UNFPA
Sexual Reproductive Health and Results Based Management Capacity Building
Paramaribo, Suriname
September 28 - 30, 2011

Workshop Report
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### Acronyms

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<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ASRH</td>
<td>Adolescent Sexual (and) Reproductive Health</td>
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<tr>
<td>AWPMT</td>
<td>Annual Work Plan Monitoring Tool</td>
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<td>C-PAP</td>
<td>Country Programme Action Plan</td>
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<td>CARICOM</td>
<td>Caribbean Community</td>
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<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>COSHOD</td>
<td>CARICOM Council For Human and Social Development</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSWs</td>
<td>Commercial Sex Workers</td>
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<tr>
<td>DOPA</td>
<td>Direct, Objective, Practical, Adequate</td>
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<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Neonatal Care</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FFA</td>
<td>Framework For Action</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>HFLE</td>
<td>Health and Family Life Education</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IGA</td>
<td>Interest Group Analysis</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MARPs</td>
<td>Most-at-Risk Populations</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MMR</td>
<td>Maternal Mortality Rate or Ratio</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NCDs</td>
<td>Non-Communicable Diseases</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>OPM</td>
<td>Other People Money</td>
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<td>PAHO</td>
<td>Pan-American Health Organization</td>
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<td>PMTCT</td>
<td>Preventing Mother-to-Child Transmission</td>
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<td>PoA</td>
<td>Plan of Action</td>
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<td>PTA</td>
<td>Parent Teacher Association</td>
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<td>RBM</td>
<td>Results Based Management</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>SMART</td>
<td>Specific, Measurable, Attainable, Relevant, Time bound</td>
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<td>SRH</td>
<td>Sexual (and) Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>T&amp;T</td>
<td>Trinidad and Tobago</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNEG</td>
<td>United Nations Evaluation Group</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCCT</td>
<td>Voluntary Confidential Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YAG</td>
<td>Youth Advisory Group</td>
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Foreword

Everyone has the right to enjoy reproductive health, which is a basis for having healthy children, intimate relationships and happy families. Reproductive health encompasses key areas of UNFPA’s vision – that every child is wanted, every birth is safe, every young person is free of HIV and every girl and woman is treated with dignity and respect.

UNFPA in fulfilment of its mandate on improving sexual and reproductive health outcomes in the Caribbean region, held a three-day workshop from September 28 – 30 at the Krasnapolsky Hotel in Paramaribo, Suriname aimed at building the capacity of programme and health professionals in the scientific application of SRH strategies and approaches to regional programming.

The overarching goal of the training was to improve and accelerate regional delivery of technical assistance across the range of sexual and reproductive health components.

The workshop focused on three key themes, which were Sexual and Reproductive Health, Results Based Management and HIV and SRH Linkages.

The training objectives specifically were to:

1. Improve understanding of selected facets of a comprehensive programme for Sexual and Reproductive Health.
2. Empower participants to play catalytic roles in advancing the SRH agenda within spheres of influence.
3. Develop skills in the application of Results-Based Management to SRH programme implementation.
4. Facilitate sharing and exchange of technical information, skills, experiences and best practice among participants.

The lessons learned from this workshop have been captured in this report and will be disseminated and shared across the region to help us meet the goal of universal access to reproductive health. UNFPA is fully committed to mobilizing support and scaling up efforts to make reproductive health for all a reality by 2015.

A special thanks goes to Marvin Gunter - UNPA Regional Adviser on HIV & AIDS, Judith Brielle - UNFPA Assistant Representative for Suriname, all of the various facilitators and presenters at this workshop, the staff members of the Suriname branch office and everyone else who helped to make this workshop a success.
Format

Over 30 participants (see annex 1) working in SRH related areas from governmental and non-governmental organizations across the region took part in this workshop.

Candidates were selected using the following criteria:

1. Keen interest advancing the SRH response in the Caribbean region
2. Current responsibilities held for SRH within the organization/country
3. Opportunity to initiate and/or impact catalytic and strategic change with a sphere of influence and/or to disseminate and defuse learning after the training
4. Available for the entirety of the training

A pre workshop assessment was sent to all participants for completion before the workshop. In addition to observation and peer assessments, a post test was also administered to measure retention of concepts and skills. During 2012, participants will be interviewed to assess the extent to which the training workshop has impacted their implementation of SRH programmes.

The workshop consisted of a combination of capacity building presentations on issues relating to Sexual and Reproductive Health and Results-Based Management, and individual presentations by each country represented at the workshop on the Reproductive Health situation in their respective countries. This was meant to foster discussion, knowledge sharing and lead to dissemination of best practices.

The presentations were spread over a period of three days (see annex 2) with important themes being built and expanded on over the course of the workshop.
Welcome

Judith Brielle, UNFPA Assistant Representative – Suriname:

Good morning to all. I would like to welcome you and say that I am so proud that you all made it to Suriname, because I know we work in a busy sector and it was a lot of effort for you to come. I have also discovered that this is the first time for many of you to be here in Suriname. I hope you get to see more than this room and I hope it was worth the early flight.

I am happy this meeting is in Suriname, as a lot of people do not realise that Suriname is part of the Caribbean. I think we have a lot of the same issues and can interact well and learn from each other. So I hope everyone learns a lot, has a pleasant stay, and really networks with the others around you. Try to take as much as possible away from this, so when you go back to your respective countries, you can say I need to come back and visit Suriname once again.

Marvin Gunter, UNFPA Regional Adviser HIV & AIDS:

There are many opportunities to share information on the agenda and lots of opportunities to maximise the ability to learn as much as you can. We will first start with introductions to break the ice. Find the person you least know and go over to that person, get to know them in a minute and then introduce them to us later.

Each participant then gets to know someone else in the room and introduces them to all the other participants of the workshop.

Dr Hernando Agudelo, Deputy Director of UNFPA's Sub-Regional Office for the Caribbean:

Good Morning to everyone and I would like to welcome you all and thank you for being here and demonstrating your commitment.

The reason this workshop was organised was to add to the work that UNFPA is doing with regards to HIV & AIDS in the region. Last year, when we were putting together the workplan for 2011 we discussed that all the activities have to work towards linking SRH and HIV. The majority of HIV & AIDS cases are related to sexual reproductive health. Therefore we need to ask ourselves how to introduce HIV in our programmes. Everyone here is experienced and committed to SRH and HIV and the content in the agenda during these three days will be productive in achieving this kind of linking. Not only in the sense of the service, but also in the conception and monitoring of the programmes, using results based management.

I hope you all try to take the most of this training and remember that this workshop is not only about the technicalities but also about the interaction between all of us who are working towards a common goal. I declare this meeting open.

Marvin Gunter:

Thank you very much Hernando and I would like to mention once again the three themes - Results-Based Management, Sexual and Reproductive Health and Linkages between SRH and HIV & AIDS. As for linkages, we have to move away from the verticalization of SRH and HIV programmes. This is very important considering resource constraints. A reason for this workshop is learning how do we do that and how do we generate evidence using RBM, which is something the next presentation will take us through. With that said I will now pass the floor over to Vertha with her presentation on Results-Based Management.
Capacity Building Presentations

Results Based Management: Key Concepts
Vertha Dumont, UNFPA M&E Specialist

The presentation focused on looking at the basics of Results Based Management. It argued that in programming we have to zero in on what we are trying to achieve, otherwise we are running around like ‘a chicken without a head’.

Why RBM?

RBM is important to help us:
- Honour our commitments – such as the MDGs
- Request to Assess effectiveness
- Demonstrate the results being achieved – provide evidence
- Ensure that resources are used strategically
- Improve efficiency and accountability

OPM – Other People Money

We have to be aware of the fact that OPM comes from our taxes, it is still our money and it needs to be spent wisely, strategically and effectively.

Foci of RBM

- Analyze the problems to be addressed and their cause/effect
- Identify the results to be achieved based on problem analysis
- Design strategies and activities that will lead to the results
- Balance expected results with available resources
- Monitor your progress regularly and adjust activities as needed
- Evaluate, document lessons learned
- Report on results achieved and their contribution to overall goal

Key Phases of RBM

- Formulating SMART Results – Specific, Measurable, Attainable, Relevant, Time bound
- Monitor performance data
- Evaluation and Lessons

Casual Tree – Overview (problem analysis)

The first level is the Problem – followed by the Immediate Causes – then the Underlying Causes – and finally the Root Causes.

It is necessary to assess the problem and its causes as this determines your intervention and your results. If you can understand the problem tree and its different levels, then you can understand the linkages with the result.

Causal Tree – Example

Problem: Increased teenage pregnancies
Immediate cause: not using condoms – cause condoms are not available
Underlying causes: condoms are not available in the area
Root causes: decrease of investment in health

Different layers of causes can help us understand different layers of results.
Transition from Causality Analysis to Results Chain

Now we have identified the problem and can translate that into results.

To combat the immediate causes of increased teenage pregnancies we can supply more condoms. To combat the root cause that government does not invest health then a body such as the UNFPA regional office can go to the minister of health and explain as well as provide evidence that condoms are cheaper than treating diseases.

The causality analysis helps you understand where you as partners and ministries can intervene.

Results

- Describable or measurable changes in a state or condition which derive from a cause-and-effect relationship
- Intended unintended, positive and/or negative which can be set in motion by an intervention
- Range along a continuum from immediate to medium term to long term
- Three level of results: Goal/impact, Outcome, Output

Define...GOAL

Specific end result desired or expected to occur as a consequence, at least in part, of the intervention. These are higher level goals, that none of us can be individually held accountable towards.

Define...OUTCOME

Changes in things such as the behaviour, attitudes, commitment or socio-cultural values of groups, or in legal, institutional and societal practices. These are usually achieved in the medium term.

Define...OUTPUT

- Products and services derived from a completion of activities
- Short term, immediate

Donors are putting less emphasis on the output level. As resources globally become scarce, it is important to be able to show results.

Define...ACTIVITY

- Actions taken or work performed
- Use of inputs such as funds, technical assistance or other resources
- Aimed at producing specific outputs

Risks: Definition

It is important to examine your risks and assumptions into your planning.

A risk is:

- A potential event that could adversely affect the achievement of the desired results
- A threat to success
- Not just the negative of an assumption
- A trigger for reconsideration of strategic direction

Assumption: Definition
- A necessary condition for the achievement of results at different levels.
- Part of the cause-effect logic
- Stated as though it is actually the case
- Can help identify additional results or outputs

**Results Chain – Logic: Risks & Assumptions**

Assumption must be considered at all levels of planning. Plan downwards when dealing with your inputs to address problems: What do you need to do that, if I get this, then I can do this.

**Final Words**

- Assess and analyze the problems to be addressed
- Identify the results linked to the problems
- Propose clear strategies and activities to achieve the results
- Link strategically expected results with resources available

Be strategic, Be strategic, Be strategic.

**Discussion Points:**

**Access to condoms**

The example of tackling increased teenage pregnancies resulted in a discussion on access to condom use. Participants argued that access means more than just the physically availability of condoms, but also looking at things such as behavioural change in young people. The point was also raised that in some countries, such as Guyana, geography is very important with regards to providing condoms to the hinterland.

The presenter highlighted that in Evidence Based Programming, there is type 1 evidence, which means knowing the environment you are working in, and type 2 evidence, which means understanding the beliefs and culture of your beneficiaries and governments you are working with. This has a lot to do with access, and it is important to know the context you are working in.

**Legal framework**

It was noted that in many cases there is a strong relationship between advocacy and programming and that if the legal framework does not keep up with what you want to achieve then it is always an obstacle.

The presenter noted that it is very important throughout the region to come up with evidence to help us advocate in reaching our goals.

**Stigma and Discrimination**

A discussion ensued as to how to include tackling stigma and discrimination, particularly among health workers, in the results chain. A participant from Guyana noted that work has been done with auxiliary staff in Guyana to ensure that discrimination is tackled among that group. The participant also noted that in Amerindian communities there is a lot of openness when dealing with sexuality and they are trying to learn how to incorporate some of this behaviour in central Guyana.

The presenter noted that a HRB and gender lens should have been added to the presentation. She added that it was important to look at the big picture, as SRH is a costly activity to pursue. That is the goal of RBM: to aggregate where we want to go, who you are in the process, what can you achieve and how can you contribute?
Reproductive Health
Dr Mario Aguilar, UNFPA Regional Advisor SRH

This presentation focused on explaining the basic concepts of Sexual Reproductive Health and the links to HIV and AIDS.

Definition

-Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life.”

This is important to remember as physical RH does not necessarily equate to a state of complete well-being, if for example a person is subject to GBV. A holistic approach is needed when dealing with RH.

Reproductive health deals with the reproductive processes, functions and system at all stages of life.

Reproductive Health Components

Most people think only about contraceptives when RH comes to mind, but this is only one part.

RH includes:
- Prenatal care and clean delivery
- Postnatal Care
- Family Planning – Everyone has the right to decide how many kids they have and when.
- HIV and AIDS, STI Prevention and Care
- Breast, cervical and prostate cancer prevention
- Emergency Obstetric Care
- Infertility – RH means not only avoiding unwanted pregnancies, but also supporting people who cannot have them. Most cases of infertility are related to fallopian tube infections and those are always related to STIs. We cannot separate SRH from STIs.

Differences between family planning and natal control

In the past the term natal control was the most widely used method, but today we deal with family planning.

Family Planning vs Natal Control

Health Instrument vs Demographic Instrument
Objective: Mother-child Health vs Increase or reduce births
Requires information, education and health services vs Indiscriminately Executed
Couple or individual decision vs Government decision
Free and informed decision vs It is imposed
Exercise of human right vs coercive measure

The Problem

- Globally, about 535,000 women die each year from complications of pregnancy and childbirth - If we take the amount per day (1,465) and divide that by the amount of passengers on a Caribbean airlines plan (200), then roughly seven planes full of women crash every day.
- Each year approximately 4.3 million newborn infants die during the first year of life. An additional 4 million are stillborn. Many due to complications during pregnancy or childbirth.
• More than 2.7 million new HIV infections in 2010, for every 2 people that begin treatment, 5 new people are infected.

Infant mortality related with death of parents

There is a strong correlation between mothers dying and infant mortality among girls. The reason why girls die more is because quite often the husband has another woman within a short period of time. The new wife starts neglecting the health of the daughters of the last wife, because unlike the boys they are seen as a threat. Every time we allow a woman to die we are putting in jeopardy the health of a girl.

Family Planning: Unfinished Agenda

• 200 million women have unmet need for contraception – this means they do not want to get pregnant but do not use contraceptives
• 60 million unintended pregnancies causing about 50,000 abortion related deaths per year - only legal in two countries in the region, Guyana and Cuba

The clear rationale for investing in RH

Falling fertility rates in low-income countries correlate with a decline in poverty. Population growth is also higher in low-income countries. There are exceptions, particularly in the Caribbean where some small islands considered poor countries have a low fertility rate.

Multiple studies demonstrate that family planning programmes produce tangible savings - In Mexico, for every dollar the MOH invested, saved 9 dollars in expenses; Thailand, 16 dollar; Egypt, 31 dollars; Guatemala, 6.10 dollars

Maternal Mortality Rate: Life saving obstetric equipment and drugs are essential to ensure safe motherhood. Also, using contraceptives to avoid too early and unwanted pregnancies and to space births (preferring to deliver in another country) is crucial to efforts to reduce MMR.

Gender equality and education: Women who get more educated realise they and their children’s health will be better if they have less children.

HIV and AIDS: The second highest region of HIV prevalence is the Caribbean. This is about more just than health; it is about economics, human rights, stigma and discrimination.

Prevention should be as part of all the health services. These should be linked. SRH programmes can make an important contribution to HIV prevention, treatment care and support. For example, HIV and AIDS fundamentally changes the experience of pregnancy and delivery, but it is often the case that those providing care regarding SRH and HIV do not communicate. SRH is important for those living with HIV and IDS and key links should be made between the two.

Adolescents and Young People: The largest ever number of young people (>1.3bn) are beginning their reproductive and sexual lives.

Our actions are right on target and we are working in the areas where the service is really needed.

What do we need?

• Political Commitment
• Partnership and active involvement of all stakeholders - we need to start by identifying who is doing what?
• Resources (financial, trained manpower) - we need to retrain people on a yearly basis about what we are doing
• Supplies (quantities and quality) – there are serious problem with the logistics, we do not distribute the number of contraceptives that people need
• Community Awareness and participation for demand creation and utilization - it does not matter what we do, if we do not present our services in an attractive way no one will use them
• Monitoring and evaluation, including mechanisms for periodic review and continuous feedback
Reproductive Health and The ICPD Agenda
Melissa McNeil Barrett, UNFPA Assistant Representative - Jamaica

This presentation explored the issues and commitments coming from the International Conference on Population and Development and how it affects and informs RH programmes.

ICPD and Reproductive Health

The ICPD agenda presents a very good for a framework for thinking about Reproductive Health. The ICPD was a landmark event.

ICPD

The ICPD was held in 1994 in Cairo, Egypt. It was landmark conference with a far-reaching vision on population and development for the next 20 years and was attended by representatives of 179 countries.

Background

The backdrop to this conference includes the baby boom of the 60s and the growing population and the effect on the economy. Many countries were coming up with a form of population control to reduce their populations. In 1974 there was a UN conference that looked at population control measures.

You also had a growing women’s rights movement and women’s empowerment began to be seen as a way of reducing fertility.

In 1992 there was a UN conference on environment and the concept of sustainable development was introduced.

In 1993 the UN held a human rights conference that put people at the centre of rights.

The ICPD in 1994 looked at all these issues including the women’s movement, sustainable development, population control and human rights. It found that development was important, but needs to have a human face, as people have individual human rights. The ICPD was the first that took a comprehensive approach to all these various issues and looked at the linkages of issues such as the involvement of men being important to gender equality. The conference outlined key objectives that countries hoped to achieve.

Significance of ICPD

- The IPCD was the first time that women's issues were a main focus of attention
- Introduced concept of reproductive health - This shifted the focus on the individual and not only physical but mental well being
- Applied basic human rights principles, rejected violence and discrimination
- Affirmed fact that RH is essential for all people, married, unmarried, young
- Emphasises importance of family planning – One objective was to have family planning universally available by 2015
- Provided estimates of national resources and international assistance needed to meet these goals
- Reinforced that men must be key players, in relation to STIs, sexual behaviour, and welfare of their children.
- Speak to the family, internal and international migration, technology, research and development

ICPD Key Principles

15 guiding principles
These principles included that everyone has the right to enjoy the highest attainable standard of physical and mental health (principle 8). They also spoke of advancing gender equality and equity and the empowerment of women, and eliminating all forms of violence against women, are the cornerstones of population and development-related programmes (principle 4).

Reproductive Rights and Reproductive Health

The ICPD also sought to:

- Ensure full range of RH services
- Family planning to reduce pregnancies
- Enable and support responsible voluntary decisions about child-bearing and methods of family planning
- Use of programmes to engage adolescents and men
- To improve quality of family planning advice
- Information, education and services
- Promoting women's health and safe motherhood
- Reducing Maternal Mortality and Morbidity a reduction of half of the 1990 levels by the year 2000 and a further half by 2014

So we see that many of these issues have been on the agenda for almost 20 years. If we had taken some of these more seriously then we would have been far further than we are today.

ICPD provides our marching orders, our framework of reference and informs much of the work we do today. It also introduced the concept of the human rights based approach, which is not about imposing but providing people with accurate information so they can make the right decisions.

ICPD influence on UNFPA’s work

UNFPA’s list of things required to ensure access to RH:

- Family Planning
- Antenatal, post-natal, safe delivery
- Infertility
- Prevention of Abortion and management of the consequences of abortion, does not get enough attention because of cultural sensitivities
- Treatment of reproductive tract infections
- STIs, HIV/AIDS
- Information, education and counselling on human sexuality and reproductive health
- Violence against women - prevention and surveillance and care of survivors

Implementation of ICPD PoA

So how well would you say we are doing in implementing the Plan of Action of the ICPD?

One participant noted that reaching out to youngsters is very difficult especially in giving out age appropriate information as many youngsters are very mature and need information for their appropriate ‘stage level’. The presenter said it was important to really see what youngsters need and made sure we are providing relevant services to the population. She urged everyone to take a look at the PoA as the issues found there are relevant for us today.

The presenter also noted that inequities remain with access to health information and services for MARPs. Particularly with the financial crisis, the focus has shifted and health has been moved back on the agenda. One participant added that while the legal frameworks in place do not necessarily prevent youth access, they are being used to prevent access to services. She said that in some countries, historically linked to the UK, and with no legislation with regards to youth access to RH service, they could look at the precedence presented in the case of Gillick-Fraser. In this case a parent in the UK sued because her adolescent was being provided with family planning services and the court found in favour of the State. The
presenter added that it is important to know what is real and what is perceived and that it is important to advocate for youngsters getting access to services. Countries should ensure that attitudes of health-care providers do not restrict adolescents’ access to services and information

ICPD at 20: Implication for UNFPA and partners

There have been many reviews and progress made but numerous challenges remain that have to be addressed.

- Need for increased investments in SRH information – we have to really find the evidence and advocate what countries can save if they invest in information.
- Reproductive Health and rights of the most vulnerable populations require urgent attention and resources
- Integration of key issues to increase efficiency in delivery of services (integrating HIV and SRH services)
- Strengthened partnerships for promoting reproductive health and reproductive rights
- Public health must be a priority at the national level
- Accountability for results with robust M&E – if we do not measure what we are doing it does not get done

ICPD weaknesses

The ICPD did not provide many indicators or timelines. In other words, no SMART outlines, no RBM framework. This type of framework is something that the MDGs have provided.

What is needed?

- Scaling up good practices (South-South practices) - we need to know where the good practices are and have the evidence to know the are good practices
- Investing in youth, empowering women, and also include our men – efforts are necessary to integrate and involve men in the gender equality agenda

Further

The UNGA agreed to extend PoA of ICPD beyond 2014 and UNFPA had leading role in assessing what progress needs to be made. Partners should work in earnest to achieve the results agreed in the ICPD PoA. It is important to deduce from your cultural context what is relevant for you.
Basic Demography
Mario Aguilar, UNFPA Regional Advisor SRH

This presentation examined the basics of demography and explored certain demographic terms relevant to Sexual Reproductive Health.

Demography

Demography is how can we study the human population. Human populations are dynamic, not static. Thus demography helps us to understand what happens to human beings. When we want to identify how good or bad we are doing, we always do it through statistics, which are mostly related to demography.

Rate

The frequency of demographic events in a population during a specified time period.

Ratio

Relationship of one population subgroup to the total population or to another subgroup; that is one subgroup divided by another.

Prevalence and Incidence

Prevalence is the total number of people, while incidence represents the new cases. In the case of people living with HIV prevalence is measured using a sample as it is too expensive to do a census. A generalized epidemic is an epidemic where the prevalence is more than 1% in the general population and more than 5% for MARPs. A concentrated epidemic is one where the prevalence is more than 5% for MARPs and less than 1% for the general population.

Count

The absolute number of a population of any demographic event occurring in specified area in a specified time period.

Constant

An unchanging, arbitrary number (for example 100, 1,000 or 100,000) by which rates, ratios or proportions can be multiplied to express these measures in a more understandable fashion.

Maternal Mortality Rate and Ratio

The Maternal Mortality Ratio is the ratio of the number of maternal deaths per 100,000 live births in a year period.

Maternal Mortality Rate is the ratio of the number of maternal deaths by the number of women of childbearing age in the population.

There is some confusion between confusion between the Maternal Mortality Rate and the Maternal Mortality Ratio. It is important to use the Maternal Mortality Ratio for international comparisons.

Cohort Measure

A statistic that measures events occurring to a cohort (a group of people sharing a common demographic experience) who are observed through time.
Birth Rate
The Birth Rate (also called crude birth rate) indicates the number of live births per 1,000 population in a given year.

Fertility Rate
The fertility rate is the average number of children that would be born to a woman over her reproductive lifetime.

Fertility is different to fecundity, which refers to the physiological capability of women to reproduce. Fertility is directly determined by a number of factors: social, economic, health and environment. Fecundity is determined by biological factors.

Mortality Rate
The number of deaths per 1,000 population in a given year.

Perinatal Mortality
Also perinatal death refers to the death of a fetus or neonate and is the number of stillbirths and deaths in the first week of life per 1,000 live births.

Infant Mortality Rate
The number of deaths of infants under the age 1 per 1,000 live births in a given year.

Child Mortality Rate...
Or under-5 mortality rate is the number of children who die by age of five, per thousand live births.

Replacement level fertility
The average number of children a woman must have in order to replace herself with a daughter in the next generation. For example the replacement level fertility in the US is 2.11. This means that 100 women should birth 211 children, 103 of which will be females.

Demographic Transition
This used to represent the transition from high birth and death rates to low birth and death rates as a country develops from a pre-industrial to an industrialized economic system.

Growth rate
This is the relationship between birth, death and migration (emigration and immigration). It should never be confused with the birth rate.

Immigration Rate
This is the number of immigrants arriving at a destination per 1,000 population at that destination in a given year

Emigration Rate
This is the number of emigrants departing an area of origin per 1,000 population at that area of origin in a given year.
Importance of Demography

We work with statistics on a daily basis, thus it is important for us to have basic knowledge of what the basic demographic arguments are. This will help us to plan and in doing so basic data is essential.

Discussion

Lack of Data

It was noted that there is a problem with obtaining data and it was asked what kind of recommendations in dealing with this problem. The presenter said that UNFPA will try to organise a training on data collection for next year. He added that this is a problem in all of the Caribbean and that it was important to stay proactive about creating and receiving data.
Reproductive Health and the MDGs
Isiuwa Iyahen, UNFPA Assistant Representative - Barbados

This presentation explored the Millennium Development Goals and how SRH is enshrined in them.

Sexual and Reproductive Health and the Millennium Development Goals

The MDGs have to be seen as a carpet with several threads running through it. One of those threads is SRH.

Positioning of SRH in the Global Development Agenda

Thanks to the ICPD in 1994, SRH was seen as a development issues, with at its core the ability to make healthy, voluntary and safe choices. Not only about handouts, but also about self-determination and giving power to those that need to be empowered.

SRH Extends Beyond Reproductive Years

- SRH emphasizes the need for a life-cycle approach to health - SRH is often misunderstood or conflated with family planning. It consists of more than just family planning. Sexuality occurs along a continuum of time and family planning is therefore one component. The ICPD helped to shift the focus of SRH from reproductive years to reproductive health.
- SRH touches on sensitive, yet important, issues for individuals, couples and communities, such as sexuality, gender discrimination and male/female power relations.
- SRH depends vitally on the protection of reproductive rights, a set of long-standing accepted norms found in various internationally agreed human rights instruments.

The ICPD and SRH

- The ICPD adopted the goal of ensuring universal access to reproductive health by 2015 as part of its framework for a broad set of development objectives.
- The Millennium Declaration and the subsequent Millennium Development Goals (MDGs) set priorities closely related to these objectives. The MDGs set priorities that are not really new with regards to SRH. MDGs talk about progress towards certain goals which were already set in the ICPD agenda.

The September 2000 Millennium Summit

At the Millennium summit world leaders adopted the UN Millennium declaration. They committed to reduce poverty and set a series of time bound targets of which the deadline is 2015. Even though not all targets might be reached the MDGs are important because they measure progress.

The MDGs

1. Eradicate Extreme Hunger and Poverty.
2. Achieve Universal Primary Education.
3. Promote Gender Equality and Empower Women.
5. Improve Maternal Health.
6. Combat HIV/AIDS, Malaria and Other Diseases.
7. Ensure Environmental Sustainability.
8. Develop a Global Partnership for Development.
2005 World Summit

This summit affirmed the centrality of the MDGs to international policy priorities and development discourse. It also emphasized the broader development dialogue that is needed to ensure poverty elimination. It identified key issues, including reproductive health, that deserve greater attention in strategies to accelerate development.

Regionalization/Localization of the MDGs: the Caribbean Experience

Many critique the MDGs as being something imposed from outside, but world leaders committed to them and Caribbean leaders have reaffirmed and added to the MDGs.

This regionalization/localization process assisted by collaboration between UNIFEM and CARICOM to incorporate gender sensitisation and equality across all the MDG targets and indicators for the Caribbean were crafted specifically for the Caribbean (see annex 3). The MDGs are supposed to be our local policy and development planning framework.

Caribbean Political Commitments

- On 1 August 2008 Education Ministers from Latin America and the Caribbean committed to: "Recognizing the responsibility of the State to promote human development, including education and health, as well as to implement effective strategies to educate and protect children, adolescents and youth from infection, and to combat all forms of discrimination."
- In November 2008 the CARICOM Council for Human and Social Development (COHSOD) endorsed the Caribbean Specific MDG 5 Target -Universal access to reproductive and sexual health services through the primary healthcare system by 2015". This was a step further from the international MDG.

SRH in the MDG framework

- Addressing "demographically driven" poverty traps under Goal 1;
- Promotion of gender equality and empowerment of women under Goals 2 and 3;
- Safe motherhood and child survival under Goals 4 and 5; prevention (as part of a continuum of services) of HIV/AIDS under Goal 6;
- Population–environmental linkages under Goal 7; and
- International cooperation for equitable access to basic medical interventions under Goal 8.

Why has SRH not been given higher priority?

Some have given it priority but there is a question if leaders really understand what 'universal access' means. For examples, MSMs would need access to services, adolescent would need access to services and you cannot turn them away. This is really an advocacy document to remind leaders of what they endorsed to in 2008.

SRH is hard to understand. It is a complex issue and we have to be able to craft our sales pitch: This is a social and economic priority and development issue and national leaders have endorsed this.

SRH services are delivered in a very fragmented way. If you talk about SRH you have to speak to the Ministry of Education, HIV services, maternal health, family planning, it is hard to coordinate a constituency for this broader SRH and gender focus.

Many national planners have to be explained the effects of what SRH on age structures and poverty reduction.
The Sensitivity of Sexuality

These kinds of issues are very sensitive and require public discussion, public attention and political will. Stigma and discrimination need to be addressed, and a frank discussion about sex and sexuality is necessary.

The Dissonance Between the Targeted Time Frames of the MDGs and the SRH Agenda

The MDGs have a targeted time frame while the SRH agenda spans beyond 2015. We have to advocate in such a way that issues related to women and marginalised groups have to be featured higher in the list of priorities.

While the MDGs and SRH agenda are not coherent in some ways we have to find a way to fit the SRH agenda into the MDG target time frame.

What Needs To Be Done?

- Task 1: Integrating SRH analyses and investments into national poverty reduction strategies
- Task 2: Integrating SRH services into strengthened health systems – We need to provide SRH services as part of a ‘continuum of care’.
- Task 3: Systematically collecting data
- Task 4: Improving access to information and services – We need to improve access to SRH literature to empower men, young people, women, girls, to understand what their rights are and also understand sexuality at a personal level.
- Task 5: Meeting the needs of vulnerable and marginalized population.

Discussion

Caribbean MDGs

Participants expressed their surprise of the Caribbean MDGs and noted that had they known about these commitments they would have used this document to greater effect in advocating for access to SRH health. The presenter noted that she herself was unfamiliar with these Caribbean-specific MDGs before making her presentation and promised to disseminate them with the participants of the workshop.
This presentation explored how to think critically and strategically when planning for real results.

Presentation

When taking the linkages between SRH and various other services in consideration, you have to ask yourself, “How are you going to tackle them?” It is important to be strategic and to learn how to plan interventions so we can reach some of the desired results.

What is Planning for Results?

Planning for Results is the first phase of the annual organizational activities – At the beginning of the year you have to sit down and look at what you want to achieve. There is a huge list of things on the agenda and you cannot tackle it all in one day or even one year, you then have to ask yourself what am I going to achieve this year. In doing this you also have to propose periodic reviews of the progress made.

How do you plan for results?

- Problem or issue – You have to identify the problem, because if you do not know what you are doing then you will not know how to get there
- Causal tree or problem analysis
- Solution -- transition to results chain
- Gauge progress, monitoring activities -- indicators
- Link results to resources

Setting Strategic Priorities

To set our strategic priorities we first need to start at our problem (causal) tree. Once we have unpacked our problem tree we need to link that to our resources. After that we need to develop strategies. Different problems need different strategies and in strategies you have include your advocacy and to whom you have to communicate and articulate the problem to.

All these steps lead to stronger programme development. It is important to take the time you need to design a good programme.

Why do we need to set strategic priorities?

- Effectiveness of our programmes – it is important to see if you are achieving the priorities you set
- Impact on beneficiaries and outcomes – the work we are doing is not done in a vacuum, it is important to ensure that our strategic priorities if we are reaching greater goals
- Resource constraints
- Resource Mobilization
- Accountability
- Opportunities – We need to look for opportunities to collaborate with others that are working on the same issues as us. There are lots of issues that have to be tackled, we have to put our heads on our shoulders. We cannot carry on business as usual.

Situation Analysis

It is important to gather evidence on the context and environment you are working in. The situation of women, for example, is different in each environment. Cultural sensitivity is very important in the work that you are doing.
Assess Comparative Advantage

- Mandate to Act – the mandate of your organization should act as your compass before you engage or set your priorities.
- Capacity to Act
- Better positioned to Act – you have to look at which organization would be better (best) to help tackle the problem.
- Track record

Stakeholder Analysis

Inadequate stakeholder involvement is one of the most common reasons of programme failure.

A simple stakeholder analysis can help identify:

- Potential risks, conflicts and constraints
- Opportunities and partnerships that could be explored and developed
- Vulnerable or marginalized groups that are normally left out of planning processes

Interest Group Analysis

IGA looks at three groups of people: Those who support what you are doing, those who oppose it and those who are neutral towards you. We need to do more to get people to support our agenda.

IGA is one of the approaches for encouraging us to think politically and strategically through a structured political analysis and can be used in planning and stakeholder analysis exercises. For more information on the UNFPA tool see: https://www.myunfpa.org/Portal/?pageid=119

Results chain ‘theory of change’

When you set up your strategic priority you need to understand your inputs and outputs. Questions have to be asked such as ‘Did you do the right thing?’ and ‘Did you do the thing right?’

The theory of change is questioning your assumptions at each level of results. Ask yourself what you achieved and will have changed: What is going to be affected at the outcome level?

Final Consideration

Planning for real results requires thinking critically and strategically about desired change and what is required to bring it about.

- What precisely do we want to see changed? – This change should be clearly specified and unambiguous.
- How will this change occur? Who needs to be involved? What resources are needed? What conditions need to be in place and who/what will influence these conditions? – You have to find out how you will strengthen your capacity and what resources you need. A dollar sign has to be put behind everything.
- How will we monitor and evaluate the changes? –
- How will we use the information?

Discussion

Stakeholder Analysis

One participant noted that during a programme a full stakeholder analysis was not completed and this impeded on the results of the programme. The presented said she would circulate information on the Interest Group Analysis.
RBM

One participant remarked how important it is to entrench RBM in programmes and that is still not always followed through. The participant encouraged everyone to use RBM and to integrate that in work with partners. The presenter added that by next year UNFPA was hoping to give their partners 1-2 day courses on RBM.

Data Collection

A discussion ensued about the lack of feedback/information in countries and that impeding the ability to do proper RBM for projects. A participant from the Bahamas made mentioned of the Talibook, which patients carry around and information is added by medical professionals. Another participants from Belize mentioned that the country established electronic patient files in 2008, which is a comprehensive system that helps to make data collection and dissemination easier. Another participant noted that regular and permanent data gathering is crucial in evaluating how the Ministry of Health, the main service provider in most Caribbean countries, is doing.
Adolescent Sexual and Reproductive Health Issues
Patrice La Fleur, UNFPA Assistant Representative - Guyana

This presentation examined and sparked debate around sexual and reproductive health issues of adolescents and young people in the Caribbean.

Outline
- Snapshot of the Context/Situation of Adolescents
- Global commitments
- UNFPA and other UN agencies' strategic focus
- Mitigation strategies for addressing the issues

Context
- Rising mortality and morbidity rates due to violent crimes, substance abuse, traffic accidents, rape, domestic abuse, malnutrition, obesity & mental illness
- Boys and girls sexually initiated at 10 years or younger
- AIDS is the leading cause of death
- Increasing amounts of suicides among youth 16 – 18
- Alcohol, marijuana and tobacco the most abused substances
- Low self esteem
- Governments are making attempts to provide recreational facilities for the youth, however these are often inadequate and under-funded especially in disadvantaged communities

Situation of Adolescents:
Transition from adolescent to adulthood must be understood in the larger development context of poverty, social inequalities, challenges in the education system, gender discrimination, unemployment and health systems, which often do not respond to adolescent needs.

- Adolescents often victims or perpetrators of crime
- HIV infected and/or affected
- Lack support systems and enabling environments for the development of their full potential
- Increased exposure to mass media and information technology - Facebook, Twitter, all young people have a phone nowadays
- Impact of global youth culture, constructing regional and national cultures
- Impact of the global youth culture
- Reconstruction of regional and national youth cultures
- Sexual intercourse at a much earlier age
- Many adolescent girls become mothers and are often denied access to education either through unwritten policies or a value system which prohibits access – this is because it is felt they would tarnish other young people
- Adolescent boys engaging in risky behaviours, gangs, crime and drugs
- Some adolescent boys and girls live in difficult circumstances - Homes prone to GBV and outside of safe home structure and school

Programme response
- Some excellent initiatives
- Wide range of organisations with different objectives operating in a variety of settings – these are often not comprehensive and not working together
- Initiatives are often small scale & time limited – usually not programmes but little projects
Some initiatives are poorly designed and implemented – do not cover large groups of communities

Patchy coverage - especially in countries like Guyana that are very large

Comments from Colleagues

A participant from Grenada noted that adolescent health has been given priority and the country is looking to develop an adolescent health and youth social policy. She also noted that issues of substance abuse and attempted suicides among adolescents.

A participant from Trinidad & Tobago noted that there was a big difference in the youth culture of Trinidad and of Tobago. In Trinidad there is growing gang warfare, while in Tobago there a culture whereby women have to show their femininity by becoming pregnant by the age of 15. This is an issue especially for those working in the area of HIV & AIDS.

Another participant from Jamaica noted that a lot of the same issues were affecting young people there as well. Issues they were facing included violence, motorcycle injuries, violence based on sexual orientation, the lack of physical activity and the growing problem of NCDs due to the lifestyles youngsters are leading, then the use of drugs, suicide and, teenage pregnancy although some gains have been made. She also mentioned the impact of new media, the freedom that gay youth have because of the media and also music and lyrical content and how that has played a role in the behaviour of young people.

The presented added that in a way most participants agree that some of these issues are the same in most of the countries in the region.

Global Commitments

- Convention on the Rights of the Child (CRC) – the definition of adolescents is 10 to 19 and the CRC is for 0 to 18 years
- Convention on the Elimination of all forms of Discrimination against Women (CEDAW) – speaks to issues of adolescent girls, this has been in force for a long time and the presenter said it bothered her that there are still issues with this
- 1994 ICPD - Adolescent Reproductive Health Rights were placed on the international agenda. The ICPD PoA recognised the specific sexual and reproductive health needs of young people and focussed on overall health, sexuality, rights and wellbeing of adolescents
- MDGs – Including universal access to education, gender equality, HIV & AIDS
- UNFPA Framework on Adolescent & Youth
- Policy documents on adolescent health and development, including SRH – PAHO
- UNAIDS and other UN organisations – Policies and Strategic Plans
- CARICOM – Declaration of Paramaribo – Adolescents & Youth - Unfortunately only four heads of Government came to listen to the findings of that study
- 2000 – MDGs – Governments resolved to achieve goals by 2015
- 2001 - Importance of young people accessing HIV education and services and life skills for reducing their vulnerability to HIV infection
- 2005 – World Summit –Universal Access to reproductive health services by 2015

Even though we have these commitments, many of the same issues still happen year on year, so we need to look at this information on a larger level. There are many problems that have root causes that many organizations like us cannot address. It is up to the Government to address these.

Comments from Colleagues

One participant from Suriname noted that the Ministry of Education has a Youth Policy and UNFPA ensures that aspects of SRH are included in that policy. It also has a Youth Institute and Youth Parliament that in theory acts as an advisory body to the Parliament. Suriname does not have the problem of gangs, but does have vulnerable communities where many
young people are out of school. She asked if the participant had any suggestions when dealing with young people. She mentioned a situation where the CARICOM Youth Ambassador had an initiative that seemed too big to succeed. The presenter noted that it is about what an adolescent needs and wants and how to bring that challenge to bear.

One participant from Belize noted that many young people lack social skills, something she realised during a counselling for teen mothers. This was organised to really help emphasise social skills for teen mothers. Not only did teen mothers have to be trained in social skills but the counsellors as well.

Another participant added that governments that have signed on to these commitments have to be held accountable. It is necessary to be aware of these commitments and use them as tools to advocate for these agendas. It is also important to make people aware of these rights and translate them so that people can understand what they mean. She also added that while for young people issues such as SRH and HIV are important they have to be viewed in a broader context of income generation and job creation and it is necessary to link with other partners that are involved in other aspects of youth development.

A participant from Jamaica noted that initiatives have to be comprehensive focusing on issues such as tackling child labour and empowering parents. Currently in Jamaica they are developing a reintegration programme of school age mothers in the educational system. This looks at supporting, intervening and preventing.

A last participant noted that it was important to see how these treaties contribute to the big picture. He added that it was important for individual offices to see where the major gaps lie and how to contribute to this bigger picture.

**UNFPA Strategic Direction:**

The UNFPA Strategic Direction advocates a life cycle approach for sexual and reproductive health and reproductive rights. It recognises that youth and adolescents represent a priority group given their particular social, economic and health vulnerabilities, especially in the area of sexual and reproductive health. – It is very important to have someone to speak to when it comes to these physical and psychological changes that they are undergoing with regards to SRH.

**UNFPA Framework for Action on Adolescent and Youth**

UNFPA developed its Framework For Action (FFA) on Adolescents and Youth. – This was designed using the situation of young people and the global commitments towards them.

UNFPA made a shift from a focus on only reproductive and health aspects of young people’s development towards advocating a more integrated and comprehensive approach that considers the environment in which young people live, their education, health (including sexual and reproductive health) and employment in the context of poverty reduction. – This saw young people not only also sexual beings but as individuals that want to work and learn and have basic needs first, while Reproductive Health comes down the line.

**UNFPA Vision for young people**

"A world fit for adolescents and youth is one in which their rights are promoted and protected. It is a world in which girls and boys have optimal opportunities to develop their full potential, to freely express themselves and have their views respected, and to live free of poverty, discrimination and violence" - That is UNFPA’s vision for young people and, as the presenter states, I think the vision of all UN agencies and the vision for all CARICOM.

To ensure this vision is achieved, four key components are advanced.
Key 1 Creating a supportive policy environment:
- Advocate for greater investments in youth - If you do not invest in them today, a few years down the line you will have to invest in prisons
- Integrate youth issues in national development plans and poverty reduction strategies
- Conduct evidence based research particularly focussing on the vulnerabilities of young people
- Link young people’s issues with population structure and poverty dynamics

Key 2 Life skills based education including comprehensive sexuality and relationships education:
- Integration of sexuality education in schools’ curricula and non-formal education programmes.
- Promote gender sensitive and skills oriented (critical thinking, negotiation, conflict resolution) approaches in transacting SRH messages.
- Develop out of school education programmes through innovative approaches, including multi-purpose peer education and social change communication strategies.
- Link sexuality education programmes with mass media, ICT, legal and support services

CARICOM is working towards this and have established a working group on health and family life education. and schools across the region, CARICOM working group on health and family life education. Jamaica has one of the best models and very dynamic coordinator but there are some challenges with teachers who do not feel comfortable to teach HFLE. In Guyana there are about 30 schools that have HFLE as a stand-alone subject and in other schools it is infused with other subjects. There are different models in various countries and there remain some challenges. There have been talks of integrating it into teacher training colleges so that they all become exposed to it.

Key 3 Sexual and Reproductive Health Services:
- Provide an essential package of services for adolescents and youth.
- Target adolescents/youth in particular those who are out of reach from existing programmes.
- Health/SRH services should provide commodities, maternal health and HIV prevention services.
- Service Delivery should be linked and integrated – Health, Social Services, Schools, Pharmacies, Outreach-Communities).

There needs to be access to information and services at health centres for adolescents. There are still many health centres that do not provide these services.

Key 4 Young People’s Leadership and Participation:
- Support young people’s participation in policy dialogue and other national processes
- Build strategic alliances with youth networks and civil society partnerships
- Invest in capacity building and leadership skills so they advocate for their own rights
- Promote Peer Educators as agents of change

We need to get young people to participate and tell us what they want. We need to build their capacity as we cannot say we want them to build tomorrow, they have to build today. We have YAGs across the Caribbean and we see our young people building and growing into leaders who can push the agenda in the future.

Guiding Principles

Underlying UNFPA’s Strategic Direction are Four Principles.
1. Rights Based Approach – non discrimination, universality, knowledge, access, participation and accountability
2. Gender Perspective-understanding the societal gender norms and expectations which impact on girls as well as boys
3. Culturally sensitive approach - Programmes should take account of values, practices and beliefs which affect young people’s behaviour as well culturally sensitive language should be used in all communication, for example with regards to MSMs and gay and lesbian participants.

4. Diverse Groups of Young People – Many sub groups of adolescents and young people, hence the need to understand the varied issues and challenges which confront them.

Special attention must be given to the vulnerable and excluded adolescents and youth (rural, indigenous, disabled, out of school, unemployed, adolescent mothers)

**UN Adolescent GIRL TASK FORCE**

Several UN agencies are working together on this with the goal to:

- Educate girl – an investment in girls is an investment in family, in the community, in the country and in the world. This is part of the Girl Effect.
- Improve health of adolescent girls
- Keep adolescent girls free from violence
- Promote the empowerment of adolescent girls

This is very relevant for us as we have a lot of adolescent mothers who are not prepared to become mothers. We also have a lot of girls who become heads of their households and a lot of adolescent girls are abused in their homes. We have to continue to empower girls to be assertive and to have a high sense of self.

**UNAIDS 2012 – 2015 Strategy**

- Zero new infections
- Zero aids related deaths
- Zero discrimination
- Advocating Human rights and Gender Equality
- Increased knowledge of condom use
- Increase HIV testing & counselling, encouraging that young people know their testing

**Comments from Colleagues**

A participants from Belize noted that they realised that a more comprehensive approach was necessary and in 2006 they started working towards a youth policy looking at SRH, health, crime and violence, life skills, income generation, suicide rates, etc. It was a very tedious and very long consultative project, which is almost finished this year. They have been getting inputs from youngsters across the country and within that policy there is also a communications strategy. They are looking at different things and using a framework that is good for Belize.

**Strategies for Effective Mitigation**

- Comprehensive integrated approach involving all sectors and stakeholders – such as in Jamaica which has a comprehensive national policy for adolescents and pre-adolescents
- Advocacy using evidence – We need to advocate at all levels, such as to politicians for them to see the benefits of an SRH policy and we need to advocate to young people.
- Partnership Building – This cannot be overemphasised. Partnerships are needed, it is very important to know who should be able the table when planning interventions.
- Capacity Building & Institutional Strengthening – Scaling UP – We have to continuously do this, particularly in primary health care and especially in countries with a lot of migration.
Strategies

- Comprehensive multi-sectoral Adolescent/Youth Policy
- Monitoring and Evaluation Plan - clear indicators
- Programme design using various models and approaches - There are quite a lot of theoretical models and we have to ensure that we know which one to use. One size shoe does not fit all.
- Understand the situation – vulnerabilities, risks, needs – We have to know where we can intervene and where others can intervene.
- Collect and analyse data
- Define goals to improve the ASRH needs – We have to take a closer look to the Caribbean MDGs in this respect and we have to work closer with CARICOM. Advocacy and lobbying are very important in this respect.
- Identify the outcomes desired – Sometimes we work in silos and do not look at the greater outcome.
- Identify the various groups in the adolescent population and which groups should be reached. – Not all of them are at risk and some have a higher risk. We need to think about who we should target at different levels with different interventions.

Strategies/Approaches

- Programme Interventions at all levels of the society
  - National
  - Regional/Districts
  - Community
  - Homes

Interventions will be different at each level, but must be complimentary.

Discussion:

Parents

A participant from Jamaica said that they are looking at implement parenting parent centres, which give parents the opportunity to come to receive training and learn skills. A lot of these will be in churches or other faith based places. She added that parents are important stakeholders in all that we are discussing. The presented noted that it is important to have complimentary interventions that add up to reach our goals and therefore it was important to reach parents as well.

One participant from Trinidad and Tobago expressed interest in learning more from Jamaica and the parent centres. She added that so far in Trinidad they have only tried to reach parents through the PTA.

The participant from Jamaica responded that many of the parents they want to capture do not go to the PTA, but they have been trying to have community PTAs. They have developed a parenting policy and are hoping a lot of initiatives will come into places and five parent centres by November. They also have early childhood centres that are mainly located in church halls. They want to empower the communities to monitor and manage these parent centres. We are going to find those leaders who will champion those places.

HFLE

The participant from Jamaica also shared their experiences with regards to HFLE in schools. Over a five year period they trained all schools in teaching HFLE or 98%. The 2% that did not participate over the summer, are being given in-service training. She noted that there have been difficulties to get the teachers to understand their own sexuality. They have officers across the region that monitor and give support to the implementation of the programme. They are also developing a policy with regards to HLFE from early childhood to grade nine.
level. At the secondary level they have a sex and sexuality educating aspect where they show the youngsters what a condom is but they do not provide them, but can refer.

A participant from Guyana noted that the infusion method of HFLE was very difficult to implement. She added that the country has undergone a pilot project 30 schools in the country where it is an examinable subject.

The presenter noted that at the level of CARICOM continuously it is being said that the only way HFLE will fully be accepted is if it an examinable subject. Guyana will be looked at to see how that works.
This presentation explored the basics on how contraceptives work and the types of contraceptives available.

**Presentation**

At the last Special Session of the UN General Assembly the focus was strongly situated on NCDs, such as diabetes, coronary heart diseases, hypertension, cancer and respiratory chronic diseases. UNFPA asked what is in for us, but many of these diseases have links to SRH such as diabetes and high blood pressure in pregnant women. The only thing we do not look at is pulmonary heart disease.

HIV for the first time is not one of the priorities, even though there is a big link between HIV and cervical cancer.

**Contraceptives**

There are two big areas, temporary and permanents, however with new technology and in good hands those who have undergone a tube ligation or a vasectomy can go back to fertility.

**Basic Concepts in Reproduction**

Everything related to getting pregnant or avoiding it starts in the brain in the pituitary gland. This is the area where the human being produces two hormones which send messages to the ovaries to tell it to let an egg grow.

**Modern Contraceptive Methods**

Contraceptives work by inhibiting ovulation and this is done by preventing the release of luteinizing and follicle hormones and preventing the release of an egg. Combined estrogen - progesterone birth control pills and progestin only pills or implants prevent the pituitary gland's release of hormones that stimulate ovulation. You are not committing a crime or a sin, because you are not killing a human being, you are inhibiting the process that will eventually end in a human being, but you are not killing a human being.

**Basic Concepts in Contraceptives**

The longer a woman uses a contraceptive method the less likely it is to fail, because the body has an adjustment period for each one of the medications.

Perfect use is a measure of efficacy if the method is used perfectly. Typical use estimates the probability of pregnancy during the first year of typical use of the method.

**WHO Eligibility for Contraceptive Use**

Four Categories:
1. No restriction for use
2. Benefits generally outweigh risks
3. Risks generally outweigh benefits
4. Unacceptable health risk

This is different for each contraceptives, this is why if we know all the side effects of a particular contraceptive and all the alternatives we can provide the best treatment.
**Oral Contraceptives**

Monophasic Birth Control Pill - Estrogen amount will never change. The Ministry of Health will always gives monophasic pills, as it is cheaper and easier to control.

Biphasic - half of the dosage change in the middle of the cycles, this attempt to mimic the normal estrogen level and the normal progesterone level in the cycle.

Triphasic – this meant to mimic the cycle again, finally there are also four and five phasic pills.

There are three ways to decide when to start taking birth control pills. First the quickstart which means starting a contraceptive today but this will take seven to nine days to work properly. The second is the first Monday after you have your menstrual cycle this will also takes seven to nine days to work. The last is to start taking the pill the day after your menstrual cycle starts then you can start having sex right away.

It is important that if we provide contraceptives to make sure to see if a woman is not pregnant. This is a very common mistake.

**Injectables**

One of the most popular is Depo-Provera, this is a deep intramuscular injection of progesterone every 12 weeks. The biggest problem is that if someone injects Depo and then massages the area, they are destroying the product and something that should last 12 weeks will only last four or five. Another important thing to remember is that in order for a person to absorb calcium in the bones, the person needs estrogen, which the Depo is preventing. After two years it is important to change to something that has estrogen. There is the monthly injectable mesigyna, which has estrogen and progesterone. Another injectable is noristerat which is often provided in Trinidad and Tobago. One of the big problems is that the optimal time the product is supposed to be used is eight weeks or a few weeks more but people are using it for 12 weeks. They are going to be reviewing noristerat.

**Intrauterine Device**

The IUD inhibits spermal migration to the upper part of the female reproductive tract. Depending on the type of IUD it works between five – 10 years.

**Sub Dermal Implants**

These are little sticks of latex that contains progesterone. The first one was to be named norplant and we have to implant six of these in the skin. Now we have jadelle, which has to be in the skin of a person through the needle. This last five years.

**Condoms**

These are designed to block the passage of genital fluids and its components.

The one problem with condoms is that it does not 100% protect against HPV, genital herpes, chancroid and syphilis. Female condoms cover the vulva and this does protect more, the problem is that it can be transmitted during oral sex rather than the actual penetration.

Even though the condom does not protect as well against some diseases it is still the best way to protect against STDs. The only way to protect yourself completely of course is abstinence.

**Diaphragm**

The main problem with this method is that people have to know how to use it. You have to introduce it and fill it up with spermicide. This method is also more prone to lead to
pregnancy, the more children a woman has had as the cervix changes shape depending on the amount of children a woman has and depending on the use of estrogen or progesterone.

**Spermicides**

These come in many shapes such as gels, fills and tablets. The problem with spermicides, the most common non-oxynol-9 and if we combine it with condoms it produces little lacerations in the mucus and it creates an opening for STIs.

Other methods include the vaginal sponge made of latex, which is not recommended for use and the vaginal film, which you cut and place in the vagina and this will then dissolve.

**Fertility Awareness Methods.**

The problem with the occurrence of ovulation and menstruation is that it also has a component linked to emotion. Depending on a woman’s emotional state sometimes they might menstruate or ovulate, so we cannot expect a human being to be like a machine. There is Billings method used by the Catholic Church, which calls to check how the vaginal mucus is. If the mucus is elastic and transparent like egg white then couples should avoid intercourse. However if there is a vaginal infection, which is the case in 30 per cent of the population, this method will not work.

**Coitus Interruptus**

Also known at the withdrawal method, coitus interruptus entails withdrawal of the penis from the vagina (and external genitalia) immediately prior to ejaculation.

**Lactation Amenorrhea Method (LAM)**

Breastfeeding provides more than 98% protection from pregnancy in the first six months after birth. This method works but requires frequent breast feeding, at least six to 10 times a day.

**Permanents**

Then there are the permanent contraceptives including voluntary surgical contraception, the clamping method here is not recommended. There is also the vasectomy which is an effective method.

**Comparing Typical Effectiveness of Contraceptive Methods.**

The less a person/patient that has to do with contraceptive such as implants, vasectomies, the more effective a contraceptive method mostly is.

Most important to remember is that being able to avoid unwanted pregnancies is priceless.
Monitoring and Evaluation of Results  
Vertha Dumont, UNFPA M&E Specialist

This presentation explored the basic concepts of the monitoring and evaluation aspect of RBM.

Presentation

RBM is not a new concept, but one that was started 20 years ago by CIDA. Not a lot of things were checked back then to see if they were actually effective, hence the need for RBM.

Sometimes what we learn we do not apply regularly to see where we are going. During earlier presentation we learned to analyze our problem. We also learned that we work in SRH and we cannot do it alone. We have stakeholders and partners and we have to identify results and learn to use limited financial and technical resources. We learned how to use these resources strategically.

We have not really looked at monitoring and evaluation and in our last stop of our RBM journey we will look at indicators, data, and M&E.

Results Chain

We have to know we our doing our work properly and we can do this thanks to indicators. This helps us monitor progress and lets us know we are on the right track. We need a maximum of three indicators, not 10 but three.

Define…INDICATOR

- Tool to measure evidence of progress toward a results or that a result has been achieved – the agenda for this workshop for example is an indicator as it shows you how our workshop is going
- Describe how the intended result will be achieved
- Force clarification on what is meant by the results – If we cannot identify what the results mean then it is not clear in our own minds. If your outcomes are too big you will never be able to find an indicator. If your results are clear you should be able to find a good indicator.
- Objectively verifiable – SMART, DOPA
- Baseline and target

Characteristics

We have to make sure what we want to achieve is SMART.

Specific,  
Measurable,  
Attainable - you need to be strategic,  
Relevant – to what you want to achieve and to your programme,  
Time Bound – we implement every year

DOPA Criteria

Direct, closely measure intended change  
Objective, unambiguous about what is being measured  
Practical, reasonable in terms of data collection  
Adequate, minimum number necessary to ensure that progress is captured

Good Indicator

- Clear and unambiguous
• Relevant to the results they measure
• Feasible to collect
• Adequate and easy to interpret to guide decision
• Available and reliable over time
• Able to track changes
• Measurable - if not then it is not a good indicator

Indicators

Types: Quantitative, Qualitative, Hybrid and Proxy

When you are working in sensitive issues you use proxy indicators such as with MSMs, abortion and HIV, because you cannot go directly and ask that question. You will use another question somewhere in the area of the question you want to ask and when you analyze that, it ends up being your question. This reiterates type 2 evidence that you have to understand cultural sensitivity.

Baseline: This is point zero - The conditions existing at the initiation of a programme or intervention. The baseline is important to know where you are in your programme. How do you know where you are going if you do not know where you are starting from? This is often a big problem in our region because we lack data. In some cases, it is because governments do not want to make the data available, and often it is because we do not have the resources to analyze and disseminate the data. We need to invest more in data collection. UNFPA is looking into better data collecting systems and by the end of the year will be getting in touch with the participants from this workshop and others around the region to work together in strengthening data collection.

Target: Value to be attained at a certain time during the programme cycle. It is important to look at how you have to set it. You need to be strategic in setting your target. The results for example when looking at behavioural change in condom use could be zero at the end of year one. You need to set your target well. It is also important to remember that at the end of the day you might not reach your target, but you are conscious of your situation and conscious of your resources. We need to see where you are at and where you are going and the donors need to see this as well.

Why monitor activities?

You need to know where you are going.

Monitoring:
• Tracks inputs and outputs and compare to plan better
• Identifies and addresses problems
• Ensures effective use of resources
• Strengthens accountability
• Captures information on success or failure for knowledge sharing and provision of corrective measures

Results Based Monitoring

• Follow-up of activities to measure progress towards the achievement of programme results
• Alerts managers and partners to implementation problems
• Answers the question -What are we doing?”
• Continual
• Regular, continuous activity meant to track progress and question our assumptions
• Are we doing the right thing?
• Situation and context of our intervention -Where are we at?
• Capture information relevant to the programme
• Improve reporting requirements
• Stronger based on regular feedback, data collection, analysis supported by indicators and reporting

**Results Based Monitoring Tools**

• UNDAF M&E Plan  
• CPAP Planning and Tracking tools  
• AWPMT - Quarterly monitoring report  
• Field monitoring visits – We do not do this enough. We very rarely take the time to go to do a spot-check. In Haiti the UNFPA M&E officer went to see the places where money was being donated to and in some cases there was absolutely nothing. So it is not that you do not trust your partners, it is just to see if you are on track. Because if not then your partners’ effectiveness and your effectiveness is questioned.  
• Annual Progress Report

**Evaluation**

• Periodic  
• Forward looking  
• Accountability for results  
• Impartial  
• Types—formative (tells you where you are), summative (lets us see what have done in RH in the last 3 years for example), impact (what have you done over the whole course of the programme)  
• Criteria—UNEG (relevance, effectiveness, efficiency, sustainability, etc…)  
• Generate evidence  
• How are doing the things right?  
• Expected=Actual results – allows you to compare expected results with actual results, giving you the real number  
• Linking operations with effectiveness or not of interventions  
• Validate assumptions  
• Provide recommendations for future planning – out of an evaluation a few years ago from UNFPA it was found that we focus on too many areas and need to be focus on less to see more results

**Monitoring & Evaluation**

Monitoring asks if are we doing things right, and evaluation asks if we are doing the right things.

**RBM Final Considerations**

• Need to define expected results first and activities later – you need to know what you want to achieve  
• Depends on a management culture that is focused on results – RBM has to be embedded in culture of organization  
• Should be integrated in all phases of programme cycle – you are not reporting on activities, you are reporting on results  
• Apprise your work critically and learn  
• Link strategically results with resources
Inter-linkages & dependencies between planning, monitoring, evaluation & reporting

**PLANNING**
Without proper planning and clear articulation of intended results, it is not clear what should be monitored and how; hence monitoring cannot be done well. Without effective planning (clear results frameworks), the basis for evaluation is weak, hence evaluation cannot be done well.

**MONITORING**
Without careful monitoring, the necessary data is not collected; hence evaluation cannot be done well. Monitoring will often lead to changes in programme plans.

**EVALUATION**
Evaluation of a programme will often lead to changes in programme plans.

**REPORTING**
Unless there is robust planning and regular monitoring, there cannot be effective reporting on results. Lessons learned/analysis from reporting inform planning. Evaluation provides evidence base for quality reporting.

Constant knowledge sharing is what RBM is all about.

**Discussion:**

*Quantitative vs. Qualitative*

One participant asked if quantitative types of indicators were not better to use, as qualitative indicators could be subjective. The presenter responds by saying the indicators themselves are not subjective, but they are just subjective to what you want to look at.

*In-house M&E*

The presented added that in many countries there is now increased competition for funds, such as in Guyana where USAID will stop its funding, and this means RBM and M&E will be very important in-house activities and must be included in the planning process. The presenter added that the monitoring component is part of the programme and the evaluation team should be composed of an external team, not people who designed the programme.
Link Between HPV and Cervical Cancer  
Dr Mario Aguilar, UNFPA Regional Advisor SRH

This presentation gave a brief overview of the link between the sexually transmitted human papilloma virus and cervical cancer.

Basics on Cancer

Cancer involves the abnormal multiplication and spread of cells in the body: abnormal morphology. The faster cells divide the more this then spreads to the rest of the body. It is usually caused by mutations in somatic cell genes that regulate cell growth. Almost every tissue in the body can produce cancer; some even generate many different types of cancer. Cancer cells follow own internal plan for reproduction and they have the ability to migrate, also known as metastasis.

HPV and Cervical Cancer

For many years we have been accusing many factors of being the main cause of cervical cancer until lately they found a common denominator and this is the presence of HPV. This is an STI, one that is usually neglected.

Prevalence

- At least 50% of sexually active men and women acquire genital HPV infection at some point in their lives.
- A recent estimate suggests that 80% of women will have acquired genital HPV by age of 50.
- An estimated 9.2 million sexually active youths 15 – 24 years of age are currently infected with genital HPV.

Most HPV infections are transient, asymptomatic and have no clinical consequences. In the US it has the second highest estimated incidence compared to other STIs, after Trichomoniasis and followed by Chlamydia, Herpes, Gonorrhea and Syphilis.

HPV is practically invisible as 11.4% of the population harbors an infection at any given time. This stands at 14.3% in developing countries.

Transmission of Genital HPV

- Transmission of genital HPV is predominantly associated with sexual activity; viable HPV and micro-trauma to skin or mucous membranes are likely required.
- Transmission can occur from asymptomatic and subclinical patients.
- Although rare, HPV can be transmitted form mother to baby during delivery and causes respiratory tract warts in the baby.

HPV family

There are dermal HPVs, the common skin warts and mucosal HPVS of which there are low risk wart types and and high-risk cancer types.

From the 100 types of HPV some are specifically related to cervical cancer. Like HPV 16 and 18, which are 70% attributable to cervical cancer.

What happens once people get infected with HPV?

For most people, nothing will happen –
- The body’s immune system usually eliminated HPV infection
- Cervical HPV becomes undetectable within two years in around 90% of women
- Relatively few will develop symptoms
- Persistent infection with high-risk HPV types is associated with pre-cancerous and cancerous cervical changes.

**Vaccine**

The HPV vaccine protects you from 16 and 19, which are the most common types.

Any woman who has not had sex yet should be vaccinated. It takes about three injections to get as protected as possible. Some viruses have been eradicated but HPV has so many different types that it is impossible to get rid of.

It costs 17 USD through PAHO and will help to save the lives of countless women.

**Testing for HPV**

We can test the blood for antibodies, we can give a pap smear and there is also the visual inspection with acetic acid method.

**Risk Factors for Cervical Cancers**

- Persistent high risk HPV infection
- Multiple sex partners
- Little or no history of Pap screening
- History of cervical dysplasia
- Early sexual debut
- Smoking
- Parity and long term OC use….women 5 times more chances to develop cervical cancer if they are infected with HPV
- Increasing age
- Immunosuppression
- Other STIs

**Global Trends**

Incidence: 530,000 cases each year
Mortality: 275,000 deaths each year
Second most frequent cancer for women between the ages of 15 – 44, especially in Latin America, Africa and South East Asia
Gender-Based Violence and Reproductive Health
Dr Mario Aguilar, UNFPA Regional Advisor SRH

This presentation explored the relationship between gender-based violence and reproductive health.

Gender Based Violence

Definition:

-Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm of suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

Background

- Ten to 52% of women reported being physically abused by an intimate partner at some point in their lives - This is regardless of social or economic status.
- Between 10 to 30% reported they had experienced sexual violence by an intimate partner.
- Between 10 to 27% of women and girls reported having been sexually abused, either as children or adults.
- Around the world at least one out of five women have or have received mistreatment from a male person.
- It is a cause of incapacity and death in women in reproductive age as bad as female cancers.
- GBV causes more health problems than car accidents and malaria combined.

Gender discrimination through a woman’s life

GBV start from the prenatal moment. For example prenatal sex selection, battering during pregnancy, coerced pregnancy and continues on in infancy. During childhood you have cases of genital cutting, there is an area in Colombia where genital cutting is practiced. GBV can continue on in adolescence, reproductive age and old age.

The Problem

In reproductive health settings victims of GBV are often stigmatized as difficult clients. When there is a patient you see every week, you get tired of seeing them. To see a patient get better is part of the payment. The victims are considered “failures” because they often do not use the family planning methods prescribed to them, do not follow behavioural or health recommendations, fail to return for follow-up visits and fail to get treatment for their STIs.

One of the most common forms of GBV is that performed by a husband or male partners.

This type of violence is frequently invisible since it happens behind closed doors. The only thing we see are the results of the gender based violence.

Domestic Violence

Domestic violence is the physical, verbal, emotional and psychological and/or sexual battering of a woman by her partner or spouse. This type of GBV can involve the use of threatening or intimidating words and acts, hitting, use of a weapon, rape, imprisonment, financial control, cruelty towards her or other people and things she cares about and abusive and or demeaning language.
Cycle of GBV

GBV often works in a continuous cycle of - violence – honeymoon – increase tension. This is usually followed by a period of greater violence.

Types of Abuse

- Physical Abuse
- Sexual Abuse
- Emotional and Verbal Abuse
- Psychological Abuse

Health Effects of Gender Based Violence

- Childhood Sexual abuse (for adolescent and adult victims) can lead to gynecological problems, STIs, etc.
- Rape can lead unwanted pregnancy and abortion.
- Domestic violence can lead poor nutrition and chronic pain. A large study on women suffering from chronic pain found that most of them were associated with GBV.

The Survivor’s Experience

Reactions from the Public or Health Providers

- Denial
- Rationalization
- Minimization
- Identification – ‘This could never happen to me so it could not be happening to a woman like me.’
- Intellectualization – ‘A woman who is being hit should leave.’

Why someone remains in a Relationship with the Perpetrator

Internal factors
Father of retaliation, Economical dependency, Because she/he learned that marriage is forever, Not know the exit, Low self-esteem

External factors
Lack of legal support (Police re-victimize as does the judge. Most of the time we blame or judge someone without knowing what is going on.), Lack of knowledge about help

Why a Person can get out of a Relationship with the Perpetrator

Internal Factors
Empowerment, Positive attitude, Improved self-esteem, Personal history with no exposure to violence

External
Family Support, Economic independence, Higher levels of education and information, Access to institutional and professional services

Sexual Violence

Slavery, harassment, trafficking, forced exposure to porn, forced pregnancy, sterilization, abortion, marriage, female genital mutilation

What can we do about it?

Promote zero tolerance with regards to GBV
Advocate with local authorities, leaders and community the promotion of prevention of GBV
Advocate with victims to speak up about it
Advocate for creation of jobs, shelters, legal, social, health and economical support

**Discussion:**

*Tackling Men*

A discussion ensued on the importance of working with men when it comes to gender issues. The presented noted that one of the MDGs is to improve education for girls, but while women are becoming more educated their income levels have not changed. Another participant argued that in 20 years time women will be earning the same salary as men because of their education and there will be a lack of educated men: We will then have a 'crisis of men'. Another participant added that it was important to look at the direction that boys in the region are heading and look to tackle gang culture and delinquency among young men. The presenter said that the mothers play critical roles in perpetrating the macho culture that a lot of young men in gangs are familiar with. He added that a stable human being starts at home and with mothers being the primary caregiver in a majority of households they play a key role in reeducating boys. A last participant argued that it is not the mothers or fathers that are responsible as nobody is parenting. This is a problem that has to be addressed.
**Key Populations, Stigma and Discrimination**
Marvin Gunter, UNFPA Regional Advisor HIV & AIDS

This presentation explored feelings on stigma and discrimination and explored how that affects personal attitudes.

**Prejudice, Stigma and Discrimination**

How do you define these three concepts?

**Prejudice**

These are preconceived notions, something you would have some knowledge of and as a result of this knowledge you would have developed a certain bias.

**Stigma**

This is expressed in the context of placing negative labels and usually results in the action of discrimination.

**Discrimination**

This is differential treatment based on certain features.

Scholars have argued that prejudice and stigma will always be there and are very difficult to remove from society. What we can manage try to get rid of is discrimination through policies, regulations, sanctions and discussions we have had a lot of success in managing discrimination.

**Dynamic Inquiry**

Participants were asked to get in four groups and identify the question which matched their group number. They then had to find three to four people who did not have your question and allow them to ask them a question. The information would then be collated per group and the findings presented to the rest of the participants in 15 minutes.

**Question 1.** Describe a situation in which you believed you were discrimination against? What were your feelings and emotions?

**Question 2.** Describe an issue, situation or activity with which you personally have grave difficulties based on your morals, values, religion, culture, etc.?

**Question 3.** In your opinion, why does stigma exist and why do people discriminate?

**Question 4.** From your experience, what are effective ways of reducing the effect of stigma and discrimination?

**Feedback on the Process**

Participants noted that some of the questions were very difficult to answer in such a short period of time. They also noted that the answers were however very insightful and people had various fears and issues, because of cultural biases and so on.

**Group 1**

Describe a situation in which you believed you were discrimination against? What were your feelings and emotions?

- Racial discrimination, unsure
- Job, hatred & withdrawn, disappointment
• Behaviour, singled out
• Status, unimportant
• Location where you live, sad and upset
• Excluded from participation, depressed
• Language, upset and disappointment

A discussion ensued on who discrimination is the biggest problem for, the person who is discriminated against or the person who discriminates.

**Group 2**
Describe an issue, situation or activity with which you personally have grave difficulties based on your morals, values, religion, culture, etc.?

• Abortion – this is conflict with medical and religious beliefs, but acceptable if person was raped. As a medical professional they would not do it themselves, but based on client situation they would refer.
• Self taught from young to not stigmatize or discriminate, and gets along with everyone
• Not against political favours towards friends for employment, but if the person hired is not performing on the job, then that is a problem that affects them
• Difficulty with children being caregivers of their siblings, this is the job of the parents
• Doing what job requires, expect staff to be honest with processes, this goes against their morals if they are not
• Exploitation of people, especially women and girls
• Dishonestly, when someone is dishonest you cannot trust them
• Do not understand the LGBT lifestyle, while they do not religiously or professionally discriminate, they do not personally understand it

**Group 3**
In your opinion, why does stigma exist and why do people discriminate?

• Afraid of things are unfamiliar or are taboo
• Afraid of the unknown
• Lack knowledge and awareness
• Insecure
• Expression of shortcoming
• Personal myths and misconceptions
• Think they are better than other
• Societal norms and values, misconceptions
• Humans have a natural inclination to notice differences due to value system
• Don’t want to be associated
• Not being culturally aware
• It makes them feel better about themselves
• Cultural influence, cultural
• Part of a group
• Low self esteem
• Belief system, socialization and values
• Feel they are better than other
• Discrimination due to stigmatization
• Society forces you to discriminate

**Group 4**
From your experience, what are effective ways of reducing the effect of stigma and discrimination?

The group presented their findings by placing the answers in four categories.

• Knowledge/Education/Awareness
- Education
- Info sharing
- Understanding cultural context
- Having close contact with individuals
- Involving everyone in decision making

• Self Perception
  - No one should exalt themselves over the other
  - People’s own views of themselves
  - Even if it may not be positive in everyone’s eyes, everyone has the right to their own destiny

• Policies/Legislation/Human Rights
  - Sometimes you also need legislation and policy, even if it does not solve the problem, if people are not aware of the legislation, they will not use it.
  - Awareness and knowledge of legislation.

• Personal experiences
  - Expose the individual to situations to minimize their fears
  - Re-socialization
  - If you know how others feel, walk in someone else’s shoes

The group noted that hopefully these answers will begin to unpack some of the issues and most importantly get us to think about the way our perceptions impact the way we programme and provide services, and how we can grow and develop ourselves. They added that for SRH it can be very instructive, not only to listen to the thoughts of other but also to identify some of our personal feelings. There might be some of us, for example, who are hurting because of past experiences.

**Final Points**

The presenter added that he hoped everyone got a bit a more insight into his or her own personal feelings because of this and hoped that everyone would remember that sometimes when we recall a painful experience, we might be discriminating as well. Lastly he added that discrimination comes in the most unlikely situations, when working on a project with sex workers for example, there was a lot of contention between who is sex workers, escort, exotic dancer etc. It was all about labels. The discourse and discussion is needed to help tackle discrimination.
Country Presentations

The country presentations have each been summarized and the points included in this report are the facilities, statistics, policies, issues, challenges, successes, lessons learned, initiatives and research, and discussion points.

Grenada
Nester Edwards

Facilities

Six health centres and 30 medical stations which provide MCH services. Three health centres also have maternity units and MCH services also provided at the three hospitals on the island.

Policies

Grenada does not have a Sexual and Reproductive Health Policy. Sexual and Reproductive Health are not integrated into many of the ministry's programmes, apart from the maternal and child health programme.

Issues

- Teenage pregnancy and its consequences – On average between 20 – 25% of first antenatal clinic visits to public health care facilities are done by teenagers.
- Early unprotected sex
- Inappropriate or lack of contraceptive use by those who are sexually active
- Multiple sexual partners

Challenges

- Policy and planning – centralized management
- Weak collaboration between government and NGOs for clinical and non-clinical SRH and HIV service provision – characterized by informal and ad hoc relationships
- Attitudes of health professionals towards persons with HIV, MSM, homosexuals

Successes

The Maternal Mortality Rate in Grenada is zero. Achieved the MDG of reducing maternal deaths. Factors contributing to the low maternal mortality rate include:

1. Yearly Refresher training for community midwives
2. Early identification of high risk pregnancies and prompt referral of such cases
3. An obstetrician as head of the obstetric department for 15 years who understood pre-eclampsia and eclampsia

Initiatives and Research

- Development of an adolescent and youth health and social policy
- Piloting of a clinic for men
St Lucia
Diana King-Dornelly

Facilities

Two general hospitals, two district hospitals, one psychiatric hospital, one polyclinic, one private hospital and 33 health centres.

Four STI clinics offering:
STI screening
VCT screening
Rapid HIV testing

Policies

No RH policy, although Maternal and Child Health services are guided by the following:
- Maternal and Child Health Strategy for the Caribbean Community
- Ministry of Health Policy Manual
- Maternal and Child Health Manual
- National HIV/AIDS and STI Protocol
- Guidelines for Developmental Assessment

Statistics

Maternal Mortality Rate in 2006 of 1.4%
Maternal Mortality Rate in 2007 of 2.7%

Infant Mortality Rate in 2006 of 25.8%
Infant Mortality Rate in 2007 of 15.9%

Issues

Teenage pregnancy rate of 15.7%, age of sexual debut around 13 years.

Challenges

- Inadequate human resource
- Limited financial resources
- Inadequate training (example policies and protocols on management of gender based violence)
- Information gap exists / updated figures not available
- Lack of policies on contraceptive use and cancer screening
- Lack of policies on referrals between primary and secondary care facilities
- Cultural factors

Discussion

*Integrating SRH and Family Planning Services*

St Lucia working towards integrating SRH and family planning services although there are still some gaps. They used to be separate offices but are not both part of Ministry of Health and attempts are being made to integrate these two.

*Services at Adolescent Health Clinics*
The adolescent health clinics provide counselling, family planning, HIV, health promotion, cancer screening. St Lucia is still working on getting the policies in place to support adolescents.
**Suriname**
Beverly Ting A Kee

**Facilities**

56 clinics of the Medical Mission in the interior, 42 clinics of the regional health foundation, 120 private physicians, 5 hospitals, 1 district hospital

**Policies**

Review and update of SRH policy taking place
Safe Motherhood Needs Assessment in 2008, which led to Neonatal Health PoA
Prevention Programme of teenage pregnancies

**Issues**

High MMR although a lot of people deliver in the hospital

**Challenges**

Weak legal framework for SRH – updates needed especially for adolescents
Relative inaccessibility of the interior
Lack of capacity at the Ministry of Health
Lack in data collection, analysis and we need to disseminate better
Deficiencies in M&E system

**Initiatives and Research**

Training to implement Family Planning Decision Making Tool
Studies on condom use among youth and sex workers
Research on GBV

**Discussion**

*Hinterland*

One participant from Suriname noted that since the MM has been working in the hinterland, there has been a lot of improvement. This area remains a challenge but is something we can share information about, as there has been a lot of progress. Another participant from the Bahamas shared that there they use a lot of telemedicine for doctors and nurses to communicate between the outer islands and the main island of Nassau. She noted that this could be useful for Suriname.
Guyana
Marcia Bassier-Paltoo

Facilities

Government Sector
Health Posts - 39
Health Centres (Polyclinics, Health Centres, Satellite clinics) - 194
District or Cottage hospitals - 18
Regional Hospital - 4
National Referral Hospitals - 1

Statistics

Maternal Mortality Rate per 100,000 of 113
Adolescent Birth Rate of 24%
Prevalence of contraceptive use of 32.4%
Adult HIV prevalence of 1.2%

Policies

SRH:
Health Sector Strategy 2008-2012
Package of Publicly Guaranteed health services developed
Health information systems
EmoNC assessment done in 2010 (UNFPA & MCH)
Demographic Health Survey 2009
Domestic Violence Act 2010

Adolescent Health:
Adolescent Health Unit since 2005
Adolescent Health Strategy
Teenage Pregnancy Prevention Strategy

Issues

HIV prevalence going down, but remains high in adolescents and young adults.

Challenges

- Financial support
  - To reach hinterland areas, Amerindian villages and roll out programmes nationally
- Inconsistent/no formal policies or legislation on SRH in schools
  - HIV – VCT testing age varies; no clear policy
  - SRH in schools – School Health Unit at Ministry of Education; varies across schools and teachers
- Age of sexual consent is 16 years; age of legal abortion is 13 years
- Cultural diversity and challenges across Regions

Successes

Strong partnerships with international agencies, FBOs, NGOs and private companies.
Lessons Learned

- Adolescents need to included in programmes to be advocates for their own health
- Greater attention for men
- Existing health care workers can be trained in adolescent health
- Services need to be comprehensive and incorporated in programmes that work well
- Strong Political Will
- Strong Partnerships
- Good surveillance and evidence give a situation analysis and help guide programmes

Initiatives and Research

SRH programme in schools – 150 trained peer educators as well as a texting service that gets over 100 texts a day. The service is not health specific, but provides social and emotional services.

Discussion

Abortion

Most participants were surprised to hear of abortion being legal for girls as young as 13 in Guyana. The presenter noted that while this is the case legally it is often something medical professionals are unwilling to carry out.
Facilities

66 public health clinics

Challenges

- In the Family Islands, not all clinics have a doctor and there are a few with no nurse
- Expensive for Family Islanders to come into Nassau for referrals
- Persons are afraid to access service eg. illegal immigrants and young people
- Ignorant to importance of SRH
- Late antenatal or no ANC
- Language barriers – difficult to communicate with Haitian client, many of them do not trust medical professionals
- Locating clients
- Cultural beliefs

Successes

- Public health clinics have easy access
  - Located in the communities
  - Located within walking distance of public bus routes
- Most services are free
- Adolescent Health Clinic
- Interdisciplinary team is present
- Reduction in mother to child transmission of HIV from 30% in 1995 to 2%

Initiatives and Research

- To develop an After Hours Women's Clinic aimed at the Commercial Sex Workers
  - Still in the initial planning stages
  - Location that is frequented by CSWs has been identified to house the clinic
  - CSWs have shown interest in this type of service

Discussion

CSWs

A participant from Guyana noted that together with the Guyana Sexual Coalition they opened an office/building where sex workers can interact and feel comfortable with other sex workers. She noted that sex workers are more prone to come to these kinds of places if other sex workers are there to support them. A sex workers group might be a way to get them to make use of a clinic as well. Another participant added that the legal frameworks also have to be looked at when dealing with commercial sex workers. The presenter added that it was also very important to liaise with police as in the past nurses have been arrested for being in a brothel at the time of a raid.
**Belize**
Melanie Montero

**Facilities**
7 public hospitals, 3 community hospital, 1 tertiary level care hospital, 5 private hospitals in Belize city, 43 health centres, 48 rural health posts

**Policies**
Sexual and Reproductive Health Policy approved since 2002. The national strategic plan 2006-2010 is currently being evaluated and a national SRH committee is to be established by the end of 2011 to substitute multiple national subcommittees.

**Issues**
- Adolescent Birth Rates
- Low contraceptive use prevalence rate – 34 in 2007

**Challenges**
- Missed opportunities of people with access to health services (emphasis on preventive services)
- Sexual and reproductive health within HFLE not fully implemented (attitude from management and school teachers, poor skills among teachers, insufficient job aid tools, taboos and myths) despite Family Health Survey 1999 where females recommend SRH education in schools (almost 90%)
- Poor parenting skills
- Early sexual activity, commercial sexual exploitation of children, peer pressure, low self-esteem, sexual violence and incest.
- Legal barriers for adolescents to access sexual and reproductive health services without parental consent (ongoing legal consultancy)
- Missed opportunities in identifying and providing care Gender based care for gender based violence survivors
- Low contraceptive use prevalence rate
- Inadequate coordination among partners implementing the SRH Policy
- Strengthening of maternal and neonatal care, and PITC for HIV and other STIs
- HIV Stigma and discrimination

**Successes**
Very good Maternal Mortality Rate, in 2005 10 cases, in 2010 four cases. Mainly thanks to implement quality assurance procedures.

**Discussion**

**MMR**
One participant noted that the work done in Belize with regards to the MMR was very impressive and that whomever is training obstetricians knows their emergency medical care.
Jamaica
Joyce Chambers

Statistics

Adult HIV prevalence rate of 1.7%

Policies

Implementation of activities focused on the youth in National Strategic Plan for Pre-adolescents and Adolescents 2011 - 2016

Issues

- AIDS Epidemic, of which the driving factors are:
  - Multiple partnerships
  - Transactional sex
  - Intergenerational sex
  - Incorrect and inconsistent condom use
  - Early sexual debut
  - Gender norms and values
  - Lack of STI Treatment and testing
  - Commercial sex
  - Men who have sex with men
- Teenage pregnancy:
  In 2008, 14.6% of girls in the 15-19 age group have ever been pregnant, a decline from 19.2 percent in 2002. Also in 2008, there were 72 births per every 1,000 women in the 15-19 age group down from 79 in 2002.

Challenges

- Expanding HIV prevention to those most at risk e.g. MSM, SW and clients of SW
- Continued stigma and discrimination
- Timely diagnosis of HIV infection and universal access to anti-retroviral drugs
- Building regional, parish and NGO capacities
- Slow progress with social policy & legislation
- Sustainability including human and financial resources
- Social programs & opportunities for the poor including education and employment
- Policies that address critical social needs and rights of vulnerable populations
- Greater gender equity and reorientation of gender roles
- Safe sex education and life skills in schools

Successes

Youth:

- Out of School Youth Intervention
- Situational Analysis – VCCT for minors below 16 years
- HFLE in all primary and secondary schools and being introduced to early childhood institutions
- Policy development for re-integration of teen mothers back into schools.
- Establishment of Adolescent Policy Working Group
- Establishment of youth information centres 6 centres island-wide

Lessons Learned

Build partnerships and strengthen existing ones. These include:

- NGOs
- Line Ministries
- Faith-based Organizations
- UN Groups
- Community-based Organizations

**HIV:**
- We need to expand our outreach programs to those most at risk, improve the quality and assess effectiveness
- Structural changes to reduce social vulnerability and change social norms & gender inequity is important
- Increase Access to HIV testing (especially among key populations) is critical

**Youth:**
- Develop educational activities to promote abstinence & safer sex
- Address gender power relations in programmes when working with adolescents.
- Include in sexuality education, a gender and rights perspective.
- Increase accessibility to contraceptive methods for adolescent girls and boys.
- Acceptance of antenatal and post-partum care should be promoted for adolescents and viewed as opportunities for contraceptive counselling and provision.
- Male participation in pregnancy prevention and care also needs to be promoted.

**Discussion**

*Teenage Mothers in Schools*

One participant asked if teenage mothers were allowed back on school grounds. The presented responded that they are but this is up to the principles, but they are working on making this a rule. They are also looking at policies to ensure that all teenage mothers have to be in contact with the women's centre to give them support.
Trinidad and Tobago
Ingrid Neckles

Facilities
Under the Ministry of Health, 114 health centres, 96 in Trinidad and 18 in Tobago, 7 major hospitals, 5 district hospitals, 30 private hospitals, all health centres provide family planning services at specific days and times. Nine VCCT clinics across Trinidad and Tobago.

Policies
- Population Programme responsible for SRH, HIV & AIDS Coordinating Unit, National SRH Programme under Technical Working Group
- Draft integration policy for HIV services
- Draft new national HIV Strategic Plan

Issues
HIV prevalence, particularly in Tobago as it has the highest national HIV prevalence at 2.4%

Challenges
- Legal frameworks – legal access to contraceptives above 18, health care professionals can provide contraceptives to 14 – 18 years olds depending on emotional maturity, consent is 16 while the age of sexual debut is 11 years

From SRH Assessment
- Overall availability of service
- Training
- Staffing, physical facilities always a problem
- Physical Facilities; Equipment
- Communications materials
- STI/HIV services
- Integration of other SRH services
- Services for men - we have to include the men more often as well services for adolescent and young persons

Lessons Learned
Recommendations of SRH Assessment
- Service delivery
- Vertical nature of services - integration required
- Review
- Establishment of adolescent friendly services
- A minimum package of services for all clients
- Written protocols for young people under the age of 16
- Establish special clinics for men, especially for MSMs, particularly teenage MSMs
- Determine protocols
- Training for contraceptives
- Structured training schedules for doctors and nurses in RH
- Integration and networking has been established between government units and PAHO and UNFPA

Discussion

Tobago Health Promotion Clinic
The presenter works at the Tobago Health Promotion Clinic and this has won a best practice award for discordant couples. The clinic includes five counselors, two doctors, two nurses, one gender counselor, one psychologist and the director is an HIV specialist. The programme is particularly focused on keeping people couples together. The presenter was asked if she could partake in an exercise to document best practices for UNFPA.
Discussion Points

Facilitator Marvin Gunter, UNFPA Regional Advisor HIV & AIDS, asked participants if there were any insightful moments for them related to the three themes of the workshop: SRH, RBM and Linkages with HIV & AIDS.

A participant from the Bahamas noted that the fact that Depo-Provera leads to reduced calcium absorption was something as a medical nurse she never knew about.

Another participant from Belize said what stood out significantly for her was the Caribbean specific MDGs. This was a total shock, very enlightening and something she still could not get over. She added that during advocacy with they used to focus on sexual health but if she had known about the Caribbean specific MDGs she might have chosen something else to focus on. It will become a tremendous new advocacy tool for her.

A participant from Suriname said that they were in the process of doing a project on GBV and in their last review they found that abortion is classed as violence and punishable by law. She was very surprised to hear that in Guyana a 13-year old girl is able to have a legal abortion. I thought Suriname and Guyana and their laws were quite similar.
Closure

**Marvin Gunther, UNFPA Regional Advisor HIV & AIDS:**

Thanks to Judith Brielle and Suriname branch office of UNFPA. Unfortunately the Regional Director Geetha Sethi could not be here, but Hernando Argudelo, the Deputy Director was sent in her place. Thank you to the sound engineers, the rapporteur, the hotel staff, the media, the photographer and all the facilitators, including Vertha Dumont, Patrice La Fleur, Melissa McNeil Barrett and Isuiwa Iyahen. Vertha will still get in touch with everyone about what you have learned about RBM and what you will be using in the future.

**Vertha Dumont, UNFPA M&E Specialist:**

We would also like to give a big thank you to Marvin for organizing this workshop.

**Marvin:**

Lastly we would like everyone to take a piece of paper and write down quickly two things you liked and two things you did not like about the workshop and anything else you would like to reflect on.
Annex 1: List of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
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<tbody>
<tr>
<td>1 Alba Ferguson</td>
<td>Belize</td>
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<td>2 Anne Matute</td>
<td>Belize</td>
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<td>3 Antoinette Brooks</td>
<td>Jamaica</td>
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<td>4 Beverly Ting a Kee</td>
<td>Suriname</td>
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<td>5 Branishka Lewis</td>
<td>The Bahamas</td>
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<td>6 Clonel Samuels</td>
<td>Guyana</td>
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<td>7 Diana Dornelly</td>
<td>St Lucia</td>
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<td>8 Elly van Kanten</td>
<td>Suriname</td>
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<td>9 Inder Gajadien</td>
<td>Suriname</td>
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<td>10 Ingrid Neckles</td>
<td>Trinidad &amp; Tobago</td>
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<td>11 Joyce Chambers</td>
<td>Jamaica</td>
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<td>12 Maeryl Maes</td>
<td>Suriname</td>
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<td>13 Mahelia Breidel</td>
<td>Suriname</td>
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<td>14 Marcia Paltoo, Dr</td>
<td>Guyana</td>
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<td>15 Maureen van Dijk, Dr</td>
<td>Suriname</td>
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<td>16 Melanie Montero</td>
<td>Belize</td>
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<td>17 Nester Edwards</td>
<td>Grenada</td>
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<td>18 Patricia Arrias</td>
<td>Suriname</td>
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<td>19 Roma Peroti</td>
<td>Suriname</td>
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<td>20 Sheila Yaw-Fraser</td>
<td>Guyana</td>
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<td>21 Erica Goldson</td>
<td>Belize</td>
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<td>22 Hernando Agudelo, Dr</td>
<td>Jamaica</td>
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<td>23 Ingrid Caffe</td>
<td>Suriname</td>
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<td>24 Isuwa Iyahen</td>
<td>Barbados</td>
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<td>25 Jason Shepherd</td>
<td>Guyana</td>
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<tr>
<td>26 Judith Brielle</td>
<td>Suriname</td>
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<td>27 Mario Aguilar, Dr</td>
<td>Jamaica</td>
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<tr>
<td>28 Marvin Gunter</td>
<td>Jamaica</td>
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<tr>
<td>29 Melissa McNeil Barrett</td>
<td>Jamaica</td>
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<td>30 Patricia La Fleur</td>
<td>Guyana</td>
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<td>31 Robin Tuenter</td>
<td>Suriname</td>
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<td>32 Rosienne Talman</td>
<td>Suriname</td>
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<td>33 Sher Ibisilio</td>
<td>Suriname</td>
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<tr>
<td>34 Tammy Yates</td>
<td>Trinidad &amp; Tobago</td>
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<tr>
<td>35 Vertha Dumont</td>
<td>Jamaica</td>
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Annex 2: Agenda
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Contents</th>
<th>Methodology</th>
<th>Facilitators</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Arrival and Registration</td>
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<tr>
<td>8:30 – 9:30</td>
<td>Welcome and Introduction</td>
<td>Introduction Review the objectives of the workshop and for Day 1 activities.</td>
<td>Presentation and group activity</td>
<td>Hernando Agudelo, Judith Brielle, Marvin Gunter</td>
<td>Build learning community and align participants' learning expectations</td>
</tr>
<tr>
<td>9:30 – 11:00</td>
<td>Result-Based Management Key Concepts</td>
<td>Introduce the participants to the concept and explain how important it is to use it to ensure the effectiveness of any interventions</td>
<td>Interactive power point presentation, group activity, discussion and Q &amp; A</td>
<td>Vertha Dumont</td>
<td>Increase understanding of the RBM concept and will be able to define the outcomes of their interventions in a more strategic manner</td>
</tr>
<tr>
<td>11:00 – 11:15</td>
<td>Reproductive Health</td>
<td>Review basic information about RH its component and relationship with human wellbeing and development.</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Mario Aguilar</td>
<td>Identify the basic concepts in RH and how to related the exercise of Reproductive rights with human well being and Development</td>
</tr>
<tr>
<td>1:00 – 2:00</td>
<td>Reproductive Health And The ICPD Agenda</td>
<td>Introduce the participant to the UNFPA mandate based on the ICPD agenda</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Melissa McNeil Barrett</td>
<td>Review the key pillars, concept and spirit of the ICPD and implication for UNFPA's mandate</td>
</tr>
<tr>
<td>2:45 – 4:00</td>
<td>Basic Demography</td>
<td>Basic concepts in Demography</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Mario Aguilar</td>
<td>Increase knowledge and understanding of key demographic terms and measurements used in Sexual Reproductive Health</td>
</tr>
<tr>
<td>4:00 – 4:15</td>
<td>RH situation in countries</td>
<td>Key issues, successes and challenges with SRH in the countries</td>
<td>Interactive presentation and discussion</td>
<td>Panel</td>
<td>Facilitate information sharing and technical exchange of programme skills, techniques and strategy</td>
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<tr>
<td>4:15 – 5:00</td>
<td>St Lucia and Grenada</td>
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END OF DAY 1 – Consolidation, wrap up and closure
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<tr>
<th>Time</th>
<th>Session</th>
<th>Contents</th>
<th>Methodology</th>
<th>Facilitators</th>
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</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Arrival, Registration and Welcome</td>
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<tr>
<td>9:00 – 9:45</td>
<td>Reproductive Health and the MDGs</td>
<td>The MDGs, including the main health related indicators</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Isiuwa Iyahen</td>
<td>Explore the MDGs and examine its relationship to sexual reproductive health and its impact on UNFPA's mandate</td>
</tr>
<tr>
<td>9:45 – 11:00</td>
<td>Planning for Results</td>
<td>Using the RBM concept to introduce the participants to the planning for results process</td>
<td>Interactive power point presentation, group activity, discussion and Q &amp; A</td>
<td>Vertha Dumont</td>
<td>Introduce the concept of comparative advantage, interest-group analysis and evidence in order to properly plan for results</td>
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<td>11:00 – 11:15</td>
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<tr>
<td>11:15 – 12:00</td>
<td>Adolescent Sexual and Reproductive Health Issues</td>
<td>Adolescent vulnerabilities and appropriate strategies for effective mitigation</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Patrice LaFleur</td>
<td>Increase understanding of the unique issue of adolescents and build capacity to programme effectively around them</td>
</tr>
<tr>
<td>12:00 – 1:00</td>
<td>RH situation in countries</td>
<td>Key issues, successes and challenges with SRH in the countries</td>
<td>Interactive presentation and discussion</td>
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<td>Facilitate information sharing and technical exchange of programme skills, techniques and strategy</td>
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<td>1:00 – 2:00</td>
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<tr>
<td>2:00 – 5:00</td>
<td>Family Planning and Contraceptives</td>
<td>Family Planning</td>
<td>Interactive power point presentation, group activity, discussion and Q &amp; A</td>
<td>Mario Aguilar</td>
<td>Enhance ability to identify the main contraceptive methods, use, indications, contraindication, side effects</td>
</tr>
</tbody>
</table>

END OF DAY 2 – Consolidation, wrap up and closure
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Contents</th>
<th>Methodology</th>
<th>Facilitators</th>
<th>Objectives</th>
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<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Arrival and Registration</td>
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<tr>
<td>9:00 – 10:00</td>
<td>Monitoring and Evaluation of Results  60 mins</td>
<td>Monitoring and evaluation terms, concepts and processes</td>
<td>Interactive power point presentation, group activity, discussion and Q &amp; A</td>
<td>Vertha Dumond</td>
<td>Introduce monitoring and evaluation concepts</td>
</tr>
<tr>
<td>10:00 – 10:45</td>
<td>Link Between HPV and Cervical Cancer 45 mins</td>
<td>Examining to the link between the sexually transmitted Human Papillomavirus (HPV) and Cervical Cancer</td>
<td>Interactive power point presentation, discussion and Q &amp; A</td>
<td>Mario Aguilar</td>
<td>Explain the link between HPV and Cervical Cancer</td>
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<td>10:45 – 11:00</td>
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<tr>
<td>11:00 – 11:45</td>
<td>RH situation in countries Jamaica and Trinidad and Tobago 45 mins</td>
<td>Key issues, successes and challenges with SRH in the countries</td>
<td>Interactive presentation and discussion</td>
<td>Panel</td>
<td>Facilitate information sharing and technical exchange of programme skills, techniques and strategy</td>
</tr>
<tr>
<td>11:45 – 12:30</td>
<td>Gender Based Violence and Reproductive Health 45 mins</td>
<td>Verbal, emotional, patrimonial, sexual and physical violence and SRH of women</td>
<td>Interactive power point presentation, group activity, discussion and Q &amp; A</td>
<td>Mario Aguilar</td>
<td>Discuss the impact of gender based violence in the reproductive health of women</td>
</tr>
<tr>
<td>12:30 – 1:00</td>
<td>Key Populations, Stigma and Discrimination 30 mins</td>
<td>Defining key populations Issues with SRH and key populations Opportunities to improve programming for with key populations</td>
<td>Interactive presentation, group activity, discussion and Q &amp; A</td>
<td>Vertha Dumont, Marvin Gunter</td>
<td>Facilitate candid introspection on our capacity to work with key populations and opportunities to enhance same</td>
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<tr>
<td>1:00 – 2:00</td>
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END OF DAY 3
Annex 3: Caribbean MDGs
CARIBBEAN SPECIFIC TARGETS & INDICATORS
(some renumbering of targets and indicators would have occurred as a result of the expansion of targets and indicators)

<table>
<thead>
<tr>
<th>Goals</th>
<th>Targets</th>
<th>Indicators</th>
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</thead>
<tbody>
<tr>
<td>1. Eradicate extreme poverty and hunger</td>
<td>1. Halve, between 1990 and 2015, the proportion of people who fall below the poverty line.</td>
<td>1. Proportion of population living below the poverty line by sex; 1(a). Proportion of households living below the poverty line, by sex of Head of Household 1(b). Proportion of employed living in households with a household per capita income which is below the poverty line, by sex of head of household 2. Poverty gap ratio, by sex; 3. Share of poorest quintile in national consumption, by sex;</td>
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<tr>
<td></td>
<td>2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.</td>
<td>4. Prevalence of under weight children under 5 years of age by sex; 5. Proportion of population below minimum level of dietary energy consumption by sex.</td>
</tr>
<tr>
<td></td>
<td>3. Halve, between 1990 and 2015, the proportion of persons without access to basic services.</td>
<td>6. Proportion of households with access to electricity by sex of head of household; 7. Proportion of households using pit latrines by sex of head of household.</td>
</tr>
<tr>
<td>2. Achieve universal primary and secondary education</td>
<td>4. Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary and secondary schooling, up to Form 5.</td>
<td>8. Net enrolment ratio in primary education by sex; 9. Proportion of students of school age attending primary school by sex and grade; 9(a). Proportion of students of school age attending secondary school by sex and form; 10. Proportion of pupils starting Grade 1 who reach Grade 5 by sex; 11. Net enrolment ratio in secondary education by sex; 12. Proportion of students starting Form 1 who reach Form 5 in secondary school by sex; 13. Proportion of students who complete secondary school</td>
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<tr>
<td>Goals</td>
<td>Targets</td>
<td>Indicators</td>
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<td>at Form 5 with passes in at least two subjects English (or official language of country), and Maths by sex;</td>
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<td>14. Literacy rate of persons 15-24 year olds by sex;</td>
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<td>15. Proportion of students in secondary schools in 5th Form enrolled in science and technical subjects, by sex</td>
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<td>15(a) Proportion of teachers trained in the area of gender sensitisation</td>
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<td>16. Proportion of schools implementing a gender-sensitisation programme</td>
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<td>17. Proportion of children in class above the average age of the class, by sex</td>
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<td>17(a) Proportion of children in class below the average age of the class, by sex</td>
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<td>18. Percentage of trained teachers in primary schools by sex;</td>
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<td>18(a) Percentage of trained teachers in secondary schools by sex;</td>
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<td>19. Average class size by grade/form</td>
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<td>5. Ensure that, by 2015 pre-school age children have universal access to early childhood education</td>
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<td>20. Proportion of children attending early childhood education institutions, by sex</td>
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<td>21. Ratio of girls to boys in primary enrolment</td>
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<td>22. Ratio of girls to boys in secondary enrolment</td>
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<td>23. Ratio of girls to boys in tertiary enrolment;</td>
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<td>24. Ratio of literate women to men of 15-24 years;</td>
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<td>25. Proportion of students who take Mathematics and at least one of the Sciences in examinations (CXC or equivalent) at 5th Form by sex;</td>
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<td>7. Eliminate gender disparities in income and occupational opportunities at all levels and in all sectors, no later than</td>
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<td>26. Share of women in wage employment in the non-agricultural sector;</td>
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<td>27. Average earned income (gross) of men and women by</td>
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<td>4. <strong>Reduce child mortality</strong></td>
<td>10. Reduce by two-thirds between 1990 and 2015, the under-five mortality rate.</td>
<td>37. Under five mortality rate by sex; 38. Infant mortality rate by sex; 39. Proportion of children 1-4 years of age who have</td>
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<td>8. <strong>Reduce by 60%, the incidence of physical acts of gender based violence by 2015.</strong></td>
<td>32. Incidence of reported physical abuse by sex of the abused; 33. Number of persons per 1,000 population who have been victims of major crimes, by sex 33(a) Average age of victim of major crimes, by sex 34. Number of persons per 1,000 population who have committed major crimes, by sex 34(a) Average age of offender who have committed major crimes, by sex 35. Number of persons per 1,000 population who have experienced physical violence in the past 12 months at the hands of spouse/partner, by sex 35(a) Average age of persons who have experienced physical violence in the past 12 months at the hands of spouse/partner, by sex</td>
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<td>2015.</td>
<td>28. Proportion of the employed persons by occupational group and sex; 29. Proportion of seats held by women in national parliament; 30. Proportion of women holding office in local government. 31. Proportion of women in other decision-making occupations;</td>
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<td>received complete immunisation coverage (BCG, 3 doses DPT, oral polio and measles); 40. Number of deaths of children through violence per 1,000 population under 5, by sex 40(a) Average age of children under 5 who died through violence, by sex 40(b) Number of perpetrators responsible for the death of children under 5, by sex 40(c) Average age of perpetrators responsible for the deaths of children under 5, by sex</td>
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<td>14. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.</td>
<td>52. Proportion of children orphaned by HIV/AIDS by age group; attendance of non-orphans 14 and under;</td>
<td>53. Prevalence of malaria by sex and age; 53(a) Death rates associated with malaria by sex and age;</td>
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<td>7. Ensure environmental sustainability</td>
<td>54. Proportion of population in malaria risk areas using effective malaria preventative and treatment measures;</td>
<td>55. Prevalence of tuberculosis, by sex and age; 55(a) Death rates associated with tuberculosis, by sex and age;</td>
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<td>15. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.</td>
<td>56. Proportion of tuberculosis cases detected and cured under DOTS.</td>
<td>57. Prevalence of Dengue, by sex and age; 57(a) Death rates associated with Dengue, by sex and age;</td>
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<td>16. Halve by 2015 the proportion of people without sustainable access to drinking water and to improve sanitation.</td>
<td>58. Prevalence of selected chronic non-communicable diseases by sex and age; 58(a) Death rates associated with selected chronic non-communicable diseases by sex and age;</td>
<td>59. Proportion of land area covered by forest;</td>
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<td>17. Have achieved by 2020 significant improvement in the lives of at least 70% of persons living in poor communities.</td>
<td>60. Ratio of area protected to maintain biological diversity to surface area;</td>
<td>61. Energy use (kg oil equivalent) per $1 GDP (PPP);</td>
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<td>62. Carbon dioxide emissions (per capita);</td>
<td>63. Proportion of population using solid fuels by type of tenure;</td>
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<td>64. Proportion of population with sustainable access to an improved water source;</td>
<td>65. Proportion of population with access to improved sanitation facility, urban/rural;</td>
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<td>66. Proportion of households with own dwelling;</td>
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<td>18.</td>
<td>Ensure the availability of a vulnerability index for the Caribbean which is sensitive to economic, social and environmental threats within the next five years.</td>
<td>67. Percentage of coral reefs destroyed by human activity and by natural disasters; 68. Incidence of natural disasters; 69. Economic losses resulting from natural disasters; 70. Social dislocation resulting from natural disasters;</td>
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<td>8. Develop a global partnership for development</td>
<td>19. Develop further an open ruled-based predictable, non-discriminatory trading and financial system.</td>
<td>ODA 71. Net ODA as a percentage of OECD/DAC donors’ gross national product (targets of 0.7% in total and 0.15% for LDCs); 72. Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water and sanitation). 73. Proportion of ODA that is untied; 74. Proportion of ODA for environment in Small Island Development States; 75. Proportion of ODA for transportation in land-locked countries.</td>
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<td>20. Address the special needs of the Least Developed Countries, LDCs, (includes tariff and quota free access for LDCs' exports; enhanced programme of debt relief for HIPCIs and cancellation of official bilateral debt; and more generous programmes of debt relief for countries committed to poverty reduction).</td>
<td>Market Access 76. Proportion of exports (by value and excluding arms) admitted free of duties and quotas; 76(a) Export of services as a proportion of total goods and services exported 77. Average tariffs and quotas on agricultural products and textiles and clothing from developing countries; 78. Agricultural subsidies for OECD countries as a percentage of Gross Domestic Product for respective countries, 79. Cost of implementing sanitary/phytosanitary measures as a percentage of the total value of exports for which these measures are required; 80. Proportion of ODA provided to help build trade capacity.</td>
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<td>21. Address the special needs landlocked countries and SIDS.</td>
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<td>22. Deal comprehensively with the debt problems of developing countries, through national and international measures in order to make debt sustainable in the long term.</td>
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| **Debt Sustainability**                                             |                                                                                                                                                                                                      | 81. Proportion of official bilateral HIPC debt cancelled;  
82. Debt service as a percentage of export of goods and services;  
83. Proportion of ODA provided as debt relief;                                                                                       |
| 23. In cooperation with developing countries, develop and implement  | 84. Unemployment rate by sex;  
84(a) Unemployment rate for the 15-24 age group by sex                                                                                                                   |
| strategies for decent and productive work for youth, women and especially vulnerable groups.                         |                                                                                                                                                                                                      |                                                                                                                                                                                                         |
| 24. In cooperation with pharmaceutical companies, provide access to | 85. Proportion of population with access to affordable essential, approved drugs on a sustainable basis;                                                                                               |
| affordable internationally approved essential drugs in developing   |                                                                                                                                                                                                      |                                                                                                                                                                                                         |
| countries.                                                           |                                                                                                                                                                                                      |                                                                                                                                                                                                         |
| 25. In cooperation with the private sector, make available the       | 86. Telephone lines per 1,000 people;  
87. Personal computers per 1,000 people;  
88. Ratio of personal computers/laptops available for use in primary and secondary schools to number of students enrolled in primary and secondary schools (respectively);  
89. Ratio of ministerial/departmental websites used in providing information to the population to the number of ministries/departments within the government.  
90. Internet users per 100 population  
91. Cellular subscribers per 100 population.                             |                                                                                                                                                                                                         |