stepparents, godparents, or in-laws. Few lived alone. Most adolescents lived in large families with their parents and relatives. In fact, 58.2 percent of adolescents lived in households with 5 to 9 family members; 36.7 percent lived with 1 to 4 relatives; and 5.1 percent lived with 10 or more relatives.

**More adolescent boys reported living with their fathers than adolescent girls (46.2 percent and 39.5 percent respectively).** Participants were less likely to live with their mothers (30.9

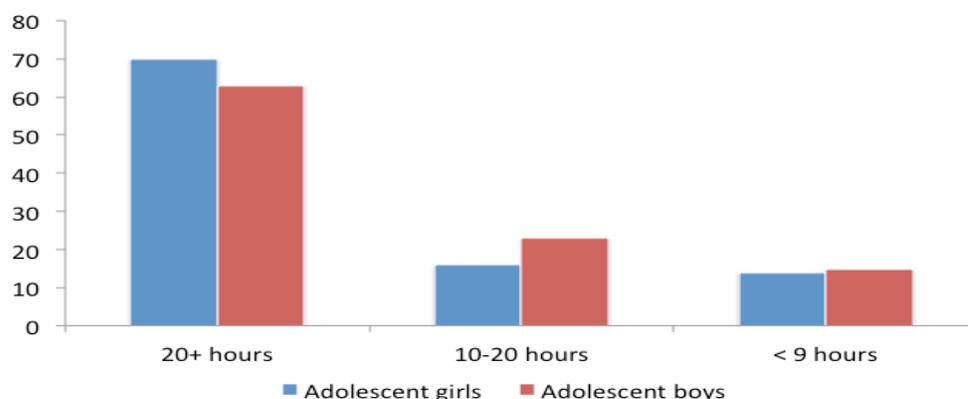
percent of boys and 33 percent of girls), and even fewer with their grandparents (10.8 percent). More than half of participants' parents lived together (54.1 percent) or were married (boys were more likely to report this than girls at 57.4 percent and 50.5 percent respectively). Approximately 32.6 percent reported that their parents were divorced or separated, with 4.1 percent having a deceased parent.

**Most of the participants were financially supported by their fathers (47.2 percent), while 28.7 percent were supported by their mothers.** Further, approximately 28 percent reported that both parents worked, while 32.6 percent stated that their father was employed and 16.8 percent reported that their mother was employed.

### **Employment**

**A total of 17.5 percent of participants reported that they worked.** Adolescent boys were more likely to work outside of their homes than girls (25.6 percent and 9.3 percent respectively) ( $p = 0.000$ ).<sup>3</sup> Among girls who worked, 70 percent worked more than 20 hours a week, 16 percent worked 10-20 hours, and 14 percent worked less than 9 hours. Among the boys who worked, 63 percent worked more than 20 hours a week, 22.9 percent worked between 10 and 20 hours, and 14.9 percent worked less than nine hours (figure 2). On average girls made approximately USD \$47.50 per month while boys made USD \$50.80 per month.

**Figure 2. Percentage of Weekly Hours Worked among Adolescents (10-19 years of age) by Sex.**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### **Remittances and Household Expenses**

**Remittances are an important source of Salvadorian family income, with 30.3 percent of adolescents reporting that they have lived in households that receive them.** Only 3.5 percent of adolescents, however, reported directly receiving remittances. The average amount of each household remittance was approximately USD \$173.20, with an average household receiving

<sup>3</sup> Chi square was applied.

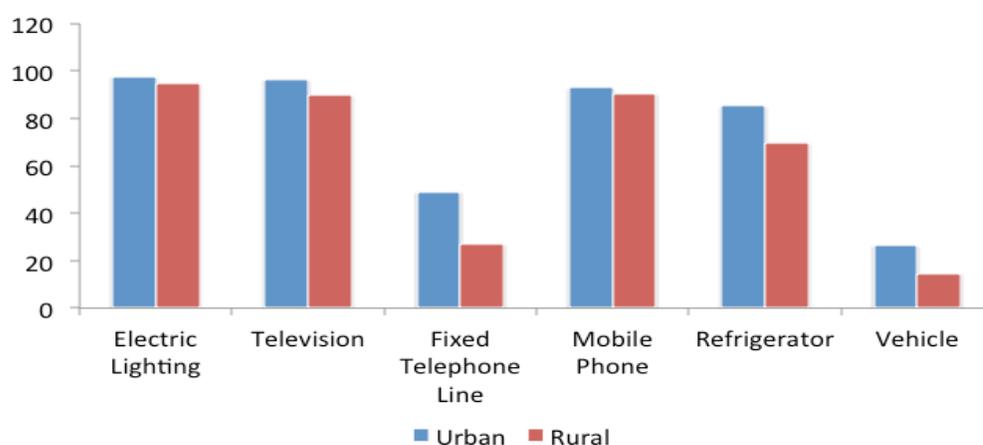
approximately USD \$2,279.60 per year in remittances. There was no significant difference by area of residence ( $p=0.28$ )<sup>4</sup>.

**On average, households spent approximately USD \$160.20 on monthly food purchases (for example, food, drinks, and tobacco).** Urban areas spent significantly more on monthly food purchases than rural areas (USD \$176.20 and \$138.90 respectively) ( $p=0.000$ ).<sup>5</sup> Further, the average total monthly expense per household was approximately USD \$312.10 and significantly differed based on area of residence ( $p=0.000$ ).<sup>6</sup> Urban households on average spent USD \$342.50 per month while rural households spent approximately USD \$273.10 per month.

### ***Area of Residence***

**When looking at household differences by geographic location, the study found that adolescents in rural areas were less likely to have a television, fixed telephone line, refrigerator, and vehicle** in comparison to adolescents in urban areas (figure 3).

**Figure 3. Household differences by Geographic Location among Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### ***Social Benefits and Group Membership***

**Sixty percent of Salvadorian households benefitted from educational programs provided through the Ministry of Education (MOE).** These included such programs as the “healthy school program” (25.8 percent), school meals (78.5 percent), and uniforms (95.8 percent). This differed by geographic location in that households in rural areas received more social benefits than urban areas (67.9 percent and 55.3 percent respectively).

**Approximately a third of the adolescents (35.2 percent) reported belonging to a youth group, with more boys than girls participating in these groups (39.8 percent and 30.5**

<sup>4</sup> T-test applied for independent sample.

<sup>5</sup> T-test applied for independent sample.

<sup>6</sup> T-test applied for independent sample.

**percent respectively).** Approximately 47 percent of adolescents reported that these programs were generally organized through schools; 37.2 percent stated they were organized through churches; and 15.6 percent stated that they were organized around community associations and NGOs. Typical activities included sports, cultural and religious events, and social work. Boys were more likely to partake in sports (60 percent and 31.8 percent respectively), while girls were more likely to participate in religious activities (44.6 percent and 29.2 percent respectively).

## **4.2 Sexual and Reproductive Health**

This section presents information collected through the survey on adolescent SRH in El Salvador. There are multiple factors that influence adolescent SRH including education and career aspirations; access to healthcare; attitudes towards contraception; community, cultural, and familial expectations; among others. These findings provide evidence for the importance of developing adolescent SRH programs and guaranteeing and enforcing adolescent SRHR policies in El Salvador.

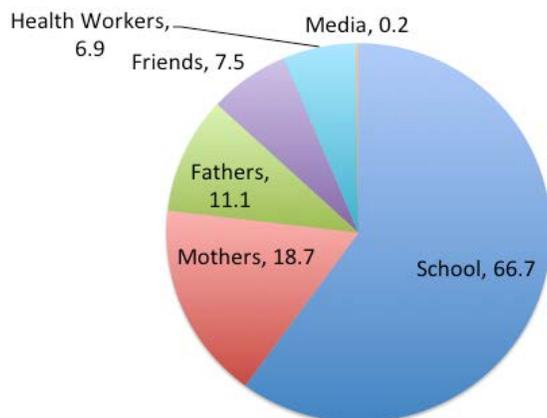
### ***Access to SRH Information***

**The study found that although 85 percent of Salvadorian adolescents reported learning about SRH, the information was often insufficient.** For example, only 10 percent of adolescents knew at which stage in the menstrual cycle they were most likely to become pregnant. This varied by age, sex, and residence. Adolescents 15-19 years of age were significantly more likely to know more about SRH than those 10-14 years of age (57 percent and 36.9 percent respectively); adolescent girls had greater knowledge than boys; and urban residents were likely to receive more information on SRH than rural residents. Furthermore, the information varied by topic and sex. Adolescent girls were more likely to learn about the female reproductive system, FP, and violence; while adolescent boys were more likely to learn about the male reproductive system, sexual rights, and making informed decisions.

**When asked to provide the most common sources for learning about SRH, 67 percent of adolescents ranked school as the most common source (figure 4).** Adolescents stated that – at school – they were most likely to learn about the human reproductive system and HIV/AIDS, followed by FP, gender equality, and responsible decision-making (figure 5).

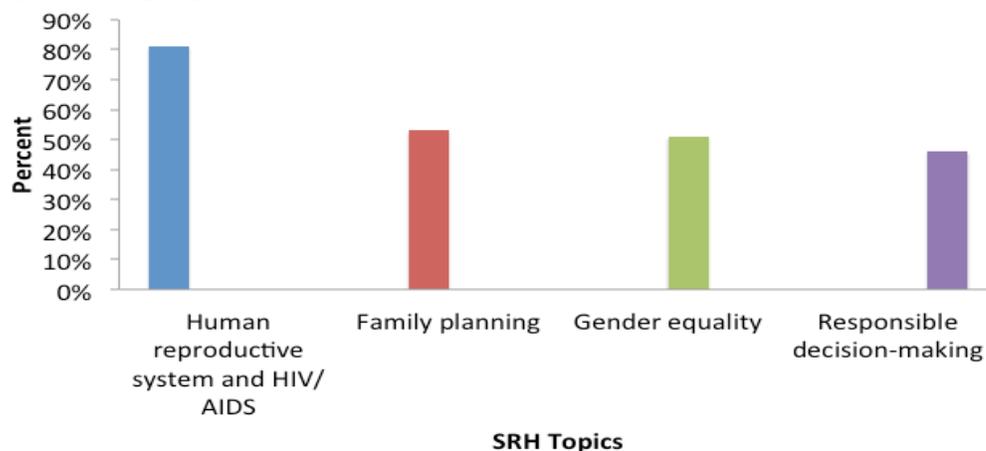
**The second most common source for learning about SRH was mothers, followed by fathers.** Adolescent girls were more likely to speak with their mothers about SRH while adolescent boys were more likely to speak with their fathers. At home, adolescents reported that they were most likely to learn about responsible decision-making and life- plans from their parents. Similar results were found in both urban and rural areas (52.9 percent and 46.2 percent respectively). In addition, 8.8 percent of adolescents stated that they talked to their parents about their sexual health rights, while 8.4 percent reported that they spoke about their reproductive health rights. Further, adolescent females were more likely to state that family was the most important source for learning about sexuality than adolescent males (54.7 percent and 45.5 percent respectively).

**Figure 4. Most Common Sources of SRH Information as Reported by Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group. Adolescent sexual and reproductive health and rights Survey: El Salvador. Health Focus GmbH. 2012. Data collection commissioned by the World Bank.

**Figure 5. Most Common SRH Topics Taught in Schools as Reported by Adolescents (10-19 years of age) (percent)**



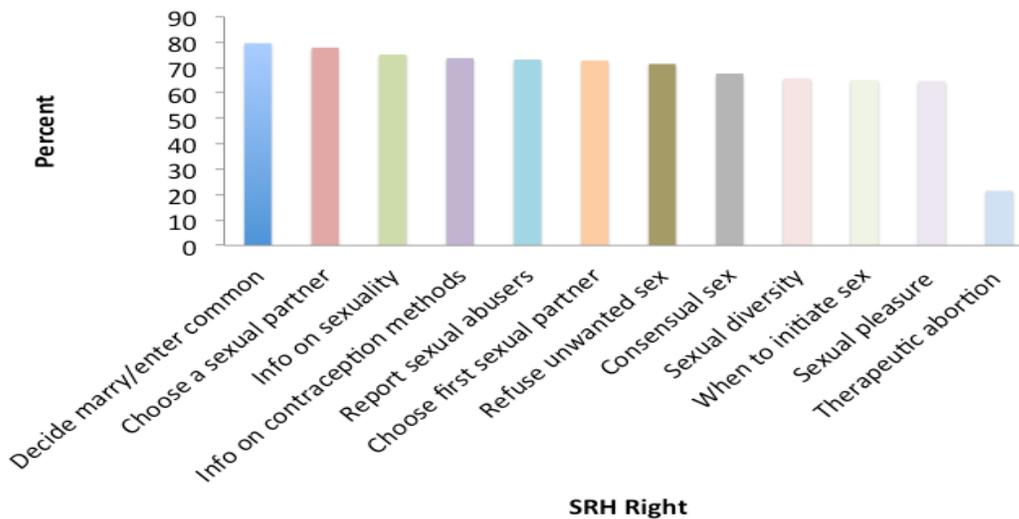
**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Another common source of information about SRH was health personnel.** Adolescents reported that they were most likely to learn about health-related issues, such as sexually transmitted infections (STIs), contraception and FP methods, and sexuality. In fact, 4.4 percent of rural adolescents reported that they received SRH information from health centers as opposed to 2 percent of urban adolescents. Friends were another importance source of providing information on SRH. In contrast, the study found that the media (for example, radio, television, the internet, and newspapers) was not an educational source for SRH information. In fact, adolescents found that the media increased their interest in pornography, glorified risky sexual behaviors, and sexually stimulated them.

### SRHR Knowledge and the Exercise of these Rights

Approximately 50.6 percent of adolescent males and 49.4 percent of females reported that they knew about SRHR, with adolescents 15-19 years of age more likely to know about these rights than those 10-14 years of age (57 percent and 36.9 percent respectively). Of those aware of their rights, 92.1 percent reported that they understood them and 93.7 percent said that the knowledge was valuable. Regression analyses conducted found that knowing about SRHR reduced the risk of becoming a parent by 66 percent, while it also reduced the risk of being mistreated by 46 percent. The figure below indicates that adolescents were most aware of the right to marry or enter into a common law union, followed by the ability to choose a sexual partner, and the right to information on sexuality. Adolescents were least aware about rights concerning sexual pleasure and therapeutic abortion. Adolescents 15-19 years of age and adolescent boys were more likely to think that these rights were guaranteed and should be respected in comparison to their counterparts.

**Figure 6. Knowledge of Adolescent SRHR according to Right as reported by Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Adolescents did state, however, that they believed that their SRHR were not fully guaranteed in El Salvador.** This was due to a lack of adequate and available SRHR information, as well as a perception of having limited control over their lives and relationships due to societal and familial restrictions. For example, the right to decide when to marry or enter a common law union could not be exercised because parents and friends influenced their relationship, as well as their right to choose a sexual partner, as sex was not permitted in their household.

**Further, adolescents stated that there was a lack of information on: contraceptive use, the right to decide when to initiate one's sex life, and the right to sexual pleasure.** Of great concern to adolescents was that the right to report sexual abuse was not guaranteed and enforced.

**When asked where they had learned about these rights, adolescents stated that they heard about them through schools and at home.** Other sources included health centers, NGOs, the Attorney General's office, and television.

**Importantly, adolescents questioned the validity of some SRHR principles recognized by the international community.** They stated that they thought that the right to sexual pleasure did not exist and that sexual pleasure should not be promoted given that it represents promiscuity and the spread of STIs. Further, due to social norms and discrimination, adolescents questioned the right to sexual diversity. In addition, a third of adolescents stated that the right to therapeutic abortion did not exist, and more than 15 percent of adolescents knew that abortions were illegal in El Salvador.

## ***Gender and Sexuality***

### ***Gender Norms***

**According to the study, Salvadorian adolescents' ideas of masculinity and femininity were based on social, community, and religious beliefs.** For example, adolescents reported that they believed that physical differences exist between men and women and that this defines societal expectations: the woman's role is to be a mother, raise children, and take care of the household, while the man's role is as the head of the household, responsible for working and supporting the family. Although they reported that it was also the woman's role to defer to the man's opinion and that young women often felt guilty over expressing their own opinion, the majority of adolescents felt that women were not respected in their communities.

**Adolescent boys were seen as disruptive, associated with gangs, substance abuse, and crime; while adolescent girls were disrespected for being teenage mothers and not provided adequate assistance or counseling.** According to the study, adolescents reported that these gender differences were associated with risky sexual behaviors and unplanned pregnancies.

### ***Sexual Norms***

**When asked about male and female sexual norms, 30.9 percent of adolescents (33.3 percent of adolescent girls and 28.5 percent of adolescent boys) reported that they thought all men had an uncontrollable need to have sex while 15.3 percent of adolescents (12.7 percent of adolescent girls and 17.8 percent of adolescent boys) thought that women had this same need.** Forty-four percent of adolescents thought that it was acceptable for men to have multiple sexual partners, while only four percent thought this was acceptable for women. Further, 30.4 percent of adolescents said men should initiate sexual relations, while 17.6 percent said women should.

**Five percent of adolescents stated that men could have sex with their partner even if his partner didn't want to, while eight percent stated that a woman could have sex with her partner, even if her partner did not want to.** Moreover, 7.9 percent of adolescents stated that women should only have sex to please their partners. In addition, 13.8 percent of adolescents reported that males could postpone having sex while 11 percent of adolescents said that females

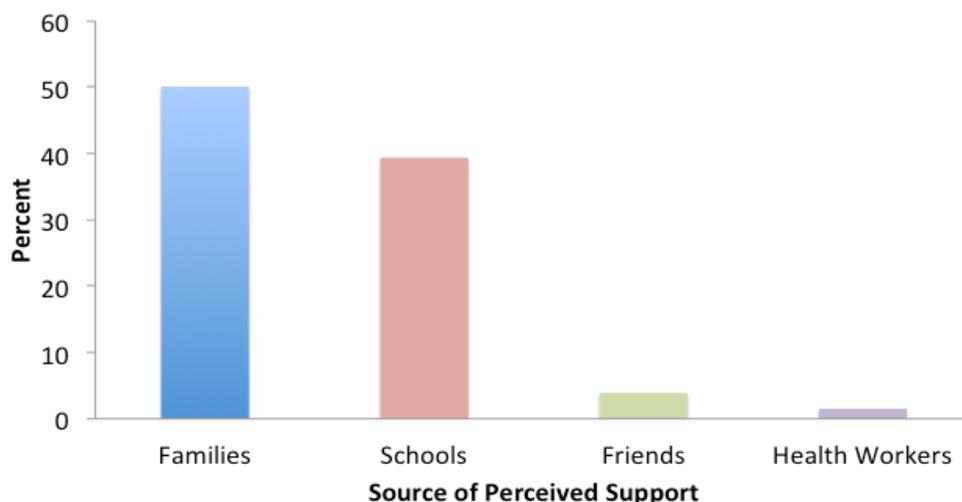
could do the same. They also reported that young women were much more likely to be stigmatized for being unfaithful than young men.

### **Sexual Orientation**

**Most adolescents reported that homosexuality was abnormal.** They stated that they thought they would fail as parents if their children were homosexual; in fact, the majority stated that they would try to seek professional help to change their child’s sexual or gender identity. Although 11.4 percent of adolescents reported that sex among same-sex couples was acceptable and 0.7 percent identified as being attracted to the same sex, the majority used negative terms when referring to homosexuality stating that it was against religion. In addition, adolescents thought that homosexuality arose from childhood sexual abuse, as well as the media’s influence on promoting sexual diversity. Despite their overall negative view of homosexuality, the majority of adolescents stated that all people should be respected, regardless of their sexual or gender identity.

**When asked about where they sought support for their sexuality, 50.1 percent of adolescents reported that their families supported them, followed by schools, friends, and health workers (figure 7).** Other responses included churches, boyfriends/partners, spiritual guides, godmothers, books, and the media (for example, internet, radio, and television).

**Figure 7. Adolescents (10-19 years of age) Perceived Support for their Sexuality by Source (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### **SRH Knowledge, Attitudes, and Practices**

#### **Sexual Debut**

**The average age of sexual debut among 10-14 year olds was 13.2 years, while the average age among 15-19 year olds was 15.4 years.** There was a statistically significant difference between the age at sexual debut for adolescent girls (15.9 years) and adolescent boys (14.8 years). Further, the average age at sexual debut was significantly higher among rural areas in comparison to urban areas (15.6 years and 15 years respectively). Most adolescents reported having their first sexual experience with either a boyfriend/girlfriend, friend, or spouse.

**Approximately 3 percent of adolescents 10-14 years of age claimed to have had sex in comparison to 40.8 percent of those 15-19 years of age.** More adolescent boys stated that they had sex than girls (32.1 percent and 23.1 percent respectively), and more adolescents in rural areas had sex than urban areas (29.2 percent and 26.3 percent respectively).

**Over 50 percent of adolescents stated that their first sexual experience was voluntary and planned.** Of these, 77.2 percent of adolescents reported that the decision was made jointly with their partners, while 6.6 percent stated that the decision was made alone. Of those that made the decision alone, 2.1 percent were girls and 6.8 percent were boys. Further, 49.6 percent of adolescents stated that their first sexual experience was voluntary but not planned. This was true for 61.5 percent of 10-14 year olds and 49.1 percent of 15-19 year olds.

**Three adolescents reported that their first experience was the result of sexual abuse and one reported that it was involuntary due to pressure.** Approximately 5.6 percent of adolescents 15-19 years of age reported that they felt pressured the first time they had sex, with adolescent girls more likely to feel pressure than boys (9.7 percent and 2.5 percent respectively). Of those who felt pressured, 6 became pregnant and 2 thought about having an abortion.

**Of those who were sexually active, 88.5 percent of adolescents reported that their first sexual experience was enjoyable, while 11.5 percent stated that they did not enjoy it.** Of those who did not enjoy it, approximately 18.5 percent were adolescent girls and 6.4 percent were boys.

**Adolescents 15-19 years of age were more likely to report that alcohol consumption was a factor during their first sexual experience (8 percent in urban areas and 5.1 percent in rural areas).** This varied by sex with adolescent boys more likely to report alcohol consumption than girls (8.2 percent and 4.4 percent respectively).

**Table 2. Adolescents' (10-19 years of age) Reasons for Not Wanting to have Sex by Sex (percent).**

Reason	Both	Adolescent Girls	Adolescent Boys
Not emotionally mature		43.8	41.3
Wanting to wait		13.7	13.1
Worried about pregnancy		5.6	
Worried about impregnating			2.4
Parental advice against sex	3.1		
Religious reasons	0.7		

**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

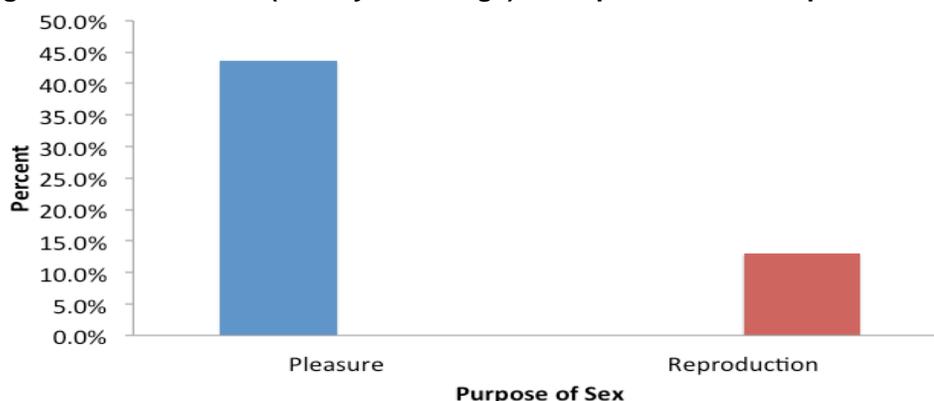
**When asked about their greatest fear in having sex, 84.7 percent of adolescents reported that they were most afraid of getting pregnant (91.7 percent of 10-14 year olds and 84.4 percent of 15-19 year olds), with girls more afraid of getting pregnant than boys**

**impregnating someone (86.2 percent of girls and 83.6 percent of boys).** Other reported fears included parents finding out (4.6 percent of girls and 4.2 percent of boys); an inability to satisfy a sexual partner; or an inability to fulfill the act.

**Of those who were not sexually active, reasons as to why they have not had sex yet included that they were not emotionally mature; they wanted to wait; they were worried about getting pregnant; they were afraid to impregnate someone; they were following parental advice; and religion (table 2).** Other reasons included not being old enough and the negative consequences associated with sex.

**In addition, more adolescents thought that pleasure was part of having sex** and was not just for reproduction (figure 8); while 41.4 percent thought it was bad to masturbate.

**Figure 8. Adolescents’ (10-19 years of age) Perceptions of the Purpose of Sex (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### **Contraceptive Use**

**Approximately 54 percent of sexually active adolescents reported using a contraceptive method the first time they had sex.** This varied by age and geographic location. At first sex, the study found that adolescent boys (64.8 percent of boys and 38.2 percent of girls) and urban areas were more likely to use contraception (57.3 percent in urban areas and 49.4 percent in rural areas). In both sexes, the use of contraception increased substantially from first to last sex: from 38.2 percent to 55.6 percent in adolescent girls and 64.8 percent to 67.3 percent in adolescent males.

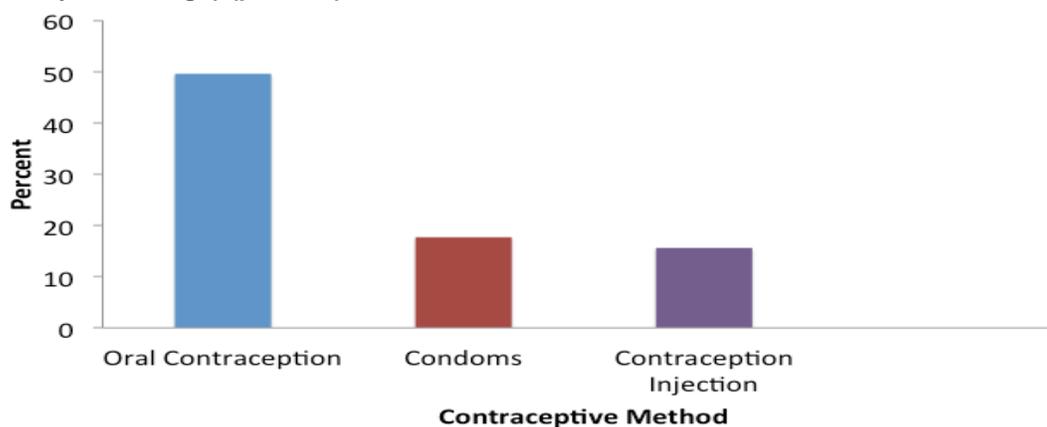
**When asked about regular use of contraception, adolescent boys were more likely to report regular use than girls (51 percent and 38 percent respectively) (table 3).** Oral contraceptives were the most common method, followed by condoms and contraception injection (Figure 9). Other contraceptives and practices adolescents reported using were anal sex, oral sex, intra-uterine devices (IUDs), the “day-after” pill, skin patches, vaginal rings and implants, abstinence, coitus interrupts, and the rhythm method. Furthermore, approximately 52.9 percent of sexually active 15-19 year olds and 20 percent of 10-14 year olds stated that they used the morning after pill at some point in their life.

**Table 3. Adolescent (10-19 years) Frequency of Contraceptive Use by Sex (percent).**

Frequency	Males ( percent)	Females ( percent)
Always	51.2	38.0
Almost always	15.9	16.8
Rarely	22.9	15.3
Never	10.0	29.0

**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank. 2012.

**Figure 9. Most Commonly Used Contraception by Method as Reported by Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Approximately 87.5 percent of adolescents had heard of condoms and knew how to use them, however only 17.7 percent of adolescents reported using them regularly.** Further, 12.5 percent of adolescents did not know about condoms (30 percent of which were 10-14 years of age and 3.1 percent were 15-19 years of age), while 2.7 percent of adolescents stated that individuals should always use a condom. Access to and preference for condoms was limited among adolescents. For example, 11.4 percent of adolescents 10-14 years of age and 9.9 percent of 15-19 year olds stated that condoms were not sold to minors.

**Among those who were sexually active but did not use contraception, when asked why they did not use contraception,** adolescents responded that: they did not think about it; they were too embarrassed to buy them; they didn't think they were sold to minors; they weren't prepared; they lacked contraceptive knowledge; they weren't sexually active; they thought it caused health problems; they thought it was too much work and didn't know how to use them; their partners might think them unfaithful; they didn't think it was one hundred percent effective; and they thought it reduced sexual pleasure.

**Approximately 10.8 percent of adolescents did not know how to prevent pregnancy, with adolescent boys less likely to know than girls (12.5 percent and 8.7 percent respectively).** This was associated with age and residence. Among adolescents 10-14 years of age, 27.9 percent did not know how to prevent pregnancies in comparison to 7.9 percent of those 15-19 years of age; those in rural areas had less knowledge than urban areas (9.1 percent and 11.8 percent respectively). Further, of those who were sexually active, 7.1 percent reported that they did not know how to prevent pregnancies.

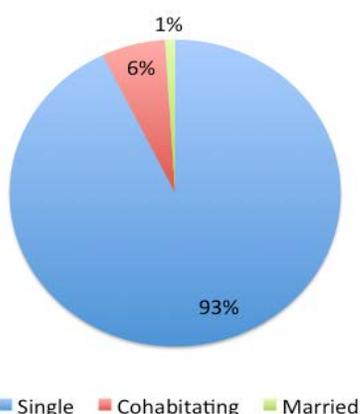
**Slightly more than half (53.4 percent) of the adolescents surveyed attended information sessions on contraception, and approximately 63.8 percent thought both men and women were responsible for preventing pregnancies.** More adolescent girls stated that it was the woman’s responsibility to prevent unplanned pregnancies (25.5 percent of adolescent girls and 12.9 percent of boys respectively), while more adolescent boys reported that it was the man’s responsibility (13.8 percent of adolescent boys and 6.4 percent of girls). In addition, more than half (55.3 percent) thought that abstinence was the best contraceptive method. Further, 39.7 percent thought that adolescent girls should take the pill, while 54.4 percent thought that a correctly used condom protected against pregnancies in 96 percent of the cases.

**Approximately 35.7 percent of adolescents 10-14 years of age and 6.5 percent of adolescents 15-19 years of age thought they could easily obtain contraceptives** from health centers; while slightly more than half stated that they did not know if this was possible, indicating that they did not associate or access contraceptives at health centers.

### *Pregnancy*

**Among female participants, approximately 12 percent had given birth, while among male participants approximately 3 percent were fathers.** In fact, adolescent girls were significantly more likely to become a mother than adolescent boys becoming a father. Further, results from the regression analyses found that an adolescent girl was 8 times more likely to become a parent than an adolescent boy, even if the boy underreported paternity. Furthermore, the risk of becoming a parent increased with age (by a factor of three for each year); however the risk of becoming a parent was reduced by one-fifth if the household benefited from social programs; if the adolescent participated in a youth group; and it reduced the risk by one third if the household had a telephone line.

**Figure 10. Relationship Status (single, cohabitating or married) of Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

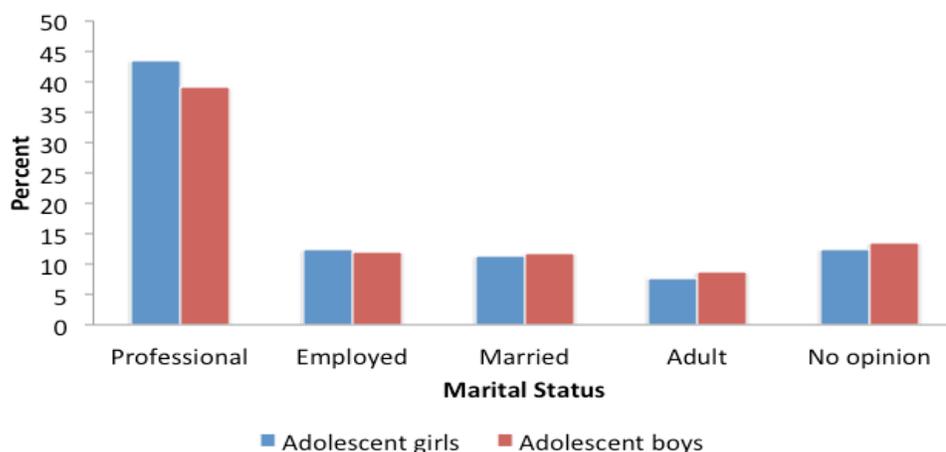
**In terms of relationship status, 92.9 percent of adolescent parents were single; 6.2 percent were cohabitating with their partner; and 1 percent were married (9.7 percent of girls and 2**

**percent of boys) (figure 10).** However, more boys (41.5 percent) claimed to have a lover or girlfriend than girls (32.6 percent).

**Knowledge about pregnancy was limited among both 10-14 year old and 15-19 year old adolescent girls.** For example, although 75 percent of 10-14 year olds had been taught when a woman becomes pregnant, only 16.6 percent knew at which point in the menstrual cycle this was most likely to occur. Among 15-19 year olds, although 49.9 percent stated that they learned at which stage this was most likely to occur, 9.6 percent knew the correct answer.

**The study also found that adolescent knowledge about pregnancy-related health issues was limited.** According to the surveyed adolescents, the most common diseases for pregnant women were HIV (52.5 percent), heart problems (9.4 percent), and genital herpes (7.9 percent). Diseases less frequently mentioned were dengue, influenza, systemic lupus erythematosus, chronic heart or kidney diseases, breast and uterine cancer. This varied with age in that adolescents 10-14 years of age were less likely to identify potential diseases in comparison with their older counterparts.

**Figure 11. Adolescent (10-19 years of age) Perception on the Most Ideal Time for a Woman to Become Pregnant by Sex and Stage of Life (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**The study also found that adolescents had a negative view of pregnancy, with adolescents stating that a woman should become pregnant when she is economically independent from her parents (figure 11).** They also stated that becoming pregnant signified the end of adolescence and the beginning of adulthood (39.2 percent of adolescent girls and 28.7 percent of boys); and 54.9 percent stated that it signified school abandonment. Approximately 31 percent stated that it meant entering the workforce in order to financially provide for the child. Further, 6.1 percent of adolescent boys and 3.1 percent of girls stated that pregnant girls had fewer work opportunities, while 1.4 percent of boys and 0.3 percent of girls reported that they could become criminals or commit suicide.

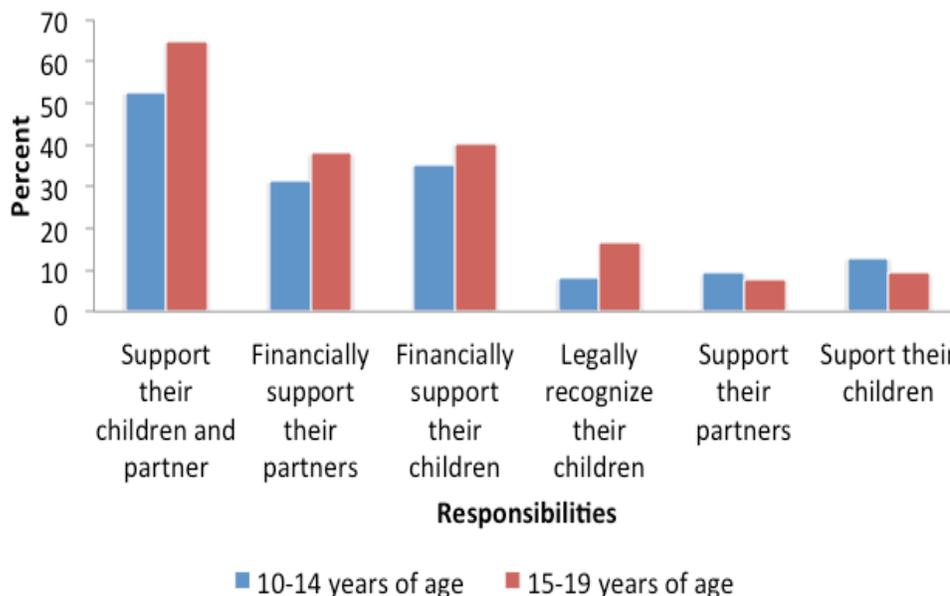
**Fifty-three percent of adolescents thought that adolescent mothers' responsibilities involved taking care of the child (39.4 percent of adolescent girls and 32.6 percent of boys) and fighting for their rights (9.4 percent of adolescent girls and 6.2 percent of boys).** Other

responsibilities included helping their partner and sharing responsibilities (25.5 percent); self-care during pregnancy (16.5 percent); accepting the pregnancy even if it was unplanned (10.7 percent); and taking steps to prevent future pregnancies (3.6 percent). More adolescent boys and adolescents 10-14 years of age reported that they did not know what a pregnant adolescent's responsibilities were.

**For an adolescent father, 35.6 percent of adolescent girls and 31.8 percent of boys stated that it implied the beginning of adulthood; it also signified the end of life plans, as they had to work to provide for their family (31.8 percent of adolescent girls and 29.1 percent of boys).** Sixty percent of adolescents reported that it also connotes school abandonment and limited career opportunities (5.9 percent of adolescent girls and 3.3 percent of boys), while approximately 8 percent of adolescents stated it that it implied marriage or a common law union with the mother of the child.

**According to the figure below, participants stated that they thought adolescent fathers had to assume more parental responsibilities in terms of physical, emotional, and financial support for both their partner and child.** Adolescents 15-19 years of age were more likely to think that adolescent fathers had to assume more responsibilities than their younger counterparts. They also thought that adolescent fathers should live in a common law union with the mother of their child; establish a household; and not have other girlfriends.

**Figure 12. Adolescent (10-19 years of age) Perception of Adolescent Father's Responsibilities by Age (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

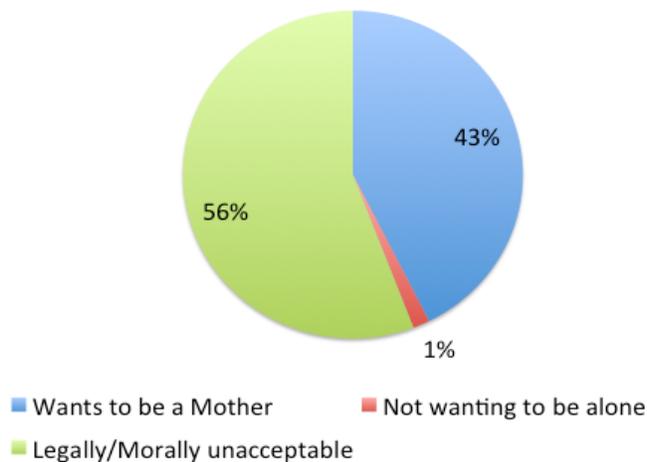
**Among adolescent girls who reported having been pregnant, 86.1 percent had been pregnant once and 13.9 percent had been pregnant twice.** This varied by area of residence with adolescents in rural areas significantly more likely to get pregnant than adolescents in urban areas (16.7 percent and 10 percent respectively). Approximately 43.8 percent were planned

pregnancies and 56.2 percent were unplanned. Reasons for keeping the child included wanting to be a mother; not wanting to be alone; and stating that it was morally and legally unacceptable (figure 13).

**Of the 56 percent who thought that not keeping their baby was morally and legally unacceptable, they gave the following reasons:** 16.4 percent stated that abortion was a sin; 11.5 percent stated that the child was a gift from God; 8.2 percent stated that they had no other alternative; 6.6 percent had to accept the consequences of their behaviour; 4.9 percent thought the child was part of them; 4.9 percent stated that the child was innocent; and 3.3 percent thought that the child meant life. Despite these figures, adolescent girls were significantly more likely to have a negative view about parenthood than boys.

**Complementing the results of the Adolescent sexual and reproductive health and rights Survey, the focus group discussions with the participation of 18 adolescent fathers (15-19 years old) provided valuable information about their perception about fatherhood.** When asked about fatherhood, 5 fathers saw it as a way to gain social respect and status; 2 reported that it was experience; 2 stated that it was responsibility; and 1 thought it was joy. Five adolescent fathers said they gained nothing and one said he did not know what to think. In addition, 5 stated that they lost their freedom; 3 their childhood and adolescence; 2 reported that they lost their academic opportunities; 1 stated that he lost financial and emotional support from his family; and 2 stated that they had lost nothing.

**Figure 13. Adolescent Girls' (10-19 years of age) reported reasons for keeping their baby (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Of the 18 adolescent fathers participating in the focus group discussions, 13 (72 percent) reported that they financially supported their children while 1 stated that he did not; 4 did not respond.** When asked what activities they engaged in with their children, adolescent fathers stated that they played with them; took care of them; fed them; clothed them; bathed them; and took them to school.

**Further, adolescent fathers reported that their partner's pregnancy changed their lives.** In fact, 8 started to work; 4 left school; and 3 had to leave their parents' home. They stated that they were more responsible; that they would be more careful in the future; that they learned that there were consequences to sex; that life was more difficult; that they had to do an apprenticeship to work; that they were working more than normal; and that they did not go out with their friends anymore.

### ***Sexually Transmitted Infections***

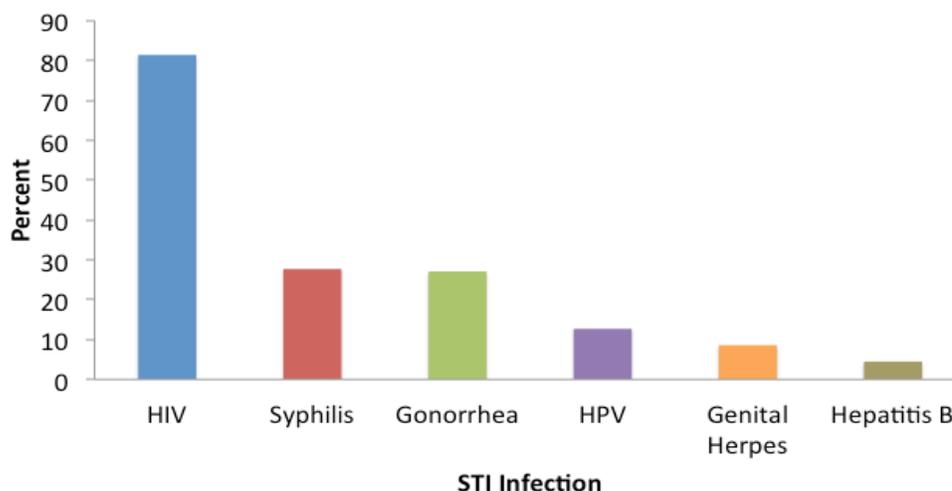
**The study found that adolescent knowledge about STI transmission was limited, with adolescents 15-19 years of age knowing more about transmission than those 10-14 years of age.** For example, approximately 50.7 percent believed that they could get an STI if they did not use a condom; 36.8 percent if they had multiple sexual partners; 13.3 percent if they did not know that their partner was infected; 6.4 percent if they did not practice abstinence; and 5.1 percent if they had unplanned sex. Less frequently mentioned sources for STIs included infected needles and blood transfusions (2.2 percent). Eleven percent of adolescents reported that they did not know how people contracted an STI. This varied by area of residence with rural areas knowing significantly less about STIs than their urban counterparts.

**Approximately 6.7 percent denied that STIs existed, while 68.4 percent of adolescents 10-14 years of age and 93.7 percent of adolescents 15-19 years of age stated that STIs did exist,** with urban areas more likely to report this than rural areas (87.1 percent and 82.1 percent respectively).

**Thirty-five percent of adolescents (17.6 percent of 10-14 year olds and 44.8 percent of 15-19 year olds) stated that they received information from health centers about STI prevention, while 57.6 percent of adolescents stated that they did not receive any information from health centers.** Of those who received information, they all agreed that the information was useful. More adolescents from rural areas received information from health centers on STIs than their urban counterparts (39.7 percent and 32.1 percent respectively). In terms of knowledge about STIs, adolescents knew most about HIV, followed by syphilis, gonorrhea, HPV, genital herpes, and hepatitis B (figure 14).

**A total of 6 adolescents 15-19 years of age stated that they were diagnosed with an STI (4 girls and 2 boys; 4 lived in urban areas and 2 lived in rural areas).** All stated that health providers respected their right to confidentiality. Further, they reported that they received medical care from one of the following: the MOH, a private clinic, university physician, or pharmacy. All stated that they had not used condoms during their most recent sexual encounter, although they said that they had received information on STIs and contraception.

**Figure 14. Adolescent (10-19 years of age) Knowledge about STIs by Infection (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

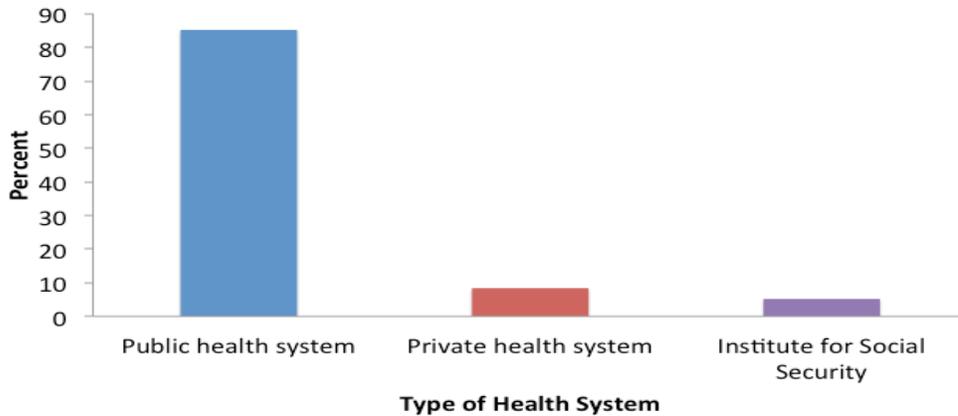
### **SRH Services**

**Almost two thirds (62.7 percent) of adolescents reported that they used general health care services, with similar rates found in rural and urban areas.** However, it was significantly higher among adolescent girls than boys (66.6 percent and 58.9 percent respectively). Among those who did not use health services, reasons they gave for not using these services included, among others, not needing to; fear; not believing in western medicine; and not feeling comfortable.

**In comparison, 12.3 percent (17.2 percent of 15-19 year olds and 3.3 percent of 10-14 year olds) ever used an SRH service such as FP, STI counseling, and pre-natal care.** Adolescent girls and rural areas were more likely to report using SRH services than their counterparts, while adolescents 15-19 years of age were significantly more likely to use these services than younger adolescents.

Of those who used SRH services, most sought services through the public health system, followed by the private sector and the Salvadorian Institute for Social Security (ISSS) (figure 15).

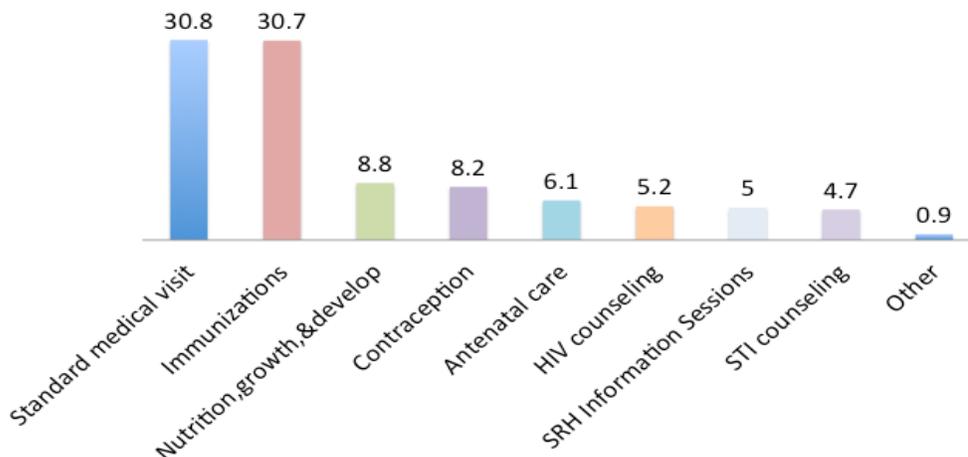
**Figure 15. Type of Health System used for SRH Service among Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Further, adolescents in rural areas were more likely to use public services than urban areas (91.7 percent and 77.5 percent respectively).** Figure 16 provides the type of SRH service adolescents used, with medical consultations and immunizations used most often. Adolescents 15-19 years of age were more likely to use these services than those 10-14 years of age. Further, there was a difference in use of these services based on residence. Adolescents from urban areas were more likely to use standard medical visits in comparison to rural areas, while adolescents from rural areas were more likely to use preventative services (figure 17).

**Figure 16. Adolescents (10-19 years of age) use of SRH services by Service (percent).**

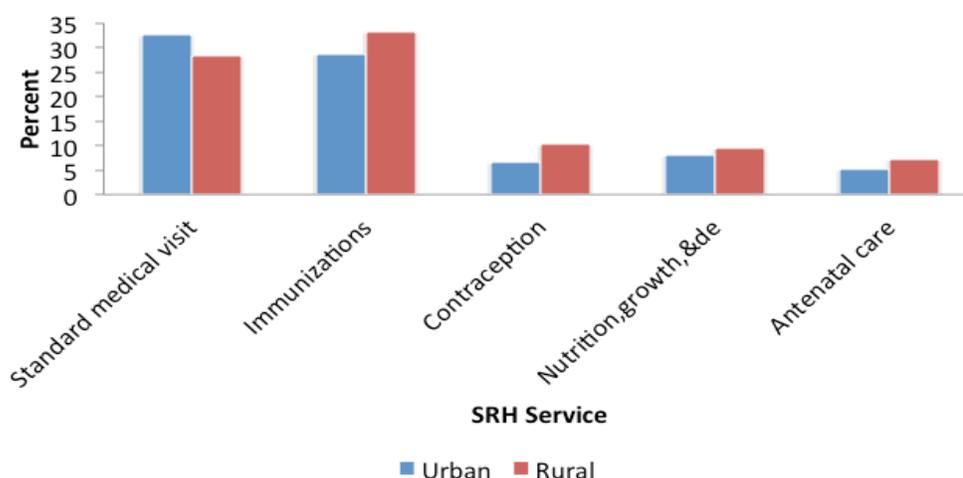


**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

When asked if they were satisfied with the services they received, 92.6 percent of adolescents reported that they received the information that they needed and 66.4 percent stated that the health care providers listened attentively when they explained their health problems. However, 11.2 percent stated that health care providers were disrespectful; and 8.4 percent stated that providers divulged their confidential information to a third party. In addition, 48 percent of adolescents stated that health care providers asked for parental authorization, with adolescents 10-14 years of age experiencing this more than those 15-19 years of age (76.6 percent and 33.6 percent respectively).

Of the thirteen adolescents who reported that they were sexually abused, only three (2 adolescent girls and 1 boy) stated that they received medical attention (for example, treatment and psychological support) in a health center. Of those who did not receive health care attention, they stated that they did not know about these services or did not want to go to the health centers.

Figure 17. Adolescent (10-19 years of age) use of SRH service by Residence (percent).



**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

Among those who did not use SRH services, when asked why they did not use these services, reasons included age (for example, they were too young); sexual inactivity; a lack of time; not comfortable; length of waiting time; and negative attitudes from health providers; among others.

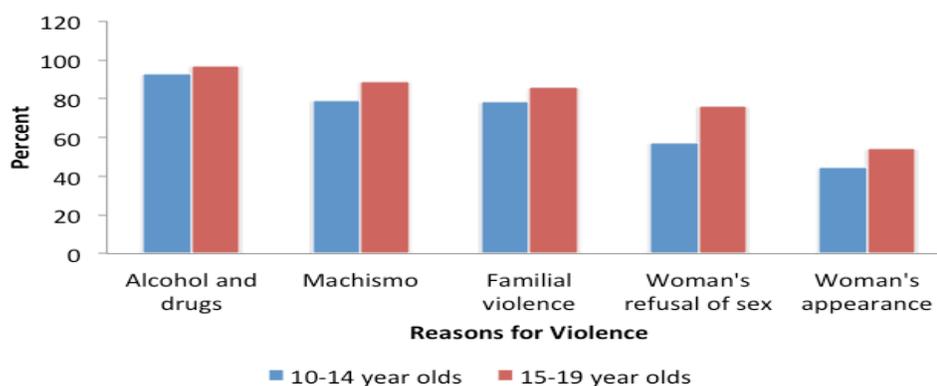
Approximately 86 percent of girls who had given birth were satisfied with the health services offered, while 14 percent were dissatisfied. Of those dissatisfied, 21.6 percent were from rural areas and 3.7 percent were from urban areas. Reasons for dissatisfaction included: poor bed-side manner, long wait times, a lack of privacy, an inability to understand the language used by the healthcare worker, non-availability of toilets, and health complications due to medical errors. Further, adolescents stated that administrative personnel, guards, and nurses treated them disrespectfully.

## Violence, Depression, and Discrimination

### Sexual Abuse

All adolescents stated that they were against gender-based violence. When asked how to prevent and respond to sexual violence, 94.7 percent of adolescent girls and 97.7 percent of adolescent boys thought the best way was to report the perpetrator, while 87.4 percent of adolescent girls and 84.3 percent of boys thought that the victim should inform someone they know and trust. When asked what they would do if they were sexually abused, 92.7 percent of adolescent girls and 91.1 percent of boys said that they would report the person. These opinions were slightly more prevalent in urban areas.

Figure 18. Adolescent's (10-19 years of age) reported Reasons for Violence by Age (percent).



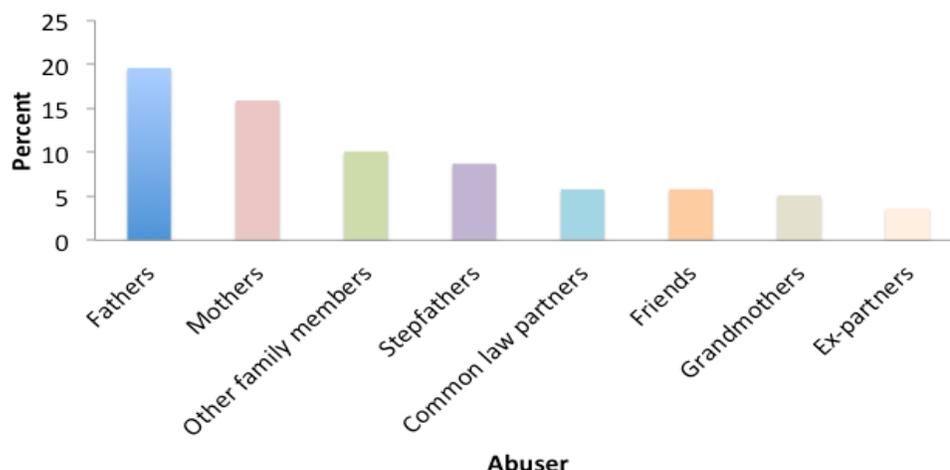
**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### Violence

Adolescents identified alcohol and drugs, “*machismo*”, and family conflict, among others, as causative factors for violent behavior (figure 18). Adolescent girls were significantly more likely to experience abuse than boys (13.2 percent compared to 9.3 percent respectively) and more frequently (11.1 percent compared to 5.4 percent respectively).

Approximately 11.3 percent of adolescents stated that they were victims of abuse (including sexual, mistreatment, and violence), of which 74 percent were 15-19 year olds and 26 percent were 10-14 year olds. In fact, age modified being mistreated slightly, with adolescents 15-19 years of age at a 20 percent increased risk for abuse than their younger counterparts. They were also more likely to live in urban than rural areas. Victims stated that the abuse included name-calling, threats, intimidation, physical violence, and being treated poorly by the police. Regression analyses indicate that having a telephone line in the house reduced the risk of mistreatment by 50 percent.

**Figure 19. Main Perpetrators of Abuse as Reported by Adolescents (10-19 years of age) (percent).**



**Source:** World Bank Group. Adolescent sexual and reproductive health and rights Survey: El Salvador. Health Focus GmbH. 2012. Data collection commissioned by the World Bank.

**Adolescents reported that abusers tended to be family members; the main perpetrators of which were fathers, followed by mothers, other family members, and stepfathers (figure 19).** Furthermore, adolescents reported that pregnancy was associated with familial sexual abuse and could lead to suicide among pregnant adolescent girls. In addition, results from the regression analyses found that living in a household where a member was a victim of a crime in the past 6 months increased the risk of adolescent mistreatment by 64 percent.

**65.5 percent stated that they told someone about the abuse, with adolescent girls more likely to tell someone than boys (72 percent and 56.1 percent respectively).** Further, when asked whom they told, they were most likely to tell their mothers, teachers, friends, siblings, or fathers about the abuse.

**When asked if they had reported the abuse to law enforcement, 5.7 percent of 10-14 year olds and 8.8 percent of 15-19 year olds reported that they had, with adolescent girls more likely to report than boys (11.1 percent and 5.4 percent respectively).** Although adolescents in urban areas were more likely to tell someone that they were abused (69.6 percent and 60 percent respectively), adolescents in rural areas were more likely to report the abuse (13.3 percent and 5.2 percent respectively). Those who reported the incident did so alone or with a close family member (for example, mother, aunt, grandmother). They stated that they reported to one of the following: the public prosecutor, the national civil police, the Institute for the Development of Women, family court, attorney general's office, court of peace, and the school director. Adolescents stated that most often, if the perpetrator was a parent or partner, nothing happened; for relatives, some were sent to jail while others were sent to therapy; and some complaints were withdrawn due to parental divorce.

**Among those who did not report the abuse, when asked why, most stated that they did not know how to press charges; did not know if the incident needed to be reported; were embarrassed; and unsure if the perpetrator would be punished.** Others were afraid of the consequences; wanted to avoid problems, as the aggressor was a family member; felt sorry for

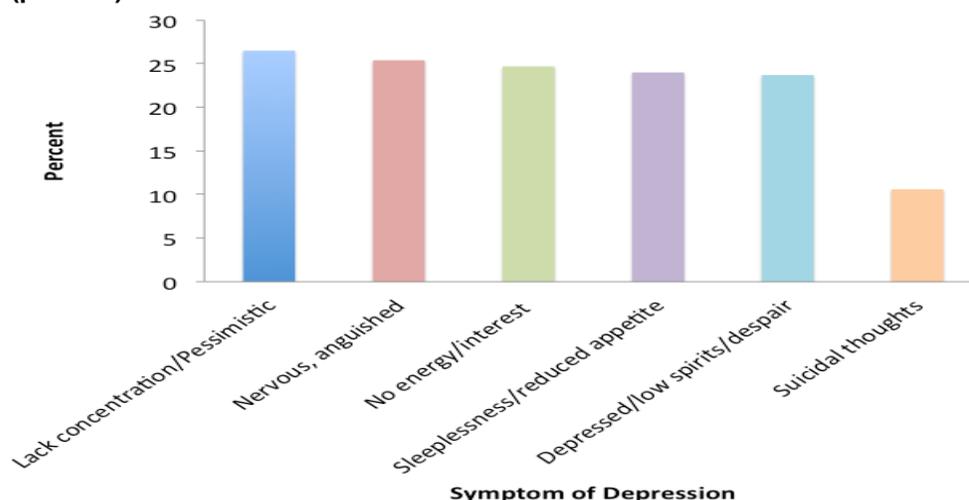
the perpetrator; did not want to lose privileges like going to school; said that it was not a big deal; and preferred to forgive.

### Depression

The study found that 44 percent of adolescents displayed at least one symptom of depression, while 11.2 percent of adolescents displayed five or six symptoms. Symptoms were significantly more common among adolescent girls and those 15-19 years of age. For example, 27.6 percent of adolescent females and 19.4 percent of males displayed three or more symptoms ( $p=0.003$ ). Similarly, 26.1 percent of 15-19 year olds and 18.7 percent of 10-14 year olds displayed three or more symptoms ( $p=0.012$ ). Suicidal thoughts were also higher in 15-19 year olds (11.2 percent among 15-19 year olds and 9.7 percent among 10-14 year olds respectively) and adolescent girls (14.5 percent among adolescent girls and 6.8 percent among boys respectively). Figure 20 demonstrates the most reported symptoms.

A significant correlation was found between victims of abuse and displaying symptoms of depression. For example 33.3 percent of abused adolescents displayed 5 or 6 symptoms of depression compared to 8.5 percent of those who had not been abused, while 55.3 percent of abused adolescents displayed three or more symptoms compared to 19.5 percent of those who had not been abused.

Figure 20. Symptoms of Depression reported by Adolescents (10-19 years of age) (percent).



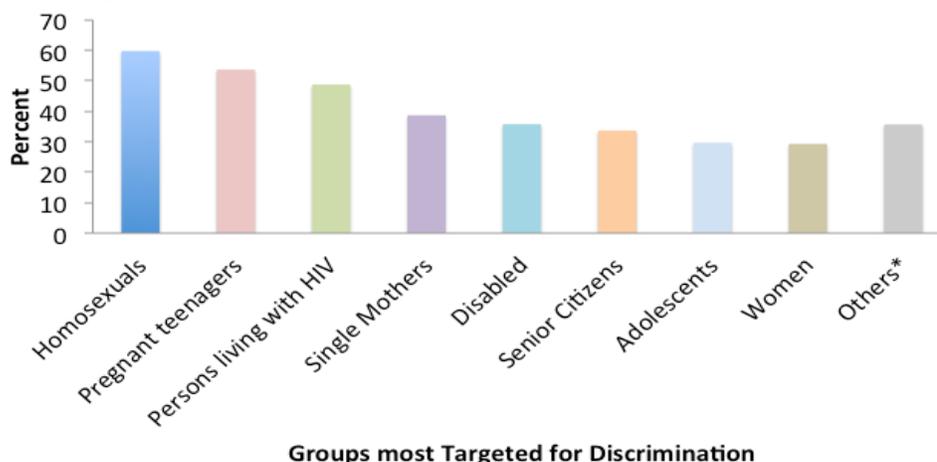
Source: World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

### Discrimination

The study found that adolescent girls were at a 66 percent higher risk of being discriminated against for their sexual behaviour and identity than boys. Similarly, adolescents in rural areas were at a 35 percent higher risk of being discriminated against than their urban counterparts. Interestingly, living in a household where a family member was the victim of a crime in the past 6 months doubled the risk of being discriminated against for both adolescent boys and girls.

**Adolescents acknowledged that discrimination existed in various forms in their communities.** In fact, groups most targeted for discrimination included homosexuals, pregnant teenagers, persons living with HIV, single mothers, people with disabilities, senior citizens, adolescents, and women (figure 21).

**Figure 21. Groups most Targeted for Discrimination as reported by Adolescents (10-19 years of age) (percent)**



\*Others includes skin color, weight, mental illness, extreme poverty, abuse victims, alcoholics, sex workers, and transvestites.

**Source:** World Bank Group and Health Focus GmbH. 2012. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey commissioned by the World Bank.

**Over half of the surveyed adolescents (56.6 percent) did not discriminate against and had positive attitudes towards homosexuals.** In fact, 66.1 percent of adolescents stated that they were comfortable around them; 64.9 percent stated that they would work with them; 18.6 percent stated that they would defend their rights; and 12.7 percent said that they would be happy to have a homosexual friend. These attitudes were more frequent among 10-14 year olds, adolescent boys, and rural areas. However, 5 percent thought that homosexuals should be expelled from school because they negatively influenced others, while 3.2 percent stated that they would not defend them if they were bullied.

**Results from the regression analyses found that knowledge about SRHR, participating in a youth group, and households that benefitted from social programs protected adolescents against discrimination.** Interestingly, education level had no effect on risk for discrimination.

**There was a statistically significant correlation between having experienced discrimination and symptoms of depression<sup>7</sup>.** Among the discriminated, 52.7 percent had three or more symptoms of depression compared to 17.2 percent among those who were not victimized.

<sup>7</sup> Chi-square test was applied.

### 4.3. The Government's Efforts at Guaranteeing Adolescent SRHR

The section below describes the extent to which the government has been responsible for guaranteeing adolescent SRH in El Salvador. It is divided by three human rights principles (as described in the conceptual framework) including equality and non-discrimination; participation and empowerment; and transparency and accountability. The information provided below was collected through interviews with key stakeholders.

**The study also found that LGBT individuals were exposed to high level of discrimination, despite the government's efforts to protect and guarantee their rights in recent years.** For example the Secretary of Social Inclusion created a unit on Sexual Diversity and passed various policies and mandates prohibiting discrimination against these individuals. In addition, in 2009 the MOH passed a mandate to eradicate discrimination based on sexual orientation. Although the study found that most Salvadorian adolescents show negative opinion on homosexual sexual orientation, they did state that they were starting to understand that LGBT individuals deserved equal rights and respect. Additionally, the study found that adolescent girls were a vulnerable population. Salvadorian adolescents still hold traditional beliefs about gender roles. Adolescents accept that men cannot control their sexual desire and some of them justified sexual violence against women, if they refuse sex. Further, the government has not passed many laws that change gender stereotypes, despite the *National Policy on Women*, which requires that the government guarantee gender equality.

#### Participation and Empowerment

**Stakeholders stated that they could not think of any programs that were developed with adolescent participation, indicating that these programs did not empower adolescents or reflect adolescents' needs and desires.** In fact, the government's policies reflect, instead, what authorities believe to be best for adolescents, which often does not coincide with adolescent needs and desires.

Despite this setback, the government is making progress towards increasing adolescent and youth participation in designing programs. For example, the MOE recently started a program in primary school that teaches children about empowerment and decision making. This program includes peer education, preventing adolescent pregnancies, and strong families. Such programs are not the norm, however their primary role is preparing high school students for parenthood. One program called *City Woman*, recommends a multi-sectorial approach to SRH activities given that the information sessions that the MOH provides on SRH are not sufficient. Stakeholders recommended that this approach needs to involve law enforcement, the judicial sector, women's groups, nongovernmental agencies, among others.

#### Transparency and Accountability

**El Salvador has passed the following policies that provide protection for adolescent SRH, including:**

- The *National Policy on Women*, which states that the prevention of adolescent pregnancies requires an integrated approach using gender and human rights. This is headed by ISDEMU.

- The *National Policy on Sexual and Reproductive Health Rights* was passed in July of 2012. It focuses on inclusion, gender, and rights and includes eight specific objectives to increase access to SRH through health promotion, prevention, care, and rehabilitation with a comprehensive primary healthcare framework.
- The *National Policy on Youth 2011-2014* promotes an integrated approach to adolescent health and as a result, the Institute for Youth was created. Programs and projects with specified budgets that focus on adolescent SRHR have not been developed yet.

Despite these efforts, the government's challenge is to fully operationalize all these policies. In fact, the National Policy on Health's *Building Hope* proposal recommended several SRH strategies to the MOH including the promotion of sex and peer education programs, adolescent pregnancy prevention, and guaranteeing adolescent SRHR, among others. Further, the government should develop campaigns to raise awareness on challenging traditional gender stereotypes.

*Through the law on Transparency*, the MOH established an office on the right to health. This office was developed to provide information to the public on the MOH's work and file complaints if necessary. Also, the Minister attends meetings in which the public can pose questions. The aim of the office is to foster a culture of transparency and accountability. However, all stakeholders stated that adolescent SRHR has hardly been discussed at meetings. In addition, all stakeholders agreed that they did not know how the government monitored SRHR enforcement or evaluated the impact of these laws and policies. The only monitoring that was noted was a color system used by health managers to determine if their jurisdictions were meeting MDG5, reducing the maternal mortality rate (associated with a woman's right to health). In terms of impact evaluations, stakeholders thought that the government should promote and conduct impact evaluation analysis of school sex education programs in order to understand why so many adolescents have become pregnant in El Salvador.

## 5. CONCLUSIONS AND RECOMMENDATIONS

### 5.1 Conclusions

**The study confirms the multisectorality and complexity of adolescent SRH in El Salvador,** indicating a need for coordinated efforts between the MOH and the MOE, the Ministry of Labour, and the Ministry of Social Protection.

**Given that most adolescents were unaware of or able to exercise their SRHR,** particularly their rights to reproductive health, education, equality, freedom from sexual violence, and protection of minors, this demonstrates that policymakers need to implement, educate, and enforce these policies.

**In addition to developing policies on adolescent pregnancy prevention, policies should focus on gender equity.** For example, adolescent girls are more likely to abandon school, have unplanned pregnancies, and suffer from abuse. Although the MOE has passed a policy on preventing schools from expelling pregnant adolescents, most of the adolescent girls interviewed stated that they decided to leave school once they became pregnant. Similar results were found with adolescent fathers, stating that they had to abandon school in order to financially provide for their families. This provides evidence that policy makers need to ensure that these adolescents do not abandon school and are provided an opportunity for re-entry once the child has been born.

**The government has a mandate to protect the most vulnerable and is also required to enforce the right to equality and non-discrimination.** Despite this mandate and the government's efforts to prevent mental, physical, and sexual abuse (through the ratification of the *Convention of Belem do Para*, developing the *Salvadorian Institute for the Development of Women*, and passing the *Special Integrated Law for Women's Access to Life without Violence*), a significant proportion of adolescents continue to experience violence. Given that male dominance and aggression persist without sufficient penalization, adolescents lack trust in the public and legal systems. Ultimately, the findings from the quantitative and focus groups surveys show that the right to protect and assist minors is not being fully guaranteed.

**Moreover, the study found that many LGBT rights were not guaranteed and the majority of adolescents expressed some negative attitudes against LGBT.** In 2009 the MOH passed a law that prohibits any discrimination based on sexual orientation and gender identity demonstrating that the MOH is working to change these attitudes.

**The right to information on SRHR implies that the material given to adolescents is appropriate and correct, however, this right was not fully guaranteed in El Salvador.** For example, adolescents 10-14 years of age were significantly less likely to receive information on SRHR than their older counterparts. This has implications for their future in that these adolescents are experiencing puberty and are unaware of the risks they are exposed to. Policymakers need to ensure that these adolescents are being reached. Further, the information given to adolescents 15-19 years of age was not correct. Many were told that masturbation is bad and that oral contraceptives are not healthy. Importantly, although information is essential it is not the solution to all problems. For instance, international evidence as well as the statistical analyses done for this study, indicate that merely providing adolescents information on SRHR has no impact in reducing adolescent pregnancy – although it is the first step towards empowerment.

**The right to information also includes the dissemination of appropriate information through the media.** However, the government's efforts at regulating the media have not been enforced. Most adolescents stated that the media promoted risky sexual behaviors and a hyper-sexualized culture. Further, all adolescents stated that they had not been informed about their SRHR through the media.

**The right to privacy and family signify parental responsibilities.** The study found that most pregnant adolescents have few options but to give birth and raise their children. However, adolescent boys who become fathers can decide whether they want to care for the child. This demonstrates that adolescent fathers are not conscious of their parental responsibilities. This violates international standards, and the government should enforce laws that require fathers to share parental responsibilities (Convention on the Right of the Child, Article 18<sup>8</sup>).

**When examining the right to a happy adolescence, according to the study adolescence was not an important stage of life among El Salvadorians.** For example, many adolescents stated that they were discriminated against and seen as troublemakers within their community. It also indicates that young people are not given many opportunities to reach their full potential and become respected members of society. If parents and society do not approve of adolescent pregnancies, then adolescent boys and girls need to be better informed about sex and provided access to contraception and SRH services and empowered to take control of their bodies and lives.

**In addition, adolescent girls are more likely to face stigma and discrimination due to traditional gender roles in El Salvador, which contributes to their vulnerability.** For example, all adolescents identified becoming a woman as being a mother. Further, adolescents identified that there were few options for young people to develop as individuals, which may explain why most adolescent mothers easily accept their pregnancies.

**A third of adolescents belong to a youth group, with adolescent boys more active in sports and girls more active in churches.** Upon further analysis, participation in youth groups does have a positive effect; therefore communities should involve adolescents and youth in the development of youth-friendly services and engage them politically, socially, and culturally.

**Social security coverage is low among adolescent mothers indicating a need for coverage among this group.** However, adolescent mothers stated that they were satisfied with the maternal and child health services they received. Further, adolescent girls were protected and guaranteed under the right to an adequate standard of living. Indeed, a pregnant adolescent is considered to be of high obstetrical and perinatal risk and is entitled to comprehensive medical care through the public health system.

**The right to health for adolescents is partially guaranteed in El Salvador.** The study found that the greatest criticism of health services was a lack of adolescent-friendly health services. As a result, many adolescents were not provided with or seeking SRH services. In addition, the right to life is a controversial topic in El Salvador as abortions are illegal. The study was unable to discuss this topic in depth with adolescents.

---

<sup>8</sup> "States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child"

## 5.2 Recommendations

The following section provides recommendations by sector to improve adolescent SRH and SRHR in El Salvador. They are multi-sectorial challenges that require the collaboration of all sectors.

### *Ministry of Education*

**Given the importance that education plays in an adolescent's life in terms of sexual and reproductive health, impact evaluations on sex education courses should be conducted in order to determine impact and quality of course.** It is recommended that programs include topics such as SRH, SRHR, gender, life plans, contraception, FP, sexuality, sexual identity, and sexual diversity. According to the study, it found that less than half of the adolescents in school are exposed to such classes. Further, these programs could progressively be introduced into health education courses, which start in the 5<sup>th</sup> grade. These educational courses, though, should be introduced at a younger age, as most adolescents are sexually active by the time they learn about sex education in school.

**Acceptance and non-discrimination of sexual identity and sexual diversity should also be taught in sex education courses.** Given that the study found that many adolescents had homophobic attitudes, these topics need to be covered in order to help change behaviors and attitudes and to establish a more accepting community. Schools should also consider providing sex education courses for parents so that they can empower their children and teach them sex education correctly.

**It is important that the Ministry promote educational rights, empower adolescents, and change traditional perceptions of gender roles.** This includes building self-esteem among adolescent girls, which could potentially prevent adolescent pregnancies. As the study found, most adolescents thought that a female's primary role was to become a mother. Courses need to be offered in primary and secondary school that empower adolescent females, teaching them that they deserve respect and that they can assume other roles in life. Schools also must reinforce the importance of adolescence as a key stage in life that should include studies, the enjoyment of life, puberty, and reflecting on their aspirations and goals in life.

**The MOE should also monitor pregnant adolescents, ensuring that they stay in school, even when they become pregnant.** If they leave school, the MOE needs understand why so that pregnant adolescents stop abandoning school. They also need to ensure that they have programs for re-entry into school for the mother once the child has been born.

### *Ministry of Health*

**For the most part, the MOH has been successful at providing and disseminating information on adolescent SRH.** Approximately 86 percent of pregnant adolescents stated that they were satisfied with the maternal care provided by the public health system. Adolescents also stated that the Ministry disseminates information on SRHR topics such as sexuality, STIs, contraception, and FP in health centers and schools.

The MOH, however, still faces challenges and needs to ensure the following:

- To better coordinate adolescent SRHR institutional efforts and policy enforcement
- To better communicate the SRH services offered to adolescents
- To ensure that health services are adolescent-friendly and that health care providers are trained and sensitive to adolescent SRH needs

**As found in the study, most adolescents thought that they could not receive effective counseling about contraception at health centers.** This was illustrated by low contraceptive use among adolescents as well as a lack of knowledge about contraception. Further, adolescents stated that they did not use the health centers when they found out they had an STI. In order to improve upon these health outcomes, the MOH needs to raise awareness among adolescents, families, and communities on the importance of contraception, STIs, and effective health counseling at health centers through campaigns and programs. It also needs to monitor adolescents' right to privacy and confidentiality in health centers, ensuring that health care providers are following protocol to protect these young people.

### ***Adolescent and Youth Programs***

**The study found that there were insufficient adolescent SRHR programs while adolescents and stakeholders reported that all of the programs had been designed without the participation of adolescents and youth.** The Ministry of Health, Ministry of Education, and other sectors, therefore, need to ensure that when developing programs for adolescents on SRHR, they need to involve adolescents and youth in the process. For example, given that the study found that 12 percent of adolescent girls had given birth, adolescent and youth programs could focus on pregnancy prevention and safe SRH lifestyles. Further adolescents reported not having much respect within their community, and programs could focus on adolescent empowerment and making responsible decisions.

**These programs could be funded by various sectors including the National Council on Childhood and Adolescence (CONNA).** One project that CONNA could develop is a website for adolescents on SRHR so that adolescents could send anonymous questions to experts about their SRH and SRHR. Another proposed program could be a toll-free hotline for adolescents who are victims of sexual abuse and other serious problems. Importantly, these programs should be broad enough and focus on youth empowerment and participation in the process.

### ***Relevant Governmental Bodies***

**Although the Law of Transparency is a step in the right direction, the government needs to more rigorously enforce human rights.** Adolescent girls should be fully protected from sexual violence. In order to do this, law enforcement, the Attorney General, and social services, among other key stakeholders all must work together to play a greater role.

## REFERENCES

Asociación Demográfica Salvadoreña. 2008. Encuesta Nacional de Salud Familiar de. 2008. (FESAL). San Salvador: ADS. Available at:  
<http://www.fesal.org.sv/2008/informe/final/default.htm>.

\_\_\_\_\_. 2003. Encuesta Nacional de Salud Familiar de 2002-2003. 2003 (FESAL). San Salvador: ADS. Available at:  
[http://www.fesal.org.sv/2003/informe/resumido/descargas/Informe\\_percent20Resumido\\_percent20-percent20FESAL\\_percent20-percent202003.pdf](http://www.fesal.org.sv/2003/informe/resumido/descargas/Informe_percent20Resumido_percent20-percent20FESAL_percent20-percent202003.pdf).

Azevedo J. P., M. Favara, A.E Haddock, L. Lopez-Calva, M. Muller, E. Perova. 2013, Teenage Pregnancy and Opportunities in Latin America and the Caribbean: on Early Child Bearing, Poverty and Economic Achievement. Washington, DC: World Bank.

Boesen J.K., and T. Martin. 2007. Applying a Rights-based Approach: An Inspirational Guide for Civil Society. Danish Institute for Human Rights: Copenhagen. Available at:  
<http://www.gsdr.org/go/display&type=Document&id=3780>.

Boston University School of Public Health. 2011. Increasing Female Adolescent Contraceptive Use in Nicaragua: A Behavior Change Assessment. Boston: Boston University. Available at:  
[http://sarahvoorhees.myefolio.com/Uploads/Increasing\\_percent20Female\\_percent20Adolescent\\_percent20Contraceptive\\_percent20Use\\_percent20in\\_percent20Nicaragua.pdf](http://sarahvoorhees.myefolio.com/Uploads/Increasing_percent20Female_percent20Adolescent_percent20Contraceptive_percent20Use_percent20in_percent20Nicaragua.pdf).

Comisión Interamericana de Derechos Humanos y Organización de los Estados Americanos. 2011. Acceso a la Justicia para Mujeres Víctimas de Violencia Sexual en Mesoamérica. Washington, DC: CIDH, OAS. Available at:  
[http://www.cidh.oas.org/pdf\\_percent20files/MESOAMERICA\\_percent202011\\_percent20ESP\\_percent20FINAL.pdf](http://www.cidh.oas.org/pdf_percent20files/MESOAMERICA_percent202011_percent20ESP_percent20FINAL.pdf).

Conde-Agudelo A., J.M Belizán, C. Lammers. 2005. *Maternal-perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: Cross-sectional study. Am J Obstet Gynecol.* 2005 Feb;192(2):342-9.

Ehrle N., and M. Sarker. 2011. Emergency Contraceptive Pills: Knowledge and Attitudes of Pharmacy Personnel in Managua, Nicaragua. *International Perspectives on Sexual and Reproductive Health*; 37(2): 67–74. Available at:  
<http://www.guttmacher.org/pubs/journals/3706711.html>.

German Technical Cooperation Agency (GTZ). 2009. The Human Rights-Based Approach in German Development Cooperation: short version. Eschborn: GTZ; 2009. Available at:  
[http://www.institut-fuer-menschenrechte.de/uploads/tx\\_commerce/hr-based\\_approach\\_in\\_dc\\_short\\_version.pdf](http://www.institut-fuer-menschenrechte.de/uploads/tx_commerce/hr-based_approach_in_dc_short_version.pdf).

\  
Health Focus GmbH (2013). Sexual and Reproductive Health Among Adolescents in El Salvador” Adding a human rights perspective to the World Bank’s operational work. Contract 7161595. Consultancy Report commissioned by the World Bank. Potsdam.

Instituto Salvadoreño para el Desarrollo de la Mujer (ISDEMU). 2011. Segundo Informe Nacional sobre la Situación de Violencia contra las Mujeres en El Salvador: Un Problema de Seguridad Pública. El Salvador. San Salvador: ISDEMU.

Inter-American Development Bank. 2011. The Paradox of Stagnant Adolescent Fertility in Latin America and the Caribbean. Washington, DC: IDB. Available at: <http://events.iadb.org/calendar/eventDetail.aspx?lang=en&id=3300>.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. AIDS info database. Geneva: UNAIDS; 2012. Available at: <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>.

Lakhani N. 2013. El Salvador: Where Women May be Jailed for Miscarrying. BBC News Magazine. Available at: <http://www.bbc.com/news/magazine-24532694>.

La Asamblea Legislativa de la Republica de El Salvador. 2010. *Ley Especial Integral Para el Acceso de las Mujeres a una Vida Libre de Violencia*, decreto No. 520, noviembre 2010. Available at: [http://www.sicelsalvador.gob.sv:4847/agenda/agenda/documentos/ppc/ley\\_percent20especial\\_percent20integral\\_percent20para\\_percent20una\\_percent20vida\\_percent20libre\\_percent20de\\_percent20violencia\\_percent20para\\_percent20las\\_percent20mujeres.pdf](http://www.sicelsalvador.gob.sv:4847/agenda/agenda/documentos/ppc/ley_percent20especial_percent20integral_percent20para_percent20una_percent20vida_percent20libre_percent20de_percent20violencia_percent20para_percent20las_percent20mujeres.pdf)

\_\_\_\_\_. 2009. *Ley de Protección Integral de la Niñez y Adolescencia (LEPINA)*, decreto No. 839, marzo de 2009. Available at: [http://www.oei.es/pdf2/ley\\_ninez\\_el\\_salvador.pdf](http://www.oei.es/pdf2/ley_ninez_el_salvador.pdf)

Ministerio de Salud El Salvador. 2012. Plan Intersetorial para la Atención Integral de la Salud de la Población Adolescente y Joven 2012-2014. San Salvador: MINSAL; 2012. Available at: [http://asp.salud.gob.sv/regulacion/pdf/planes/plan\\_intersectorial\\_adolescentes.pdf](http://asp.salud.gob.sv/regulacion/pdf/planes/plan_intersectorial_adolescentes.pdf)

\_\_\_\_\_. 2012. Informe de Labores 2012-2013. San Salvador: MINSA. Available at: <http://www.salud.gob.sv/servicios/descargas/documentos/Documentación-Institucional/Memorias-de-Labores/Memoria-de-Labores-2012-2013/>.

\_\_\_\_\_. 2012. El Banco Mundial, y la Organización Panamericana de Salud. Presentado al Seminario y Taller Internacional *Salud Sexual y Reproductiva de los Adolescentes y Jóvenes en América Latina: Incorporando la Perspectiva de Derechos Humanos en las Inversiones de Salud Pública*, Agosto de 2012, San Salvador, El Salvador.

Osorio A, López-del Burgo C, Carlos S, Ruiz-Canela M, Delgado M, de Irala J. 2012. *First Sexual Intercourse and Subsequent Regret in Three Developing Countries*. *J Adolesc Health* 2012; Mar 50(3):271-8.

Pallitto CC, Murillo V. 2008. *Childhood Abuse as a Risk Factor for Adolescent Pregnancy in El Salvador*. *J. Adolesc Health* 2008 Jun; 42(6):580-6.

Pan American Health Organization. 2012. Health of the Americas: El Salvador. Washington DC: PAHO.

Pathfinder International. 2011. Promoting the Sexual and Reproductive Rights and Health of Adolescents and Youth: Building on the Global Health Initiative Country Strategies and Supplemental Guidance on the Women, Girls, and Gender Equality Principle. Massachusetts: Pathfinder; 2011. Available at: <http://www.pathfinder.org/publications-tools/pdfs/Promoting-the-sexual-and-reproductive-rights-and-health-of-Adolescents-and-Youth.pdf>

Rani M., M.E. Figueroa, R. Ainsle. 2003. The Psychosocial Context of Young Adult Sexual Behavior in Nicaragua: Looking Through the Gender Lens. *International Family Planning Perspectives* 2003; 29(4): 174-181.

Reichenbach L., and M. J. Roseman. 2009. *Reproductive Health and Human Rights: The Way Forward*. University of Pennsylvania Press

Remez L., E. Prada, S. Singh, L. Rosero Bixby, A. Bankole. 2008. *Ensuring a Healthier Tomorrow in Central America: Protecting the Sexual and Reproductive Health of Today's Youth*. New York: Guttmacher Institute. Available at:  
[http://www.guttmacher.org/pubs/2008/06/16/PNG\\_CentralAmerica\\_en.pdf](http://www.guttmacher.org/pubs/2008/06/16/PNG_CentralAmerica_en.pdf)

Ruiz-Canela M., C. Lopez-del Burgo, S. Carlos et al. 2012. Familia, Amigos y Otras Fuentes de Informacion Asociadas al Inicio de las Relaciones Sexuales en Adolescentes de El Salvador. *Rev Panam Salud Publica*; 31(1): 54-61.

Rodriguez Vignoli, Jose. 2008. *Reproducción Adolescente y Desigualdades en América Latina y el Caribe: un Llamado a la Reflexión y a la Acción*. Santiago: OIJ/CEPAL. Available at:  
[http://www.oij.org/file\\_upload/publicationsItems/document/EJ1264091957.pdf](http://www.oij.org/file_upload/publicationsItems/document/EJ1264091957.pdf)

Samandari G., I.S Speizer. 2010. *Adolescent Sexual Behavior and Reproductive Outcomes in Central America: Trends Over the Past Two Decades*. *Int Perspect Sex Reprod Health*. 2010 Mar;36(1):26-35.

Springer A., G. Parcel, E. Baumler, M. Ross. 2006. *Supportive Social Relationships and Adolescent Health Risk Behavior Among Secondary School Students in El Salvador*. *Soc Sci Med*. Apr; 62(7):1628-40.

Springer A.E., B.J Selwyn and S.H Kelder. A Descriptive Study of Youth Risk Behavior in Urban and Rural Secondary School Students in El Salvador. *BMC International Health and Human Rights* 2006, 6:3.

United Nations Children's Fund. 2007. *Teenage Motherhood in Latin America and the Caribbean: Trends, Problems and Challenges*. Challenges: Newsletter on Progress towards Millennium Development Goals from a Child Right Perspective. New York: UNICEF.

United Nations Department of Economic and Social Affairs. 2012. *World Population Prospects: The 2012 Revision*. Fertility database. New York: DESA. Available at: <http://esa.un.org/wpp/Excel-Data/fertility.htm>.

\_\_\_\_\_. 2012. *World Population Prospects: The 2012 Revision*. Population database. New York: DESA. Available at: <http://esa.un.org/wpp/Excel-Data/population.htm>

United Nations Office of the High Commissioner for Human Rights. *International Covenant on Economic, Social, and Cultural Rights*. Geneva: OHCHR; 1976. Available at:  
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

United Nations General Assembly. 1989. *Convention on the Rights of the Child*, 20 November 1989; available at:  
<http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

\_\_\_\_\_. 1979. *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, A/RES/34/180, available at:  
<http://www.ohchr.org/en/ProfessionalInterest/pages/cedaw.aspx>

\_\_\_\_\_. 1948. *Universal Declaration of Human Rights*, 10 December 1948, available at:  
<http://www.un.org/en/documents/udhr/>.

United Nations Economic Commission for Latin America and the Caribbean. CEPALSTAT. Santiago, Chile: CEPAL. Available at:  
<http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>.

United Nations Population Fund. 2013. State of World Population. Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy. New York: UNFPA. Available at:  
<http://www.unfpa.org/public/home/publications/pid/15395>.

\_\_\_\_\_. 2010. Sexual and reproductive health for all: Reducing poverty, advancing development and protecting human rights. New York.. Available at:  
[http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/uarh\\_report\\_2010.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/uarh_report_2010.pdf).

\_\_\_\_\_. 2008. Making Reproductive Rights and Sexual and Reproductive Rights a Reality for All. New York.. Available at:  
[http://www.unfpa.org/webdav/site/global/shared/documents/UNFPA\\_SRH\\_Framework\\_FinalVersion.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/UNFPA_SRH_Framework_FinalVersion.pdf)

\_\_\_\_\_. 1995. International Conference on Population and Development – ICPD – Programme of Action. New York: UNFPA. Available at:  
<http://www.unfpa.org/public/home/publications/pid/1973>

\_\_\_\_\_. 1994. UNFPA and Adolescents. New York. 1994. Available at:  
[http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/unfpa\\_and\\_adolescents](http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/unfpa_and_adolescents).

Vala-Haynes E., C. Vallenggia. 2013. *Sexual Initiation, Marriage, and First Birth in Central America: Trends in Timing and Context*. Population Studies Center, University of Pennsylvania.

World Bank Group. 2013. Data: adolescent fertility rate. Washington, DC: World Bank. Available at: <http://data.worldbank.org/indicator/SP.ADO.TFRT>.

\_\_\_\_\_. 2013. World Development Indicators. Washington, DC: World Bank. Available at: <http://data.worldbank.org/news/new-suite-of-world-development-Indicators-products-now-available>

\_\_\_\_\_ 2012. World Bank Group and Health Focus GmbH. Adolescent sexual and reproductive health and rights Survey: El Salvador. Survey collected by Health Focus GmbH and commissioned by the World Bank.

\_\_\_\_\_ 2012. World Bank Group and Health Focus GmbH. Adolescent sexual and reproductive health and rights Qualitative Surveys and Focus Group discussions: El Salvador. Information collected by Health Focus GmbH and commissioned by the World Bank

\_\_\_\_\_. 2011. Population Aging: Is Latin America Ready? Washington DC: World Bank. Available at:  
[http://www.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/01/07/000356161\\_20110107011214/Rendered/PDF/588420PUB0Popu11public10BOX353816B0.pdf](http://www.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/01/07/000356161_20110107011214/Rendered/PDF/588420PUB0Popu11public10BOX353816B0.pdf).

\_\_\_\_\_. 2007. World Development Report. Development and the Next Generation. Washington DC: World Bank. Available at:  
[http://www.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/13/000112742\\_20060913111024/Rendered/PDF/359990WDR0complete.pdf](http://www.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/13/000112742_20060913111024/Rendered/PDF/359990WDR0complete.pdf).

# ANNEXES

## Annex I: Design and Instruments of Study

Survey instruments are available upon request. Please make your request to:  
rcortez@worldbank.org

## Annex II: The International Treaties Ratified by El Salvador Include:

- 1948 Universal Declaration<sup>9i</sup>
- 1966 Convention on Economic, Social and Cultural Rights, or Social Pact, in force since 1976 and ratified by El Salvador in 1979
- 1966 Convention on Civil and Political Rights, or Civil and Political Pact, in force since 1976 and ratified by El Salvador in 1979
- 1969 American Convention on Human Rights, or Pact of San José, in force since 1978 and ratified by El Salvador in 1978
- 1979 Convention on the Elimination of All Forms of Discrimination against Women, or CEDAW, in force since 1981 and ratified by El Salvador in 1981
- 1988 Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, or Protocol of San Salvador, in force since 1999 and ratified by El Salvador in 1995
- 1989 Convention on the Rights of the Child, or CRC, in force since 1990 and ratified by El Salvador in 1990
- 1994 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, or Convention of Belem do Para, in force since 1995 and ratified by El Salvador in 1995

---

<sup>9</sup> The Universal Declaration has no ratifications but is considered binding international law.

## **Annex II: The International Treaties Ratified by El Salvador Include:**

- 1948 Universal Declaration<sup>9i</sup>
  - 1966 Convention on Economic, Social and Cultural Rights, or Social Pact, in force since 1976 and ratified by El Salvador in 1979
  - 1966 Convention on Civil and Political Rights, or Civil and Political Pact, in force since 1976 and ratified by El Salvador in 1979
  - 1969 American Convention on Human Rights, or Pact of San José, in force since 1978 and ratified by El Salvador in 1978
  - 1979 Convention on the Elimination of All Forms of Discrimination against Women, or CEDAW, in force since 1981 and ratified by El Salvador in 1981
  - 1988 Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, or Protocol of San Salvador, in force since 1999 and ratified by El Salvador in 1995
  - 1989 Convention on the Rights of the Child, or CRC, in force since 1990 and ratified by El Salvador in 1990
  - 1994 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, or Convention of Belem do Para, in force since 1995 and ratified by El Salvador in 1995
- 

---

<sup>9</sup> The Universal Declaration has no ratifications but is considered binding international law.



The aim of the study is to understand the sexual and reproductive health (SRH) behavior and determinants among adolescents in El Salvador using data from a survey of 1,258 adolescents' aged 10-19 and 12 interviews with representatives from the Ministry of Health (MOH), Ministry of Education (MOE), nongovernmental organizations (NGOs) and UN agencies. The study found that adolescents were not educated enough on their sexual and reproductive health rights (SRHR), and have limited use of and access to contraceptives. Alcohol and violence were found to be associated with risky sexual behavior, requiring a multisectoral response from the government and civil society. Adolescents need to receive earlier and more accurate information on their sexual and reproductive health rights (SRHR); and this information should be disseminated in a way that empowers adolescents to make responsible decisions about their sexual reproductive health. The MOE could play a vital role in informing adolescents in this area, and adjust these programs when necessary. Further, the role of parents is critical, as the study found that adolescents are not receiving adequate and enough SRHR information from their parents. In addition, the MOH needs to offer adolescent-friendly health services, which includes trained health personnel. Although adolescents stated that the maternal and child health programs offered were satisfactory and the government has made an effort at educating adolescents on HIV/AIDS, both the promotion of contraceptive methods and monitoring adolescent SRHR remain as key challenges to be addressed by multisectoral interventions.

## **ABOUT THIS SERIES:**

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@worldbank.org) or HNP Advisory Service (healthpop@worldbank.org, tel 202 473-2256).

For more information, see also [www.worldbank.org/hnppublications](http://www.worldbank.org/hnppublications).



1818 H Street, NW  
Washington, DC USA 20433

Telephone: 202 473 1000  
Facsimile: 202 477 6391  
Internet: [www.worldbank.org](http://www.worldbank.org)  
E-mail: [feedback@worldbank.org](mailto:feedback@worldbank.org)