



# Blueprint to Address the Sexual and Reproductive Health Care and STI/HIV Prevention Needs of Adolescent Girls and Young Women in Latin America and the Caribbean



## Document Description

Biological and social vulnerabilities increase the risk of acquiring sexually transmitted infections, including HIV, in adolescent girls and young women in the Latin America and Caribbean (LAC) region. This “Blueprint to Address the Sexual and Reproductive Health Care and STI/HIV Prevention Needs of Adolescent Girls and Young Women in Latin America and the Caribbean” will provide an overview of the major health care issues faced by this high-risk population and examine the obstacles that reduce access to reproductive and sexual health services. The Blueprint is also meant to guide clinicians and health administrators in the LAC region to consider the most common points of entry into the health care system for this vulnerable population, and interventions to assure comprehensive sexual and reproductive health care in primary and specialty care settings. Regional health care providers, health administrators, and policy makers in the LAC region may also use this Blueprint to develop a regionally relevant, country-specific plan for decreasing HIV, sexual, and reproductive health risk among adolescent girls and young women.

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## Disclaimer

Normative guidance such as that contained in this Blueprint cannot always account for individual variation among patients. The recommendations made in this Blueprint are not intended to supplant clinician judgment with respect to particular patients or special clinical situations. IAPAC considers adherence to the recommendations made in this Blueprint to be voluntary, with the ultimate determination regarding their application to be made by the clinician in the light of each patient's individual circumstance.

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## Introduction

The health of a community and a nation depends upon equitable access to comprehensive primary and specialized health care resources to all members of the community, regardless of gender, sexual identity, race, ethnicity, or socioeconomic status, including those groups in the community who are marginalized and stigmatized. Because of biological and social vulnerabilities, adolescent girls and young women in Latin America and the Caribbean (LAC) have high rates of acquisition of sexually transmitted infections (STIs), particularly human immunodeficiency virus (HIV), the infection that causes acquired immunodeficiency syndrome (AIDS). Stigma and discrimination and the same vulnerabilities that threaten the health of this population make accessing comprehensive health care services difficult for this high risk population.

## Situational Analysis: HIV in the LAC Region

The number of people living with HIV worldwide continues to rise because of the continued incidence of new infections and decreased mortality from successful treatment with antiretroviral therapy (ART). The number of people newly infected with HIV per year continues to decrease since peaking in 1996. Additionally, because of the benefits of ART and increased availability of treatment worldwide, the number of AIDS-related deaths per year peaked in 2004 and has decreased annually since then. Overall, the prevalent number of people infected with the virus worldwide continues to increase.

The HIV pandemic has demonstrated remarkable geographic variation within and between countries in regards to the prevalence of infection, the modes of transmission, and the populations that are most commonly infected within the epidemic. The World Health Organization (WHO) therefore recommends using epidemiological data from individual countries and regions to ground strategies and interventions targeted at the populations who are most at risk for acquiring HIV to prevent the virus' further transmission (UNAIDS/WHO, 2009).

### THE HIV EPIDEMIC IN LATIN AMERICA

There is marked regional variability in the LAC region's HIV epidemic. The number of adults and children living with HIV has largely stabilized in Latin America, and currently 2 million adults and children are infected. Percent prevalence of HIV among adults has shown a small increase from 0.5% in 2001 to 0.6% in 2008. This increased prevalence has been fueled by an increase in the annual incidence of new infection from 150,000 per year in 2001 to 170,000 in 2008. At the same time, the number of AIDS-related deaths per year rose from 66,000 in 2001 to 77,000 in 2008. Within Latin America, the epidemic has shown dramatic variations between different countries and regions (UNAIDS/WHO, 2009). Brazil has been noted for its strong efforts to use evidence from its own epidemic to guide the design of interventions to reduce HIV transmission (Okie, 2006). Other countries in the region have been less successful at aiming interventions at the populations most at risk based on evidence of transmission patterns individualized to the unique data of that country's epidemic. In Latin America, national epidemics are generally concentrated among men who have sex with men (MSM), injection drug users (IDUs), and sex workers, but efforts to mitigate HIV transmission have not been concentrated in these populations. High rates of treatment with ART among those infected with HIV, however, have helped to slow the epidemic and health providers are starting treatment sooner in the course of infection (UNAIDS/WHO, 2009).

### THE HIV EPIDEMIC IN THE CARIBBEAN

In the Caribbean region, the HIV epidemic has shown marked variability. The region has been more heavily impacted by HIV than any other region outside of sub-Saharan Africa with a prevalence of 1.0% among adults. HIV incidence has declined sharply in the region, though most of the Caribbean has seen

a stabilization in the rates of new infection (UNAIDS/WHO, 2009). Lack of behavioral data makes determinations of why these variations occurred difficult. In some areas such as Cuba, new HIV infections have been on the rise since 1996 perhaps because of improvements in the efficiency of their detection system (De Arazoza, 2007). Prevalence varies considerably in the Caribbean from very low prevalence in Cuba to 3% prevalence in the Bahamas (UNAIDS/WHO, 2009). Overall, the number of adults and children living with HIV infection in the Caribbean has remained steady from 220,000 in 2001 to 240,000 in 2008, with an equally stable number of annual new infections of 21,000 in 2001 and 20,000 in 2008. Meanwhile the number of annual deaths from HIV/AIDS decreased from 20,000 in 2001 to 12,000 in 2008, and there was a small decrease in the percent prevalence of HIV among adults in the Caribbean from 1.1% in 2001 to 1.0% in 2008 (UNAIDS/WHO, 2009).

The transmission pattern and the risk groups affected by HIV in the Caribbean region are different from those in Latin America. In the Caribbean, women account for half of HIV infections and the prevalence is especially high in young and adolescent women (UNAIDS/WHO, 2009). Even within a single country, HIV prevalence can vary considerably. In Haiti, for example, 2006-2007 estimates of HIV prevalence among pregnant women showed 0.75% in one antenatal site in western Haiti and 11.75% in an urban setting (Gaillard & Eustache, 2007).

#### LOW PREVALENCE AND CONCENTRATED HIV EPIDEMICS

The low prevalence of HIV infection in the LAC region makes broad and generalized coverage of HIV testing and sexual health services less practical. Instead, efforts at HIV prevention should be targeted at specific vulnerable populations in which the epidemic is concentrated. In the 1990s, the HIV epidemiologic transmission patterns of HIV infection changed in the LAC region, and the proportion of women among the population of people infected with HIV increased rapidly. In the last decade, the gender differential stabilized so that women constitute 34% of the population infected with HIV in Latin America and 48% in the Caribbean (UNFPA/WHO, 2006). Young women and adolescent girls in the LAC region are now at high risk of acquiring STIs, and particularly HIV infection, because biological and social conditions make them vulnerable.

## HIV Risk Factors among Adolescent Girls and Young Women in the LAC Region

Many factors may increase vulnerability to HIV among young women and adolescent girls in the LAC region. HIV risk in this population is associated with sexual behaviors of the women themselves, the behaviors of their male partners, age and power differentials in sexual relationships, and the presence of transactional sex. The following sections will further define the rationale for targeting this high-risk population for HIV prevention in the LAC region's low prevalence and concentrated HIV epidemic.

#### SEXUAL BEHAVIOR OF YOUNG WOMEN

**Age of sexual debut** – Women are usually infected through sex with their steady male partners, reflecting biological vulnerability and socioeconomic inequalities related to gender-based power differentials in their sexual relationships. A variety of factors that affect the health of adolescent girls and young women confer risk for STIs and particularly HIV infection. Among these is the high incidence of early sexual debut. In a study of 15,695 adolescent students age 10 to 18 selected from nine Caribbean countries and surveyed in their school, one third reported prior sexual intercourse. In females with sexual experience, one quarter reported first intercourse at age 10 or less, and almost two-thirds reported the first episode was before age 13 (Halcon, 2003).

**Married young women** – Women who have sex within marriage are often presumed to be safe from STIs, including HIV. Many HIV prevention interventions emphasize abstinence until marriage, but this may not confer complete protection to young women. International surveys indicate that early marriage before the age of 20 is common in the LAC region and that married adolescent girls are more likely to have unprotected sex than unmarried adolescent girls. In addition, the first year of marriage, when couples are attempting to conceive their first child, is often the most sexually active period of time. Because married adolescents spend less time in school and have less access to media, they are less attuned to HIV prevention and other sexual health messages. Indeed, married adolescent girls are less likely than unmarried sexually experienced adolescents to be able to identify a viable way to avoid HIV. HIV prevention methods identified by unmarried women, such as abstinence or use of condoms, may not be feasible options for married adolescents who rely on their partner’s monogamy. The age differential between spouses tends to be larger than that between unmarried partnerships, and this may make sexual negotiations and control of the partner’s sexual behavior more difficult for married adolescents even when they are faithful themselves (Clark, 2006).

**Beliefs that impact HIV risk** – Adolescent girls and young women are also at high risk of acquiring HIV because of beliefs common throughout the region. A study among Jamaican adolescents identified a number of common beliefs that hamper HIV prevention messages: religious beliefs; self-consciousness about the use of condoms; belief that condoms hinder sexual pleasure or a Rastafarian belief that they “take something away”; belief that condoms lack efficacy for prevention of sexually transmitted infections and HIV; belief that HIV can be spread through contact with perspiration, mosquitoes, and toilet seats; belief that the United States sent AIDS to Jamaica in condoms; and finally, belief that HIV can be cured by having sex with a virgin. These beliefs impede the dissemination of accurate HIV prevention messages (Hutchinson, 2007).

Detailed sexual behavioral data are limited in the Caribbean region. However, heterosexual sex seems to be the most common risk factor for HIV acquisition. A 2004 behavioral survey in Jamaica showed that almost half of young men and 15% of young women had more than one partner in the previous 12 months (National HIV Program, 2008). In the Dominican Republic, the prevalence of HIV among young people has declined due to increased use of condoms and decreased multiple partnerships in men (Halperin, 2009). More behavioral data are needed to better understand the intricacies of the current epidemic and the impact of interventions applied thus far.

**Impact of sex work** – In the Caribbean region, the risk of HIV acquisition with heterosexual sex appears to be linked to sex work (UNFPA/WHO, 2006). In a 2001 survey, 2% of women in Haiti and 1.8% of women in the Dominican Republic participated in sex work (Vandepitte, 2006). Rates of HIV infection are as high as 27% among sex workers in Guyana in data from 2005 (Presidential Commission on HIV and AIDS, 2008). Sex work also plays a role in HIV transmission in Latin America, with 0.2% to 1.5% of women involved in sex work (Vandepitte, 2006), though rates of HIV seropositivity among sex workers are not as high (3.2-4.3%; Soto, 2007). The same serosurvey conducted in five countries in Central America found an 85% seroprevalence of HSV-2 among female sex workers (Soto, 2007). In a study of sex workers in Mexico, concurrent injection drug use was found to be an independent risk factor for acquisition of HIV (Strathdee, 2008). Because of its impact on HIV risk in young women in the LAC region, transactional sex and sex work will be discussed more fully below.

#### BEHAVIORS OF MALE PARTNERS

Adolescent boys in Jamaica reported pressure from their fathers and from society in general with regards to the importance of early and frequent sexual encounters for adolescent males and to have sex with multiple partners in order to prove their masculinity and to refute homosexuality; these beliefs were echoed by

adolescent girls in the study. Boys also reported that girls are often unaware that their male partner has multiple partners and do/will not mind as long as they are considered the most important (Hutchinson, 2007). Adolescent girls in Jamaica described societal expectations that they should wait until marriage to have sex and yet felt intense pressure from same age and older partners to have sex, and had even experienced coerced or forced sex. The presence of older powerful men (“big men” or “dons”) who supported girls and their families with money or material goods in return for sex were frequently cited in the community as well. In these relationships, girls reported having little or no power to refuse sexual relations or to negotiate the use of condoms or the partner’s sexual behaviors for fear of loss of financial support for themselves and their families and for fear of consequence of violence and even murder (Hutchinson, 2007).

Men who have sex with men are another high risk population greatly affected by the HIV epidemic in the LAC region, and they are likely to play a role in the HIV epidemic among women as well. Because of stigma against same-sex relationships in the region, MSM may have female partners to mask relationships with other men (PAHO, 2010). A survey in five Central American countries demonstrated that 22% of MSM reported having sex with both men and women (Soto, 2007).

### **INTERGENERATIONAL RELATIONSHIPS**

Intergenerational relationships, with a notable age difference between the male and female partners, put young women at risk for acquisition of STIs and HIV. In men, infections can be asymptomatic with few health consequences that warrant screening from an individual perspective. It is not currently recommended that men be routinely screened for STIs and, therefore, the prevalence of infections increases in men as they age. For this reason, along with various sociocultural dynamics, young women who have sexual relationships with older men may be at higher risk of HIV acquisition.

Intergenerational relationships are frequent among young women in the LAC region for a variety of reasons. Young women may have sexual relationships with older men of power (“dons,” “sugar daddies,” “big men”) in the community in return for financial support or security for themselves and their families (Clark, 2006; Hutchinson, 2007). These relationships may be motivated by a desire to protect the security of a young woman’s family in a culture influenced by the violence of the drug trade. Young women also feel pressure to marry or have relationships with older men to gain financial security (ICW, 2004). When there is not other work available, women may feel pressure to enter sex work as the only option to support themselves and their families (ICW, 2004). Sex work is more likely to occur in environments where there are large economic disparities and there are clients who can pay and women for whom the economic situation is so dismal that sex work for money is attractive and feasible (Barrientos, 2007).

### **SEXUAL ABUSE, VIOLENCE, AND RAPE**

The rationale for targeting young women and adolescent girls for HIV prevention also includes their high risk for sexual abuse, violence, and rape. The experience of violence – and sexual violence in particular – is common among young people in the LAC region (Halcon, 2003; Gomez, 2009; Baker-Henningham, 2009). Children are exposed to significant violence in their homes, schools, and communities and report aggressive behavior among their peers, physical punishment at school, and experience of violence in the community (Baker-Henningham, 2009). Violence is pervasive throughout the lives of young people. In a large cohort of 15,695 students age 10 to 18 from nine Caribbean countries, 15.9% reported having sustained physical abuse. One-fifth of the boys reported carrying a weapon to school in the last 30 days. Ten percent of boys and 5% of girls reported they had been stabbed or shot (Halcon, 2003).

Of the adolescents surveyed, 10% also reported sexual abuse from a variety of sources: adults inside or outside the home, other teens, or siblings. In addition, one-third of adolescents reported prior sexual intercourse, and of those, half said their first episode of intercourse had been forced (Halcon, 2003). The incidence of sexual violence appears to increase with age. In a group of 15 to 24 year old females, 18% reported prior experience of sexual violence (Gomez, 2009).

In a study in adolescents in Jamaica, many cultural factors and attitudes were elicited in the teens that were studied. Perceived norms and attitudes about premarital sex were different for boys and girls. Both boys and girls agreed that if a girl did not have sex, the boy would find another partner who would. The adolescents also agreed that coerced sex was common and girls reported being forced to have sex (Hutchinson, 2007).

Domestic violence, or violence within the family, is also common and occurs among all social strata (Nagassar, 2010). The effects of domestic violence are far-reaching and extend beyond the family itself with physical, psychological, financial, and societal consequences. Abuse can be physical, sexual, psychological, or financial. Psychological abuse and its effects may be less visible than physical or sexual violence, but it includes verbal abuse like cursing or demeaning language, criticism, forced isolation from family and friends, extreme jealousy or possessiveness, and personal property destruction. Financial abuse can consist of restricting funds for household needs, gambling away money intended for necessary items, intentionally accumulating debts, and selling of needed personal or household items (Nagassar, 2010).

#### **LACK OF POWER IN SEXUAL RELATIONSHIPS**

Young women may be unable to assert themselves to negotiate safer sex because of poor confidence and lack of power in their sexual relationships (ICW, 2004). Lack of power in a sexual relationship can come from the age differential inherent in intergenerational relationships, from the transactional nature of a relationship in sex work, or in the context of a forced sexual relationship or a relationship influenced by a threat of violence. Regardless of the causes, the outcome is the same. The woman is unable to choose or to control the use of methods to protect herself from STIs and HIV.

In addition, situations of poverty and economic inequality place women at great risk for loss of power in sexual relationships and increase the risk of gender-based violence (ICW, 2004). All women and all people have a right to freedom from stigma, discrimination, coercion and violence (International Conference on Population and Development, 1994a).

#### **TRANSACTIONAL SEX**

Transactional sex involves a relationship in which one partner enters into the relationship in return for something other than the pleasure of the relationship itself. Young women may enter a relationship in return for money, support of the family, or drugs. This category would include sex work. In many countries, sex work is legally abolished, but in other locales, it may be controlled or regulated by the police. Nearly everywhere, sex work is clandestine, and workers are stigmatized and therefore difficult to count and provide care to in health care settings (Barrientos, 2007).

Young women (“jineteras” or “fleteras”) may also exchange sex for goods, favors, or money they see as “scholarships” and not as remuneration for sex work. Young women may offer to accompany tourists into resorts, restaurants, or hotels where they would otherwise not be permitted access or could not afford to go without the tourist’s payment (Pope, 2005; Garcia, 2010). Some women also believe that this type of arrangement will ultimately continue as a romantic relationship which offers the ability to obtain

a foreign visa and to leave her home country (Pope, 2005). For other women, the desire to attain a job position or climb the social ladder may be an incentive to trade sex (Garcia, 2010).

Risk factors that increase a sex worker's vulnerability to HIV include higher number of daily clients, frequency of sexual intercourse, irregular condom use, history of prior STI(s), and drug use. Consistent condom use by sex workers is less with non-paying customers than paying customers and decreases with perception of intimacy in the relationship. Low-income women may have more difficulty negotiating condom use with their partners, perhaps due to financial dependence on the partnership. Studies have also shown that sex workers may not ask their clients to use condoms because they fear violent reaction from the customer. Asking clients to use condoms may also imply an undesirable lack of intimacy. Sex workers also report increased earnings when customers are willing to pay more for unprotected sexual intercourse (Murray, 2007).

Interventions among female sex workers have been undertaken in some regions of the LAC region with some success. A survey was conducted among 626 female sex workers in five clinics specializing in the provision of services related to STIs in Santiago, Chile, who had been exposed to peer-education interventions to increase their knowledge about HIV risk and skills in negotiating use of condoms with clients. The survey revealed that nearly all the women (93.4%) reported always using condoms with clients. However, among the 66.9% who reported having a steady partner, only 9.9% reported always using condoms with their steady partners (Barrientos, 2007). Condom use was also related to relationship intimacy among sex workers in Honduras where condom use was higher with clients than with casual or regular partners (96.7% with clients, 40.7% with casual partners, and 10.6% with regular partners) (UNAIDS/WHO, 2009).

Similar interventions have also been trialed in other locations. Female sex workers in Guatemala received a multilevel intervention that demonstrated a four-fold reduction in HIV incidence and an increase in consistent condom use (Sabido, 2009). In El Salvador, the rate of condom use with non-paying partners increased four-fold between 2004 and 2007 (UNAIDS/WHO, 2009). The challenge is to broaden coverage of this type of intervention to sex workers who work in different environments where sex work is illegal and women are hard to reach because of stigma. For example, it may be more difficult to include sex workers who work in the street rather than in a brothel or club because of increased police pressure and fear of risk of violence in the street. Access to HIV prevention messages and interventions should be provided within STI clinics to assure continuity and access to care for those who may be stigmatized for sex work by the police with risk of legal action when sex work is punishable. In addition, access to care by sex workers is influenced by consideration of the time at which care is available. Later clinic hours can be beneficial in improving access as sex workers usually work at night and sleep during the day (Barrientos, 2007).

## **Obstacles to Health Service Access for Adolescent Girls and Young Women in the LAC Region**

Socioeconomic inequalities present in women in the LAC region are associated with differences in sexual behavior and sexual experience resulting in a relationship between earlier unions and earlier sexual experience in women with lower levels of education (Bozon, 2009). Lower levels of education are more common among children living in poverty because they may be withdrawn from school when there is not enough money to pay school costs. They may also leave school to gain wage-earning work or help in the home caring for ill family members. In general, more value is placed in educating boys, so the lack of education affects girls more than boys. Women with less education have decreased access to information about STI and HIV prevention (ICW, 2004).

Current HIV prevention programs largely target individual behaviors, and more community-based programs are needed to address broader social, economic, institutional, and personal factors that increase the vulnerability of individuals to sexual risk. These programs should be targeted to specific high risk populations that are identified as vulnerable based on accurate, up-to-date information on the current status of the HIV epidemic in the local region (Garcia-Calleja, 2009). Because there is great variability in the epidemic from country to country and region to region throughout the LAC region, countries need more support to improve collection, analysis, and use of data to create and improve programs to reduce risk for acquisition of STIs and HIV (Garcia-Calleja, 2009).

### HIV SURVEILLANCE

Some countries have been highly successful in curbing the HIV epidemic locally. Cuba has greatly reduced the prevalence of HIV by intensively testing for HIV, interviewing HIV-positive individuals about their sexual behavior and contacts, and conducting contact tracing to locate sexual partners (de Arazoza, 2007). This approach may be limited by the availability of local resources in each country. Individual countries and local regions need additional support to give them the ability to assess the local epidemic and the impact of current measures to limit the HIV epidemic and take steps to mitigate its spread further.

In low prevalence, concentrated epidemics found in the LAC region, the WHO recommends that surveillance for HIV be conducted among certain selected high risk populations, for example, sex workers. Currently, only 17 of 29 countries in the LAC region conduct surveillance for HIV in sex workers and only 11 of 29 countries do so with appropriate frequency of testing, every one to three years (WHO/UNAIDS/UNICEF, 2010).

### HIV PREVENTION

Some countries have made efforts to conduct prevention efforts in high risk populations like sex workers but access to condoms and information about STI and HIV prevention varies by country. In the LAC region overall, 76% of sex workers had access to HIV prevention programs over the prior 12 months, but coverage varied considerably among countries reporting (from 21% in Colombia to 97% in Cuba) (WHO/UNAIDS/UNICEF, 2010).

The WHO recommends that appropriate HIV prevention programs should include access to condoms and water-based lubricant and counseling on consistent and proper use of condoms (WHO/UNAIDS/UNICEF, 2010). Only 57% of pregnant women in the LAC region received HIV counseling and testing in 2009 and increased screening coverage is needed in order to determine the needs for further interventions to decrease maternal to child transmission of HIV (WHO/UNAIDS/UNICEF, 2010).

The global burden of STIs remains high, and early STI detection is critical in controlling the transmission of HIV, especially in populations of people with multiple sex partners. Interventions to prevent HIV among sex workers have been tested around the world (WHO, 2010), but have been difficult to scale up to have large impact on HIV transmission as a whole because of inadequate access for many sex workers due to stigma and the illegality of sex work. Police efforts against the illegal sex trade makes access to care difficult for women whose work is stigmatized (Barrientos, 2007). Similar efforts to design interventions to target other vulnerable high-risk groups of young and adolescent women who have sex in relationships outside of sex work are needed as well.

### CONSENT FOR HEALTH CARE

Some young women also have difficulty accessing needed sexual and reproductive health care because of the need for parental consent to obtain care. The age of majority differs depending on local law and cus-

tom, and health care providers should make themselves familiar with their own situation. Abortion laws, in particular, differ throughout the world. In many countries, there is a need for parental consent or spousal consent prior to obtaining an abortion for termination of pregnancy. The restrictiveness or permissiveness of these laws differs greatly. Some countries restrict the timing when abortions can occur during pregnancy. Some countries make concessions for abortion in cases of rape, incest, or endangerment of the woman's health, but others do not. Familiarity with local laws and customs is thus essential (Center for Reproductive Rights, 2009).

## Addressing the Reproductive and Sexual Health Needs of Adolescent Girls and Young Women

The WHO's strategy to improve reproductive and sexual health encompasses five targets (WHO, 2004): 1) improving antenatal, delivery, postpartum, and newborn care; 2) providing high-quality services for family planning, including infertility services; 3) eliminating unsafe abortion; 4) combating STIs, including HIV, reproductive tract infections, cervical cancer and other gynecological morbidities; and 5) promoting sexual health.

The WHO further specifies a set of measures and indicators for monitoring each of these goals. Within this framework, and with the goal of decreasing rates of HIV infection in the LAC region, diagnosis and treatment of STIs is a high priority, particularly in countries or populations with high rates of HIV infection. Further, primary care or specialty clinics in which patients are treated for STIs are an ideal setting for interventions and educational programs for HIV prevention. Offering HIV prevention counseling within the health care setting when an STI is diagnosed and treated broadens access to counseling in high risk populations who might not otherwise have access to care in another setting, for example sex workers or adolescent girls.

### STI MANIFESTATIONS

According to WHO estimates, more than 340 million new STI cases occur annually. A series of guidelines was designed by the WHO and updated in 2007 to expedite treatment of STIs in the clinical setting (WHO 2007b). These guidelines suggest the utilization of a syndromic approach to the diagnosis of the most common pathogens causing groups of symptoms and signs (syndromes) that suggest STIs at the first contact with the health care setting. This approach decreases missed opportunities for diagnosis of STIs and is useful for diagnosing STIs quickly without special laboratory equipment. First, providers must be adequately trained to use a flowchart system for diagnosing and treating STIs and appropriate drugs must be widely and affordably available in order for the syndromic approach to work as indicated (WHO, 2007b).

Table 1 on the following page lists the common STIs and reproductive tract infections (WHO, 2005b) and some related syndromes (UNFPA/WHO, 2006) which can be considered and managed using this approach.

In the syndromic approach, the health care provider determines the plan for treatment based upon the patient's current symptoms on presentation for care and the complex of clinical signs found upon examination. These guidelines are intended as a starting point for creating local protocols based upon specific data available for the local epidemic of infection (WHO, 2007b).

Patients may become upset when told they have an STI and particularly if they have to notify a partner of the diagnosis. When using the syndromic approach to treat STIs presumptively, it may be helpful to counsel the patient that no screening test is perfect all of the time and that diagnosis can be nonspecif-

ic. The serious consequences that can occur from missing the diagnosis can justify treatment in this situation of uncertainty (WHO, 2005b).

The syndromic approach can be useful in diagnosing, evaluating, and managing STIs and reproductive tract infections and related syndromes that are commonly found in young women and adolescents. The following sections describe some common syndromes that can be managed with this approach.

**Abnormal vaginal discharge** – Abnormal vaginal discharge is a manifestation of either **vaginitis** or **cervicitis**. Clinical differentiation of the two entities requires internal vaginal examination with direct visualization of the cervix. Definitive diagnosis of which organism(s) is/are present relies upon collection and analysis of laboratory specimens which may not be feasible in resource-limited settings. Therefore the syndromic approach recommended by WHO can be utilized to determine which treatments are most appropriate to broadly cover for the most common organisms which cause the patient’s symptoms. If an examination or laboratory assessment is possible, treatment can be narrowed more specifically (WHO, 2007b).

**Vaginitis** causing vaginal discharge is commonly caused by bacterial vaginosis, trichomoniasis, or candidiasis. Gonorrheal and chlamydial infections can cause **cervicitis** associated with vaginal discharge but may also be asymptomatic. Because the consequences of untreated gonorrhoea and chlamydia are serious and include infertility, pelvic inflammatory disease, ectopic pregnancy, congenital infection, and adverse pregnancy outcomes, these two entities should be considered when a vaginal discharge syndrome is present, especially if

**Table 1: Common Sexually Transmitted and Reproductive Tract Infections and Related Syndromes**

STI/RTI	Organism	Type	Sexually Transmitted	Curable
<b>Syndrome: Vaginal Discharge</b>				
Bacterial vaginosis	Multiple	Bacterial	No	Yes
Yeast infection	<i>Candida albicans</i>	Fungal	No	Yes
Gonorrhoea	<i>Neisseria gonorrhoeae</i>	Bacterial	Yes	Yes
Chlamydia	<i>Chlamydia trachomatis</i>	Bacterial	Yes	Yes
Trichomoniasis	<i>Trichomonas vaginalis</i>	Protozoal	Yes	Yes
<b>Syndrome: Genital Ulcer</b>				
Syphilis	<i>Treponema pallidum</i>	Bacterial	Yes	Yes
Chancroid	<i>Haemophilus ducreyi</i>	Bacterial	Yes	Yes
Herpes	Herpes simplex virus (HSV)	Viral	Yes	No
Granuloma inguinale	<i>Klebsiella granulomatis</i>	Bacterial	Yes	Yes
Lymphogranuloma venereum (LGV)	<i>Chlamydia trachomatis</i>	Bacterial	Yes	Yes
<b>Syndrome: Other</b>				
Genital warts	Human papillomavirus (HPV)	Virus	Yes	No
<b>Syndrome: Lower Abdominal/Pelvic Pain</b>				
Pelvic inflammatory disease (PID)	Multiple	Bacterial	Yes	Yes
Urinary tract infection (UTI)	Multiple	Bacterial	No	Yes
Appendicitis	N/A	N/A	No	Yes

Source (modified): Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice. World Health Organization, 2005.

other high risk factors are present or when prevalence of these infections is high in the community. Gonorrhea and chlamydia should be considered in the treatment of the vaginal discharge when the person has had recent new or multiple partners, the partner has urethral discharge, or mucopurulent discharge or bleeding are seen on examination of the cervix (WHO, 2007b). Other high-risk factors can be determined based on factors affecting the population and the community locally (WHO, 2007b). If gonorrhea and chlamydia are treated, partner notification and treatment should be conducted to the extent possible to prevent reinfection (WHO, 2005b; WHO, 2007b). Partner notification protocols should take into consideration protecting the patient from violence in situations where partner violence is a concern.

**Genital ulcer disease** – Ulcerative lesions of the female genitalia are most commonly caused by herpes, syphilis, and chancroid infections (WHO, 2005b). Syndromic algorithms for treatment of genital ulcer disease are available as well (WHO, 2007b). Examination is the cornerstone of the syndromic management of genital ulcer disease. Upon clinical examination, ulcerative lesions of the genital tract are typically categorized as either **vesicular** or **non-vesicular**. In **vesicular genital ulcer disease**, vesicles or fluid-filled blister lesions are present on the genitalia. If examination indicates the presence of vesicles, the patient should be treated for HSV when the local prevalence of herpes disease is higher than 30%. Syphilis treatment should also be initiated if vesicles are present, the RPR is positive, and there has been no prior treatment of syphilis (WHO, 2007b). Screening all pregnant women with an RPR, a blood screening test for syphilis, is cost effective even when the local prevalence of syphilis is as low as 0.1% in order to avoid congenital syphilis (WHO, 2007b) and its risks of stillbirth, spontaneous abortion, and perinatal death. Reducing the worldwide incidence of congenital syphilis is a global priority (WHO, 2007a).

In cases where the genital exam indicates the presence of genital ulcers or sores, whether or not vesicles are also present, treatment should include coverage for chancroid as well as HSV and syphilis based on the considerations above. If lymphogranuloma venereum and/or granuloma inguinale are prevalent locally, their treatment can be included as well (WHO, 2007b).

When treatment of genital ulcer disease is prescribed, the patient should be given advice that treatment using a syndromic approach has uncertainties. Additionally, when the diagnosis of HSV is a possibility, patients should be counseled that treatment for HSV infection with antiviral medication is not curative but does shorten the course of infection and can help to decrease viral shedding and therefore transmission of the infection to partners. If only a limited drug supply is available, reserving treatment for patients with persistent or recurrent infections, which can be associated with HIV infection, can be considered. Patients who are treated need to receive adequate and appropriate counseling to provide information about the purpose of treatment and that it is not intended to be curative in order to avoid false expectations of cure (UNFPA/WHO, 2006).

**Lower abdominal/pelvic pain** – In situations where STIs are common, lower abdominal or pelvic pain is usually caused by pelvic inflammatory disease (PID), and a syndromic approach based on symptoms can be used in this situation as well (WHO, 2007b). Pelvic inflammatory disease can also be characterized by lower back pain, irregular vaginal bleeding, or pain with sexual intercourse (WHO, 2005b). The diagnoses of urinary tract infection and appendicitis are also possible diagnoses that can be associated with this syndrome of symptoms (WHO, 2007b). Physical examination can be helpful in this situation as PID is commonly associated with lower abdominal, uterine, adnexal, and/or cervical motion tenderness and vaginal discharge (WHO, 2005b; WHO, 2007b). It is important to inform and counsel the patient that a diagnosis can be imprecise in this type of situation but the severe consequences of pelvic inflammatory disease, including resultant infertility, ectopic pregnancy, and generalized peritonitis if PID persists untreated, do justify treating aggressively with appropriate antibiotic therapy

(UNFPA/WHO, 2006). Follow up within a few days to assure improvement in symptoms is advised as well (WHO, 2007b).

***Human papillomavirus and cervical cancer*** – Cervical cancer is a common malignancy and a common cause of cancer death in women. Human papillomavirus (HPV) is the most common STI worldwide with a prevalence of approximately 25-30% among women aged <25 years old. The prevalence of HPV decreases with age (UNFPA/WHO, 2006). Cervical cancer is caused by certain specific oncogenic strains of HPV – most commonly types 16 and 18. Other oncogenic strains of HPV are types 45, 31, 33, and 58, and their prevalence differs geographically (UNFPA/WHO, 2006). There are also low risk HPV types 6 and 11 that cause genital warts and not cancer. Cervical cancer develops in women who have persistent chronic cervical infection with oncogenic strains of HPV. Most HPV infections remain asymptomatic and may resolve on their own without treatment, and only a small percentage of these infections will progress to pre-cancer lesions or cancer even without screening or treatment (UNFPA/WHO, 2006).

Screening the cervix for the early changes of the cervical cells that are the precursor to cervical cancer is currently the most effective means for controlling cervical cancer, and lack of screening is a major risk factor for cancer. Screening is performed using a speculum to collect a cytology specimen, a Pap smear, from the cervix and is an effective means for reducing cervical cancer morbidity and mortality.

Screening for cervical cancer should be encouraged where resources are available. According to the WHO, the frequency of screening depends upon available resources. In areas with high resources, screening should be conducted beginning at age 35 every five to 10 years; when resources are limited, screening one time at approximately age 40 may be appropriate (WHO, 2005b). Other authorities suggest that a more aggressive approach to screening for cancer should begin now in the developing world as cancer will ultimately be a large problem (Farmer, 2010). Local decisions based on resources available and priorities should be considered in determining the local approach to cervical cancer screening and prevention. Ultimately, treatment depends upon available resources, the woman's choice, and health care worker experience.

#### UNINTENDED PREGNANCIES

An adolescent girl or young woman who is pregnant may feel intense pressure from her family, her partner, or from a health care worker to obtain an abortion to terminate the pregnancy. Alternatively, a young woman may feel pressure from her partner to continue the pregnancy depending upon the nature of her relationship with her partner. Health care providers should elicit these feelings and pressures from a client in a nonjudgmental way. All women should be provided appropriate nonjudgmental counseling about her options and should be given the opportunity to make an informed decision (UNFPA/WHO, 2006). Health care providers should be prepared to discuss the risks and benefits of alternative options to prenatal care, pregnancy, and delivery, including medical or surgical abortion and adoption.

#### CONTRACEPTIVE COUNSELING

Women who seek contraception for prevention of pregnancy should receive counseling on the variety of available options for effective contraception. Women who are prescribed hormonal contraception should also be counseled to use dual protection, condoms or other barrier methods, to prevent acquisition of both pregnancy and STI/HIV infection. There are a variety of options available to young women for contraception and the following sections describe the major contraceptive options.

***Hormonal contraceptives*** – There are two broad categories of hormonal contraceptives. **Combination contraceptives** contain both estrogen and progesterone hormones given daily to prevent pregnancy.

These are most commonly available in oral formulations taken by mouth daily but are also available as a transdermal patch worn on the skin or as a ring inserted intravaginally. **Progesterone only contraceptives** contain progesterone alone and come in different formulations as well. A depot injection contraceptive such as medroxyprogesterone is an injectable progesterone-based medication administered intramuscularly once every twelve weeks to prevent pregnancy. Progesterone-containing pills are also available, but they are less effective for preventing pregnancy than combination contraceptives unless they are used during the postpartum period when a woman is breastfeeding as the main source of nutrition for her infant.

Some studies have raised the concern that the use of oral contraceptives or depot medroxyprogesterone may increase risk of chlamydia infection perhaps because of less reliance on use of barrier methods to prevent STI acquisition, but the WHO determined that there is no evidence or insufficient evidence for the association between the use of hormonal contraceptives and STIs. They counsel that women who are living with HIV or who are at high risk for STIs can be offered oral contraceptives or depot medroxyprogesterone (UNFPA/WHO, 2006). Women who are prescribed hormonal contraception should be counseled to use dual protection with barrier methods as discussed below in the section on safer sex.

**Intrauterine device** – The intrauterine device (IUD) is a device that is sterilely placed inside the uterine cavity by a health care provider who has adequate training to do so. The IUD is not recommended in candidates who are at high risk for gonorrhea, chlamydia, or PID infections. In addition, use of an IUD increases risk of bacterial vaginosis which has been considered as a risk for acquisition of HIV and other STIs. Therefore, women at high risk of infections including HIV should primarily be counseled to use other forms of contraception, if feasible. If an IUD insertion is planned, it should not be inserted in the presence of active cervical infection or PID (UNFPA/WHO, 2006).

**Emergency contraception** – The protocol for use of emergency contraception involves the use of oral contraceptive pills taken by protocol after unprotected intercourse in order to induce the onset of the menstrual cycle. Emergency contraception can generally be used within five days of unprotected sex, but is more effective if taken sooner (UNFPA/WHO, 2006).

**Permanent sterilization** – There are permanent surgical options for sterilization that can be provided if a provider with adequate surgical training to perform the procedure is available. Health care providers should provide counseling to women considering sterilization that sterilization is permanent and does not protect against STIs or HIV. Women should be permitted to make a decision to obtain sterilization on their own without undue pressure from family, friends, or the health care provider. Providers should also consider screening for the presence of depression and the client's ability for sound decision-making at a time of crisis before permanent sterilization is offered to a patient.

## ABORTION CARE AND ITS COMPLICATIONS

Post-abortion care can be a crucial time of entry into health care services for adolescent women. It may be the first time that an adolescent has sought reproductive services, and therefore, counseling for HIV/STI prevention and contraception is important (McCarragher, 2010). Evidence shows that a high unmet need for contraception and inadequate access to family planning and reproductive health services can lead to the increased incidence of unsafe and clandestine abortions (UNFPA/WHO, 2006). Adolescent women are more likely than older women to delay obtaining abortion (McCarragher, 2010). Abortions performed later in pregnancy require different techniques and require use of anesthesia. Adolescents are also more likely to seek unsafe abortions with greater risk of complications and to delay obtaining care for complications that do occur (McCarragher, 2010). In 2003, 12% of maternal deaths in the LAC region were due to the consequences of unsafe abortions (McCarragher, 2010; WHO, 2007c).

Clandestine abortions can be done in unsanitary conditions or with methods that are not safe or effective. Unsafe abortions can have severe consequences including risk of infection or bleeding, and damage to surrounding structures due to perforation of the uterus with the instrument used to induce abortion. If the abortion procedure is not effective and products of conception are incompletely evacuated from the uterus, pelvic infection can ensue. In addition, retention of conception products and/or perforation of the uterus can lead to generalized peritonitis, sepsis, and death. A woman who requires a secondary procedure done after an unsafe abortion is performed with any of these consequences further risks the need for hysterectomy and surgery to correct or remove any other damaged surrounding structures in the abdominal cavity. She might risk infertility from either direct damage to the ovaries or fallopian tubes or from infection that occurs as a result of an abortion performed under unsanitary conditions.

Health care facilities should provide care for safe abortions or referral to another facility that can do so as allowed based on local law. Patients who seek abortion care need to receive counseling provided by trained personnel. All women who undergo abortion should be treated with respectful and nonjudgmental attitudes and should be provided with access to appropriate care and referrals and should be permitted to obtain unrestricted care as permitted by law based on their own choice (UNFPA/WHO, 2006).

Primary care providers are often the providers who counsel patients at first approach to the health care system and should be prepared to give general counseling to a client seeking abortion services even if they do not provide the abortion care itself. Patients can be counseled that there are both surgical and medical options for termination of pregnancy. If a pregnancy has progressed less than 12 weeks from the first day of the last menstrual cycle, then manual or electric vacuum aspiration is safe and effective and can be performed without use of anesthesia (UNFPA/WHO, 2006). If the pregnancy has progressed more than 12 weeks, dilatation and evacuation can be offered if skilled and experienced providers are available to perform the procedure. There are also safe and effective alternative medical options that prescribe the use of a combination of oral medications to induce the menstrual cycle and evacuate the uterine contents (UNFPA/WHO, 2006). Following the medical termination of pregnancy, women must be able to return to the medical facility to confirm that the products of conception have been expelled completely. In addition, following any abortion procedure, they should be given appropriate counseling with regards to when to return for follow up care after the procedure and in the event of abnormal vaginal bleeding, vaginal discharge, odor, or other symptoms of a pelvic infection. Ovulation usually occurs shortly after abortion, approximately two to four weeks following the procedure (UNFPA/WHO, 2006). Patients should be offered contraception counseling and provided with their choice of methods to begin after the procedure in order to decrease repeat unintended pregnancy and repeat abortion (McCarragher, 2010). They should also be provided testing for HIV and STIs at that time (McCarragher, 2010).

Health care providers should also consider clients' risk of stigma and violence after an abortion procedure (McCarragher, 2010). When abortion is stigmatized, women may also need psychological counseling and consideration of referral to available psychosocial supports. Stigma and the risk of violence may be more likely on small islands and in the small towns which are common in the LAC region (PAHO, 2010).

### **PREGNANCY**

The presence of skilled obstetrical care during maternal labor and delivery is an important intervention to prevent maternal and newborn deaths and disability. Fifteen percent of women experience a life-threatening complication of pregnancy or childbirth (UNFPA/WHO, 2006). In some areas, the use of skilled birth attendants remains low, and pregnant women are cared for only by a family member or traditional birth attendant. Delivery without a skilled birth attendant leads to an increased risk of maternal morbidity and mortality (UNFPA/WHO, 2006).

The WHO has extensive resources available that outline the protocol for increasing the safety of pregnancy, prenatal and antenatal care, labor, and delivery and should be consulted for further information (WHO, 2003).

### CONSEQUENCES OF SEXUAL ABUSE, VIOLENCE, AND RAPE

The experience of sexual violence is common among young people in that 18% of young females age 15-24 years old reported prior experience of sexual violence (Gomez, 2009). During pregnancy, it is estimated that approximately 4-32% of women experience violence (WHO, 2005).

History of sexual violence was found to increase the likelihood of risky sexual behavior leading to risk of adverse reproductive health outcomes (Gomez, 2009). The relationship between violence and HIV is thought to be indirectly mediated by risk-taking behaviors. Studies suggest that childhood sexual abuse, coerced sexual initiation, and current partner violence lead to increased sexual risk-taking with multiple partners, relationships with non-primary partners, and transactional sex, all of which increase the risk for HIV infection (UNFPA/WHO, 2006). During pregnancy, the experience of violence and sexual violence can increase the risk of spontaneous miscarriage, preterm labor, and low birth weight (UNFPA/WHO, 2006).

A study assessing children's experience of violence in the school and the community demonstrated a dose-response relationship between violence and lower academic achievement. The children who were exposed to the most violence had the poorest achievement in school (Baker-Henningham, 2009).

The consequences of abuse and violence are multiple and extend to all areas of the victim's life including physical effects such as physical bodily injury and chronic pelvic pain; sexual effects including STIs, HIV infection, unintended pregnancy, miscarriage, and inability to maintain healthy sexual relationships; psychological effects such as low self-esteem, indecisiveness, depression, frustration, embarrassment, and lack of healthy communication; and financial effects like loss of financial independence and personal dignity, restriction of lifestyle, and the lack of basic household needs such as food, clothing, and shelter which can in time lead to malnutrition or homelessness (Nagassar, 2010), and can have societal effects as well. These include loss of family income and decreased societal productivity. Children may be unable to attend school because of lack of household funds, embarrassment, or the need to hide the effects of violence. Limited access to education may later lead to difficulty obtaining sufficient employment. Juvenile delinquency, substance abuse, prostitution, theft, increased crime rates, and family dysfunction may result as well. Finally, domestic violence also draws on medical resources to provide for victims' care leaving less available resources for other medical priorities in the community (Nagassar, 2010).

Community services are needed to provide counseling to reduce domestic violence against women and girls. This counseling can be provided by community health personnel, doctors, nurses, and/or teachers. One main risk factor associated with domestic violence is drug and alcohol abuse, so rehabilitation services may help to reduce its effects as well. Other legislative and policing efforts to ensure equal human rights and treatment, and additional opportunities for economic advancement and independence are possible interventions to mitigate the epidemic of domestic violence and its effects (Nagassar, 2010).

Primary health care and specialty STI health care services can be an entry point to health care for women who are victims of violence (UNFPA/WHO, 2006). The diagnosis of violence is a marker for risk of HIV acquisition and warrants introduction of HIV testing services. Evidence shows that there is an intersection between the HIV and domestic violence epidemics (UNAIDS/WHO, 2010).

### LOVE SORROWS

Love sorrows are the emotional distress caused by emotional attachments. The breakup of romantic relationships has been associated with anxiety and depression, psychopathology, loneliness, immune suppression, physical illness, risk of accidents, and even loss of life due to suicide and homicide (Davis, 2003). Young adolescent females may have increased depression and decreased self-esteem associated with first experience of sexual intercourse. These effects are most likely in young females with sexual debut prior to age norms and in those who have sex outside of romantic relationships (Meier, 2007).

### DEPRESSION AND SUICIDAL IDEAS

Depression and suicidal ideas are common among adolescents in several studies in the Caribbean (Ali, 2005; Maharajh, 2008). In the Caribbean, suicidal behavior is a growing problem (Ali, 2005). Depression is common and was found in one-quarter of students in a study of adolescents in Trinidad and has been linked with violence in the home, injury by the parents, fear of the parents, history of physical and sexual abuse, rage, and lack of feeling connected with school and family (Maharajh, 2008). Depression should be considered when there is poor performance in school that is new, societal withdrawal, or senseless/delinquent behavior (Maharajh, 2008).

Suicidal ideations and attempts in adolescents are more common in females than in males, and have been associated with fights with a girlfriend or boyfriend, truancy, abuse, behavioral problems, family dysfunction, and personal or parental use of alcohol. Adolescents who live within a stepparent family consisting of a single stepparent, or one natural parent and one stepparent are at greater risk than those who live with an intact family (both mother and father) or a one parent family. Religiosity including prayer with the family and attending a religious institution was protective against suicidal ideation and attempts among adolescents (Ali, 2005). Interventions that target individuals with risk factors that put them at high risk of depression and those who have signs and symptoms of depression have been most successful (Maharajh, 2008). Screening adolescents for depression, suicidal ideations, and violence in a variety of health care settings should be considered.

### SAFER SEX

Interventions to reduce unsafe sex behavior should be tailored to the local culture. For example, interventions should aim to decrease local beliefs and myths that decrease the effectiveness of accurate HIV prevention messages. HIV prevention counseling should be conducted by female workers when clients are female (UNFPA/WHO, 2006).

Clients should be counseled about the recommendation to use dual protection, methods which simultaneously protect against both unintended pregnancy and STIs, including HIV. There are several methods of dual protection available that afford protection from both pregnancy and STIs. Dual protection can include the use of condoms alone or with another method of contraception including emergency contraception, or the use of safe alternatives to penetrative sex. Both the male condom and the female condom can be used for dual protection (UNFPA/WHO, 2006).

**Male condom** – Condoms are effective at preventing both pregnancy and STIs, including HIV, but there are barriers to the use of condoms. Even in serodiscordant couples where one partner has HIV infection and the other is HIV negative, rates of condom use were still low even after the disclosure of the HIV status to the partner (UNFPA/WHO, 2006). In addition, condoms are used less often when a hormonal or another method of contraceptive is used. Sexually active partners are less likely to use condoms when pregnancy is the biggest concern (UNFPA/WHO, 2006). In a study of condom use in Sao Paulo, Brazil, pregnancy was not a concern and condom use decreased after sterilization (Barbosa, 1995). In other

partnership situations, such as marriage, stable long term relationships, infertility, and in relationships with older or post menopausal women, use of condoms is decreased as well (UNFPA/WHO, 2006).

**Female condom** – Female condoms can also be used for dual protection to protect against HIV and STIs, although they are slightly less effective than male condoms at preventing pregnancy. The female condom has the added benefit that it offers more female control, though some negotiation with the male partner is still required. Use of the female condom has been limited by its cost and lack of availability. It is less familiar to clients and to health care providers than the male condom (UNFPA/WHO, 2006).

A study in adolescents in Jamaica demonstrated a variety of beliefs that hinder the use of condoms. The condom beliefs included loss of sensation or lack of sexual pleasure, religious beliefs, self-consciousness about use of condoms, lack of efficacy of condoms for prevention of STIs and HIV, and a belief that condoms from the United States spread HIV (Hutchinson, 2007). Health care providers should attempt to elicit these beliefs from clients in order to discuss them openly and non-judgmentally. In addition, the use of condoms should be encouraged and their benefits emphasized to limit the spread of STIs, including HIV, even when hormonal birth control methods are used.

The use of nonoxynol-9 may cause adverse effects and its use should not be promoted. Its use has been shown to increase the presence of ulcer disease and HIV infection in comparison with placebo, and it afforded no protection against gonococcal or chlamydial infections (UNFPA/WHO, 2006).

**Intravaginal microbicides** – Microbicides are applied intravaginally with an applicator by a woman prior to sexual intercourse. Different types of products are currently being tested for their effectiveness to protect against pregnancy, STIs, and/or HIV. There is potential in the future that one or more of these microbicides currently being trialed may offer female-controlled protection against different combinations of these risks.

Initial data was recently released from one of these microbicide trials, the CAPRISA 004 study, a double-blinded, randomized, placebo-controlled trial conducted in rural and urban South Africa testing an intravaginal gel containing a 1% concentration of the antiretroviral agent tenofovir (TDF) for its ability to prevent HIV infection among sexually active women age 18 to 40 years. Data from the study showed a 39% reduction in HIV acquisition after 30 months of use. Women with adherence over 80% had a 54% reduction in HIV infection. Infection with genital HSV virus was also decreased by half with use of the gel (Fenton, 2010).

**Pre-exposure prophylaxis** – PrEP is another potential female-controlled HIV prevention intervention which is being tested in several safety and efficacy studies currently underway. PrEP involves use of an active oral antiretroviral agent taken daily by people without HIV infection in order to block acquisition of the infection during high-risk activity. Currently tested PrEP regimens include either TDF alone or TDF in combination with emtricitabine (FTC) (CDC, 2010).

## HEALTH CARE NEEDS OF LESBIAN ADOLESCENTS AND YOUTH

In a cohort of adolescents age 10 to 18 surveyed from nine Caribbean countries, 9.5% of females reported a history of same-sex sexual experience and attraction (Halton, 2003). Access to health care can be obstructed because many countries in the LAC region, including two-thirds of countries in the Caribbean, maintain laws that criminalize sexual acts between same-sex partners (Ottosson, 2009). Criminalization of same-sex relationships increases stigma and discrimination against women who have sex with women in the region. Even though perceptions of gay, lesbian, and bisexual people are changing, stigma and discrim-

ination are fostered in the small towns and islands that make up much of the LAC region (PAHO, 2010). Health care personnel should be aware that local laws, stigma, and discrimination threaten access to health care. Health care providers should be nonjudgmental and work to ensure that clinics that serve all women are private, safe, and accessible regardless of gender, sexual identity, race, ethnicity, socioeconomic status, livelihood, or other factors that lead to stigma, discrimination, and poor access to health care.

## Conclusion

In the mid-1990s, health and development experts focused due attention to the impact of gender on sexual relations, reproductive health decision-making, and the transmission of STIs, including HIV (International Conference on Population and Development, 1994b; Fourth World Conference on Women, 1995). While these links are now commonly recognized, they have yet to be fully operationalized in health policies and health systems in many regions of the world, including the LAC region. A robust response is needed from health care providers, health administrators, and policy makers in the LAC region to develop regionally relevant, country-specific plans for decreasing HIV, sexual, and reproductive health risks among adolescent girls and young women. Key to developing such a response is understanding the biological and social vulnerabilities that increase the risk of acquiring STIs, including HIV, in adolescent girls and young women; the major health care issues faced by this high-risk population and the obstacles that reduce access to reproductive and sexual health services; and points of entry into the health care system for this vulnerable population, and interventions to assure the provision of comprehensive sexual and reproductive health care services in primary and specialty care settings. These elements together, and as outlined in this Blueprint, must be implemented in a timely manner so as to improve the health and quality of life outcomes for adolescent girls and young women in the LAC region and, as important, impact the region's HIV epidemic before it claims millions more lives.

## References

### GREY LITERATURE/ONLINE RESOURCES

Center for Reproductive Rights. *The World's Abortion Laws*. Center for Reproductive Rights, New York, 2009.

CDC, CDC Trials of Pre-Exposure Prophylaxis for HIV Prevention. Centers for Disease Control and Prevention, Atlanta, July 2010.

Fenton K. CDC Statement on CAPRISA Microbicide Study Results. Centers for Disease Control and Prevention, Atlanta, July 19, 2010.

Fourth World Conference on Women. United Nations. Beijing, China, 1995.

Gaillard EM, Eustache L. *Estimation de la Seroprevalence du VIH en Haiti en 2007 Selon le Milieu de Residence Urbain et Rural Pour Chacun des 10 Departements*. United States Agency for International Development, Washington DC, 2007.

International Conference on Population and Development. Program of Action of the International Conference on Population and Development. Paragraphs 7.2 and 7.3. New York, United Nations, 1994a.

International Conference on Population and Development. United Nations. Cairo, Egypt, 1994b.

ICW. *HIV Positive Women, Poverty, and Gender Inequality*. International Community of Women Living with HIV/AIDS, London, 2004.

UNAIDS, WHO. *Addressing Violence against Women and HIV/AIDS: What Works?* Joint United Nations Program on HIV/AIDS, World Health Organization, Geneva, 2010.

UNAIDS, WHO. *AIDS Epidemic Update: November 2009*. Joint United Nations Program on HIV/AIDS, World Health Organization, Geneva, 2009.

National HIV Program. *Country Progress report to the Secretary-General of the United Nations on the United Nations General Assembly Special Session*. Jamaica, Ministry of Health, Jamaica, 2008.

Ottosson D. *State-Sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults*. International Lesbian, Gay, Bisexual, Trans, and Intersex Association, Brussels, 2009.

PAHO. *Regional HIV/STI Plan for the Health Sector, 2006-2015*. Pan American Health Organization, Washington, DC, 2005.

PAHO. *Blueprint for the Provision of Comprehensive Care to Gay Men and other Men who Have Sex with Men (MSM) in Latin America and the Caribbean*. Pan American Health Organization, Washington DC, 2010.

UNFPA, WHO. *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment, and Support for Women Living with HIV/AIDS and their Children in Resource-Constrained Settings*. United Nations Population Fund, World Health Organization, Geneva, 2006.

WHO. *Pregnancy, Childbirth, Postpartum, and Newborn Care: A Guide for Essential Practice*. World Health Organization, Geneva, 2003.

WHO. *Reproductive Health Strategy to Accelerate Progress toward the Attainment of International Development Goals and Targets*. World Health Organization, Geneva, 2004.

WHO. *Addressing Violence against Women and Achieving the Millennium Development Goals*. World Health Organization, Geneva, 2005.

WHO. *Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice*. World Health Organization, Geneva, 2005b.

WHO. *The Global Elimination of Congenital Syphilis: Rationale and Strategy for Action*. World Health Organization, Geneva, 2007a.

WHO. *Training Modules for the Syndromic Management of Sexually Transmitted Infections*. 2nd Edition. World Health Organization, Geneva, 2007b.

WHO. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*. World Health Organization, Geneva, 2007c.

WHO. *Priority Interventions: HIV/AIDS Prevention, Treatment, and Care in the Health Sector*. World Health Organization, Geneva, 2010.

WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling Up Priority Interventions in the Health Sector, Progress Report 2010*. World Health Organization, Joint United Nations Program on HIV/AIDS, United Nations Children's Fund, Geneva, 2010.

### PEER-REVIEWED LITERATURE

- Ali A, Maharajh HD. Social predictors of suicidal behavior in adolescents in Trinidad and Tobago. *Soc Psychiatry Psychiatr Epidemiol.* 2005;40:186-191.
- Baker-Henningham H, Meeks-Gardner J, Chang S, Walker S. Experiences of violence and deficits in academic achievement among urban primary school children in Jamaica. *Child Abuse Negl.* 2009;33:296-306.
- Barbosa RM, Villela WV. Sterilisation and sexual behaviour among women in São Paulo, Brazil. *Reprod Health Matters.* 1995;3:37-46.
- Barrientos JE, Bozon M, Ortiz E, Arredondo A. HIV prevalence, AIDS knowledge, and condom use among female sex workers in Santiago, Chile. *Cad Saude Publica.* 2007;23(8):1777-1784.
- Bozon M, Gayet C, Barrientos J. A life course approach to patterns and trends in modern Latin American sexual behavior. *J Acquir Immune Defic Syndr.* 2009;51:S4-S12.
- Clark S, Bruce J, Dude A. Protecting young women from HIV/AIDS: The case against child and adolescent marriage. *Int Fam Plann Perspect.* 2006;32(2):79-88.
- Davis D, Shaver PR, Vernon ML. Physical, emotional, and behavioral reactions to breaking up: The roles of gender, age, emotional involvement, and attachment style. *Pers Soc Psychol Bull.* 2003;29(7):871-884.
- De Arazoza H, Joanes J, Lounes R, et al. The HIV/AIDS epidemic in Cuba: Description and tentative explanation of its low HIV prevalence. *BMC Infect Dis.* 2007;7:130.
- Farmer P, Frenk J, Knaul FM, et al. Expansion of cancer care and control in countries of low and middle income: A call to action. *Lancet.* 2010;376:1186-1193.
- Garcia A. Continuous moral economies: the state regulation of bodies and sex work in Cuba. *Sexualities.* 2010;13:171-196.
- Garcia-Calleja JM, del Rio C, Souteyrand Y. HIV infection in the Americas: Improving strategic information to improve response. *J Acquir Immune Defic Syndr.* 2009;51:S1-S3.
- Gomez AM, Speizer IS, Beauvais H. Sexual violence and reproductive health among youth in Port-au-Prince, Haiti. *J Adolesc Health.* 2009;44:508-510.
- Halcon L, Blum RW, Beuhring T, et al. Adolescent health in the Caribbean: a regional portrait. *Am J Public Health.* 2003;93(11):1851-1857.
- Halperin DT, de Moya EA, Perez-Then E, et al. Understanding the HIV epidemic in the Dominican Republic: A prevention success story in the Caribbean? *J Acquir Immune Defic Syndr.* 2009;51:S52-S59.
- Hutchinson MK, Jemmott LS, Wood EB, et al. Culture-specific factors contributing to HIV risk among Jamaican adolescents. *J Assoc Nurses AIDS Care.* 2007;18(2):35-47.
- Maharaj RG, Alli F, Cumberbatch K, et al. Depression among adolescents, aged 13-19 years, attending secondary schools in Trinidad. *West Indian Med J.* 2008;57(4):352-359.
- McCarragher DR, Chen-Mok M, Oronoz AS, et al. Meeting the needs of adolescent post-abortion care patients in the Dominican Republic. *J Biosoc Sci.* 2010;42:493-509.
- Meier AM. Adolescent first sex and subsequent mental health. *Am J Sociol.* 2007;112(6):1811-1847.
- Murray L, Moreno L, Rosario S, et al. The role of relationship intimacy in consistent condom use among female sex workers and their regular paying partners in the Dominican Republic. *AIDS Behav.* 2007;11:463-470.
- Nagassar RP, Rawlins JM, Sampson NR, et al. The prevalence of domestic violence within different socio-economic classes in central Trinidad. *West Indian Med J.* 2010;59(1):20-25.
- Okie S. Fighting HIV – Lessons from Brazil. *N Engl J Med.* 354;19:1977-1981.
- Pope C. The political economy of desire: Geographies of female sex work in Havana, Cuba. *J Int Womens Stud.* 2005;6:99-118.
- Sabido M, Giardina F, Hernandez G, et al. The UALE Project: Decline in the incidence of HIV and sexually transmitted infections and increase in the use of condoms among sex workers in Guatemala. *J Acquir Immune Defic Syndr.* 2009;51:S35-S41.
- Soto RJ, Ghee AE, Nunez CA, et al. Sentinel surveillance of sexually transmitted infections/HIV and risk behaviors in vulnerable populations in 5 Central American countries. *J Acquir Immune Defic Syndr.* 2007;46:101-111.
- Strathdee SA, Philbin MM, Semple SJ, et al. Correlates of injection drug use among female sex workers in two Mexico-US border cities. *Drug Alcohol Depend.* 2008;92:132-140.
- Vandepitte J, Lyerla R, Dallabetta G, et al. Estimates of the number of female sex workers in different regions of the world. *Sex Transm Infect.* 2006;82(Suppl III):iii18-iii25.





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