Training in Sexual and Reproductive Health and Rights of Adolescents in Latin America and The Caribbean

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Introduction

UNFPA is one of the most important international cooperation development agencies in terms of the obligations taken on by the States in the International Conference on Population and Development (ICPD, Cairo, 1994), and shares with the United Nations system its support for the goals adopted at the Millennium Development Summit (New York, 2000), related to the achievement of social development and the eradication of poverty.

In accordance with its mandate, for the period 2004-2007, UNFPA has committed itself to supporting the countries in achieving three overall results in the areas of sexual and reproductive health, population and development, and empowerment of women and gender equity. These are: a) For all individuals and couples to enjoy good reproductive health, including family planning and sexual and reproductive health, throughout their lives; b) For the countries to tackle population dynamics in interaction with sustainable development and poverty eradication strategies, including the impact of HIV/AIDS and; c) To reach the empowerment of women and gender equity.

Even though each of these results determines specific strategies, their mutual interaction is clear. Poverty perpetuates poor health, gender inequality and rapid population growth. It was recognised in the ICPD that broadening the means of action of each woman and each man through education, equality of opportunities and the means to determine the number and spacing of their children, is of critical importance for breaking the vicious circle of poverty and exclusion (UNFPA, 2004). The evidence shows that it will not be possible to reduce poverty and reach sustainable development if women, men and adolescents cannot exercise their reproductive rights and have access to sexual and reproductive health in accordance with criteria of socio-economic equity as well as equity of age, gender and race/ethnic origin. The lack of exercise of reproductive rights is one determinant of poverty and social exclusion. Indeed, women's empowerment, equality and gender equity are essential for reaching better levels of sexual and reproductive health (United Nations, 2005).

As an agency of the United Nations system, UNFPA uses the human rights approach for its programming, reflected in an emphasis on strengthening knowledge and the demand for the exercise of rights, promoting people's autonomous decision-making, promoting the participation of civil society in the social audit and eliminating the barriers to universal access to human rights within socio-political systems.

Within this framework, UNFPA gives priority to the sexual and reproductive health of adolescents and youth, including access to services, access to contraception and the prevention of HIV/AIDS, through criteria of gender equity, age, race/ethnic origin and socio-economic status, keeping in mind non-discrimination and respect for culture, i.e., promoting strategies in line with human rights (UNFPA, 2004).

In the analysis of the last 10 years' achievements of the countries with respect to the obligations related to the Cairo Conference, six essential aspects stand out: the political conditions that promote sexual and reproductive health and reproductive rights; greater access to comprehensive sexual and reproductive health services; strengthening of the demand for sexual and reproductive health; increasing use of population statistics broken down by age and sex; national, sub-national and sector policies, plans and strategies that link aspects of population and development; and sociocultural practices and institutional mechanisms to foster and protect the rights of women and girls and the advances in gender equality and equity (UNFPA, 2005).

The exercise of reproductive rights is essential for social development. The competencies of men, women and adolescents for controlling their sexual and reproductive health are absolutely fundamental for their empowerment and the construction of citizenship, and are thus a condition of social development. When reproductive rights are fostered, protected and exercised, including the right to take decisions about reproduction free from discrimination, coercion and violence, then all people, men, women and adolescents freely exercise full and equitable participation in the society (Obaid T. May 2005). UNFPA has stressed that sexual and reproductive health includes the fight against HIV/AIDS. Strengthening people's capacity to commit themselves to the prevention of HIV/AIDS is key to their empowerment through education, the exercise of their legal rights, the total rejection of sexual violence, and access to sexual and reproductive health (Obaid T. July 2005).

The importance of providing quality services in sexual and reproductive health has been emphasised as a key strategy for reaching the Millennium Development goals (UN, 2005) given that access to sexual and reproductive health services contributes to (Obaid T. February 2005):

- Increasing opportunities for education for all family members, particularly girls.
- A more healthy and productive workforce, with higher rates of saving and economic growth.
- Reaching higher levels of social and political participation.
- Reducing public spending related with maternal health problems, family subsidies and the care of orphan children.

UNFPA has given priority to the field of adolescents and youth, since it sees this as a broad population group whose reproductive rights are very often relegated, facing marked generational lack of equity that restricts their health and development. Since the development of adolescents conditions the human development of countries, adolescent empowerment strategies achieve a greater impact in cost-effectiveness and in the long-term (UNFPA, 2004).

UNFPA particularly has recently declared for International Youth Day (www.unfpa.org/ news(/news.cfm?ID=657 visited on 29-08-05), that youth constitutes a priority for the agency and are considered its allies. All youths have a right to have opportunities of education and health, including sexual and reproductive health, since half the new HIV infections are occurring in young people and many young women are dying as a consequence of pregnancy and childbirth. This is why UNFPA considers that this is the moment to establish the well-being and inclusion of young people as its first priority.

The present document is prepared within this context. It seeks to analyse the conceptual approaches of the strategies for training human resources in adolescent sexual and reproductive health, in order to decide on action for improving them. The final objective is for the countries of the region to be able to have qualified training available for health teams aimed at an age group whose respect for reproductive rights is key to achieving the goals in human development and the eradication of poverty.

It is hoped that this document will help to encourage regional technical institutions in their search for better competencies for guaranteeing the rights and the sexual and reproductive health of adolescents. To the extent that the training courses fit in with the framework of human rights and quality and are accessible geographically and through current distance technology, their availability will encourage more team members to access them. In this way it will be disseminating the possibility that adolescents' sexual and reproductive health and rights may be guaranteed by the health systems.

It is also hoped that the availability of quality training courses will contribute to generating a critical mass of professionals that will influence the health systems and social policies.

The main aim of this study is to offer an up-to-date analytical map of the systematic training opportunities in adolescents' sexual and reproductive health and rights available for health workers in the region of Latin America and the Caribbean, including those promoted and offered by governmental organizations, non-governmental organizations (NGOs), scientific associations and universities.

The study concentrates on training courses for health teams and, even though some of these on occasions have also been considered for educators or community monitors, it has not been thought to specifically include those that are aimed at other audiences.

The study methodology, presented in Chapter II, has focused basically on the results of a survey made among the institutions of excellence in the region. One limitation to the study is the lack of field visits, so that it has had to rely only on the information provided by the institutions. The methodology chapter comments on the difficulties faced in obtaining all the information about the region. It is doubtless probable that it has been unfair for the organizations and institutions that do not have access to Internet technology, both for knowing what they offer and for making contact with them.

The document has been structured in five sections. This first section gives the introduction to the document; the second defines the conceptual framework in which the approach of the study is situated; the third or section II, as mentioned in the previous paragraph, describes the methodology and the study findings; the fourth section summarises the reflections and recommendations arising from these results; and, finally, the last two have the detailed bibliography and the appendices with the records of the information collected.

Conceptual Framework

ADOLESCENCE

Adolescence is the period of life in which the individual's biological, psychological and social maturing processes take place that lead into adulthood, and ideally culminate with their full incorporation into society (Luengo X. 2003).

At this stage of a person's development, there are significant and vertiginous somatic, psychological and social changes, which can determine a set of strengths for their life and development, or, on the other hand, increase the conditions of social vulnerability and health risks.

Even though adolescence and youth have different social representations in different cultures –thus making it impossible to limit these concepts as pertaining to a specific age group– UNFPA, in order to have operational criteria that can aid epidemiological research and enable comparisons to be made, has agreed on the following definitions:

- Adolescents: people between 10 and 19 years of age
- Youth: people from 15 to 24 years of age
- Young People: includes both the previous groups; people from 10 to 24 years of age.

The world today is facing the largest generation of adolescents recorded in its history – more than 1,200 million people – whose needs have to be met now (UNFPA, 2003). In Latin America and the Caribbean, young people make up 30% of the population and adolescents make up 21% of the total population, with the percentage varying between 13% and 25% in different countries. The number of young people in the region in the year 2000 was 155 million with 163 million expected for the year 2025. According to data from ECLAC, 78% of youth in the region live in urban areas and, even though the situation of poverty is being overcome, it is estimated that juvenile poverty still reaches 41% in the region (ECLAC, 2004).

HEALTH AND SERVICES FOR ADOLESCENTS WITH A HUMAN RIGHTS APPROACH

As from the First International Conference on Health Promotion in Ottawa in 1986, the concept of health based on the interdisciplinary paradigm of Alma Ata has been more and more linked to the human development approach, emphasising the social environment in which individuals are inserted, which determines their conditions of living and development. This new framework abandoned the classical criterion that envisaged the social context as one more factor conditioning health, to see the socio-cultural context as the fabric of what happens with adolescents (UNFPA/PAHO, 2000). As from the Ottawa meeting, health is no longer thought of exclusively in relation with individual lifestyles, to include in a more "macro" view the environmental conditions determining human development, such as peace, education, nutrition, work, recreation and justice, through active participation (PAHO, 1998).

This moves to an approach centred on healthy adolescents exercising their human rights as citizens and on satisfying their basic needs of learning about health. It emphasises the leading role of adolescents in the development of their own well-being, recognising the influence of cultural, contextual and personal factors, and linking the quality of life with learning in terms of life competencies. This perspective democratises the power of professionals and experts, encouraging adolescent-centred interventions with strategies of empowerment and strengthening autonomy for building citizenship (UNFPA/PAHO, 2000).

A recent regional analysis considers that health programmes directed towards adolescents adhere more to the concept of disease prevention and focus on a very specific behaviour, such as HIV prevention, the avoidance of pregnancy and promotion of abstinence, rather than on that of fostering health. Many of these traditional programmes and policies have been curative in nature and have frequently defined their success as the absence of problems instead of as healthy development. Such programmes and services are vertical in their approach and do not include the concepts of family, culture, values and the global context in which adolescents take decisions. Youth does not take a full part in their design and execution, and so the interventions do not really reflect their wishes or their concerns. It is suggested that the programmes should go beyond a problem-oriented approach, to take a development approach that can stimulate factors of protection and resilience in young people (PAHO, 2003).

In order to ensure that adolescents exercise their human rights, including the right to reproductive health and rights, it is necessary to move away from the concept of receivers or beneficiaries of services, to adolescents as subjects of rights, active participants in their health and development, and away from vertical approaches towards coordinated local inter-sector strategies, integrating health prevention and promotion. In the interventions of health care service providers should be seen not only a recognition of adolescents as citizen subjects of rights, but they must also guarantee their exercise of these rights, as an obligation that the State, through its officials and the civil society, has to protect, promote and enforce. The human rights focus ensures firstly the right of adolescents to take part, individually or through civil society organizations, and

strengthens their competencies to demand their human rights with criteria of universality.

Adolescents recognise the factors that constitute barriers to their access to the right to health and to sexual and reproductive health services. In some studies (FHI, 2005), adolescents identify the health care services as being directed towards adult people; they are repelled when they attend sexual and reproductive health facilities; they are concerned about privacy and confidentiality, especially in relation to their parents; they find the attitude of health staff hostile and/or they are afraid of medical procedures, especially gynaecological examinations (Franco S., Klass R., Pittman P. 2000). Many adolescents do not have enough information to recognise the risk of pregnancy, the symptoms of STI and do not know when they should seek health care; they have no information about where the sexual and reproductive health care services are located, what services they offer, such as access to contraceptives (UNFPA-CENEP, 2005); they do not know the times they are open or these do not suit them, and they do not know the kinds of services on offer; and finally, the cost of these services is beyond their economic possibilities.

Other studies have examined the adolescents' preferences regarding health care services. The characteristics that adolescents consider essential for a friendly service have been described in documents from various cooperation agencies (PAHO, 2000; PAHO, 2003), but briefly, adolescents stress three main points (EN FOCO, 1997): characteristics of the service provider, characteristics of the health facility, and characteristics of the programme design.

In connection with the content of training courses for human resources in health, we would stress that among the characteristics of service providers the adolescents expect that:

- They have been specially trained to work with adolescents based on the human rights approach.
- They are trained to respect adolescents and their rights.
- They recognise the great importance that adolescents give to privacy and confidentiality.
- Service managers ensure that additional time is given for counsellors or health staff to be able to discuss special topics with youth.

It is interesting to note the point related to human resources training, and to keep it in mind in the programme design aimed at improving the state of health of the adolescent population and their exercise of their rights.

CONDITIONS OF THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS

The term "sexual health" refers to the experience of the continuous process of physical, psychological and socio-cultural well-being related to sexuality. Sexual health is seen in the free and responsible expression of sexual capabilities that foster harmonious personal and social well-being, thus enriching individual and social life. It is not simply an absence of dysfunction and/or illness (PAHO/World Association for Sexology, 2000).

The international consensus recognises health as a fundamental right of human beings for their appropriate development and well-being. The sexuality and the sexual well-being of adolescents are essential components of their health and development. All human beings are intrinsically sexual, and sexual development runs through infancy, adolescence and adult life. To adapt oneself to the sexual changes and to protect one's health, including sexual and reproductive health, is one of the greatest challenges. Sexual and reproductive health in adolescents is undoubtedly the area that marks their most significant health needs, as is seen in the epidemiological analysis (Camacho V. 2000; PAHO 2003; Luengo X. 2003). During this stage events occur such as the initiation of sexual activity, the establishment of life as a couple, and the start of reproduction, that mark their state of development and well-being (ECLAC/UNFPA/CELADE, 2000).

Epidemiological data in countries of Latin America and the Caribbean show that the initiation of sexual activity in adolescents occurs at earlier ages, with estimates that half or more of the adolescent girls are sexually active before 16 years of age. There are still gender differences in the region, with a trend for boys to begin on average slightly earlier than girls (Murray N. et al., 1998; Singh S. 2000; UNFPA/CENEP, 2005). Sexually transmitted infections (STI) affect a significant number of adolescents between 15 and 19 years of age every year, and it is estimated that only 1 in 10 sexually active adolescents without a stable partner uses some contraceptive method (UNICEF, 2001). These two indicators eloquently define the weight of the reproductive rights of adolescents in the region.

A set of interacting social factors determine the sexual and reproductive health of adolescents. One of these is schooling. Research has shown that adolescent girls outside the schooling system, as well as those with little chance of continuing in it, have the greatest risk of initiating sexual relations at an earlier age. This is why encouraging schooling for girls is a protective factor for delaying the start of sexual activity as well as being a stimulus for personal development (PAHO/UNFPA, 2000). The use of contraceptive methods, including condoms, has increased lately among sexually active adolescents, but a significant proportion still have no access to these rights, particularly the groups with lower levels of education and worse socio-economic status (UNFPA/CENEP, 2005). Conditions of social vulnerability, such as poverty, are also key determinants for the exercise of reproductive rights.

In terms of fecundity, in the region there is an average of 78 births per 1,000 women from 15 to 19 years of age, with a range from 36 in Trinidad and Tobago to 119 in Nicaragua. The figures from developed countries are below 20 births per 1,000 women between 15 and 19 (UNFPA, 2005).

Despite a general drop in fecundity among women over 19 years old since the 60s when oral contraception was introduced, adolescent fecundity has not fallen as noticeably as in other age groups. It has even remained stable or has increased slightly in the past 15 years in some countries, with adolescent fecundity gaining ever greater importance in overall fecundity (Rodríguez J. 2005). The highest proportions of adolescent mothers in the region are among the most vulnerable populations (UNFPA/CENEP, 2005).

Sexual and reproductive health should be understood in reference to the social and cultural context in which the adolescents live and which determines the exercise of their rights. Although it is true that the great majority of pregnancies in adolescents are unplanned and hamper the development of the woman who receives it unexpectedly, and thus constitutes a problem, for other adolescents this turns out to be the only life project available.

Thus, to characterise the reproductive health situation of the adolescents of the region is complex, given the ethnic, socio-cultural and data recording differences. To this last point should also be added the significant gender differences in that adolescent boys have for years been forgotten in research, policies and programmes (UNFPA, 2001). The sexual and reproductive health situation of adolescents is not homogeneous in Latin America and the Caribbean, but there are some situations that are shared, such as: a relatively high level of fecundity, particularly among the poorest women; little access to sexual and reproductive health services and sexuality education; low access to contraceptive methods; a high incidence of STI and a high risk for the children of adolescent mothers.

The Report on the State of World Population 2002 is emphatic in pointing out that there is an overall relatively high level of fecundity in adolescence in the region, and that from the socio-economic and cultural point of view, there are great differences between the most and the least vulnerable women. Disorders in the area of sexual and reproductive health represent more than half the disease load suffered by women of reproductive age, and it is even greater among poorer women with lower educational levels and higher fecundity. On the other hand, health indicators based on national averages do not count the internal inequalities within nations and the greater inequity that is marked by poverty (UNFPA, 2002).

The conditions of school and social exclusion, poverty, social inequities and violence in which adolescents build their lives generate vulnerabilities for the exercise of their human rights and especially their reproductive rights, and this is something that the formation of health teams should bear in mind in their curricula.

REPRODUCTIVE RIGHTS AND THE RIGHT TO HEALTH

Reproductive rights are part of the set of human rights and are similarly characterised as being universal, inalienable and interdependent, with their exercise being indispensable for the overall development of the individual (UNO, 2005). They are therefore inseparable from civil, political, social, economic and cultural rights, and involve the exercise of citizenship. They are intimately linked with the right to health, to the freedom of the individual, of thought, conscience and religion, of opinion and expression, to information and education, to justice and to the benefits of scientific progress, among others.

The reproductive rights were defined in the Programme of Action of the ICPD and were legitimated by the international community and in the separate national legislations on sexual and reproductive health. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions about reproduction free of discrimination, coercion and violence, as expressed in the human rights documents (UNFPA, 2004).

Even though all the human rights are integrated with sexual and reproductive health, some of these should be specifically mentioned, such as (PATH-UNFPA Outlook, 2004):

- The right to the freedom to decide to have a partner, whether to form a family, to decide the number of children and the spacing between them, to control one's sexual and reproductive life and to take decisions free of coercion and violence.
- The right not to be discriminated, which means equal treatment in access to health care services for men and women of whatever religion, race, ethnic origin, age, socio-economic level, sexual orientation, etc.
- The right to life and health, which obliges governments to ensure a health system that guarantees universal access to quality sexual and reproductive health services, eliminating the barriers to access and ensuring access to the most vulnerable.

Guaranteeing the exercise of reproductive rights consists in concrete actions by providers of health services, aimed at ensuring the universal access of adolescents to information, education and sexual and reproductive health services, strengthening their autonomy in decision-making, protecting their bodily integrity, without discrimination of any kind and with active interventions to eliminate

inequities, whether socio-economic, political, of age, gender, race or ethnic origin, sexual orientation, religious beliefs or others, in access to these rights. Reproductive rights are part of human rights and were recognised in the International Conference on Population and Development (ICPD, 1994) and in the Fourth World Conference on Women (Beijing 1995).

Although the Convention on the Rights of the Child (CRC 1989) recognised that boys, girls and adolescents are subjects of human rights, their reproductive rights still had a long process of social construction, making advocacy activities necessary with governments and civil society for their legitimation.

The CRC also recognised that adults, parents, officials, civil society and the State as a whole, are subjects of obligations in relation to the rights of boys, girls and adolescents, and must guarantee the social conditions to exercise these fully and watch over their higher interests. Among these rights are the rights of boys, girls and adolescents to life, survival and development, and these are intimately related with the access to knowledge and services, from the moment in which they initiate the exercise of their sexuality (UNFPA/MINEDUC, 2005).

The CRC also established the right of boys, girls and adolescents to give consent and to participate in subjects that concern them, which means that their participation must not be solely symbolic, but that they must give their opinions on concrete issues affecting them, as subjects of various rights, among them that to health.

Four years later, the International Conference on Population and Development (ICPD 1994) legitimated reproductive rights within the set of human rights and redefined sexual and reproductive health in an overall, interdisciplinary context. The Action Plan, signed by 184 States, determines the need to increase universal access to sexual and reproductive health services, in the conviction that this is the way to improve the health of the population, especially the most vulnerable.

An assessment of the progress of the ICPD in Latin America and the Caribbean 10 years after its signing indicates that in terms of health in general a profound gap can be seen of inequity in access between the poor sectors (among others the rural and indigenous sectors) and those with higher incomes. In terms of sexual and reproductive health, it is seen that in some countries there are still policies and programmes that have not moved on from the mother-child health approach, and that do not consider the different needs of women, men and adolescent girls and boys. The subject of HIV/AIDS deserves a special mention, since it is estimated that infection indices are very high in some countries of the region (CELADE–UNFPA, 2004).

One year after the ICPD, in the Fourth World Conference on Women (Beijing 1995), 189 States adopted the Beijing Declaration and Platform for Action with the aim of promoting equality, development and peace for all women. This Platform for Action incorporates the advances from previous conferences and treaties, such as the Declaration of Human Rights, the Declaration on the Elimination of All Forms of Discrimination against Women and the Vienna Declaration. It recognises women's reproductive rights, emphasising the need to guarantee self-determination, equality and sexual and reproductive security, and also clearly establishes the duties of member States in recognising and protecting these rights. The work of UNFPA is committed to this Platform of Action (Beijing at Ten, 2005).

In September 2000, 189 nations signed the Millennium Declaration. This is an ambitious document reaffirming the principles of universality, interdependence and inalienability of human rights and urges the building of a path for guaranteeing freedom for all women, men and children through a global alliance for development, in the conviction that it would be profoundly unfair for the poorest countries and populations to have to take on all the weight of development alone. In order to ensure and guarantee accountability on the part of the States, the aims were quantified in goals and indicators for fighting poverty, hunger, disease, illiteracy, the damage to the environment and discrimination against women. These measures, known as the Millennium Development Goals (MDG), have become the main focus of social development policies for the next decade of this century.

The recent World Summit (United Nations, 2005) reaffirmed that sexual and reproductive health contributes not only to improving maternal health indicators, but also to reducing poverty. For this purpose, a health system is needed that eliminates the legal and social barriers that restrict access to sexual and reproductive health information and services for adolescents, including access to contraception and condoms.

Adolescents have also been consulted about their reproductive rights and they have identified among these the right to: decide freely about their bodies and sexuality; exercise and fully enjoy their sexual life; show affection in public; decide who to share their sexual life with; have their intimacy and private life respected; live free of sexual violence; have full, scientific, and lay information about sexuality; sexuality education; sexual and reproductive health services; and to participate in public policies (www.ilsb.org.mx/09proyecto jovenes/cartas/manual_cartas.htm).

In the following table, modified from the original, elements of sexual and reproductive health are related and examples are given of actions based on human rights (UNFPA, 2005). It is considered that if all people and couples could exercise their reproductive rights, progress towards achieving the MDG would be speeded up.

Elements of reproductive health	Examples of actions based on human rights
Right to life and survival	To prevent the avoidable deaths of mothers and new-born children. To eliminate the discrimination against girls that can contribute to early deaths. To ensure access to information and methods for preventing STIs and HIV/AIDS.
Right to life and personal security	To adopt measures to prevent, sanction and eradicate all forms of gender-based violence. To eliminate female genital mutilation or cutting. To enable women, men and adolescents to adopt reproductive decisions free of compulsion, violence and discrimination. To eliminate trafficking in persons for sexual purposes.
Right to procure, receive and pass on information	To offer full information about issues of reproductive health and reproductive rights and on related policies and laws, so that people can adopt well-founded decisions on reproductive health. To support education about reproductive health and family life, inside and outside schools.
Right to decide the number, timing and spacing of one's children	To provide people with full information so that they can choose and correctly use a contraceptive method. To offer access to a broad range of contraceptive methods. To enable adolescents to postpone pregnancy.
Right to enter marriage willingly and establish a family	To prevent forced and childhood marriages and legislate to prohibit them. To prevent STIs as causes of infecundity and to offer treatment. To provide advisory services on reproductive health, including HIV prevention, to married adolescent girls and their husbands
Right to the highest possible level of health	To provide access to economical, acceptable, comprehensive and quality reproductive health services and information about them. To allocate available resources fairly, giving priority to those who have less access to education and to reproductive health services.
Right to the benefits of scientific progress	To fund research on contraceptives, including female-controlled methods, microbicides and male methods. To offer a range of contraceptive options. To have an available supply and access to drugs for the treatment and control of HIV/AIDS. To provide access to emergency obstetric care, that can prevent maternal deaths and obstetric fistula.
Right to non-discrimination and equality in education and employment	To prohibit discrimination in employment for reasons of pregnancy, evidence of contraceptive use or maternity. To establish programmes for girls to continue attending school. To ensure that pregnant and married adolescent girls and young mothers can complete their education.

GENDER EQUALITY AND EQUITY

Gender is a category of analysis describing the culturally and historically constructed inequalities of power, associated with a set of social characteristics attributable to women and men, which determines a hierarchy of power in social functioning, supported on identities, subjectivities and roles differentiating what is female from what is male, according to a particular culture and time.

Gender equality in health means that women and men find themselves with equal conditions to fully exercise their rights and their potential to be healthy. The concept of gender equity, then, is related with a fair distribution of

benefits, power, resources and responsibilities between women and men. Gender inequity in the health context refers to the inequalities in the state of health and in health care between men and women that are unfair, unnecessary and preventable. The strategy of equity has the purpose of reaching equality, or in other words, equity is the means for achieving the end-result of equality. (www.paho.org/project.asp?SEL=TP&LNG=SPA Gender and health)

Inequity in gender conditions the reproductive rights and health of adolescents of both sexes, exposing them to different vulnerabilities. In Latin America, families as institutions reproducing culture, influence the transmission of this hierarchy of power through different expectations about the exercise of rights and gender roles, promoting different practices for each sex, such as a greater independence for adolescent boys than for adolescent girls.

Gender inequality and inequity affect the exercise of sexuality of adolescent boys and girls and determines their access to health information, education and services, as well as to preventive measures against unplanned pregnancies, sexual abuse and violence, abortion or STIs and HIV/AIDS (UNFPA, 2001).

Studies made in Latin America and the Caribbean show the close relationship between gender inequalities and the attitudes, perceptions and behaviours that adolescent boys and girls adopt towards sexuality and reproduction. The initiation of an active sexual life is linked in women with the search for a stable partner, while in men it is more related with reinforcing their male identity (Olavarría J., 2003; Olavarría and Moletto, 2002). Many adolescent girls "wish" to become pregnant as a way of achieving a socially valued adult role, in this case the role of motherhood with its cultural value. This cultural trap means that these adolescent girls feel they will be socially recognised only to the extent that they are mothers, but both the health system, and their own family, tend to be more concerned about the child that they are carrying than about them (Franco S. Klass R. Pitman P. 2000).

For various health providers and educators who share this sexist culture, it seems "almost natural" that it should be the women who are most concerned about the possibilities of getting pregnant and having children. Thus the knowledge, reflections, concerns and behaviours related both to control over sexual initiation as well as to the regulation of fecundity and the consequences of carrying out this regulation or not, are also responsibilities that health teams and society as a whole leave to women.

Most health systems are organised with the mother-child model, by which only pregnant women and children find lower barriers for access to health. This type of programme, ignoring the health needs of adolescent boys and girls, contributes to perpetuating the stereotypes of gender inequity mentioned above (Franco S., Klass R. and Pitman P., 2000), with a clear message that declares its great interest in caring for the woman when she is going to be a mother, but not showing the same interest when she consults about preventing pregnancy, especially when she does not have a partner. This is how the social system implicitly constructs an identity for the woman through motherhood, and leaves the responsibility for the reproductive health of the family almost exclusively to her.

This process is different for men. Male socialisation does not promote self-care behaviours. Machismo plays a significant role in the region in the development of identity, to the extent that men are socialised to be self-sufficient and independent, not to show emotions and not to worry or complain about their physical health, nor seek help in moments of emotional stress. Adolescent boys suffer social and family pressure to comply with the standards of masculinity dictated by society. This often pushes adolescent boys prematurely towards autonomy and independence and represses the expression of emotion and vulnerability. In this way the construction of masculinity has become a public health concern in the region, since the way in which the goal of "becoming a man" is achieved constitutes in itself a risk to the health of boys and as a consequence also affects the health of the woman (Aguirre R. and Güell P., 2002).

Male socialisation means that the man becomes a factor of vulnerability for the health of women, children, other men and for himself, particularly during adolescence (De Keijzer B., 1998). Health, in male identity, is a practice with little significance; proof of this is his lack of care and valuing of the body. This kind of socialisation encourages boys to develop behaviours of independence, aggressiveness, competition and the incorporation of violent and rash behaviours in a variety of contexts, including sexuality and reproduction. The message is that they should be daring and proactive in the search for sexual activity. The data on HIV/AIDS have shown what happens within the sexual field and the huge limitations that women have to negotiate within this context.

These gender differences have historically constituted subjectivities that are expressed in the inequality of power in which adolescent boys and girls construct their identity. Inequity of gender limits the ability of women to demand condom use or other contraceptives. The need to be recognised as the "official partner", even knowing of the existence of other partners, exposes them to the risk of STI/HIV (Loutis W., 04/2005; Loutis W., 05/2005), but also conditions the silence and denial of the transmission of HIV between men having sex with men. Gender violence is one of these examples that affects the control that young women have over their sexuality and development. Its consequences include physical lesions, unplanned pregnancies, unsafe or spontaneous abortions, STIs including HIV/AIDS, as well as psychological disorders such as depression, anxiety and low self-esteem. The research shows that most of the acts of violence against women, including rape, are committed by people known to the woman, including their partner and family members. Poll data show that in some countries between 10 and 69% of women suffer domestic violence. Young and adolescent girls are especially vulnerable to

gender-based violence and almost 50% of the sexual attacks are made against girls of 15 years of age or less (UNFPA, 2003 and 2005).

Gender inequities also hit the differential in health between adolescent boys and girls. The former generally show higher mortality rates – in some places four times higher - while the girls nearly everywhere show higher morbidity rates. There are also significant differences in the causes of mortality and morbidity. Boys show higher rates of mortality and morbidity due to violence, accidents and suicides, while adolescent girls generally show higher rates of morbidity and mortality related to the reproductive system and pregnancy (WHO, 2000).

A study made in Brazil (Dos Santos L., Béria J.U. and Tomasi E., 2003) shows that adolescents approaching primary health care centres are principally female and the age range of those consulting is from 15 to 17 years old. Stratifying by sex, the reasons for consultation most commonly seen among boys were related to the respiratory system, dermatological complaints and the musculoskeletal system. The most frequent reasons among girls are related to pregnancy, the respiratory system and the musculoskeletal system. It is to be noted that in this study, sexual relations and/or contraception were mentioned as a reason for consultation only by adolescent girls. Very few adolescent boys presented complaints connected with the psychosocial area and drug-use did not appear as a reason for consulting.

Health service providers should be clear about inequities of gender and about the social and cultural structures which sustain these, in order to counteract them. Based on the different valuations made on the sexes, the health and development problems of adolescent boys and girls must be analysed in relation to the way in which they construct their sexual identity and can exercise their autonomy for decision-making. For this, health providers must have been able to analyse their concepts of gender supporting their practices within the health services.

A sexual and reproductive health programme based on human rights must guarantee reproductive rights universally for boys and girls. To do this they must start with a critical analysis of the factors that constitute barriers to access to health and services for men and women, especially those cultural stereotypes that health providers reproduce in their practice.

REVIEW OF THE HISTORY OF ADOLESCENT HEALTH CARE

Adolescent health is a relatively new area within medicine, but some publications have mentioned the medical needs of adolescents even since the end of the 18th century. These of course are isolated elements that are recovered when reconstructing the history and are mentioned to stress that interest in this subject has been around for many years now. It was in the middle of the following century that a modern concept of adolescence was introduced, concentrating on middle class youth and on a biological phenomenon, with the first studies focusing on this area of development. But it is undoubtedly the 20th century that marks a milestone for Adolescent Medicine, with the great flourishing of research in the area of psychological development, the increase in scientific studies of puberty and physical growth, with the appearance of the first services specialising in adolescents, the start of teaching activities on the subject and finally culminating in the formation of the Society for Adolescent Medicine in April, 1968 (Heald F. 1994). Since that point, scientific activity around this specialisation area has been steadily increasing.

It was not much later that the same processes occurred in the region of the Americas. In fact in Chile around 1950 there was already a General Department for the Protection of Childhood and Adolescence in the Health Ministry, and the first services for adolescents began working in the 60s (Peláez P. y Luengo X., 1993). A similar pattern is found in other Southern Cone countries such as Argentina, where also at the end of the 60s the first adolescence service was inaugurated in the Hospital Rivadavia in Buenos Aires, at the same time as the service was established in Boston, U.S.A. In Uruguay, at the end of the 70s, there was the first experience of a polyclinic for adolescents (Algazi I., Zamora R., Santi L. et al.; 1984).

In the 80s, the emergence of studies showing the figures of adolescent pregnancies was an element that triggered on the one hand the attention of clinics, and on the other a great interest from the side of public health, at that time focused on the concept of precocious motherhood, because it was seen as a risk situation for the mother-child unit. For this reason, in these years there was a steady increase in interdisciplinary professional teams and centres specialising in the comprehensive care of pregnant adolescents, coinciding with the interdisciplinary paradigm of health defined in Alma Ata. These experiences had various designs, some within a hospital context, such as that in the Hospital de Clínicas José de San Martín, in Buenos Aires, Argentina (Méndez Ribas J., Girard G. et al., 1993) aiming to give biopsychosocial care to the mother-child unit, and others that, as well as clinical care, had a strong research component, such as that of the Centro de Medicina Reproductiva del Adolescente (CEMERA) in the Medical School of the University of Chile (Molina R., Romero M.I. et al., 1985). In the course of time new initiatives have been added in various countries, such as that in the Hospital María Auxiliadora in Lima, Peru, which has been offering services since 1990 to a million adolescents living in the outskirts of the city (PATH / UNFPA Outlook, 1999). These were programmes aimed at tertiary prevention of the vulnerabilities generated by adolescent motherhood/fatherhood.

Other kinds of complementary initiatives have been generated out of the problematics of pregnancy, like that in Jamaica which has been much commented on. A programme for adolescent mothers has been run there since 1978 in the

Women's Centre of Jamaica, which enables these adolescent girls to finish their education and avoid a second pregnancy (PATH/UNFPA Outlook, 1999). Other similar experiences have arisen in the region based on this one. (Molina R. et al., 1996; FHI Network, 1993)

At present there are services for adolescents in most of the countries of the region, and even programmes within the National Health Ministries or Secretariats, at varying levels of development. It is agreed that the most effective programmes are those that are multi-faceted, focusing on the various life contexts of young men and women, and bringing in the significant adults and the communications media; that deliver contents about rights and not mere warnings; that are user-friendly and start from a broad perspective of health and development, rathear than tackling only one problem like the prevention of pregnancy, for example (PAHO, 2003).

The gynaecologists and obstetricians interested in adolescents have been grouping together in common scientific assocations, opening up their field of activity also to aspects of infant-juvenile gynaecology, understanding that sexual and reproductive health is a continuum and that the needs have to be met at all stages, from birth to youth. A holistic definition states that sexual and reproductive health in adolescence is "The set of phenomena and problems of normal growth and development and its deviations that occur in adolescence and their relationship with the evolution of the endocrine/sexual and mental process and fecundity in this period, including the psycho-social environment" (Molina R., 2003).

In a lapse of little more than one decade, most of the countries of this region now have some society of child and adolescent obstetrics and gynaecology. The Latin American Association, ALOGIA, that brings these societies together, grew out of a meeting in Chile in 1993, attended at that time by only three countries: Argentina, Uruguay and Chile. Today Alogia is made up of more than 17 countries in the region and is recognised for its participation in the FIGIJ, the International Federation of Pediatric and Juvenile Gynaecology (www.alogiaonline.org).

The work of these scientific societies initially focused on adolescent gynaecology and pregnancy, and gradually opened up to overall health, to health prevention and promotion activities, to the needs of adolescent boys and to the training environment, winning the international recognition of experts in this field.

These lines of work gave rise to many initiatives devoted to the care of pregnant adolescents, with the aim of giving them services adapted to their needs and then to the prevention of unwanted pregnancies in adolescents. The epidemiology of adolescent health showed that adolescent boys and girls were having sexual activity with limited information on sexuality and little or no access to methods for preventing pregnancy and sexually transmitted infections (STIs). With regard to STIs, after the appearance of HIV/AIDS in the 80s, the lack of knowledge about aspects of adolescent sexuality and of education in this area became even more important. For this reason, much later than the studies on the problematics of adolescent pregnancy, and not without difficulties, there has been some progress in recognising the sexual and reproductive health of adolescents.

At the same time, services growing out of pediatrics have been expanding and have taken a slightly different approach. Their initial emphasis was on aspects of physical growth and development, focusing on puberty, then starting to incorporate elements from the psychosocial area, tackling topics from the area of endocrinology, but leaving the subjects of sexual and reproductive health to the groups devoted to pregnancy. It is in these teams that most attention is paid to adolescent boys, and topics come up such as aspects of mental health and the use of substances such as tobacco, alcohol and other drugs (Peláez P. and Luengo X. 1985).

Both types of experiences, those arising out of the problematics of pregnancy as well as those of care based on pediatrics, were brought together in one main area of mental health, since the subjects of family dysfunctions, behaviour problems, psychopathology, development needs and disorders from the psychosocial area, were frequently seen to be linked.

Altogether, most of the services were created in order to give a solution to a specific type of problem, whether pregnancy, substance use, severe behaviour disorders (violence, delinquency), among others. Although this approach has the strength of tackling a particular area or problem in depth and developing knowledge on that topic, its weaknesses are that, on the one hand, it stigmatises the adolescents who consult in these centres and on the other, that it does not tackle in a comprehensive way the solution to the adolescents' needs. The stigma is due to the fact of typecasting them by the problem (pregnancy, drugs, etc.) or because it pathologises them, i.e., the consultants feel that the mere fact of going for a consultation proves that they already have the problem. This excludes any possibility of approaching youth with promotion, prevention and/or counselling activities, which are considered activities of prime importance.

In brief, health providers who devote themselves to adolescence come from different contexts: paediatrics, obstetrics and gynaecology, internal medicine, psychiatry and family medicine. The origin of these specialists will undoubtedly mark the approach they take to the rights of adolescents. However, there is consensus that, in order to offer suitable care for adolescents, interdisciplinary teams are needed and that the work should be based on the concept of transdiscipline (PAHO/UNFPA, 2000).

In a different field, starting from the presence of the women's movement, the concepts around gender equity and equality and reproductive rights were developed. A third field is being built with the professionals, particularly lawyers, who have worked for the rights of boys, girls and

adolescents. Since these are separate fields, for some adolescent health professionals, the recognition of the reproductive rights of adolescent boys and girls is still a matter of discussion and, often, of confusion.

It is probably because of this kind of limitations that youth sexuality, including sexuality education, is the area that has been least developed. This is linked to the recognition that young people have the right to access to information about sexuality, in order to achieve a healthy and pleasurable sexual life, free of coercion and violence, and access to a health care that guarantees relevant services (PAHO, 2003).

TRAINING OF HUMAN RESOURCES

Surveys made in the countries of the region have shown up an insufficient quantity of human resources trained in adolescence, which constitutes a weakness, especially at local level. The development of leadership and investment in human capital was part of the foundation of the Plan of Action 1998-2001 of the Pan American Health Organization for the health of adolescents and youth and is considered a key element for the sustainability of the initiatives in each country (PAHO, 1998).

Comprehensive care of adolescents requires interdisciplinary teams so that any one of their members can be an entrance gate to the service (PAHO, 2003; PAHO/UNFPA, 2000), not only in order to give a good welcome and to establish a link, but also to give priority to adolescent boys and girls in conditions of vulnerability. They should also have the necessary competency for working in a team, so that available resources are optimised.

Adolescent health must be seen in the framework of the human rights approach, avoiding the problem approach, which has been the one most disseminated in the region. It aims at accompanying overall growth and development, including sexuality; at interventions that analyse the capability of adolescent boys and girls to demand their rights, stimulate resilience, guarantee active participation at individual level as well as through civil society organizations, which audit the international commitments taken on by the States. For this, health teams are needed with competencies in adolescent health from the human rights approach, at all levels, managerial as well as in the primary care teams.

A document drawn up by the World Health Organization in 2002 (WHO 2002) describes the profile of providers of adolescent friendly health services and states that they:

- Are technically competent in areas specific to adolescence, and carry out health promotion, prevention, treatment and care that is relevant for each adolescent, keeping in mind their level of maturity and their social circumstances.
- Have communication and interpersonal relationship skills
- Do not judge and are respectful, easy to talk to and trustworthy
- Devote sufficient time to male and female users
- Act in the best interests of their clients
- Treat all users, male or female, with the same care and respect.
- Provide information and support to enable each adolescent to take decisions freely that are correct for their personal needs.

To this list must be added the competencies of the health teams in promoting, protecting and guaranteeing the exercise of adolescents' human rights, including their reproductive rights.

It is fundamental in all the activities, and especially in counselling, to keep in mind the ethical aspects involved in the care of this age group, including recognising their autonomy in decision-making (Gracia D. et al., 2001; Lorda S. and Cantalejo Mª., 1997; Luengo X., 2004).

These are the kinds of objectives that should be included in the training of human resources devoted to adolescent health care. To meet the overwhelming needs of training for the service providers, all the range of possibilities offered by the training institutions should be used, including new electronic technologies that enable distance education courses, as well as continuous support to courses for them to have a multiplier effect.

There are successful experiences that show that the region does have centres of excellence for training its own human resources, which also gives the opportunity for these resources to be trained in a context where conditions are similar to their country of origin, where costs are lower, and the trained professionals do not abandon the region (ICMER, 2004).

There is no doubt that the formation of new generations of university health professionals, who have overall adolescent health incorporated into each of their disciplines from undergraduate stage, will make the difference in the next decades in the capacity to tackle and resolve the health needs of this age group. It will also be essential for them to have competencies in promoting, protecting and guaranteeing the exercise of human rights in their interventions inside and outside the health service.

• Characteristics of Adolescent Friendly Services

Agreements have been reached at a regional level on the characteristics that adolescent oriented services should have, especially those of sexual and reproductive health, in order to be efficient and effective. Publications made by groups of experts provide suggestions and detail different aspects considered necessary to provide differentiated and youth-friendly care. One of the most important factors included in these is the need to have trained teams (PAHO/UNFPA/CENEP, 2000).

The concept of "friendly services" arose from an inter-agency agreement made in 1995, with the idea that these play

an important role in the prevention of youth health problems (PAHO/UNFPA, 2000). A review was carried out in 2002 on the way in which these services came to be implemented in each country (WHO, 2002; WHO, 2001). It is also recognised that adolescents face a world of opportunities but at the same time live in conditions of vulnerability that affect their health and their rights, and that they themselves represent a present and future positive force for society.

The Committee on Adolescent Health Programming formed between the international technical cooperation agencies PAHO/WHO, UNICEF and UNFPA, recommends the organization of adolescent friendly health services, stressing sexual and reproductive health care (PAHO/UNFPA/CENEP, 2000). The aim of designing this type of services is to ease the access and the welcome to adolescents and their families, and the link between adolescents and health professionals, thus contributing to giving better quality care to this specific group.

In their declarations about friendly services, the experts state that (WHO, 2001): adolescent health and development require a shared vision and complementary actions from different actors; adolescents must have access to preventive health care, promotion and curative services, relevant to their degree of maturity and life circumstances; adolescents can provide many ideas about how to make the services friendly for them; health providers are needed with technical competence about adolescent health; and, among other topics, they must know that unfortunately, merely having a friendly service does not necessarily guarantee an increase in its use by adolescents.

These agreements indicate that adolescent friendly services should be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. Each of these characteristics mentioned has its logical justification and in order to achieve these, a series of conditions must be met. Summing up the World Health Organization document, it stresses that friendly services:

- Have high clinical and quality standards, which the young people are looking for
- Are accessible, acceptable and appropriate, i.e., they are in the right place at the right time and at low cost
- Are equitable, inclusive and do not discriminate, reach vulnerable people or those who have no access to services
- Are comprehensive, providing a set of services that are essential for adolescents
- Are effective and delivered by motivated and trained providers, who know how to communicate with the users
- Have equipment and supplies
- Have a system for improving its quality that supports and motivates the staff
- Are efficient and monitor their own performance through the recording of information
- Include adolescents in planning and monitoring and work to achieve the support of the community.

Adolescent sexual and reproductive health services and programmes face a variety of challenges. The greatest challenges are related to the need to adapt clinical services to the social conditions of adolescent boys and girls through trained providers; to deliver suitable, relevant information in a way that respects their right to take decisions; to run activities aimed at the adolescent boys and girls developing competencies to demand their rights, take care of their health and take decisions about their life in general and their sexual and reproductive health in particular. To do this, it is necessary to influence the life context of the adolescents, the cultural and socio-cultural context in which they live, as elements that affect both the exercise of their rights and the choices they make, bearing particularly in mind inequities of gender, race/ethnic origin and socio-economic level. For this reason it is crucial to guarantee the participation of the adolescents as well as have the commitment of the community (Path/UNFPA Outlook, 1999). Hughes and McCauley have mentioned the difficulty of adapting programmes to the different needs of adolescents, recognising that their requirements differ depending on the different social conditions, including the sexual experiences they have had (Hughes J. and McCauley A.P., 1998), their civil status and other conditions of vulnerability.

Successful programmes are those which help youth to develop competencies that enable them to formulate plans for their lives, that respect their needs and concerns, that manage to involve the communities in their efforts and that provide clinical services without judging them and respecting their confidentiality.

• Competencies that Health Providers for Adolescents should have

There is international consensus that an adolescent friendly health service should provide overall biopsychosocial care and learning about health; be organized to cover the broadest range possible of human resources (e.g.: Admission, Nursing, Medicine, Mental Health, Social Work, Dentistry, among others); and respect the reason for the consultation that brought the adolescent to the service, offering options for its overall resolution with the local team or through the collaboration of established health networks (UNFPA/PAHO/CENEP 2000).

It is recommended that the team be as multidisciplinary as possible, or work with an interdisciplinary approach, and that its members should have acquired competencies to work with male and female adolescents from a comprehensive approach, coordinating their activities with other workers and with complementary health care services and/or community support activities available in their area. There are three recommended conditions for these teams: firstly, that they be motivated to work with adolescents, second, that they manage to work as a team and not with an individual approach from each discipline, and thirdly, that training should include everyone, from the porter to the most specialist professional. Even though it is true that

training is fundamental, given the motivation, this can be done while working, since an important part of it will be achieved from the experience acquired as a result of the interaction with the adolescents themselves (Luengo X., 1997). This will enable any health worker to be the entrance door to the service and all the professionals to be capable of making a comprehensive clinical history.

Each adolescent health worker and the team as a whole should have competencies to go beyond the limits of their discipline with an interdisciplinary and transdisciplinary perspective and practice (recognising, respecting and interacting with the specific contributions of each of the disciplines) and work in coordination with other institutions, not only in health service networks but also in intersector networks of community organizations (a variety of youth, education, justice and work organizations, among others). In addition, it is recommended that the necessary competencies be developed to (PAHO/UNFPA/CENEP, 2000):

1) Establish links by welcoming and communicating appropriately with adolescents, as well as with their fathers, mothers or responsible adults and to have the tools to mediate between them if necessary.
2) Take a good clinical history; a complete physical examination, including the evaluation of pubertal development (percentile of growth, speed of growth, body mass index, Tanner stages with orchidometry and genital examination) and a biopsychosocial diagnosis that includes an estimate of cognitive and school development, their relationship with their family and their friends, and evaluate factors of protection, vulnerability and/or risk; in order to focus relevant help in the most comprehensive way possible.
3) Carry out effective preventive interventions such as: evaluation of learning for self-care/mutual care of health, emphasising sexual and reproductive health care; counselling and learning groups for adolescents and fathers/mothers; vaccination, and even adolescents with specific needs, such as adolescents with chronic diseases, the disabled and street children, among others.
4) Tackle gender-related aspects from a critical and transforming perspective, taking special care not to reproduce gender stereotypes, based on one's own conceptions that hamper the adolescents' development and health.
5) Finally, to be able to carry out advocacy activities to promote adolescents' rights inside and outside the health service.

To contribute to adolescent development, it is recommended that, during a consultation in a health centre, in which confidentiality is guaranteed and work is performed in a framework of informed consent, the following should be promoted:

a) Autonomy to take free and responsible decisions
b) Communication between parents and children
c) Defence of adolescents' rights
d) Strengthening of the awareness of citizenship and solidarity among youth
e) Schooling and the capacity to build projects
f) Self-esteem
g) Strengthening of a critical attitude to the mass media
h) Free and responsible sexuality, independently of the sexual orientation
i) Healthy recreational habits
j) Exercising a vigilant and critical attitude about one's own performance in relation to discriminatory behaviours, about social status, race, religion, sexual orientation and gender

TRAINING IN SEXUAL AND REPRODUCTIVE HEALTH IN A CONTEXT OF THE HEALTH SYSTEM REFORMS

Implementing the proposal of adolescent friendly services often led to experiences whose horizontalization and sustainability were complicated. There is some tension nowadays in relation to the generalisation of reform processes in the health system that generates a debate over what kinds of services may be generalisable, particularly when the norms of care for adolescents, which imply quality standards, are replaced by packages of minimum provision of services, determined by their cost-effectiveness.

The objectives of the health sector reforms that have been being carried out in the countries of the region in recent decades are aimed at reaching acceptable levels of efficiency, quality and equity in health care service and to increase user satisfaction. The incorporation of sexual and reproductive health in the reform processes has been a concern both for the governments of these countries and for the civil society, who have seen this process as an opportunity.

Analysts of these processes have detected weaknesses, especially related with human resources, considered by many to be the most important and least studied aspect (Ugalde A. and Homedes N., 2005). Some of the problems detected in this area before the reform processes were the following: an imbalance between the various categories of professionals and technicians, with a marked tendency towards a greater number of medical specialists, an insufficient number of medical support technicians and a lack of professional non-medical resources with a medical over-employment, which increases stress and labour discontent; a lack of control and poor management capability; a weak regulation of professional practice; and deficient communication between health providers and the users. This analysis declares that many of the solutions to the problems of human resources require the collaboration of different ministries and institutions and that one fundamental aspect that makes the difference for achieving success is the motivation for teamwork, together with

recovering the commitment of providers to the population and to the system.

One example that can be pointed out from the dialogues held about this matter in the countries is the recommendations raised in Argentina and Chile, studied in 2004 (Gogna M. et al., 2004). These recommendations, arising from national dialogues carried out in in these two countries and aimed at the integration of sexual and reproductive health within the health reform, are related with various areas such as management, policies, legislation, funding, incorporation of the concepts of rights and gender, among others, as pointed out in the above-mentioned document.

It should be emphasised that the proposals of both countries stress the human resources training programmes, and even urge considering legislation to include these topics in the graduate and post-graduate formation of health professionals. There is agreement that the number of the human resources available and their competencies for carrying out sexual and reproductive health activities and managing financial resources are insufficient. The proposals about this are in the line of:

- Discussing the contribution of the universities in the context of social responsibility to the country in relation to sexual and reproductive health.
- Stimulating the development of formation, training and specialisation programmes in sexual and reproductive health for different professionals from the health and other areas such as social, economic, management and education sciences.
- Promoting training strategies that integrate the community with information and training in this area of the field of health.

It can be deduced from the publications of the analysts of the reform processes that the inclusion of sexual and reproductive health has not been easy and that there is still much work to be done. If this is the situation for the population in general, the subjects related especially to adolescent sexual and reproductive health are even more absent, and not even mentioned or dealt with in many of the evaluations made (UNFPA-CST, 2005).

Training available

METHODOLOGY AND DATA ANALYSIS

The work carried out to make this survey was set up as a descriptive research study. An explanatory presentation letter and a questionnaire were specially designed to request information from the people and institutions contacted. Both instruments were written first in Spanish and then translated into English, in order to reach the English-speaking countries in the region.

The request for information was mainly made via e-mail, by sending the presentation of the project and the questionnaire to each person, group of people or institutions identified as possible contacts. When no message was received confirming receipt of the communication and/or of the questionnaire, a reminder message was sent about the information requested. Telephone contact was practically unnecessary and was used occasionally, particularly to clarify directly a query with the person answering the questionnaire.

Various sources of information were used to obtain names and e-mail addresses of people and institutions, as well as addresses of websites of institutions relevant to the study. The idea was to reach all the countries of the region and the most renowned institutions in the field of adolescent health.

The sources or means of contact were:

a) *UNFPA country offices in the region:* The network of offices belonging to the United Nations Population Fund in Latin America and the Caribbean was contacted by e-mail and their officers were requested to pass on the request sent to them. They also shared their own country information about institutions or people working in the study area. Replies received from these were then incorporated into the list of contacts made.

b) *Collection of information in "existence".-* Records related to training activities for professionals in the areas of reproductive health and adolescence were examined as well as the lists of people on the sexual and reproductive health training grants programme run by ICMER in the years 2000 to 2003, and the relevant ones were contacted. The notice of the request for information was also published on ICMER's website.

c) *c) Scientific Societies, Networks of Latin American Scientific Societies and other Networks.* Relevant scientific societies were informed about the launch of the study and its objectives and their collaboration was requested. Most of the scientific societies in the region are grouped into Latin American networks, and the request for information was spread widely through these. The Latin American scientific societies, plus a Spanish one, contacted either individually or through the networks mentioned, were as follows: Associação Brasileira de Adolescência – ASBRA, Sociedad Argentina de Ginecología Infanto-Juvenil – SAGIJ, Sociedad Argentina de Salud Integral del Adolescente – SASIA, Sociedad Chilena de Pediatría – SOCHIPE, Sociedad Chilena de Obstetricia y Ginecología Infantil y de la Adolescencia – SOGIA, Sociedad Uruguaya de Ginecología de la Infancia y Adolescencia – SUGIA, Sociedad de Obstetricia y Ginecología de Venezuela – SOGV, Sociedad Peruana de Adolescencia y Juventud – SPAJ, Sociedad Española de Medicina del Adolescente – SEMA.
The request for information was published in the websites of the following organizations: ALOGIA, ASBRA and SEMA.
The networks of scientific societies contacted were: Asociación Latinoamericana de Pediatría – ALAPE, through its Adolescence Committee; Asociación Latinoamericana de Obstetricia y Ginecología de la Infancia y la Adolescencia – ALOGIA; and Asociación Latinoamericana de Investigación en Reproducción Humana – ALIRH. These networks responded by sending the e-mails of their members, lists of other possible contacts, publicising through their own networks, and in one case publicising on its website.
Other networks and institutions whose collaboration was requested were: Regional Programme on the Social Aspects of Human Reproduction – PRASSAR, Latin American Consortium on Emergency Contraception – CLAE and the International Foundation for Adolescence – FIPA (Ecuador).

d) *d) Direct Internet search.-* This active search was made through various means, such as visiting Latin American websites of: university bodies, non-governmental organizations (NGOs) and governmental organizations related to reproductive health, as well as through search engines using key words.

It was proposed to include in the results of the study some relevant training available in European countries and the United States, for purposes of comparison. Three institutions were selected from these countries and contacted to present the different modes available, and these are described in a comparative results chart.

For recording and analysing the information two databases were formed. A record database collected the contact activities made during the information request stage and enabled their follow-up. This contacts database was expanded with fresh contacts obtained from the questionnaires received in which people responded

positively to the question asking for information about possible new contacts and sent detailed answers. The data on the activities record were: institution, contact person, country, means of contact (e-mail or other), date. The record of this exchange of communications includes more than 450 e-mail messages.

A second database was build to enter data received through the questionnaires and/or training courses obtained through the active search made. The fields in this database reflect the variables consulted through the closed questions contained in the questionnaire.

The closed responses were tabulated and analysed with percentages and proportions. The open questions were analysed individually and the analysis of the contents reported was made qualitatively.

GENERAL RESULTS

The map below summarises globally the 59 institutions from which information was received, by country of origin in the region.

The information thus comes from 59 different institutions in the region and a total of 73 training courses were collected, of which 62 (84.9%) were reported directly by the institutions offering them and 11 (15.1%) were obtained from other sources. The list of these institutions with their contact references is added at the end of this document (Appendix 1), as well as the list of training courses and their objectives (Appendix 2).

The information analysed came from a total of 18 countries of the region, as can be seen in the map above, and in alphabetical order these are: Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Haití, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Uruguay and Venezuela.

88.1% (n=52) of the institutions mentioned carry out training activities. Some institutions provided direct information about the training courses they are currently running; others reported that they do not run any, and others that they are in process of preparing to offer courses soon. Several of them, even though they do not do training in the study area, provided data of contacts with other institutions.

The training activities reported by the institutions ranged from 1 to 7. These courses have different or similar modes, as well as being directed to different target publics.

Given the way in which the information was collected, in the analysis of results the distinction, if relevant, will be made between the cases in which the institutions classify themselves according to the alternatives offered in the questionnaire, and those where the information about training activities was collected and included by the research team. It has been decided to make this differentiation, considering that the replies given directly through the questionnaire are objective data that do not introduce observer bias, which is not the case of data collected directly by the researchers. The following section analyses the results of the replies obtained from the questionnaire.

INFORMATION OBTAINED FROM THE QUESTIONNAIRES

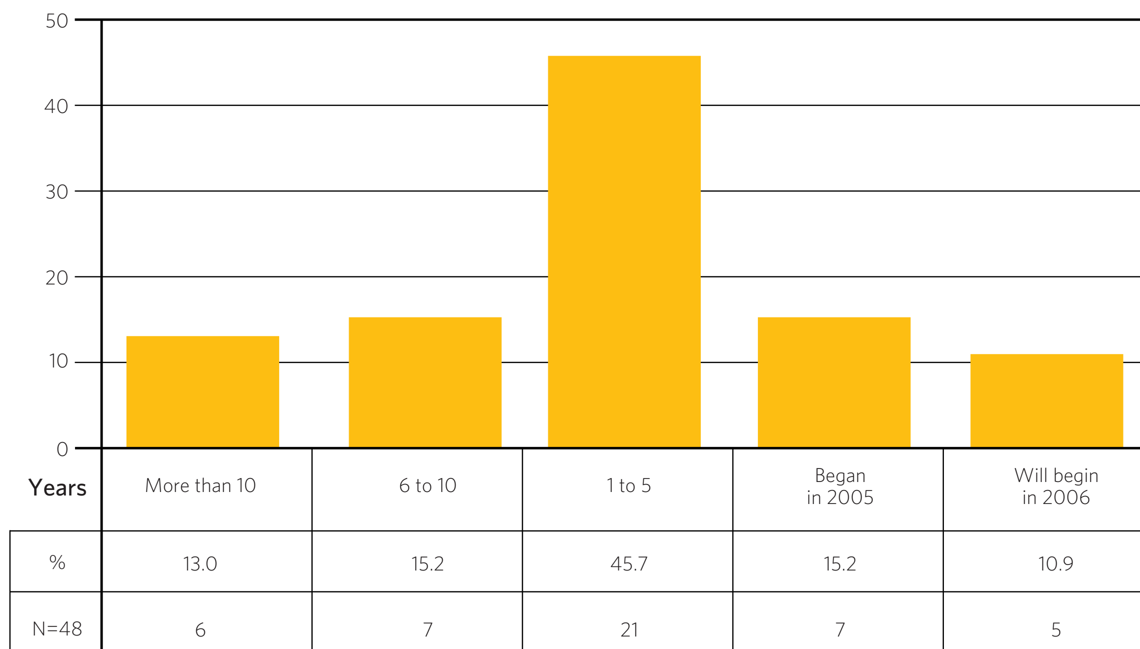
Most of the training courses are aimed at health professionals, following the request that said it was related to training for professionals of this type of teams. However, information was also received about some courses that also include educators, and other institutions sent information about activities carried out directly with adolescents.

The distribution of the various characteristics of what is available in the region according to the information obtained is commented on and illustrated in the following figures.

• Age of the Training Course

The questionnaire asked about since when the respective training course has been on offer, so as to know the age of the programme available. The breakdown of this information can be seen in the following graph.

Graph Nº 1. Time since when the the training has been carried out (Age of the programme)



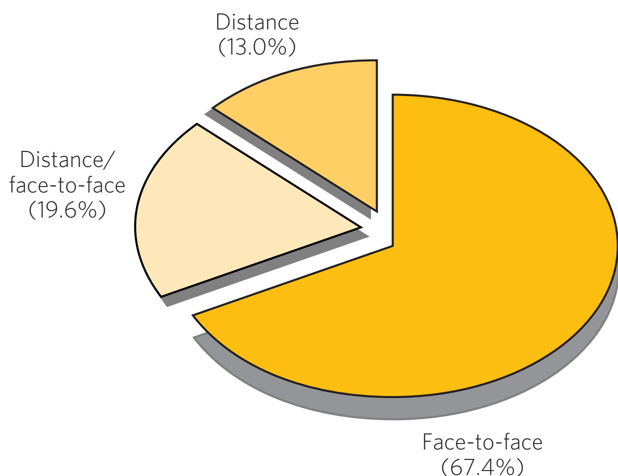
Years	More than 10	6 to 10	1 to 5	Began in 2005	Will begin in 2006
%	13.0	15.2	45.7	15.2	10.9
N=48	6	7	21	7	5

Available training in adolescent sexual and reproductive health is not so recent in the region and continues developing. More than 45% of the courses report having started in the past 5 years, almost 30% state that the programmes began more than 5 years ago, 15% during this year 2005 and more than 10% say it will be available as from 2006. There has been a significant increase in courses available in the past five years.

• Training according to the Mode of Receiving Contents and Methodology

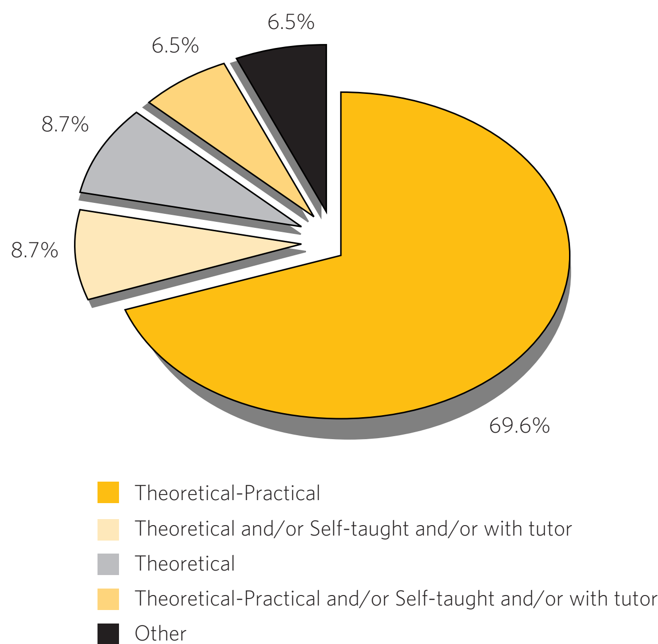
There are three modes in which the students receive the contents, and these are mostly face-to-face and have the following percentage distribution:

Graph Nº 2. Training Mode
(n = 46)



The teaching-learning methodology mentioned in the training courses was of several types, with most of them concentrating on a theoretical-practical methodology. This matches what was seen in the face-to-face mode, since the practice aspect requires the presence of the person being trained. The distribution of all the training courses analysed that report this characteristic of their programme is shown in graph N° 3. Those offering the distance methodology were classified under the category Others.

Graph Nº 3. Methodology of content delivery
(n = 46)

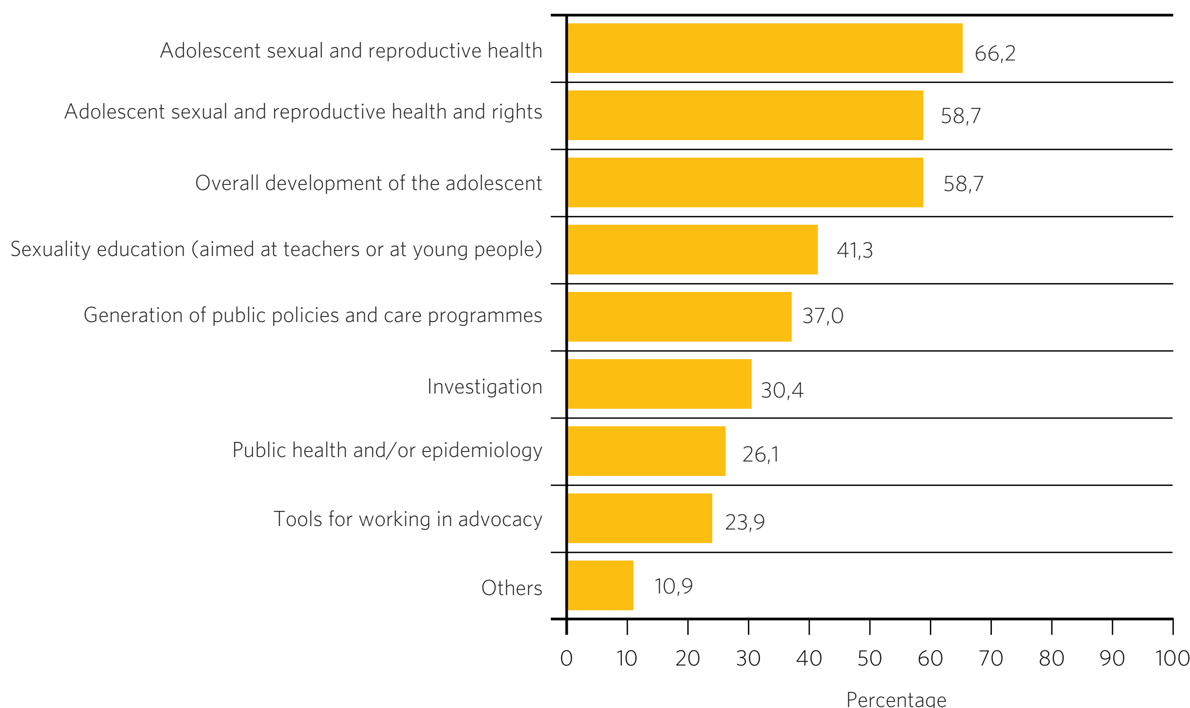


- Theoretical-Practical
- Theoretical and/or Self-taught and/or with tutor
- Theoretical
- Theoretical-Practical and/or Self-taught and/or with tutor
- Other

• Training Approach and Inclusion of the Rights Perspective

The aim of the request was to find out about health team training on the topic of sexual and reproductive health (SRH) that included the perspective of adolescent rights. So the aim of asking the question about defining the approach that they wanted to give to the training on offer was to understand the priority in the core aim of the programme that was set by those responsible. The responses obtained from the self-classifications made by the people answering the questionnaire, according to the options proposed on this specific question and bearing in mind that there was more than one response per institution, are distributed in the following way: Adolescent sexual and reproductive health, Adolescent sexual and reproductive health with rights perspective, Overall development of the adolescent, Sexuality education (aimed at teachers or at young people), Generation of public policies and care programmes, Investigation, Public health and/or epidemiology, Tools for working in advocacy, and Others. The data are shown in the following graph.

Graph Nº 4. Focus of the Training Course (n = 46)



Analysing this response by individual categories specifically linked to SRH in order to make the topics of interest to this study stand out, shows that 47.8% (n=22) mark both options, i.e., SRH and SRH with a rights perspective. 17.4% (n=8) define themselves as having a focus on SRH without linking it to rights and only 10.9% (n=5) define themselves as clearly including the rights approach in SRH training. 21.7% (n=10) of these courses did not classify themselves in this option.

In brief, more than half of all the courses offered and reported through the questionnaire consider that they include the subject of rights in the training approach.

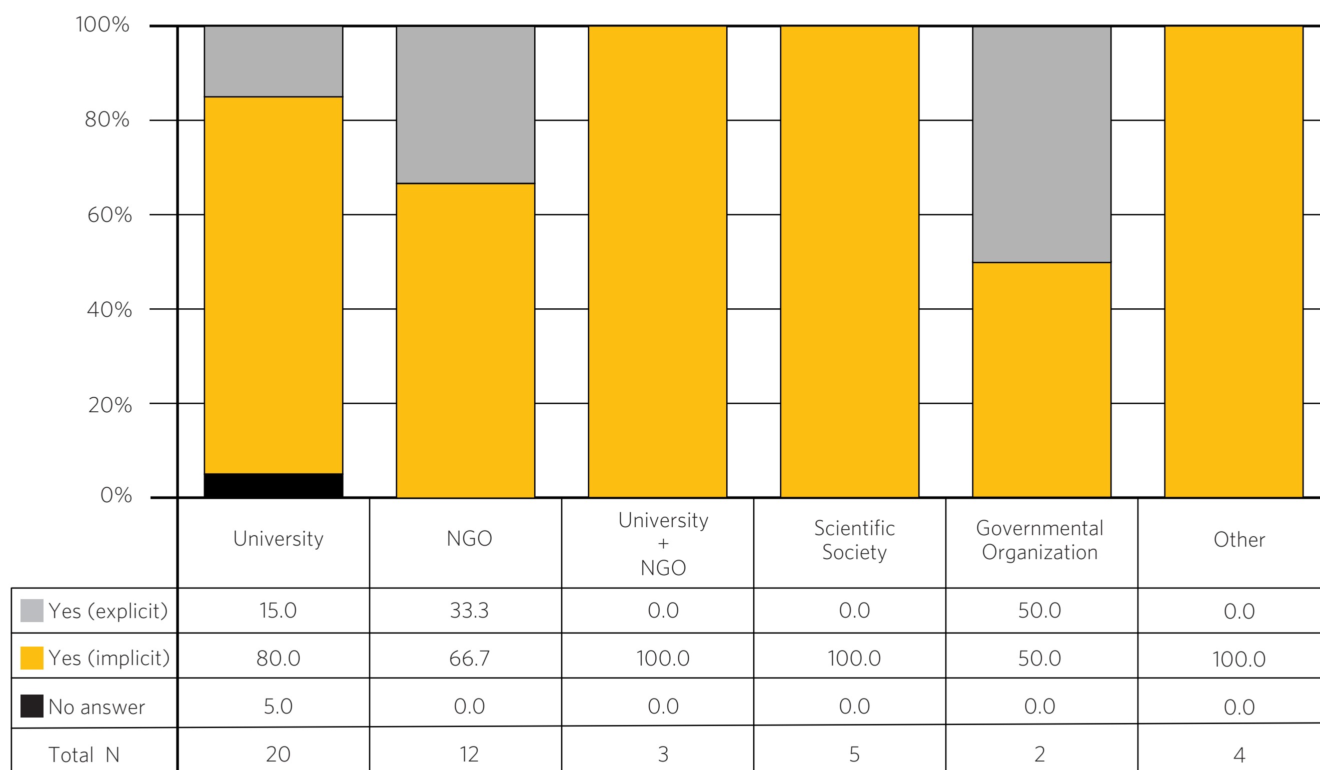
The first question offered the series of options mentioned in the graph above. However, another specific question was incorporated to ask whether the training included the human rights approach and if so, in what way: explicitly or implicitly. It was considered explicit when this stood out in the name of the course or the activity, in its aims or as part of the programme syllabus.

It also asked them to point out, if the training included a special module or activity dealing with human rights as they affect adolescents, which of these were included. Given the options presented, those most marked were the right to health, reproductive rights and sexual rights. However, the question offered the open possibility of adding others, among which were marked the following:

- Right to education of the adolescent mother.
- Right not to be discriminated, to live according to one's own convictions.
- Right to have equality and equity respected and promoted.
- Right to participate in drawing up, implementing, evaluating and monitoring policies of Adolescence and Youth.
- Right to enjoy policies favouring the strengthening of the family and the promotion of values.
- The right of the family to protection by the State and society, considering the family as the natural and fundamental nucleus of society.

It is also interesting to see in which way the rights approach is included, whether implicitly or explicitly, according to the type of institution providing the training. Even though the numbers are small, in general terms the distribution is seen in the following graph.

Graph Nº 5. Way of Including the Focus on Rights according to the Training Institution (n = 46)



	University	NGO	University + NGO	Scientific Society	Governmental Organization	Other
Yes (explicit)	15.0	33.3	0.0	0.0	50.0	0.0
Yes (implicit)	80.0	66.7	100.0	100.0	50.0	100.0
No answer	5.0	0.0	0.0	0.0	0.0	0.0
Total N	20	12	3	5	2	4

All the institutions declared that the rights approach was included, except one where this is unknown as they did not answer the question. It can also be deduced from this information that most of them say they implicitly include a focus on recognising rights in their training courses. Even though, as we said, the numbers are rather small to draw conclusions, comparing the first two columns, a greater explicit presence of this approach can be seen in courses offered by NGOs compared to those offered by universities.

CLASSIFICATION OF THE TRAINING AVAILABLE

The different training courses offered include courses, workshops, seminars, internships, post-graduate training periods, diplomas, master's degrees, and sub-specialities. With some of these a recognition of specialisation can be achieved, with others, academic degrees and even the level of sub-speciality. A distribution was made about this variable based on an individual review of each questionnaire and including the training courses collected by the research team. The breakdown of these can be seen in the appendices (Appendix 2).

Table Nº 1 - Type of Training offered

<table>
<tr><th colspan="2">TYPE OF TRAINING</th><th>N</th><th>%</th></tr>
<tr><td colspan="2">Course or Workshop</td><td>19</td><td>26.0</td></tr>
<tr><td rowspan="2">Master's degrees</td><td>5 With focus on Adolescence</td><td rowspan="2">8</td><td rowspan="2">11.0</td></tr>
<tr><td>3 With module in the Programme</td></tr>
<tr><td colspan="2">Diplomas</td><td>6</td><td>8.2</td></tr>
<tr><td colspan="2">Speciality</td><td>6</td><td>8.2</td></tr>
<tr><td colspan="2">Intra-speciality modules</td><td>3</td><td>4.1</td></tr>
<tr><td rowspan="2">Postgraduate courses and internships</td><td>3 Postgraduate specialisation courses</td><td rowspan="2">6</td><td rowspan="2">8.2</td></tr>
<tr><td>3 Postgraduate internships</td></tr>
<tr><td colspan="2">Distance and/or on-line courses</td><td>8</td><td>11.0</td></tr>
<tr><td colspan="2">Others (miscellaneous)</td><td>17</td><td>23.3</td></tr>
<tr><td colspan="2">TOTAL</td><td>73</td><td>100.0</td></tr>
</table>

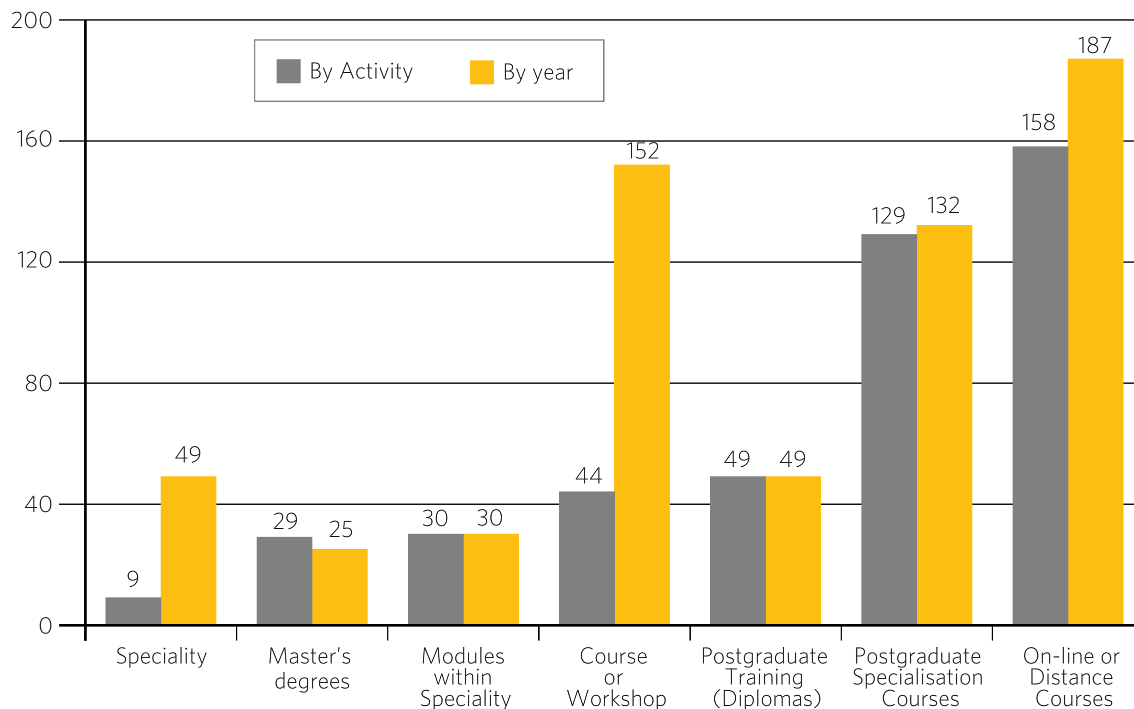
The information presented in the table shows the wide variety of possibilities for training, with different approaches and degrees of depth, but that most of the courses do not give recognition at specialist level nor a particular degree of specialisation.

Their duration is also variable and is linked to the kind of training. The length of the courses ranges from hours to days. The diplomas last months, but with activities that are not full-time, and some with only monthly or bi-monthly meetings. The specialist level is reached with courses comprising usually a minimum of two years of duration, and even on a full-time basis.

• Number of Students by Training Course

The number of people trained per year and per activity according to the information received varies according to the type of training given, as seen in Graph N° 6.

Graph Nº 6. Number of students by type of training course



Postgraduate training courses like the master's degree, for example, have no more than 30 students, although some postgraduate specialisation courses may be more numerous, even reaching 100 participants. Access to the specialities is much more restricted, with limits for people in training of one or two per year. The courses in general accept a much greater number of participants, with over 100 and even more in the case of distance courses via Internet, as these can reach a high number of enrolments simultaneously.

TRAINING MODELS IN DEVELOPED COUNTRIES

Developed countries have a broad range of training available in the area of human resources training in adolescent health matters. Some are only aimed at professionals from their country or region and others are open to all kinds of participants. As an example, three different training courses have been selected, related with the objectives set in this document, in order to illustrate the approach and the diversity of methodologies that are available for professionals.

Here we describe a training course based in Switzerland, for the whole of Europe, and two programmes given in the United States, called:

- EuTeach: European Training in Effective Adolescent Care and Health. An initiative of the Multidisciplinary Unit for Adolescent Health, University Medical Center, Lausanne, Switzerland
- Combined Adolescent Medicine and STD/HIV Fellowship Training Program. University of Washington, Seattle, USA
- The Seven European Study Tour: European approaches to Adolescent Sexual Behavior & Responsibility. Advocates for Youth and the University of North Carolina at Charlotte, USA. This programme visits centres in Holland, France and Germany.

These courses have been selected in order to describe the variety in kinds of proposals, in their objectives as well as in their methodologies, which all target the formation of professionals who attend adolescents, although the universe of professionals to whom they are directed may be different.

It is interesting to look at these courses because they represent the diversity as well as the originality of their programmes and give clear responses to the needs of their communities, and these can be used as models in the region.

A summary table is shown below in order to make the comparison of the three experiences easier.

Table Nº 2 - Examples of Training Courses in Developed Countries

	EuTeach	University of Washington, Seattle	European Study Tour
Objectives	To improve the health of adolescents in Europe, making a training curriculum to meet four specific objectives: 1. To train health professionals working in adolescent care in Europe. 2. To formulate quality standards for medical education and for adolescent health care. 3. To train health care professionals so that they collaborate with families, schools and communities and take on the responsibility of playing an important role in advocacy tasks with regard to promoting adolescent health. 4. To initiate and support, in as many European countries as possible, the development of multidisciplinary adolescent health networks that can foster training in adolescent health.	To train specialists in adolescent medicine, with an emphasis on academic matters, advanced research, teaching and public health studies for handling and preventing STIs and HIV.	To investigate the policies, programmes and practices in adolescent sexual and reproductive health in Germany, France and Holland.
Duration	Variable by modules	3 years	18 days
Place	Multidisciplinary Unit for Adolescent Health, University Medical Center, Lausanne, Switzerland	University of Washington, Seattle, USA	Advocates for Youth and the University of North Carolina at Charlotte, USA
Aimed at	Professionals involved in adolescent health, and trainers	US doctors, post-residents in Internal Medicine or Pediatrics	Professionals in the field of adolescent SRH
Address	www.euteach.com	Children's Hospital & Regional Medical Center. Seattle , USA	www.Advocatesforyouht.org
Contents	The curriculum has two parts and is adaptable to the specific needs of professionals from different disciplines. 1. General modules: cover aspects unique to adolescents (definition of adolescence, biopsychosocial development, gender matters, exploratory/experimental behaviour, communication skills, family interactions, impact of socio-economic and cultural context, legal aspects, adolescent health promotion and school health). 2. Modules on specific topics: sexuality and reproductive health, mental health, medical problems including chronic conditions, substance abuse, intentional and non-intentional lesions, violence, nutrition, physical activity and associated problems. The long-term aim of the EuTeach project is to reach health professionals, independently of their discipline and speciality.	The topics dealt with are: - 1st year: advocacy, cephaleas, endocrinology, gynaecology, adolescent pregnancy, sexuality, STI, sports medicine, school medicine. In the first year, participants will be allocated to a school clinic, a hospital adolescent outpatient clinic, a juvenile detention centre. They will spend time in the Faculties of Pediatrics (UW Division of General Pediatrics), Maternity (The Maternal and Child Health Program), Community Medicine (School of Public Health and Community Medicine) and Psychiatry (Department of Psychiatrists). - The 2nd and 3rd year of the grant focus on STI/HIV in multidisciplinary centre for AIDS and STI in the Univ. of Washington where research, seminars, directed readings, and conferences will be carried out. It includes: 1) virus study, 2) STI bacteria study, 3) epidemiology and 4) international studies on the subject.	There will be training in: - Public Health and/or Epidemiology - Creation of Public Health Care Policies and Programmes - Comprehensive adolescent development - Adolescent sexual and reproductive health - Adolescent health and sexual and reproductive rights - Research - Methodology for Advocacy (in favour of adolescents) - Sexuality Education: for teachers, facilititators and youth

PROFILE OF ADOLESCENT HEALTH WORKERS

Professionals who are recognised as specialists in adolescent health or who have had a training that gives them a specialist qualification come from a variety of origins. This is the result of a formal postgraduate training offered by university centres. Within the region, this sub-speciality is usually offered to medical doctors on the basis of a speciality in paediatrics or obstetrics/gynaecology and very rarely, although it is mentioned, in internal medicine. However there are no reports of the latter type of formation.

These are some examples of the characteristics of these postgraduate programmes, presented separately by origin of the medical training.

• Child and Adolescent Gynaecology

Three countries in the region sent information about the postgraduate training they offer to attain the sub-speciality of Infant-Juvenile Gynaecology and another said that they are hoping to be able to offer it for the year 2006. The three countries that already have this are Venezuela, Argentina and Chile. Bodies in other countries, such as Uruguay, report that they are in process of being able to implement it next year.

It is possible to qualify as a sub-specialist at postgraduate level through university programmes linked to clinical services, lasting 2 years or 4 quatrimesters. Recognition is through qualifications given directly by the universities that offer the training. The Argentine course is given through a scientific society but based in a university clinical hospital. There are in general many similarities between the courses available, as can be seen in the following table. (See table N° 3

• Medicine and/or Comprehensive Health of the Adolescent

Another way of having postgraduate training is by taking a training programme for overall adolescent health care. This is usually given at a sub-speciality level of paediatrics, another clinical area of medicine or nursing.

Information about this type of programme was obtained from the Facultad de Ciências Médicas da Santa Casa de Sâo Paulo in Brazil and from the Medical School of the Universidad de Chile, both with a similar training for doctors, and from the Universidad de Carabobo in Venezuela for the training of nurses and other health professionals. (See table N° 4)

The contents of these programmes are very similar to the training courses mentioned in the previous point, focusing mainly on the clinical medical aspects of adolescence, but obviously without the obstetric/gynaecological detail of these.

• Other Clinical Courses that Include Aspects of Adolescent Health, Courses or Modules Within Another Programme

The training of specialists in other clinical areas includes specific modules aimed at going more deeply into adolescent health matters, in order to give these professionals tools for suitably approaching the health situation of this group. The classification made in this document calls them intra-speciality modules, since their inclusion is just part of the training of another kind of specialist.

An example of this is the professional training programmes in Family Medicine. It is expected that these professionals should be trained to attend people throughout their life-cycle, and so adolescence is also included. This is particularly interesting for countries where the proposal being developed is to have professionals trained in family medicine to give all the primary health care, as is currently the case in Chile. However, some concern can be seen among specialists about the extent to which this type of professional can really get close to adolescents, if they are at the same time responsible for the health of all the family members.

There is also information that courses and/or internships are gradually being incorporated into paediatrics training which give the relevant knowledge about overall adolescent health, in order to raise their awareness and give these professionals the tools for handling the needs of this age group.

In general terms, the contents and the approach given in this type of module are not greatly different from those described in the previous point, i.e. they include aspects of the biopsychosocial growth and development of the adolescent, a comprehensive assessment, and aspects of communication within and with the family and of work in the community.

Table Nº 3 - Training Available in the Sub-speciality of Infant-Juvenile Gynaecology

Institutions	Universidad Central de Venezuela – Hosp. J.M. de los Ríos	Argentine Society for Infant and Juvenile Gynaecology SAGIJ	Universidad de Chile School of Medicine Postgraduate Department
Objectives	To train specialist doctors in the area of Infant/Juvenile Gynaecology	The training of paediatricians and obstetrician/gynaecologists in infant/juvenile gynaecology. Through the programme they should acquire knowledge, skills and attitudes that enable them to deal expertly and comprehensively with the major problems of adolescent health and paediatric gynaecology. After training, they should become change agents in their workplace, fostering adolescent development.	The training of obstetric/gynaecological doctors of excellence, with deep, comprehensive knowledge of child and adolescent gynaecology, mastering the field of obstetrics related to care of the pregnant adolescent and with general knowledge of the various disciplines related to adolescent sexual and reproductive health. They will have to have skills for making scientific research in the relevant areas.
Contents	Comprehensive assessment of girls and adolescents, without pathology, with various medical gynaecological pathologies, with surgical pathologies (genital ambiguity, malformations, etc.) adolescent sexual and reproductive health.	*Paediatric gynaecology:* Ambiguous genitals. Precocious puberty. Paediatric endocrinology. Vulvovaginitis. Synechiae. Vulvar pathology. Genital haemorrhage. Ovarian tumors. Urogenital malformations. Videolaparoscopy. Adolescent gynaecology *Normal growth development:* Normal developmental psychology. Basic psychopathology. Family. Normal pubertal endocrinology. Normal nutrition. *Reproductive health:* Normal and pathological sexuality. Sexual abuse. Adolescent pregnancy. Contraception. Abortion. *Gynaecological endocrine pathology:* Menstrual disorders. Hypothalamic amenorrhea. Alimentary tract disorders. Delayed puberty. Hyperandrogenism. Hyperprolactinemia. Premature ovarian failure. Metrorrhagia. Genetics. Primary amenorrhea. Laboratory. *Infections:* High. Low. STI/AIDS. Bacteriological laboratory. *General pathology:* Vulvar and cervical pathology in adolescents. Gynaecological oncology. Mammary pathology. Pelvic pain, endometriosis. High genital malformations. *Social aspects:* Legislation about minors. Dysfunctional families. Family violence. Community work. Sexuality Education. Addictions. Concepts of primary care for the approach to the adolescent.	At the end of the training the specialist will be able diagnose and guide about: - anatomical and physiological modifications of the genital organs and the neuroendocrine axis that occur in the foetus, newborn, child and adolescent. - the corporal and psychological changes occurring in childhood and adolescence and their importance in the doctor-patient relationship and in the family. - gynaecological and breast diseases that occur from conception to the end of adolescence. - and to apply overall measures in health care for pregnant adolescents, in a context adapted to adolescents, couples and families. - handle basic ideas of sexuality education of adolescents. - carry out research related with the subject of speciality. - develop health programmes related with aspects of the speciality including community aspects. - basic aspects of legal medicine concerning girls and adolescents.
Aimed at	Obstetrician/ Gynaecologists and Paediatricians	Obstetrician/Gynaecologists and Paediatricians with residence completed or specialist certificate	Doctors specialising in obstetric gynaecology

Table Nº 4 - Specialist Training Programmes

Institution	Facultad de Ciências Médicas da Santa Casa de Sâo Paulo, BRAZIL	Medical School of the Universidad de CHILE	Universidad de Carabobo VENEZUELA
Name	Medical Residence or Advanced training course in adolescence.	Specialist Training Programme in Adolescence	Specialisation in Adolescent Health and Development.
Objective	Teaching and Exercise of Adolescent Medicine.	The training of excellent doctors, specialists in adolescence, with the knowledge, skills and attitudes that enable them – always with a comprehensive, proactive and deeply ethical approach – to foster the positive development of adolescents, deal with their main health problems, implement health care services and programmes, do teaching and research in the area and advocate for youth, in order to contribute to resolving their main health problems.	To contribute to the formation of professionals from different disciplines for them to attain a high level of competence in promoting adolescent health and development, based on their specific needs in terms of gender, ethnic origin, socio-economic condition, social territory in the different sectors of reality; by planning, executing and assessing programmes, projects and interdisciplinary and intersector activities, in individual, family and community contexts, using the risk approach and applied research.
Approach	Comprehensive adolescent development	Comprehensive clinical care for adolescents and teacher training.	Comprehensive adolescent development, projects, programmes, research.
Tackles rights	To health, reproductive and sexual rights	Implicitly	To health, sexual, reproductive and others
Mode	Theoretical-practical, Face to face, w/ evaluation	Theoretical-practical, Face to face, w/ evaluation	Theoretical-practical, Face to face and distance, w/ evaluation
Leads to degree of	Specialist in Adolescent Medicine	Specialist in Adolescence	Specialisation in Adolescent Health and Development.
Aimed at	Clinical Care Doctors	Paediatricians	Qualified Nurses with Master's degree in Nursing or Education
Duration	"160 hours in 2 years and in 3rd year – 11 months half time"	2 years full-time	2.5 years 512 hours + time for investigation (1 year)

MASTER'S DEGREES

Information was collected about eight master's degrees, given in seven different countries of the region, i.e., Costa Rica, Cuba, Chile, El Salvador, México, two in Peru and the Dominican Republic.

Most of the master's degrees offered are linked to the area of public health. Five of them concentrate on and are fully aimed at the topic of adolescence and the other three have a module, subject or simply the possibility for the person in training to focus their research on adolescent health topics, depending on their personal interest.

The master's degrees focusing on adolescence that we mentioned, either already available or reported as being open as from 2006, are the following:

- Masters in Interdisciplinary Studies in Public Health with Reference to Adolescence and Youth. Public Health School of the University of Costa Rica Duration: 14 months full-time or 24 months part-time, face-to-face mode.
- Masters in Comprehensive Health and Adolescence. Finlay-Albarrán Medical Sciences School of the Instituto Superior de Ciencias Médicas, Havana, Cuba. Duration: 18 months as from September 2006.
- Masters in Health Sciences of Adolescence and Youth, Universidad de Guadalajara, Mexico. Duration 2 years, "on line" mode.
- Masters in Public Health with reference to Adolescent Health, Universidad Peruana Cayetano Heredia, Lima, Peru. Duration 18 months, combined face-to-face with distance mode. Will be offered as from 2006
- Masters in Comprehensive Adolescent Health, Instituto Tecnológico de Santo Domingo, Dominican Republic. Duration 2 years, combined face-to-face with distance mode.

The master's degrees with a general focus that include a module, subject or the possibility of going deeper into the subject of adolescence, according to the participants' interest, are:

- Masters in Reproductive Health Department of Obstetrics and Childcare. Medical School of the Universidad de Concepción, Concepción, Chile. It includes one subject on Adolescence, lasting one semester, with 40 academic hours. It is given in face-to-face mode.
- Masters in Comprehensive Services in Sexual and Reproductive Health. Medical School of the Universidad de El Salvador, San Salvador. Includes a module on Adolescent Sexual and Reproductive Health Prevention and Care, of 4 days and 32 hours duration. It is given in face-to-face mode and has the technical support of UNFPA.
- Masters in Gender, Sexuality and Public Policies. School of Public Health and Administration, Universidad Peruana Cayetano Heredia, Lima, Peru. It lasts 16 months, is given in face-to-face mode and enables students to focus their papers and thesis on adolescence.

Most of the masters in public health offered in the region enable the student to focus on the topic of adolescence, both in papers and in the final thesis. This, however, does not necessarily give a recognition like a special mention of the masters realised. Moreover, as we have already stated, it depends on the personal interest of the students. More details about the master's degrees mentioned can be found in Appendix 2.

MAS, INTERNSHIPS AND OTHER POSTGRADUATE TRAINING

• Diplomas

Diplomas are considered as postgraduate training as they are directed to professionals who already have their degree, but they, just like the internships, do not give an academic degree award. However, they are considered as giving a certain degree of specialisation in adolescence, given their contents and the time involved in the programmes for studying the subject in depth.

The information received and collected about Diplomas connected with this subject is related with comprehensive adolescent health, infantile/juvenile gynaecology and in one case is focused on the more political and social aspects of childhood and adolescence. Courses are available in two modes, face-to-face and/or face-to-face with distance, and fully distance. Table N° 5 summarises the characteristics of those that are currently available.

Another two diplomas from institutions in countries of Central America gave notice that they will be starting during 2006. Both will be face-to-face, include the rights approach implicitly (right to health, sexual and reproductive rights), and will be directed to health and education professionals, and are the following:

- - Diploma in Overall Adolescent Health, in the Medical Sciences School of the Universidad Nacional de Nicaragua, which will last 9 months, and
- - Diploma in Reproductive Health with emphasis on Family Planning, by the Grupo ProSSER (NGO) and the Universidad Latina in Panama. This programme has an explicit gender focus in the training and it will be open to people from the Social Sciences area.

Table Nº 5 - Diplomas

Name and Institution	Objectives	General Contents	Other Characteristics
"Distance Education in Comprehensive Adolescent Health" Universidad Autónoma de Nuevo León, Monterrey, Mexico	To train health professionals to provide comprehensive care to the adolescent population.	Health prevention and promotion. Health care policies. Nutrition, growth and development, sexual and reproductive health. Psycho-social development. Communication Clinical Assessment.	"On line" Includes the right to health. 1 year, 240 hours 120 students: clinical care professionals, policy and programme generators With PAHO support
"First National Diploma in the Care of the Healthy Child and Adolescent" Mother-Child Department, Public Health Ministry, Havana, Cuba	To train family doctors and paediatricians in the comprehensive management of the healthy child and adolescent.	Anamnesis, physical exam and vaccination. Growth, development and nutrition Psychological development, Dermatology, Ophthalmology, Adolescence, Speech therapy, Stomatology, Orthopedics Otorhinolaryngology Anticipatory guidance	Face-to-face. No declared rights focus. This 1st version exists. 360 hours. 30 students: family doctors and paediatricians. No cost
"National Diploma in Infant/Juvenile Gynaecology and Adolescent Reproductive Health" Hospital Docente Universitario Pedro Borras Astorga Havana, Cuba	To form professionals with overall knowledge of the gynaecology of childhood and adolescence and the reproductive health of adolescence, trained for clinical practice and developing programmes.	Legal and judicial aspects of the care of girls and adolescents. Normal and pathological growth and development. Reproductive health. Common gynaecological disorders. Diagnostic imaging and minimally invasive surgery. Infant-Juvenile Gynaecology Sexuality and Mental Health	Face-to-face. Implicit rights focus: to health, sexual and reproductive. 440 hours. 30 students: professionals from the health and psycho-social areas, investigators and educators. No cost
"Diploma in Childhood and Adolescence" Instituto Peruano de Investigación de Familia y Población. Escuela Iberoamericana Chiclayo, Peru	To promote awareness raising processes, research and foster the rights of children and adolescents. To form specialists in these areas to work at government level, in intervention and research.	All modules focus on childhood and adolescence. Social policies. Biopsychosocial bases. Prevention strategies with minors in condition of social vulnerability. Marketing applied to promotion. Social management. Scientific research seminar.	"On line" Explicitly includes the rights approach. 6 months, 420 hours (includes 60 hours for thesis) Students: professionals of many disciplines.

• Postgraduate specialisation courses

Three courses in Argentina were classified as postgraduate specialisation courses, since the requirements for entering the programmes, the subject matter, and their duration, are considered to give the participants a level of specialisation.

These are:

"Annual Course of Introduction to Infantile-Juvenile Gynaecology", given by the Argentine Society for Infantile-Juvenile Gynaecology.- SAGIJ. Now in its 13th version, its aim is to train paediatricians, gynaecologists and clinical doctors in general in comprehensive and interdisciplinary gynaecological care for adolescents. The course is theoretical, face-to-face, with a clinical focus, including partial and final assessments and the writing of an annual monograph. It lasts 2 years with a total of 128 hours, once a month for 8 academic hours. The certification exam for SAGIJ can be taken.

"Comprehensive Adolescent Health. Diagnostic and therapeutic approach". This is given by the Adolescent Section of the Hospital Municipal Bernardino Rivadavia in the city of Buenos Aires, Argentina. Its aim is to give knowledge about the comprehensive approach to adolescents and the diagnoses and therapies of the main pathologies. It is directed to paediatric gynaecologists, general practitioners, psychologists, and social workers. It lasts 9 months, from April to December, twice a month (1st and 3rd Thursday of the month) and includes 64 hours theory and 60 hours practice. It gives only an attendance certificate.

"Rio Negro Training Programme: comprehensive approach to Adolescent girls". This course is given by the Medical School of the Universidad del Comahue, Rehue NGO interdisciplinary team for Comprehensive Adolescent Health Care, Ministry of Coordination, Río Negro, Argentina. The aims of the course are to give an interdisciplinary and intersector training. The core subjects are: approach to adolescents, nutrition and its disorders, responsible

sexuality, substance consumption, accidents, free time, life project, culture and family. The course lasts one year, with 440 academic hours and is given in a face-to-face and distance mode. It includes assessments and a certificate is given by the University Extension Programme on Comprehensive Approach to the Adolescent.

• Internships

The centres that have adolescent care services offer postgraduate internships to health team professionals who want to go more deeply into the topic of adolescence and obtain a specialisation degree. These internships are variable in their duration and the programmes adapt to the profession of the person in training as well as to the period of the internship. Internships use a theoretical-practical methodology. Students are given the chance of complementing their formation by attending theoretical courses given during their stay in the centre, or that are run by the teachers in the centre.

The institutions listed below offer internships of this kind; their objectives are described in Table N° 6.

Table Nº 6 - Internships

Institution	Name and Objectives	Aimed at	Duration (Exists since)
Adolescence Service, Hospital de Clínicas José de San Martín. Universidad de Buenos Aires, Argentina	Interdisciplinary approach to adolescents' general and reproductive health. To give satisfactory care to young people's health.	Professionals of clinical care, the psychosocial area and educators	From 1 month to 2 years (1987)
Centre for Adolescent Reproductive Medicine - CEMERA. Medical School, Universidad de Chile	Training periods in adolescent sexual and reproductive health Objectives according to demand and needs	Health and Social Science professionals	Variable, according to demand and objectives. 160 hours per month (1986)
Paediatric gynaecology and Adolescence Unit Fundación Cardio-Infantil. Universidad de Rosario, Colombia	Advanced training in Paediatric and Adolescent Gynaecology Personalised academic programme	Obstetrician / Gynaecologists	One year (2004)

The approaches declared for these internships are all the comprehensive development of the adolescent, sexual and reproductive health and research. Two of them also state the rights approach and sexual and reproductive health, one elements of advocacy and the other sexuality education.

COURSES, WORKSHOP-COURSES, SEMINARS

The largest and widest range of topics available in adolescent sexual and reproductive health is in the area of courses and seminars. Most of these, although they do have assessments, only give an attendance certificate and do not lead to any other kind of academic recognition. These are the activities that gather the largest number of participants.

The subject matter is very diverse. Topics related to the comprehensive health of the adolescent, to adolescent sexual and reproductive health in general, as well as just specific aspects of it, are dealt with.

Among the latter for example are: Care of the Pregnant Adolescent in the Context of Sexual and Reproductive Rights; STI and HIV/AIDS Prevention; Tools for working with youth in a context of quality care in Sexual and Reproductive Health; the Sexual Rights and Reproductive Rights Approach in Adolescents; Clinical Care and Research in Sexual and Reproductive Health with emphasis on Contraception.

There is also a wide variation in their duration, which can be from one day to several months and, among those that last longer, some have sessions only one or two days a month.

Most of the courses included in this category are open to all kinds of professionals working in connection with adolescent health and their approach is more comprehensive, multidisciplinary and inter-sector. The sectors most involved are health and education.

In general, the courses have an enrolment cost for students, others have a global amount that the institution

charges when the training team moves to the place where they are required. There are practically no sponsorships or possibilities of financial aid for students, and scholarships are available only on very few occasions. The exceptions are some courses offered by institutions such as ministries or municipalities, directed to staff working in the institution itself. It can also occur with some courses made by scientific societies as a publicity activity.

The profile of the professionals to whom these courses are directed can be said to be split between two large groups: one is for clinical care professionals, including those in the psychosocial area, and the other towards a broad range from the generators of public policies to researchers and educators. It should be noted that some courses are offered as a second stage of training and so the professionals who want to take these should have passed the first stage. This is the case with those offered by two NGOs: Training for Trainers in Adolescence and Sexual and Reproductive Health by Reprolatina in Brazil, and of HIV/AIDS Counsellors by the NGO Foro Red de Salud y Derechos Sexuales y Reproductivos, Región de Los Lagos, in Chile.

Another aspect to note is that the working mode of these courses is usually of a workshop type, in order to give participants the chance of experiencing techniques and/or to provide tools for working with adolescents in a practical way.

DISTANCE COURSES WITHOUT AN ACADEMIC DEGREE

Distance training has been separated specially in this analysis, since these Internet-based courses have a new methodology, are increasingly available, and still in the midst of development.

Distance training courses by Internet leading to degrees have already been mentioned, such as the masters' offered by the Universidad de Guadalajara in México and the diplomas of the Universidad Autónoma de Nuevo León in Monterrey, Mexico and the Instituto Peruano de Investigación de Familia y Población in Chiclayo, in Perú.

Other distance courses available electronically are described in the following table (Table N° 7). Most of these focus specially on adolescent health and less on sexual and reproductive health, but they have been included because they tackle some topics of the latter and/or adolescent health. This is an emerging mode that enables wide dissemination and will surely increase in the future.

Information was received about another course, but in this case no detail was given as to whether the modules are sent through normal mail or through e-mail. This course is the “Distance Continuous Education Course on Infant-Juvenile Gynaecology” run by the Argentine Society of Infant-Juvenile Gynaecology, SAGIJ. Its aim is to update knowledge of new subjects and to reaffirm the holistic concept of adolescent gynaecological care. Its main contents come from the area of medicine with a comprehensive approach to cases. This is a one-year course of 240 academic hours, directed to clinical care professionals, those from the psychosocial area and nursing professionals and/or technicians. Attendance and assessment certificates are given.

Table Nº 7 - Distance Courses

Name of Course	**1.-** Comprehensive Development and Health of the Adolescents	**2.-** "Introduction to the comprehensive health of adolescents and youth"	**3.-** "Distance Education Course for Teachers of Basic and Middle School and Primary Care Health Staff"
Institution and Contact	Pontificia Universidad Católica de Chile – Pan American Health Organization (PAHO) http://escuela.med.puc.cl/OPS/Home.html	Núcleo de Estudos da Saúde do Adolescente (NESA) Río de Janeiro - Brazil Nesa@uerj.br Ead.adolescentes@gmail.com	Centre for Reproductive Medicine and Comprehensive Adolescent Development, School of Medicine, Universidad de Chile. cemera@uchile.cl
General Objective	To strengthen the competencies of health professionals in the overall health and development of adolescents and youth, in order to foster the implementation of policies, plans, programmes and services in LAC countries.	Update on comprehensive adolescent and youth health care.	To prepare qualified professionals in Sexual Education, to attend in a timely and efficient manner children and youth within the formal education system and in primary health care. To provide novel and motivating strategies for tackling sexuality education.
Main Contents	Adolescent growth and development. Clinical Assessment. Adolescent health problems. Strategies for promoting adolescent and youth health.	Growth and development; sexuality and reproductive health; main clinical problems. There is no rigid structuring in modules because the course was developed in case study models tackling specific, transversal competencies.	Sexuality Education. Adolescent sexuality. Sexual response. Adolescent pregnancy. Sexually transmitted Infections and HIV/AIDS. Family. Sexual abuse.
Aimed at	Health professionals involved in adolescent care: doctors, nurses, midwives, nutritionists, social workers, psychologists.	Teachers, facilitators.	Educators and health professionals.
Duration and Certification	Asynchronous, 170 academic hours. Minimum 6 and maximum 12 months. Face-to-face final meeting for the assessment. Post-graduate course certificate.	Module of three months (80 hours)	120 academic hours. Attendance certificate.

Table Nº 7 - Distance Courses (continued)

Name of Course	**4.-** "Development and health in adolescents and youth"	**5.-** "First Virtual Course in an Comprehensive Approach to the Adolescent"	**6.-** "Distance course with e-learning: What is Essential in Contraceptive Methodology"
Institution and Contact	SASIA and the Fundación Barceló. School of Medicine www.iucs.com.ar/adolescencia	Universidad de Buenos Aires, Argentina Virtual School of Medicine sec-fmv@fmed.uba.ar www.fmv-uba.org.ar	Medwave Ltda. Technical and Training Body. Santiago de Chile. www.medwave.cl
General Objective	To contribute to the formation of professionals to work with populations of adolescents and youth with a global, interdisciplinary and inter-sector approach. To promote the formation of consultative teams, for advising parents, institutions, and providing specialised assistance when requested. To focus on adolescent health as an important public health topic. To foster the acquisition of knowledge and tools for the task of promotion and prevention in the community.	To meet a growing demand for distance training in subjects related to adolescence and to contribute to disseminating knowledge about adolescent care.	On finishing the course, the participants will manage up-to-date information about contraceptive methods available in the country and will be able to administer them.
Main Contents	Aspects of adolescent clinical medicine. Biopsychosocial aspects. Systems of care and modes of working.	Comprehensive approach to the adolescent. Diagnosis of the needs of the adolescent population. Interview with the adolescent. Family and peer group. Common reasons for consulting. Common endocrinological consultations. Adolescent rights. Youth participation. Message to the community.	Hormonal contraceptive methods. Intra-uterine devices and barrier methods. Voluntary surgical contraception. Contraception in special cases (adolescents, post-partum, post-abortion, over 35 years of age). Counselling and ethics in contraception.
Aimed at	Health professionals Social workers Education and Justice professionals University students of Health Sciences. Interested professionals with some connection with it.	Health professionals involved in adolescent care.	Health professionals: medicine, nursing, obstetric and childcare nursing, others.
Duration and Certification	The course is in modules. It lasts one year. The study load is 250 hours.	The first year includes 130 hours training. The course will start on April 10, 2006 and finishes April 10, 2007.	Course cycles of two months. 60 academic hours. Certificate of passing the course (attendance and assessment).

OTHER TRAINING COURSES

In this separate category has been included all the information that was received but that does not fit in with the requirements set for this survey. This is either because they are not training courses for health teams, because they are not in the area of sexual and reproductive health or because they do not deal with the subject of adolescent health.

Many of the activities reported and classified in this point are directly aimed at adolescents and youth. Here too can be found training for school teachers, orientators, voluntary health agents, parents, information services and counsellors, among others. More details can be found in the attached list of training courses, which has been included with the aim of sharing the information received.

Reflections and Recommendations

The study has demonstrated the existence of a wide range of training available for health team workers in the field of adolescent sexual and reproductive health, in centres of excellence in the region.

Those available present mainly a comprehensive approach, with different focuses and different levels of depth. The most developed mode is that of workshop courses, delivered by varying kinds of institutions, but undoubtedly this is the one with the least specialisation.

Although these courses are not new, they have lately increased significantly and the distance programmes that can nowadays be accessed by Internet are well publicised. One definite limitation to obtaining this kind of training is being able to have access to this technology, but once this is done it gives people significant flexibility for taking such training programmes. Their disadvantage is that at a distance it is not possible to carry out practical activities with the supervision of a teacher.

Some training courses are offered in the field, with the training team travelling to wherever it is requested. The date and the focus of the programme are agreed jointly with those asking for training. If the activity is done for a large group of people, it can even be more cost-effective compared to the cost of financing individual training.

Institutions with a longer history in the region have achieved high levels of experience and are recognised as benchmarks in the subject, which enables them to offer a broad spectrum of training activities in terms of programmes, modes, target groups, focuses, etc. These institutions can even offer the option of personalised or "bespoke" training, depending on the formation and interests of the team or professional requesting it.

Special mention should be made here of the inter-sector courses, which generally include the health and education sectors, which are of course those closest to adolescents. The subject which most frequently gathers these participants is that of sexuality education, but also the area of adolescent sexual and reproductive health in general. The inclusion of other sectors in joint training with health teams does not in itself guarantee that they will really work together in an inter-sector network.

Also, from the point of view of the recommendation that work carried out in adolescent care should be multidisciplinary, there is no difference to be seen between the contents of the courses that bring together participants of different disciplines compared to those aimed at a single kind of professionals. The invitation to participate is multidisciplinary, but the contents are similar and the emphasis on inter- and transdisciplinarity is no greater in these cases. The foundation is biomedical with other disciplines, mainly in the psychological area, contributing theoretical information, but there is no evidence of a stress on what each of these can contribute in tackling adolescent health, nor as tools to be borne in mind for fostering promotion and prevention activities, for example.

Community training courses are also reported, which in this case include not only health staff but also adolescents, monitors and other people interested. These kinds of activities, based on field work, are mainly carried out by the non-governmental organizations. A Paraguayan NGO mentioned in their questionnaire that they deliver their training in the native language (Guaraní). This types of training courses are those that are closest to the real life of the vulnerable communities where the teams are working.

From the point of view of postgraduate training, the specialisation and sub-specialities with their formal recognition are given by universities. These are the longest courses, generally lasting two years, and usually directed to paediatricians and gynaecologists, with a clearly clinical focus. They are also the ones with the highest costs and which include the fewest students per activity.

The information received shows great interest on the part of the universities and/or scientific societies in different countries in developing this kind of programmes, for obtaining recognition as a specialist. This reflects the interest in raising the specialisation or skills for working in the area of adolescent medicine to the level of recognition obtained by any other medical speciality, which at this moment is achievable in very few places in the region. These goals would be an incentive for many professionals and it does seem necessary to have specialists in adolescence in the centres of greater complexity, where adolescents referred from other levels of care can be assessed globally by staff with a higher degree of specialisation.

Reviewing the contents of these postgraduate programmes shows a clear split, maintained over time, in that the field of sexual and reproductive health has been handed over to specialists in gynaecology and obstetrics, whether doctors, obstetricians (midwives) or obstetric nurses. The area of sexuality, however, is seen more included in the overall adolescent development programmes that are linked with paediatrics, and in which aspects of reproductive health are only very partially dealt with. There is thus a dichotomy between sexuality and reproductive health that is transferred into the way in which these services are delivered.

In gender terms, clinical training is still clearly linked with women's health. Many programmes focus on the gynaecological and reproductive area of the woman, specifically on pregnancy and contraception in adolescence,

which in a way indirectly reflects the persistence of a focus of attention on mother-child health. This fact has been pointed out on several occasions, that the health care services give the message that a woman is welcome and cared for when she is going to be a mother and then the interest focuses on the health of her child. She is not as welcome when she is single or wants to prevent her first pregnancy. It is thus clear that the right to have children in the best conditions and without risks to the woman's health is widespread and respected by health providers, but the same cannot be said of the right to decide how many children to have and when to have them, as the possibility of obtaining information through counselling and access to contraceptive methods for adolescents are less well-known subjects. The same is true of the prevention of STIs and HIV/AIDS, which appears as a secondary subject in the training courses on adolescent health, ignoring the fact that this is one of the populations most vulnerable to these pathologies, with consequences that involve a significant social impact. It is clear that the approach described works against a more comprehensive view of sexual and reproductive health.

It is also evident that the health needs and rights of adolescent boys are not visible. They may be supposed to be included in the subjects of overall adolescent development, but they make practically no explicit appearance in the programmes. And moreover, as we have already remarked, many of the programmes focusing on comprehensive adolescent development, where boys are supposedly included, do not include sexual and reproductive health.

Finally, training courses in the health area is still linked to care of individual needs, to health promotion focused on risks, with few elements that tackle vulnerable populations with holistic strategies.

The adolescent right that is implicitly most recognised is the right to health, which can be taken for granted as part of the "right to be attended", but there is no emphasis on the adolescent as a subject of rights and there is a lack of recognition of the necessary participation of adolescents in decision-making and in the construction of their own well-being.

The region has few master's degrees specifically dealing with topics of adolescent health. Most of these are connected to public health and include a module on adolescence within the programme, or allow the students to interest themselves spontaneously in going more deeply into or majoring in adolescence. However, it is in these programmes where the students usually obtain the tools they need for carrying out research in this field, and based on these, push for achieving the political commitments needed for generating policies and programme legitimating the rights of youth. The examples of masters mentioned in this document illustrate most of those available in Latin America in this training area.

The topic of rights is mentioned in most of the courses available, but only implicitly. As we commented, it can be deduced from the information that the mere recognition of adolescents' health needs is an indirect way of recognising the right to health and only at times specifically the right to sexual and reproductive health. Exceptionally some programmes mention other rights recognised for adolescents, but these are considered as included implicitly in the contents and are only very rarely made explicit. The situation of recognising implicitly the right to health does not guarantee that the professionals are trained to analyse the competencies of the adolescents to demand their rights and guarantee them through the programmes and services offered.

It is interesting to see that fundamentally the training courses delivered by NGOs or the programmes made together with NGOs, in universities for example, manage to deal with human rights and reproductive rights explicitly. No details are mentioned about the way in which they work or deliver the courses. Some mention the reading of Internacional Conventions, for example, but no other type of contents is stated nor the methodology used for teaching.

As a final reflection, the very scarce presence, or rather the frank absence, of the gender equity perspective stands out in the programmes, as does also the explicit delivery of advocacy tools. Training in management is also insufficient, being given only in the master's degrees and, as we have mentioned, there are very few master's degrees in adolescence, so that this is a weakness for the design of policies and programmes and their long-term sustainability. Another topic clearly absent, which cannot be ignored, is that of the sexual and reproductive health of adolescents with special needs (disabled).

RECOMMENDATIONS

The most important recommendations arising from this analysis can be summarised in the following points:

- To strengthen the concepts of health and sexual and reproductive health as connected with the construction of citizenship and empowerment, and this requires the participation of the adolescent population involved. There is still a clearly persistent concept of health joined to medicine and to the absence of illness or problems.
- Adolescent participation is a fundamental human right to be guaranteed and a means of illustrating the reality in which the health care providers work, for participating in the design and in the running of the programmes. Otherwise there is a risk of the rights of youth not being recognised more than theoretically and the quality of the services and the programme not being effective or relevant or sustainable over time.
- To promote the inclusion of aspects about adolescent boys within the training programmes on sexual and reproductive health. It is necessary to link together the sexual and reproductive health of men and of women, without ignoring their particularities of sex and gender, recognising that the mutual interaction directly affects both, in order to achieve gender equity and equality.

- To consolidate the gender equity pespective linked to sexual and reproductive health, so that the people in training have efficient tools for perceiving how this affects the sexuality and health of men and women and can act against the social structures that sustain these inequities. Likewise, providers should have competencies to review their performance in order to perceive how they contribute or otherwise to perpetuating power differences.
- To promote strategic alliances, for example between NGOs and universities, to ensure that the rights approach is included. Such an alliance can contribute with technical-scientific knowledge and competencies in the field of reproductive rights in the human rights context, thus supporting advocacy activities, complemented by elements of citizen participation and representation of the civil society, enabling social auditing of the exercise of rights.
- The workshops should include the delivery of tools for working in advocacy activities and include practical activities so as to allow training in this kind of task. People working for adolescent health should be considered as potential allies in terms of adolescent advocacy and it is desirable for these activities to be carried out in alliance with the adolescents themselves.
- It is necessary to distinguish between the theoretical reference to human rights, implicit or explicit, and its concrete implementation at the level of policies and programmes. For this, we suggest qualitative in-depth studies should be made and the activity of centres of formation should be strengthened in competencies for human rights based programming.
- To encourage and support the development of programmes aimed at drawing up innovative methodologies based on human rights and, at the same time, facilitate the empowerment of adolescents to be able to demand their rights, exercise them and respect other people's rights. The fact of adults recognising the rights of adolescents is an element for establishing a relationship of mutual respect, but the most important part is that the adolescents themselves are informed and empowered to insist on them. These programmes and their activities should consider women, those with less schooling, and those living in poverty as their priority focus in the adolescent population, since these are the most vulnerable groups in terms of the exercise of human rights.
- To encourage the integration of the multidisciplinary health teams, since interdisciplinarity is not widely seen at the moment. Multidisciplinarity is reflected in the target public to whom the training courses are directed, but the contents do not go more deeply into trans- and interdisciplinarity. Communication about the contribution that each discipline can make is very little disseminated, the stress on teamwork is very slight in the training courses and a predominantly medicalised approach is maintained.
- To investigate from the perspective of the health teams the reasons connected to the split between the comprehensive approach linked to paediatrics and sexual and reproductive health managed by the specialists in gynaecology and obstetrics, both in training courses and in clinical care. It is necessary to find out the specialists' opinions and, based on these, decide if a new proposal is needed in order to achieve a meeting point and/or define common working areas, or if it is necessary to maintain and complement the specific nature of each.

The evidence indicates that the topics of rights and the gender equity perspective have not yet sufficiently permeated the activities of training human resources in adolescent sexual and reproductive health. Active work is needed in order to effectively operationalise these approaches. It is important to recognise that the approach of articulating the cultural aspects, gender perspective and human rights will contribute effectively to social inclusion and overcoming poverty.

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Appendix 1 - List of Institutions and their Contact Details

COUNTRY	NAME OF THE INSTITUTION	ADDRESS	TELEPHONE	E-MAIL
ARGENTINA	Centro de Estudios de Población – CENEP (*)	Corrientes 2817-7º A y B (1193) Buenos Aires	(+54-11) 4961-8195/ 0309	cenep@cenep.org.ar
	Escuela de Medicina de la Universidad del Comahue- Rehue ONG Equipo Interdisciplinario para la Atención de la Salud Integral del Adolescente	Escuela de Medicina: UNCo- Toschi y Arrayanes. Cipolletti Rehue: Perito Moreno 3648 (8430) Río Negro	(+54) 2944 491190	rehue@ elbolson.com http://www.rehueong.com.ar
	Hospital General de Pediatría Pedro de Elizalde	Capital Federal. Buenos Aires	4-3075842 al 44 Interno 69	mgsilgarcia@sinectis.com.ar;mercedesfidalgo@argentina.com
	Hospital Rivadavia – Sección Adolescencia	Av. Las Heras 2670 Buenos Aires	(+54 - 11)4809-2000 int.2127	lkaufman@fibertel.com.ar
	Programa de Adolescencia. Hospital de Clínicas. Universidad de Buenos Aires	Av. Córdoba 2321 Buenos Aires	(+54 11) 5950-8476.	programaadolescencia@ciudad.com.ar
	Sociedad Argentina de Ginecologia Infanto Juvenil	Sarmiento 1617 Local 39 Buenos Aires	(+54 11) 4371- 3113	sagij@merci.com.ar
	Universidad de Buenos Aires. Facultad de Medicina Virtual	Buenos Aires	(+54 11) 5950-9524	Sec-fmv@fmed.uba.ar www.fmv-uba.org.ar
	SASIA y Fundación Héctor A. Barceló. Facultad de Medicina. Instituto Universitario de Ciencias de la Salud	Buenos Aires	No information available	www.iucs.com.ar
BRAZIL	Irmandade da Santa Casa de Misericordia de São Paulo	Rua Dr. Cesário Motta Junior, 112. 01221-020 São Paulo – SP	011 – 223.9922 ramal 253	pos.pediatria@fcmscsp.edu.br
	Reprolatina - Soluções Inovadoras em Saúde Sexual e Reprodutiva	Rua Maria Tereza Dias da Silva, 740 – Cidade Universitária – CEP 13083-820 São Paulo – Campinas	No information available	Reprolatina@reprolatina.org.br
	Secretaria Municipal da Saúde de Curitiba – PR Brasil	Michele Caputo Neto – Secretário Municipal da Saúde Paraná – Curitiba	(41) 33509436	adolescente@sms.curitiba.pr.gov.br
	Núcleo de Estudos Científica da Saúde do Adolescente (NESA) - Universidad del Estado de Rio de Janeiro	Av. 28 de setembro 109 – CEP 20551 – 030 Río de Janeiro – RJ	2125876570	Nesa@uerj.br Ead.adolescentes@gmailcom

LIST OF INSTITUTIONS AND THEIR CONTACT DETAILS (continued)

COUNTRY	NAME OF THE INSTITUTION	ADDRESS	TELEPHONE	E-MAIL
COLOMBIA	Territorio Adolescente Las Américas	Diagonal 47 # 15 Sur – 51 Medellín – Antioquía	(574) 313 76 34. (574) 310 13 70	info@territorioadolescente.com
	Unidad de Ginecología Pediátrica y de la Adolescencia de la Fundación Cardio Infantil – Universidad del Rosario	Calle 163 A No 28 - 60 Bogotá	5 71 667 27 27	www.cardioinfantil.org - germansalazar@cardioinfantil.org
COSTA RICA	Asociación de Gineco Obstetricia y Medicina Infanto Juvenil	Heredia Centro Heredia	506 268 52 18	coapsi@racsa.co.cr
	Asociación de Mujeres en Salud (*)	Del Automercado de Los Yoses, 200 metros Sur, 50 Oeste y 25 Sur, casa color papaya, Los Yoses, Montes de Oca San José	(506) 224-3678, (506) 225-0260	ames@racsa.co.cr
	Programa Atención Integral a la Adolescencia, Caja Costarricense de Seguro Social (PAIA-CCSS)	Frente a Clínica Carlos Durán, Barrio Luján San José	(506) 223 - 8948 / 295 - 2299 / 295 - 2369	cgarita@ccss.sa.cr
	CIPAC – Centro de Investigación y Promoción para América Central de Derechos Humanos (*)	200 mts sur y 75 este Bomba el Higuerón San Pedro de Montes de Oca San José	(506) 280-7821	cipacdh@racsa.co.cr
	Universidad de Costa Rica. Escuela de Salud Pública	Ciudad Universitaria Rodrigo Facio, San Pedro	207 4455 / 4420	Ppsapu@cariari.ucr.ac.cr
CUBA	Hospital Docente Universitario Pedro Borras Astorga	Calle C #_513 apartamento 14 entre 21 y 23 Vedado 10400 La Habana	537 8320372	mprieto@infomed.sld.cu
	Hospital Docente Ginecoobstétrico "América Arias"	Línea y G, Vedado CP 10400 La Habana	No information available	No information available
	Ministerio de Salud de Cuba, Departamento Materno Infantil	La Habana	No information available	No information available
	Instituto Superior de Ciencias Médicas. Facultad de Ciencias Médicas Finlay – Albarran.	Calle 21 y 146. Municipio Playa La Habana	8329823 y 8313807	adolesc@infomed.sld.cu

LIST OF INSTITUTIONS AND THEIR CONTACT DETAILS (continued)

COUNTRY	NAME OF THE INSTITUTION	ADDRESS	TELEPHONE	E-MAIL
CHILE	Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente, Facultad de Medicina Universidad de Chile	Avda. Profesor Zañartu Nª1030, Independencia Santiago	56-2-978 6484	cemera@med.uchile.cl
	Centro de Salud del Adolescente SERJOVEN	Av. Raúl Labbé Nº 13.649, Lo Barnechea Santiago	56-2-241 8492	mgaete@med.uchile.cl
	Departamento Obstetricia y Puericultura, Facultad de Medicina	Ciudad Universitaria Concepción	56-41-207 202 / 56-2-204 592	marmolin@udec.cl
	Escuela de Obstetricia y Puericultura	Campus Isla Teja, Casilla 567 Valdivia	No information available	nsantana@uach.cl
	Foro Red de Salud y Derechos Sexuales y Reproductivos, Región de Los Lagos	Casilla Nª 1214 Puerto Montt	96685417	forodecima@yahoo.es / forovih@surnet.cl
	Instituto Chileno de Medicina Reproductiva	José Ramón Gutiérrez 295 Depto. 3, Santiago	56-2-632 1988	info@icmer.org / gnoe@icmer.org
	Medwave Ltda.	Irarrázaval 5185 Of. 609, Ñuñoa Santiago	56-2-2266415	vbachelet@medwave.cl
	Pontificia Universidad Católica de Chile -Facultad de Medicina	Santiago	56-2-354 6422	www.puc.cl
	Pontificia Universidad Católica de Chile - Organización Panamericana de la Salud	Santiago	56-2-354 6422	http://escuela.med.puc.cl /ops/honie,html/
	Universidad de Chile Facultad de Medicina	Santiago	56-2-978 6000	www.med.chile.cl
	Universidad de Valparaiso (Uv) Facultad de Medicina Departamento de Salud Pública	Casilla: 92-V Hontaneda 2653 Valparaiso	56-32-596 453	pmccoll@vtr.net
	Centro de Estudios de la Sexualidad-Chile	Ana María Carrera 5090, Las Condes Santiago	56-2-212 5636	info@cesch.cl / www.cesch.cl
ECUADOR	Fundación Internacional para la Adolescencia	Av. Mariana de Jesús 813 y Moreno Bellido – Quito	593 2 2506507	fipaec@yahoo.com
EL SALVADOR	Facultad de Medicina. Universidad de El Salvador	Final 25 avenida Norte, Ciudad Universitaria San Salvador	(503) 2225 - 6229	saludsexualyreproductiva@yahoo.es / saludsexualyreproductiva@hotmail.com

LIST OF INSTITUTIONS AND THEIR CONTACT DETAILS (continued)

COUNTRY	NAME OF THE INSTITUTION	ADDRESS	TELEPHONE	E-MAIL
GUATEMALA	Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva (*)	1ª. Avenida 10 -50 Zona 1, Sótano Ciudad de Guatemala	Sin información	Sin información
	Ministerio de Salud Publica y Asistencia Social de Guatemala, Componente de Atención a los y las Adolescentes	11 Av "A" 12-19 Zona 7 La Verbena Ciudad de Guatemala	(502) 52039737	mairasandoval@yahoo.com
HAITI	Foundation for Reproductive Health and Family Education (Fosref)	30 Rue Debussy Port-au-Prince	(509) 245-0423 / (509) 401-5990	fritzmoise@yahoo.com / taniaviala@yahoo.fr
MEXICO	Centro Médico Nacional 20 de Noviembre ISSSTE	Av. Coyoacan y Felix Cuevas Ciudad de México	52 00 50 03	dignacioflores@yahoo.com.mx
	Centro Universitario de Ciencias de la Salud Universidad de Guadalajara	Sierra Mojada No. 950, Col. Independencia Guadalajara	33 36185930	ahidalgo@adolec.org.mx
	Programa Universitario de Salud; Universidad Autónoma de Nuevo León	Edificio de Radiodiagnóstico 1er Piso; Avenida Madero y Gonzalitos S/N, Colonia Mitras Centro Código Postal 64460 Monterrey; Nuevo León	(01 81) 83 33 17 55	tmartinez@prounisev.uanl.mx
NICARAGUA	Secretaría de la Juventud	ENEL Central 25 varas al Sur, contiguo a MIFAMILIA	277-59-42 al 45 extensión 117	denis.aleman@sejuve.gob.ni
	UNAN Managua, Facultad de Ciencias Médicas Maestría en Salud Sexual y Reproductiva	De ENEL Central 3 km al sur, Villa Fontana Managua	2786403 – 2704031	mssr@unan.edu.ni
PANAMA	Grupo ProSSeR / Universidad Latina de Panamá	Ciudad del Saber, Clayton / Edificio de la Facultad de Medicina, Universidad Latina, Ave. Justo Arosemena, frente al Instituto Gorgas Ciudad de Panamá	507-6660-4486	ojbrathwaite@yahoo.com / grupoprosser@yahoo.com
PARAGUAY	Promoción y Mejoramiento de la Salud (PROMESA)	Abente Haedo 4067 c/ Chaco Boreal Asunción	(595-21) 615782	promesa@promesa.org.py www.promesa.org.py

LIST OF INSTITUTIONS AND THEIR CONTACT DETAILS (continued)

COUNTRY	NAME OF THE INSTITUTION	ADDRESS	TELEPHONE	E-MAIL
PERU	INPPARES – Instituto Peruano de Paternidad Responsable/sillabus	Av.Gregorio Escobedo 115 Jesús María Lima	2615310 – 2612670	www.inppares.org.pe
	Instituto Especializado de Salud del Niño (IESN) - Servicio de Medicina del Adolescente	Av. Brasil cda. 6 –Breña. (Antigua Emergencia) Lima	3300066 anexo 374	Web site:www.isn.gob.pe/espe_adolescente.asp;E-mail:contigoadolescente@yahoo.com
	Instituto Peruano de Investigación de Familia y Población	Chiclayo	(0051) (074) - 22-2133 // 239461	http://www.ipifap.org/index2.htm
	REDESS Jóvenes	Calle Los Tumbos Nº 268 Urb. Matellini - Chorrillos Lima	252-2523	redessjovenes@millicom.com.pe
	Universidad Peruana Cayetano Heredia	Av. Armendáriz 445, Lima 18, Perú (Campus Sur) Ó Avenida Honorio Delgado 430, (Campus Norte) Lima 31	51 1 241 8334 / 241 6929 (Campus sur); +51 1 319 0025 (Campus Norte)	fspmgssr@upch.edu.pe; faspa@upch.edu.pe
DOMINICAN REPUBLIC	Instituto Tecnológico de Santo Domingo (INTEC)	Av. Los Proceres. Gala Santo Domingo	567-9271.EXT 293	msuazo@intec.edu.do
URUGUAY	Mujer y Salud en Uruguay (MYSU)	Salto 1267CP 11200 Montevideo	(598+2) 410-3981 – 410-4619	mysu@adinet.com.uy - secretaria@mysu.org.uy
	Sociedad Uruguaya de Ginecología de la Infancia y Adolescencia	Javier Barrios Amorin 1515 ap. 101 Montevideo	(598 2) 9087290	ggh@adinet.com.uy
	Universidad de la República. Facultad de Psicología. Cátedra Libre en Salud Reproductiva, Sexualidad y Género	Tristán Narvaja 1674 CP 11200 Montevideo	(598+2) 400-8555 int. 236	sexrep@psico.edu.uy
VENEZUELA	Sociedad de Obstetricia de Venezuela (*)	Edificio Anexo Maternidad Concepción Palacio. Av San Martin Caracas	0212-4515955 Tele Fax 0212 4510895	aogvzla@ca.vtv.net
	Universidad Central de Venezuela-Hospital J.M. de los Rios	Av. Volmer San Bernardino Caracas	58-212-5747049	fannycarrero@hotmail.com
	Universidad de Carabobo	Universidad de Carabobo. Área de Postgrado. Trigal Norte – Mañongo Valencia	58 – 241 – 8421297	caracho@postgrado.uc.edu.ve

(*) They thank for the information provided, but have no training on the subject of the study.

Appendix 2 - List of Training Courses Following the Classification in Table nº 1

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
MASTER'S DEGREE	Masters in Reproductive Health Subject: Adolescence	Departamento Obstetricia y Puericultura, Facultad de Medicina. Universidad de Concepción - **Chile**	No information available	24
	Masters in Comprehensive Services in Sexual and Reproductive Health.	Facultad de Medicina. Universidad de **El Salvador**	To analyse the biopsychosocial development of adolescent girls and its relationship with SRH problems in order to prevent and give comprehensive care to the needs of this population group.	35
	Masters in Health Sciences of Adolescence and Youth, Distance Mode for Professionalisation.	Centro Universitario de Ciencias de la Salud Universidad de Guadalajara **Mexico**	To develop competencies in adolescence and youth health, in theoretical-methodological and technological aspects to put them into practice in professional performance.	5
	Masters in public health with major in adolescent health	Universidad Peruana Cayetano Heredia **Peru**	To form human resources to promote and attend the comprehensive health of adolescents and youth	30
	Masters in Gender, Sexuality and Public Policies.	Universidad Peruana Cayetano Heredia **Peru**	The formation of human resources at masters level for the investigation and promotion of public policies in topics related with gender, sexuality and reproductive health, from a rights perspective.	25
	Masters in Comprehensive Adolescent Health.	Instituto Tecnológico de Santo Domingo (INTEC) **Dominican Republic**	To train professionals working with adolescents from an integral perspective.	20
	Interdisciplinary Masters in Public Health Emphasis on Adolescence and Youth	Universidad de Costa Rica. Escuela de Salud Pública. San Pedro. **Costa Rica**	To provide the health services, academia and society in general with properly trained human resources to work with the adolescent and youth population.	15
	Masters in Comprehensive Adolescent Health.	Instituto Superior de Ciencias Médicas. Facultad de Ciencias Médicas Finlay – Albarran La Habana Cuba	To update knowledge and develop skills for a professional theoretical-practical postgraduate training and research in the field of comprehensive adolescent health. To strengthen the theoretical aspects and the different experiences in management, teaching, research and clinical-social application for comprehensive adolescent health. To make use of methods and tools to carry out a practical task or project that is useful to the professional in their work context.	40

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
DIPLOMAS	First National Diploma in the Care of the Healthy Child and Adolescent	Ministerio de Salud de Cuba, Departamento Materno Infantil Cuba	To train family doctors and paediatricians in the comprehensive management of the healthy child and adolescent.	30
	National Diploma in Infant/Juvenile Gynaecology and Adolescent Reproductive Health	Hospital Docente Universitario Pedro Borras Astorga Cuba	For the participants to acquire the necessary knowledge and skills that enable the identification, monitoring and handling of adolescents at risk, differentiated care to pregnant girls whether or not they continue their pregnancy and the implementation of measures to prevent and preserve reproductive health.	30
	Distance Education in Comprehensive Adolescent Health	Programa Universitario de Salud; Universidad Autónoma de Nuevo León Mexico	To train health professionals to provide comprehensive care to the adolescent population.	120
	Masters in Comprehensive Adolescent Health	UNAN Managua, Facultad de Ciencias Médicas Maestría en Salud Sexual y Reproductiva Nicaragua	To form qualified staff for comprehensive adolescent care.	35
	Diploma in reproductive health with emphasis on family planning	Grupo ProSSeR Universidad Latina de Panamá Panama	To provide health, education, social sciences and related personnel with the most up-to-date tools needed for creating sexual and reproductive health programmes with emphasis on family planning, in health and educational bodies, with a gender, multidisciplinary and high quality approach.	30
	Diploma in Childhood and Adolescence	Instituto Peruano de Investigación de Familia y Población Peru	To promote awareness raising processes, research and debate, and foster the rights of children and adolescents as a world, national, regional and local imperative. To train specialists in fostering childhood and adolescence for optimising the social services of the regional governments, local governments, NGOs and other associations. To strengthen skills and capabilities for intervention with minors at social risk, with emphasis on processes for eradicating and discouraging child labour and other forms of social vulnerability. To facilitate theoretical-methodological instruments for the design, management, running and monitoring of programmes and activities fostering childhood and adolescence, with a gender approach. To encourage interdisciplinary academic exchange.	Sin información

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
SPECIALITY	Medical Residence or Advanced training course in adolescence.	Irmandade da Santa Casa de Misericordia de São Paulo Brazil	Teaching and exercise of adolescent medicine	3 – 4
	Infant-juvenile gynaecology	Universidad Central de Venezuela Hospital J.M. de los Rios Venezuela	To train specialist doctors in the area of Infant/Juvenile Gynaecology	2 – 3
	Infant-juvenile gynaecology scholarship	Universidad de Chile – Facultad de Medicina Chile	No information available	Sin información
	Infant-juvenile gynaecology formation programme	Sociedad Argentina de Ginecología Infanto Juvenil Argentina	The training of paediatricians and obstetrician / gynaecologists in infant / juvenile gynaecology. Through the programme they should acquire knowledge, skills and attitudes that enable them to deal expertly and comprehensively with the major problems of adolescent health and paediatric gynaecology. After training, they should become change agents in their workplace, fostering adolescent development.	Sin información
	Specialisation in Adolescent Health and Development.	Universidad de Carabobo Venezuela	To contribute to the formation of professionals from different disciplines for them to attain a high level of competence in promoting adolescent health and development, based on their specific needs in terms of gender, ethnic origin, socio-economic condition, social territory in the different sectors of reality; by planning, executing and assessing programmes, projects and interdisciplinary and intersectorial activities, in individual, family and community contexts, using the risk approach and applied research.	30
	Training programme for specialists in adolescence	Centro de Salud del Adolescente SERJOVEN Chile	The training of excellent medical specialists in adolescence, with knowledge, skills and attitudes that enable them to foster the positive development of adolescents, deal with their main health problems, implement health care services and programmes for this age group, do teaching and research in the area and advocate for youth, in order to contribute to resolving their priority health problems.	2

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
INTRA-SPECIALITY MODULES	Family Medicine Residency in Adolescence	Pontificia Universidad Católica de Chile – Facultad de Medicina Chile	To acquire knowledge, abilities and skills in comprehensive out-patient care of the adolescent patient	No information available
	Adolescence modules	Fundación Internacional para la Adolescencia (FIPA) Ecuador	To train postgraduate paediatrics students in comprehensive care for adolescents.	30
	Family Medicine Scholarship	Universidad de Chile – Facultad de Medicina Chile	No information available	No information available
SPECIALISATION COURSES AT POSTGRADUATE LEVEL	Programa de Capacitación Rionegrino: Abordaje Integral de l@s Adolescentes	Escuela de Medicina de la Universidad del Comahue – Rehue ONG. Equipo Interdisciplinario para la Atención de la Salud Integral del Adolescente, Ministerio de Coordinación de Río Negro Argentina	Interdisciplinary and inter-sector training	500
	Comprehensive Adolescent Health. Diagnostic and therapeutic approach	Hospital Municipal Bernardino Rivadavia – Sección Adolescencia Argentina	To provide knowledge about the comprehensive approach to adolescents and the diagnoses and therapies of the main pathologies. Directed to paediatricians, gynaecologists, general doctors, psychologists, and social workers.	30
	13th Annual Course of Introduction to Infant-Juvenile Gynaecology	Sociedad Argentina de Ginecología Infanto Juvenil Argentina	To train paediatricians, gynaecologists, and clinicians in the comprehensive gynaecological care of adolescents	100
POSTGRADUATE INTERNSHIPS	Advanced training in paediatric and adolescent gynaecology (the speciality in paediatric and adolescent gynaecology will start soon)	Unidad de Ginecología Pediátrica y de la Adolescencia de la Fundación Cardio Infantil Universidad del Rosario Colombia	Currently advanced training; the certificate of specialist will be granted as soon as the supraspeciality is approved.	2
	Interdisciplinary approach to adolescents' general and reproductive health.	Programa de Adolescencia. Hospital de Clínicas. Universidad de Buenos Aires Argentina	The training of paediatricians and obstetrician / gynaecologists in infant / juvenile gynaecology. Through the programme they should acquire knowledge, skills and attitudes that enable them to deal expertly and comprehensively with the major problems of adolescent health and paediatric gynaecology. After training, they should become change agents in their workplace, fostering adolescent development.	8
	Training periods in adolescent sexual and reproductive health	Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente, Facultad de Medicina Universidad de Chile Chile	Understanding of sexual and reproductive health, basic gynaecological pathology of girls and adolescents, care system, contraception, STI, aspects of mental health, sexual abuse and pregnancy in the adolescent	15

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
ON-LINE OR DISTANCE COURSES	Distance continuous education course in infant-juvenile gynaecology	Sociedad Argentina de Ginecologia Infanto Juvenil Argentina	To update knowledge of new subjects - to reaffirm the holistic concept of adolescent gynaecological care.	500
	Distance course in paediatric and adolescent gynaecology for obstetricians and gynaecologists and paediatricians (in preparation)	Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente, Facultad de Medicina Universidad de Chile - Chile	Theoretical training for access to the practical and face-to-face courses given by CEMERA	50
	Distance Education Course for Teachers of Basic and Middle School and Primary Care Health Staff	Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente, Facultad de Medicina Universidad de Chile Chile	To prepare professionals qualified in Sexual Education, to deal in a timely and efficient manner in this context with children and youth in the formal education system and in primary health care. To provide the participating professionals with novel and motivating strategies to ease the approach to sexual education in the school and health systems in which they work.	100
	Distance course with e-learning: What is Essential in Contraceptive Methodology	Medwave Ltda. Chile	The participants will manage up-to-date information about contraceptive methods available in the country to be able to administer them in accordance with the biomedical criteria of eligibility established by the WHO.	40
	Distance Education course in Comprehensive Adolescent Development and Health	Pontificia Universidad Católica de Chile – Organización Panamericana de la Salud Chile	To provide knowledge and skills for professionals involved in adolescent health care. To strengthen interdisciplinary work teams of primary level health. To promote the interdisciplinary approach to adolescent health problems. To promote health promotion programmes To promote the implementation of differential services for adolescents.	No information available
	On-line course - Development and health in adolescents and youth	SASIA y Fundación Barceló. Facultad de Medicina del Instituto Universitario de Ciencias de la Salud – Argentina	To contribute to the formation of professionals from different disciplines who work with populations of adolescents and youth with a global, interdisciplinary and inter-sector approach.	No information available
	First Virtual Course in an Comprehensive Approach to the Adolescent	Universidad de Buenos Aires. Facultad de Medicina Virtual. Argentina	To meet a growing demand for distance training in subjects related to adolescence and to contribute to disseminating knowledge about adolescent care.	No information available
	Distance course by Internet: Introduction to the comprehensive health of adolescents and youth	Núcleo de Estudos da Saúde do Adolescente (NESA). Universidad del Estado de Rio de Janeiro - Brazil	Update on comprehensive adolescent and youth health care.	100

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
COURSE OR WORKSHOP	Model of Basic Intensive Course to be run in Latin American countries	Sociedad Argentina de Ginecologia Infanto Juvenil Argentina	Initial training for medical professionals interested in adolescent health in general and reproductive health in particular.	30
	Training on the adolescent programme of the Municipal Health Secretariat.	Secretaria Municipal da Saúde de Curitiba – PR Brazil	To raise awareness and train the multiprofessional team in municipal health units for attending adolescents in questions of basic care in public health and to carry out preventive tasks.	1.100
	Adolescence and sexual and reproductive health: A New Vision, a New Action – training for health providers and educators.	Reprolatina – Soluçoes Inovadoras em Saúde Sexual e Reprodutiva Sao Paulo Brazil	To prepare educators in the schools and health professionals to implement the programme of adolescent sexual and reproductive health run by Reprolatina, through joint activities contributing to the development of a culture of health promotion and prevention and the improvement of access to and the quality of the sexual and reproductive health of adolescents.	20
	"Adolescence and sexual and reproductive health: Learning to teach - 2nd stage – training the trainers"		To prepare health and education professionals to act as trainers of the health and education teams in adolescent sexual and reproductive health.	20
	"Care of the pregnant adolescent in the framework of sexual and reproductive rights – training for the health team"		To train health professionals to act in the care of the pregnant adolescent, in order to optimise quality and humanise care, using sexual and reproductive rights as a basis.	20
	Adolescence and the prevention of STIs and HIV in the school – training for educators and health professionals		The train and prepare educators and health providers to implement the Integrated programme for the prevention of STI/HIV-AIDS in the school and the health services, so that adolescents adopt self-care practices and a culture of promotion and prevention of STI/HIV-AIDS is developed.	20
	Training in adolescent sexual and reproductive health	Territorio Adolescente Las Américas Colombia	To train a group of health professionals in working with adolescents so that they obtain the tools needed to set up and launch comprehensive care centres for adolescents.	35
	Biopsychosocial development in adolescence	Programa Atención Integral a la Adolescencia, Caja Costarricense de Seguro Social (PAIA-CCSS) Costa Rica	To provide the basic theoretical-conceptual elements about the biopsychosocial development of adolescence to intern students of medicine and pharmacy in the Universidad de Costa Rica, so that they have tools to enable them to offer a comprehensive approach to adolescents within the health care services.	40
	Bi-monthly seminars for health staff, open to the public	Asociación de Gíneco Obstetricia y Medicina Infanto Juvenil Costa Rica	To provide an interdisciplinary space for reflection and training in topics related with the health of adolescents.	200

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TYPE OF TRAINING	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
COURSE OR WORKSHOP (continued)	Sexually Transmitted Infections in adolescents and youth.	Hospital Docente Ginecoobstétrico "América Arias" Cuba	No information available	80
	Tools for working with youth in a context of quality of sexual and reproductive health care	Instituto Chileno de Medicina Reproductiva Chile	To promote self-care in youth in sexual and reproductive health	15
	Training programme in research and services in Sexual and Reproductive Health.	Instituto Chileno de Medicina Reproductiva Chile	To give training in care and clinical research in sexual and reproductive health, with emphasis on contraception.	No information available
	Training modules in working for adolescent care	Fundación Internacional para la Adolescencia (FIPA) Ecuador	To train top level health professionals for comprehensive adolescent care	30
	Short postgraduate course in comprehensive adolescent health	UNAN Managua, Facultad de Ciencias Médicas Maestría en Salud Sexual y Reproductiva Nicaragua	To form qualified staff for comprehensive adolescent care.	35
	3rd National Course in Comprehensive Adolescent Health.	Instituto Especializado de Salud del Niño (IESN) – Servicio de Medicina del Adolescente Peru	To improve the level of knowledge of participants about the normal (biopsychosocial) events that occur during the stage of adolescence. To diagnose and provide suitable and timely handling of the most common health problems in adolescents. To reinforce the application of the comprehensive approach to health in work with adolescents.	No information available
	Professionals who work with youth	INPPARES – Instituto Peruano de Paternidad Responsable/sillabus Peru	To strengthen and/or update knowledge and skills of staff working with juvenile and adolescent population, for tackling topics of sexual and reproductive health with youth and adolescents.	60
	Sexual and reproductive health with emphasis on adolescents	Mujer y Salud en Uruguay (MYSU) Uruguay	To provide theoretical-methodological tools for analysis and intervention from the health care services in SRH topics, from a gender and rights perspective, and with special attention to the adolescent and youth population.	50
	Approaches in sexual rights and reproductive rights in adolescents	Universidad de la República. Facultad de Psicología. Cátedra Libre en Salud Reproductiva, Sexualidad y Género Uruguay	To provide theoretical – methodological tools for informed professional intervention in promoting adolescent sexual and reproductive rights, from a gender perspective.	50
	Training for work with adolescents	Sociedad Uruguaya de Ginecología de la Infancia y Adolescencia Uruguay	To improve knowledge and skills for working with adolescents; to modify attitudes for approaching interaction with adolescents; to ease handling of respect for adolescent autonomy in decision-making about their sexual and reproductive life; to promote the capacity to incorporate non-traditional methodology in work with adolescents	15

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TIPO DE CAPACITACIÓN	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
MISCELLANEOUS	Basic training in sexual and reproductive health for adolescent volunteer health agents	Reprolatina – Soluçoes Inovadoras em Saúde Sexual e Reprodutiva Sao Paulo Brasil	To train and form adolescent volunteer health agents (AAVS) for working on the prevention and promotion of sexual and reproductive health	20
	Counsellors for pre- and post HIV/AIDS testing	Foro Red de Salud y Derechos Sexuales y Reproductivos Región de Los Lagos Chile	Those (university) youths who we form in the first stage as sexual and reproductive health monitors during 14 sessions, after an evaluation of their knowledge and a psychological assessment, can go on to the second stage, which is that of pre and post testing counsellor	30
	Formation of Sexual and Reproductive Health Monitors	Foro Red de Salud y Derechos Sexuales y Reproductivos Región de Los Lagos Chile	Students from the Universidad de Los Lagos de Osorno, AIEP of Puerto Montt, are offered the chance of making a three month course as a Monitor in sexual and reproductive health	30
	Diploma in Human Sexuality	Centro de Estudios de la Sexualidad Chile	To understand and be trained in a broad view of the phenomena shown in sexual interaction	60
	Training of Doctors	Universidad de Valparaíso – Facultad de Medicina Departamento de Salud Pública Chile	No information available	
	Information, education in aspects of sexuality, contraception and sexually transmitted infections	Centro Médico Nacional 20 de Noviembre ISSSTE Mexico	To inform To educate	No information available
	SEJUVE promotors guide curriculum	Secretaría de la Juventud Nicaragua	To provide scientific information about the responsible exercise of sexuality	30
	Formation of Matrons	Escuela de Obstetricia y Puericultura Universidad de Chile Chile	To acquire skills in making the overall biopsychosocial anamnesis of the adolescent, full physical examination and correct use of the standard precoded clinical card normally used in the Centre. To understand the normal process of pubertal development and its sequence, to evaluate correctly the degree of pubertal development and understand its clinical application	No information available
	Youth leaders	INPPARES – Instituto Peruano de Paternidad Responsable/sillabus Peru	To contribute to the overall well-being and development of children, adolescents and youth based on preparing them by using available resources in their own communities.	60

LIST OF TRAINING COURSES FOLLOWING THE CLASSIFICATION IN TABLE Nº 1 (continued)

TIPO DE CAPACITACIÓN	TRAINING COURSE	INSTITUTION	OBJECTIVES	Nº STUDENTS
MISCELLANEOUS (continued)	Teachers		To strengthen and/or update the teachers' knowledge for work on topics of sexual and reproductive health with adolescents.	60
	Orientators in sexual and reproductive health		To increase the capability of the participants to analyse, systematise, propose and act in the different fields and levels associated with the sexual and reproductive health of the population with emphasis on personal and group orientation.	50
	Parents of families		To identify and understand the changes in adolescents and youth as well as their needs; to make use of the affective and effective communication that enables us to identify problems and face them.	60
	Youth force: colleges		To contribute to the overall well-being and development of adolescents and youth based on preparing them and on joint work with their fathers, mothers and teachers.	60
	Youth force vulnerable population		To contribute to the overall well-being and development of children, adolescents and youth based on preparing them by using resources available in their own communities.	240
	Information for pregnant adolescents	Hospital General de Pediatría Pedro de Elizalde - Argentina	No information available	No information available
	Sexuality, Rights and Responsibilities: Contraceptive options	REDESS Jóvenes Peru	To recognise the importance of sexual and reproductive rights in improving health and quality of life To identify the advantages and benefits of reproductive health for youth	35
	Sexuality Education aimed at teachers in schools in the more vulnerable areas of Asunción	Promoción y Mejoramiento de la Salud (PROMESA) Paraguay	To provide basic information on introduction to sexuality; psychological and physiological changes and human reproduction, for promoting the healthy psycho-sexual development of children and adolescents.	30

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