

Situation Analysis of Adolescent Sexual and Reproductive Health and HIV in the Caribbean



Executive Summary

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Executive Summary

At the beginning of the twenty-first century, the adolescent and youth population¹ is the largest cohort in the history of the Caribbean region, representing 26.6% of the total population. They are living in a world undergoing demographic transition, globalization, environmental changes, and a growing reliance on new communication technologies. The disproportionate impact of these issues on low-income, poorly educated, indigenous, migrant, cross-border, and ethnic minority adolescents and youth is of special concern and requires a targeted response.

Adolescence is a key stage of the life course that affects health, opportunities and development for the rest of life. It is a time of physical, mental, social and emotional change accompanied by an increasing definition of sexual identity and social status. Managing these changes to achieve optimal health and personal development is challenging and is profoundly affected by social experiences.

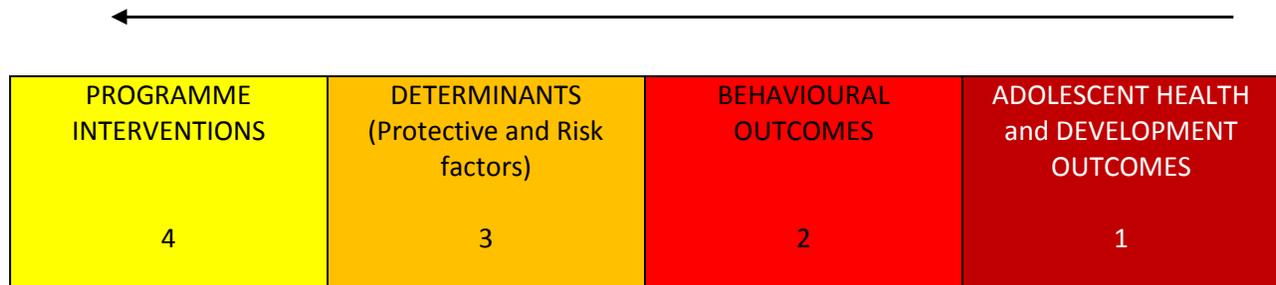
This Caribbean adolescent sexual and reproductive health (ASRH) situational analysis is informed and structured by two conceptual frameworks: the Mapping Adolescent Programming and Measurement (MAPM) framework and the Ecological Framework for Health. The MAPM framework (Figure 1) complements the logical framework and other tools for designing, monitoring and evaluating programs. It begins by defining the *outcomes* that are subject to change. For the purposes of this analysis the ASRH outcomes analyzed are HIV, sexually transmitted infections (STIs), adolescent pregnancies and abortions. The framework then identifies the behaviors that are directly related to these outcomes. For HIV, STI and adolescent pregnancies we examine age at sexual initiation, age differences with partners, condom use and multiple partnerships. Once the behaviors have been identified, risk and protective factors associated with ASRH are determined. There are numerous ASRH risk and protective factors including alcohol and drug use and sexual violence, among others. The framework then determines program interventions in order to increase protective factors and decrease risk factors. For the purposes of this document, not only will programmatic interventions focusing on particular determinants be reviewed but policies, laws and social environmental factors as well, that are related to outcomes.

The Ecological Framework supplements the MAPM framework by examining the contextual issues affecting interventions, determinants, behaviors and outcomes. According to this framework, individual characteristics and behavior are framed and influenced by relationship experiences, community contexts, and social contextual factors. Use of this framework enables an understanding of the vulnerabilities arising from experiences and contexts that limit and shape action.

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

Figure 1: The Mapping Adolescent Programming and Measurement (MAPM) Framework

Building the framework



Flow of logic

Limitations of situational analysis include the lack of a separate section that looks at structural determinants of ASRH, such as poverty, migration, racial discrimination and employment levels. However, they are analyzed to the extent that they emerge in studies as factors associated with poor ASRH outcomes. A second limitation is that, given the broad scope of the review, some relevant studies and promising practices may not have been included. This is especially likely for those that have not been published or which have only been published in non-English texts.

It should be noted that the focus of this situation analysis is on adolescents (10-19 years of age), which conforms to the WHO definition of adolescence. International human rights agreements and conventions relating to SRH are also detailed in terms of discrimination, power, and abuse indicating the need to determine actions to be taken in order to address vulnerabilities that lead to poor ASRH outcomes. Gender and sexual identity dimensions of ASRH are also detailed.

ASRH outcomes: HIV, STI and adolescent pregnancy

- The picture of HIV, STI and adolescent pregnancy is constrained by data inconsistencies.
- Data on diagnosed HIV cases show that girls are more likely to be in vulnerable situations, as rates are higher among women (15-24 years of age) than men of the same age (0.6% and 0.4% respectively). 53% of diagnosed HIV cases in the region are now among females.
- Diagnosed cases may underestimate the male to female ratio as many females are diagnosed during pregnancy. Data on behavioral patterns consistently show that males are more likely than females to initiate sex at a younger age and have a greater prevalence of multiple partners, suggesting that the number of male adolescent HIV cases may be substantially higher than those diagnosed.

- STI data are not presented by age group and are of variable quality depending on surveillance and reporting practices in countries. The data indicates that the numbers of cases of chlamydia, genital discharge syndrome and gonorrhoea have exceeded the numbers of HIV cases since 2008. Genital discharge syndrome is the most prevalent and arises from a number of STIs and reproductive tract infections. Note that these may arise not only from sexual transmission but from vaginal practices relating to menstruation, personal hygiene and sexual enhancement (also a source of vulnerability for females).
- Currently, the age specific adolescent fertility rate (among 15-19 year olds) is 63.8 (per 1,000 adolescent women) – higher than the global average of 55.7 (per 1,000 adolescent women), and slightly higher than the level of developing countries as a whole (60.4 per 1,000 adolescent women) though several Caribbean countries have medium to high levels of economic development. It is falling in common with fertility globally, but available data suggest it is not falling as a percentage of all pregnancies. Rates vary in the Caribbean and are especially high in the Dominican Republic (108.7 per 1,000 adolescent women) and Jamaica (77.3 per 1,000 adolescent women). Recent surveys conducted by PAHO in British and Dutch Overseas Caribbean Territories (OCT) yielded extremely high rates of up to 1 in 3 adolescent girls who had been pregnant and around 1 in 10 boys who had caused a pregnancy.
- Rates of abortion were correspondingly high, ranging from 6% in the British Virgin Islands and St. Maarten to 14% in St. Eustatius. These findings are consistent with data showing that the abortion rate in the Caribbean is high: 39 per thousand women aged 15-44, as compared with 29 in developing countries and 24 in developed countries. The unsafe abortion rate per thousand women aged 15-44 was estimated at 18 in 2008 in the Caribbean, as compared with 16 in developing countries as a whole, 1 in developed countries and 31 in sub-Saharan Africa.

Behaviors related to ASRH outcomes

Surveys that include questions on adolescent sexual behavior include the WHO Global School-Based Student Health Survey (GSHS) (among 13-15 year olds), the PAHO Adolescent Health Survey conducted in nine countries in 2000, and the 2012 PAHO studies in British and Dutch Overseas Caribbean Territories. A few single country studies offer points of comparison, as do a number of surveys with youth aged 15-24.

Primary abstinence

In the most recent GSHS surveys, approximately 80% of girls and 60% of boys (13-15 years of age) reported that they had never had sex indicating that approximately 20% of girls and 40% of boys have been sexually active.

Age at first sex

In the GSHS, the PAHO Adolescent Health Survey and the British and Dutch Overseas Caribbean Territories studies, as well as a number of surveys with 15-24 year olds, boys consistently report earlier

age at first sex than girls. In the Caribbean GSHS, 56% of girls and 79% of boys on average had sex before the age of 14. More than half of adolescents who have ever had sex report initiating sex before the age of 16. First sex for boys is usually with someone roughly the same age. Girls are more likely to have an older partner and a larger age difference.

Multiple partnerships

More males than females report multiple partnerships. According to the most recent GSHS surveys, on average three times as many boys (31%) as girls (10%) (13-15 years of age) reported multiple partners.

Condom use

According to the literature, condom use varies widely, with no clear pattern by sex. In the most recent GSHS surveys, on average 38% of adolescents (13-15 years of age) *did not* use a condom at last sexual intercourse. In the British and Dutch Overseas Caribbean Territories studies, approximately 28% of females and 42% of males (11-24 years of age) *had not* used a condom at first intercourse. In the study in St. Eustatius, where 31% of girls reported they had ever been pregnant, it should be noted that only 18% of girls who reported multiple partners used a condom at last sex.

Risk and protective factors

PAHO has been at the forefront of quantitative studies to identify risk and protective factors for adolescent sexual behavior, namely the Adolescent Health Survey in 2000 and the British and Dutch Overseas Caribbean Territories studies in 2012. Other studies have also been reviewed to arrive at the following general findings for the Caribbean.

Risk factors

1. *Being male.* Boys are significantly more likely than girls to report sexual activity. They are also more likely to report multiple partnerships.
2. *Age.* Not surprisingly, older adolescents are more likely to report sex than younger ones.
3. *Sexual or physical abuse.* Adolescents with a history of physical or sexual abuse are more likely to be sexually active and not to use a condom.
4. *Psychosocial wellbeing and mental health.* Rage, gang membership, and carrying or fighting with a weapon increased the risk of sexual activity for both boys and girls in the Adolescent Health Survey. Two studies found that girls who did not expect to live to age 25 and those with lower self-esteem were more likely to have experienced a pregnancy.
5. *Drug and alcohol use.* Sexual activity was more likely if adolescents used alcohol or drugs, including marijuana and cigarettes. Higher levels of use of alcohol also increased risk. The risk of pregnancy was associated with drug and alcohol use in all territories in the British and Dutch Overseas Caribbean Territories studies.

6. *Peer influence/ pressure.* Youth who perceived their friends to be sexually active and those who felt their friends would make fun of them if they did not have sex were more likely to be sexually active. The pressure for boys to be sexually active is higher than for girls.
7. *Attitudes to gender.* Adolescent males who ascribe to the cultural attitude that it is necessary to have sex to prove manhood are more likely to have STIs.
8. *Poverty.* In the British and Dutch Overseas Caribbean Territories study in the British Virgin Islands, being hungry in the past 30 days was a risk factor for having sex by age 15 and for not using a condom at last sex. In St. Eustatius, adolescents who worked for pay were more likely to have multiple partners. One study found that adolescents from households of low socio-economic status were less likely to use condoms.
9. *Transactional sex.* Transactional sex is associated with lower condom use in some studies. However, others have shown that with transactional sex partners who are considered casual, condom use is more frequent than among regular transactional sex partners. Likewise, among sex workers, condom use is higher with clients than with regular partners.
10. *Sexual orientation.* In the British and Dutch Overseas Caribbean Territories study in the British Virgin Islands, bisexual or homosexual attraction was a risk factor for early intercourse and for not using a condom at last sex.

Protective factors

1. *Family connectedness.* If adolescents felt connected to their families they were less likely to have sex. Connectedness was measured by agreement with statements such as “family pays attention to you”, “family understands you”, “can tell mom/ dad your problems”, “mom/ dad cares about you” and “other family members care”. On the other hand, running away from home was a risk factor for sexual activity. Family violence was found to be a risk factor for multiple partnerships among males in one study. In the studies in the British and Dutch Overseas Caribbean Territories, living with at least one biological parent and having no “family problems” in the past 5 years were protective for sexual activity and pregnancy.
2. *School connectedness.* If adolescents felt connected to school they were less likely to have sex. This was measured by the questions, “Do you get along with teachers?” and “Do you like school?” On the other hand, skipping school was a risk factor for sexual activity.
3. *Religion.* Religious attendance and considering oneself or being considered a religious or spiritual person reduced the likelihood of sexual activity.
4. *Individual values.* Values such as endorsing security, tradition, self-direction and universalism are protective against sexual activity.

Analyses of the Adolescent Health Survey also led to the following conclusions:

- Risk and protective factors had larger impacts for girls than boys. This implies that females are especially responsive to their experiences and social environments when it comes to having sex.

- Protective factors had larger effects than risk factors, implying that health promotion interventions should strengthen protective factors in the lives of adolescents, namely schools, the family and faith-based organizations
- There is a “clustering” of risk factors, so that some youth are at far higher risk by being affected by several risk factors.

Adolescent vulnerabilities

A variety of qualitative and quantitative studies throw light on the contextual factors at relationship, community and societal levels that increase adolescent vulnerability.

Interpersonal and sexual violence

The health consequences of sexual violence include STIs/HIV and unwanted pregnancies, among others. Research indicates that many adolescents are exposed to physical, sexual and/or emotional violence with a high level of social tolerance in this domain, especially at home, at school and in the context of discipline and punishment. Violence between young people at school and in their communities is also common.

Violence against women and girls and lesbian, gay, bisexual, transsexual and intersex (LGBTI) youth is perpetuated by gender norms that support male control over their sex partners and children and over economic, political and military resources. Indeed, between 52 – 73% of young women in the Caribbean report being victims of intimate partner violence. These norms also promote incest and child abuse and prevent the reporting and prosecution of many cases. Popular culture sometimes celebrates violent men who have multiple partners.

Adolescents are at high risk of sexual violence, especially if education has not provided them with skills to resist sexual pressure and be assertive. According to a recent study done in four British and Dutch Overseas Caribbean Territories, 24.7% of young people (11-24 years of age) reported that the first time they had sexual intercourse, they were forced or threatened into it against their will. Some adults believe that girls who have started menstruating are sexually available. Further, some girls feel pressured to become pregnant to demonstrate that they are women, while boys are expected to be sexually active to prove that they are men. Data on age mixing in sexual relationships suggests that some older men target adolescent girls. For example surveys with Caribbean 15-19 year old females have shown that between 4% and 29% of them have had sex with a man at least 10 years older than them in the past 12 months.

Recent trends indicated that cell phone pornography has become popular, with adolescents taking sexual images of themselves or others using cellphone cameras and distributing them. The internet and smartphones have also opened avenues to access pornography. Adolescents are also increasingly involved in sex tourism.

Transactional sex and sex work

In the Caribbean, consumerism and poverty co-exist and impact youth employment especially that of women. Under these circumstances, trading sex for material items, gifts, basic needs, security and money occurs. In recent years, this has been associated with a subculture in which it is highly important for young women to maintain themselves superficially through considerable expenditure on hair, nails, make-up, shoes, clothing and accessories, especially smart-phones. Some develop relationships with men involved in violent and criminal activity, further exposing themselves to the risk of gender-based violence (GBV). While less common, some young men engage in transactional sex for consumer goods as well. Transactional sex often takes place with considerably older partners who are more likely to be infected with HIV.

Alcohol and drug use

Alcohol and drug use are often associated with mental health problems, violence, low connectedness to social institutions, transactional sex, sex work, and poverty. In the Caribbean, drug trafficking is attracting disaffected and impoverished youth with its promise of financial reward, further exposing these young people to ASRH risk factors.

A study conducted in the Caribbean found that 40% of females and 54% of males 12-18 years of age consumed alcohol. This is of concern given that early age of first use of alcohol and drugs have been associated with increased risk of suicide, violence, delinquency, adolescent pregnancy, transmission of STIs and HIV, alcohol and drug abuse. According to the most recent GSHS survey, Anguilla had the highest percentage of students (13-15 years of age) reporting that they had their first alcohol drink before they were 14 years of age (94% of males and 87% of females). This was followed by Antigua and Barbuda (88% of females and 85% of males), and Belize (80% of males and 78% of females). Indeed, those who drink before the age of 14 are four times more likely to develop alcohol abuse and dependence than those who begin drinking at twenty-one. In addition, according to a report on drug use in the Americas, countries with the highest prevalence of alcohol use within the last month among adolescents 13-17 years of age include Trinidad and Tobago (49.93%), Dominica (52.26%), Uruguay (52.7%), and Saint Lucia (63.77%). The British and Dutch Overseas Caribbean Territories studies showed rates of alcohol and drug use similar to the highest rates in Caribbean countries.

Regarding drug use, a study done in 11 countries in the Region found that more than 50% of 13 to 15 year olds who are in school report having used drugs one or more times during their lives, with the highest consumption percentage in Antigua and Barbuda, Dominica and Jamaica. Similar to alcohol consumption, adolescent boys aged 13-15 were more likely to have used drugs one or more times during their lives than girls the same age.

Sexual diversity and gender identity

According to the Caribbean Adolescent Health Survey conducted in 2000, approximately 4.5% of females and 5.5% of males (10-19 years of age) report being attracted to the same sex only with 5.0% of females

and 4.3% of males being attracted to both sexes. This is consistent with findings from four British and Dutch Overseas Caribbean Territories countries with approximately 4% of young people (11-19 years of age) reporting that they are attracted to the same sex with approximately 5% reporting that they are attracted to both sexes.

LGBTI adolescents do not conform to societal norms and face discrimination, including bullying and violence at the individual and community levels. At the societal level, laws against “buggery” (widely retained from colonial times) reinforce homophobic stereotypes and practices. The many layers of discrimination affect mental health and the engagement of LGBTI in risky behaviors including sexual behaviors such as non-use of condoms and drug and alcohol use. Caribbean studies with men who have sex with men (MSM) have shown rates of HIV prevalence in excess of 6%. They also show that most also have sex with females, whether because of bisexual orientation or because discrimination pushes them to hide homosexual orientation. This increases HIV risk for their female partners.

Adolescents living with HIV and HIV stigma

With the exception of adolescents infected via mother-to-child transmission, adolescents living with HIV are likely to have been economically and socially vulnerable and engaged in high-risk behaviors prior to infection. Therefore sexual risk behaviors may persist, increasing risk of reinfection and onward transmission. A study of people living with HIV (PLHIV) in three Caribbean countries found that condom use at last sex was more likely as the level of economic security rose, suggesting the need to address poverty and the economic needs of PLHIV as a means to stem the epidemic. The same study examined adherence to antiretroviral therapy, which has been shown to be effective in decreasing viral load and thus decreasing the risk of onward transmission. It was found that counseling increased adherence while alcohol use lowered it. This again points to the importance of psychosocial support and mental health in HIV epidemiology in the Caribbean.

Adolescents with disabilities

People with disabilities, in addition to the impact of the disability itself, are likely to be affected by other vulnerabilities, especially physical and sexual violence, poverty and mental health problems. Disabilities increase the risk of exploitation and violence. Many disabled adolescents are unable to attend mainstream school and few are offered SRH education and services that take account of their disability and are tailored to their needs.

Interventions

At societal level, national policies and laws help define the scope of intervention for ASRH, along with regional and international policies, guidelines and events. At community level, ASRH policy and health promotion operate in institutional settings such as schools and health care centers and via NGOs. How they operate in practice depends on community level norms and opportunities and how the individuals

in each setting behave in relation to the policies and interventions and towards each other. Chapter 4 focuses on interventions and how they are conditioned by issues at the community and societal levels.

Laws relating to ASRH

Disparities between the age of consent to sex and legal access to health care

In most Caribbean countries the legal age of consent to sex is 16, but the legal age of majority is 18. Below the age of majority, the law requires parental consent for medical treatment. This effectively restricts access to contraception and other aspects of SRH care for 16 and 17 year olds though they are legally allowed to have sex. Given the evidence that most Caribbean adolescents are sexually active under the age of 18, the age whereby young people are able to access health care without the need for parental consent should be lowered to 16.

In the English-speaking Caribbean, where many laws are styled on the English legal system, reference is sometimes made in common law to “Gillick competence” to justify cases where SRH care is provided to adolescents under 18. This term is based on an English legal case and is used to decide whether a child is able to consent to his or her medical treatment without the need for parental permission or knowledge. It establishes that if adolescents are competent in being able to understand fully the medical treatment being proposed, they should be able to exercise choice without the need for parental permission. The “Fraser guidelines” supplement this ruling by encouraging health care workers to find out not only whether the child is competent but also whether s/he can be persuaded to inform their parents and whether risks to ASRH would ensue if the service is not provided.

Legal access to abortion

The grounds under which abortion is legal vary widely in the Caribbean, from complete illegality in the Dominican Republic, Haiti and Suriname, to having no restrictions in Guyana and Cuba. In between these two extremes, some countries require justification on the basis of saving the life of the women, or preserving her physical or mental health. In a few countries abortions can be legally justified on socioeconomic grounds. Evidence suggests that legal stipulations do not determine access to abortion in a straightforward way. However, in countries with more restrictive laws, many women and girls seeking abortion try to bypass the formal medical system, ingesting dangerous chemicals or seeking private medical practitioners with varying levels of competence.

Abuse and gender-based violence

The Convention on the Rights of the Child and the Convention on the Elimination of all forms of Discrimination Against Women support action to eliminate child abuse and gender-based violence. The legal division of CARICOM has drafted model legislation in these areas that has helped guide legal reform in member countries. There are however a number of outstanding issues in some countries:

- Some laws continue to define rape, incest and unlawful sex with minors in terms of actions perpetrated against women and girls by men. There is a need for gender neutrality to protect boys from these abuses.
- Most countries define incest in terms of sexual relations with a blood relative. Only a few have extended the definition to include sexual intercourse with a minor who is the adult's adopted child, stepchild, ward or dependent.
- Only some countries have broadened the definition of rape beyond penetration of the vagina by the penis against the will of the woman to include forcible anal intercourse, oral intercourse and other invasive sexual acts.
- Sexual harassment legislation is relevant to adolescents who enter the workforce and may also be applicable to harassment from teachers or others in authority, but has only been instituted in a few countries.
- In some countries sex with a minor can be defended if the person charged can prove that he "honestly believed" the child was over the legal age of consent. A stronger alternative would be to make sex with a minor a strict liability offence
- There are no laws to address child pornography.
- The conduct of parents who encourage the sexual exploitation of their children is only criminalized in a few countries.
- "Domestic violence" legislation is not appropriate to addressing intimate partner violence, stalking and harassment among adolescents as it generally applies only after partners have been living together for 12 months.

Vulnerable adolescents

Adolescents vulnerable to HIV/ STI and pregnancy may come into conflict with the law. Most of those who are found guilty of offences are put into custodial institutions. There are few opportunities for rehabilitative measures outside custodial settings that may reduce risk of poor ASRH outcomes. ASRH education and services are available only in some institutions.

In terms of economic vulnerability, challenges include the fact that children born outside marriage in some countries do not have the same entitlements to public assistance and benefits as children born within marriage. While Education Acts in some countries prohibit various forms of discrimination regarding access to schooling, this does not include medical conditions such as HIV. Only some countries include a legal obligation to provide schooling to adolescent mothers.

Legislation prohibiting discrimination only refers to HIV-related discrimination in some countries, with this usually being limited to employment. Coverage of access to goods and services, accommodation and education is rarer.

To reduce discrimination against LGBTI adolescents and those engaged in sex work, laws prohibiting sexual acts, including adultery, sodomy and commercial sexual encounters should be repealed.

Quality of health care

The World Health Organization notes that to be considered adolescent-friendly, health services should be accessible, acceptable, equitable, appropriate and effective.

Accessibility

Barriers to access include perceived lack of confidentiality or privacy, location, opening times and design of facilities. Access can be enhanced by educating adolescents about the services.

The PAHO Adolescent Health Survey 2000 showed that physicians were the most likely port of call if young people required contraceptives, possibly because they offer more privacy than other options. Pharmacies were the second most popular choice, with clinic settings coming in third and girls choosing family planning clinics more often than boys.

Caribbean initiatives to increase accessibility include several outreach and peer education initiatives and some mobile clinics such as The Bashy Bus in Jamaica. Interactive discussions with youth and entertainment are often included in the package of services. In some countries, specialist youth-friendly health centers are being established via collaborations between governments and NGOs.

Acceptability

The PAHO studies in British and Dutch Overseas Caribbean Territories showed that many adolescents had concerns about the confidentiality of health care, the friendliness and caring of health care workers and their respect for adolescents. Less than one third of adolescents felt comfortable discussing SRH concerns with health care providers. Some adolescents travelled to other islands to seek health care to safeguard their confidentiality.

Peer outreach and communications campaigns have been major strategies used to enhance the acceptability of SRH services. For example, the Live Up campaign on HIV employs Caribbean celebrities to enhance the acceptability of messages and increase uptake of HIV testing and condoms. With regard to clinic settings, the Caribbean HIV/AIDS Regional Training Network has trained many health care workers in ethical procedures to HIV care and support but its major focus has been on strengthening medical procedures. Specialist training to increase the acceptability of health care services to adolescents appears to be absent.

Equity

Gender inequities and other forms of social marginalization restrict the ability of some adolescents to obtain the SRH services that they need. Health care settings and procedures should be designed in such a way as to assure access to all and to seek to combat marginalization. In Antigua and Barbuda, a service has been designed to increase access and quality of care for survivors of rape and domestic violence. This seeks to combat barriers to access such as the need for a police referral as survivors can

self-refer. The service offers forensic investigation alongside clinical care, access to legal services and referral.

Appropriateness

Appropriateness means that the required package of health care is provided to fulfill the needs of adolescents either at the point of service delivery or via referral linkages. An example is the system of community health workers called *accompagnateurs* in Haiti, who are allocated to each person living with HIV. They support adherence to treatment, provide psychosocial and economic support by responding to patient and family concerns, offer moral support and assistance with children's school fees. Such an approach is appropriate in this resource-poor setting where many people cannot access health centers easily for geographic and economic reasons, and it also provides psychosocial support to reduce vulnerability.

Effectiveness

Effectiveness requires health care worker competency and required equipment and supplies. The Pan Caribbean Partnership Against HIV/ AIDS and other Caribbean technical support agencies have developed numerous guidelines and trained health care workers in responding to SRH. Mostly the focus has been on HIV care and support with relatively little focus on other STIs, adolescent pregnancy and broader aspects of behavioral and environmental change. They have focused on government health care workers more than NGOs.

Educational approaches

The education sector has a major part to play in addressing the multiple risk factors and vulnerabilities of youth. Parents, other family members and guardians, peers, local organizations and the legal system are also integrally involved as relationship, community and societal level influences on ASRH.

Health and family life education in schools

Health and family life education (HFLE), incorporating life skills alongside health education, is carried out in schools under the purview of Ministries responsible for education. In CARICOM countries teacher training to follow CARICOM HFLE guidelines is provided by Ministries responsible for education.

Challenges to implementation include:

- HFLE is not an examinable academic subject. Therefore the numbers of hours allocated to it are squeezed.
- HFLE is generally not taught by specialist teachers, and it is often left to teacher discretion how the subject will fit in teaching schedules alongside academic subjects.
- Some teachers are not comfortable in discussing issues of sexuality and SRH. Some important topics are therefore neglected or poorly taught.

- Teachers accustomed to teaching didactically find it difficult to “bring HFLE to life” by providing real life examples and discussing interactively with adolescents.
- Given teacher turnover, HFLE training may not keep pace with the needs of each school.

Communication between adolescents, parents and teachers about sex

In the PAHO studies in British and Dutch Overseas Caribbean Territories, it was found that more than half of adolescents *do not* discuss sex with parents or other adults in their households. Furthermore, around two-thirds of females and three-fifths of males did *not* find it easy to talk to teachers about sex. The evidence suggests that the skills of teachers and parents should be enhanced to address the need for discussions about SRH.

Two evidence-based interventions involving training of parents and teachers have been adapted to Caribbean contexts. The Trinidad and Tobago Family HIV Workshop was adapted from the US Collaborative HIV and AIDS Mental Health Workshop (CHAMP). The skills imparted to primary caregivers and their 12-14 year old adolescents were taught via the use of scenarios concerning a fictional family dealing with various challenges, breakout groups, individual family discussions and workbook activities. Compared to controls, intervention parents reported improvements in HIV knowledge, attitudes towards AIDS, general communication with adolescents, conversations about sexual risks and values, monitoring of adolescents, conflicts with adolescents, and intensity of daily parenting hassles.

In The Bahamas, a trial was conducted of a school-based intervention, Focus on Youth Caribbean (FOYC), supplemented by a parental monitoring intervention, Caribbean ImpACT. FOYC consists of weekly sessions followed by annual boosters designed to develop a lifelong perspective in decision-making, communication and listening skills, and protective knowledge regarding sexual behavior. Caribbean ImpACT includes a video filmed in The Bahamas addressing parent-child communication, followed by role-playing and a condom demonstration. Analysis demonstrated significant sustained program effects 36 months after the intervention, including enhanced HIV/ AIDS knowledge, increased self-efficacy and intention to use a condom. Youth who received FOYC plus the parental monitoring intervention had higher condom use rates.

Educational responses beyond the education sector

A number of agencies employ peer educators and helpers to increase knowledge and access to ASRH services. Communication campaigns also usually target youth. A variety of organizations supplement the work of teachers, visiting schools to provide special sessions. Through this outreach work, these agencies also serve to increase knowledge and access to their own services and support mechanisms. Faith-based organizations play an important role in values-based education on ASRH. However, they may not serve the needs of all adolescents, especially those with HIV and others who are socially marginalized such as MSM and sex workers.

In St. Vincent and the Grenadines, the Ministry of Health runs weekly sessions in some schools on self-esteem; values clarification; growth and development; STIs; HIV/AIDS; conflict resolution; child abuse;

drug abuse; diabetes; environmental health; hypertension; cancer, and discipline. Adolescents who have participated in the 13 week program are eligible to become part of HELTA groups, standing for Health Education for Life through Adolescents. The groups meet outside the school setting and out-of-school youth are welcome to join. HELTA groups have started to work with parents to improve communication and support between parents and children.

Meeting the needs of vulnerable adolescents

Much of the support for vulnerable adolescents has come from NGOs. Some examples are as follows:

- The Vulnerabilised Groups Project of the Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) brings together the work of NGOs working with vulnerable groups on HIV issues around the Caribbean. One of the projects they support is the Sex fX project In Trinidad, which provides SRH education to boys age 10-18 in the St. Michael's Home for Boys, where boys are placed by the courts either for criminal offences or because no one is willing to take care of them. Initial results are promising in terms of knowledge and condom use skills, but project implementers aim to supplement them by providing counseling to those who are more deeply affected by issues such as previous abuse.
- The Caribbean HIV and AIDS Alliance focusses on vulnerable populations, especially sex workers, MSM and PLHIV, with community animators from these communities working with peers to provide HIV education, condom use skills, access to HIV testing and treatment and psychosocial support. They work closely with National AIDS Programs and Ministries of Health with their largest project being the Eastern Caribbean Community Action Project, supported by USAID.
- In Grenada, the Programme for Adolescent Mothers (PAM) provides academic and vocational education and life skills over a two year period for mothers aged 11-18. Counsellors are available for the students and a nursery for the babies of the students.
- The Jamaican NGO Children First has developed the Male Awareness Now (MAN) project providing out-of-school young males from poor communities with vocational skills training and life skills education required to enter into formal schools, training programs or employment opportunities. Active participation of the young men in the design and ongoing involvement of parents have enabled the project to work on key masculinity issues and parent-child dialogue.
- Most countries have NGOs representing people with disabilities, but specialized attention to the SRH needs of adolescents varies. In St. Vincent and the Grenadines, the National Council for People with Disabilities provides educational sessions on ASRH for parents and adolescents.

These valuable initiatives however are not all part of a coherent plan to address ASRH among vulnerable adolescents in the Caribbean, and there are some notable areas for strengthening. For example the issue of mental health has apparently not been the major focus of any single project.

Recommendations

ASRH outcomes

1. Age disaggregated data are needed for STIs and abortions.
2. HIV testing and counseling should be made more accessible and promoted among adolescents. This will improve the data on HIV based on diagnosed cases.
3. There is a need for research on vaginal practices relating to menstruation, personal hygiene and sexual enhancement that can lead to reproductive tract infections and greater risk of STIs.
4. The extent to which adolescent pregnancies are changing as a percentage of all pregnancies should be monitored at Caribbean regional level, to assess progress in decreasing adolescent pregnancy and fertility.
5. Sexual health surveys, including behavioral surveillance and HIV Knowledge, Attitudes, Beliefs and Practices surveys, should include questions for both male and female respondents on whether they have made someone pregnant or been pregnant.
6. Univariate and multivariate analyses should be conducted of results of sexual health surveys to identify risk factors for early sexual intercourse, multiple partnerships, condom use, adolescent pregnancy and abortion.
7. Strategies to address adolescent pregnancies are urgently needed as rates are higher than for the world as a whole and for developing countries, despite several countries having medium to high levels of economic development.

Behaviors related to ASRH outcomes

1. Differences by sex in percentages of adolescents having sex, early sexual intercourse and multiple intercourse demonstrate a clear need for gender-sensitive strategies to address ASRH, including approaches to address harmful gender norms.
2. Median ages at first sex are around 15 for boys and 16 for girls demonstrate the urgent need for access to ASRH education and services for adolescents below the legal age of consent to sex.
3. High rates of early intercourse and multiple partnerships among boys show that adolescent interventions to address concepts of masculinity are needed.
4. Condom promotion and access initiatives should be strengthened for adolescents.

Risk and protective factors

1. Interventions are needed to address the following risk factors among adolescents: sexual and physical abuse of children and adolescents; poor mental health; drug and alcohol use; peer pressure; gender attitudes supporting male sexual dominance; poverty; transactional sex, and homophobia.

2. Interventions are needed to strengthen the following protective factors among adolescents: family connectedness, school connectedness, religious affiliation and values supporting security, self-direction and universalism.
3. Some adolescents experience a “cluster” of risk factors and these vulnerable adolescents should receive targeted health promotion interventions and resources.

Vulnerabilities

1. Sexist and homophobic attitudes must be tackled if serious headway is to be made in reducing gender-based violence and child abuse.
2. Non-violent methods to discipline children should be promoted.
3. Services to address child abuse, gender-based violence, HIV, STI and pregnancy should be integrated via service linkages, protocols and referral systems.
4. Child pornography and child sex tourism should be combatted via legal reform and interventions
5. Popular artists, celebrities, social media and new communications technologies should be used to communicate health promotion messages to adolescents, particularly regarding the negative impacts of cellphone and internet pornography and transactional sex.
6. LGBTI adolescents should be integrally involved in the ASRH response. SRH education should include discussion of sexual identity and discrimination against sexual minorities.
7. Efforts to increase treatment adherence and safer sexual behaviors among adolescents living with HIV should be underpinned by an understanding of the vulnerabilities they faced prior to infection which are now compounded by HIV stigma and discrimination. Economic empowerment and psychosocial support strategies including counseling are critical.
8. Disabled adolescents often face multiple forms of vulnerability in addition to those imposed by the disability itself. SRH education and services should aim to overcome the limits imposed by their disabilities (e.g. through the use of access ramps and braille materials). They should also seek to address other vulnerabilities such as poverty and mental health problems.

Laws relating to ASRH

1. Human rights instruments should be invoked in support of legal and policy reforms to support ASRH, especially the Convention on the Rights of the Child, the Convention for the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of Persons with Disabilities.
2. Legal access to all forms of ASRH medical care and technologies, including contraception and abortion, should be extended to all persons above the legal age of consent to sex without the need for parental consent.
3. Health care workers should be trained in the concept of “Gillick competence” and the Fraser guidelines to extend access to ASRH care and technologies to all adolescents who are at risk of negative ASRH outcomes if they cannot access them.

4. Laws restricting access to abortion should be relaxed to prevent unsafe abortions.
5. Gender neutrality is needed in legal definitions of incest, rape and unlawful intercourse with a minor.
6. Definitions of incest should include sexual intercourse with a minor who is the adult's adopted child, stepchild, ward or dependent.
7. Definitions of rape should be extended to include forcible anal intercourse, oral intercourse and other invasive sexual acts.
8. Sex with a minor should be made a strict liability offense without the defense of "honest belief" that the child was above the legal age of consent.
9. The conduct of parents who encourage the sexual exploitation of their children should be criminalized.
10. Sexual harassment legislation is needed in all countries.
11. Laws should be developed to address child pornography, stalking and intimate partner violence among adolescents.
12. Non-custodial sentences and rehabilitative measures in the community should be available for adolescents who break the law.
13. ASRH education and access to ASRH services should be provided as part of the juvenile justice system.
14. Anti-discrimination legislation should include assuring the rights of adolescent mothers and adolescents living with HIV to education and goods and services.

Quality of health care

1. Specialist training should be offered to health care workers on the SRH needs of adolescents, including procedures to assure privacy and confidentiality and non-judgmental approaches to discussing sexuality.
2. Protocols should be developed for the management of adolescents who seek access to contraception and abortion before the age of legal majority, particularly regarding the issue of disclosure to parents.
3. Opening times and the design of health care facilities should be oriented to the needs of adolescents and those with disabilities.
4. Adolescents should be educated about the services available to them.
5. Examples of good practice in terms of outreach, mobile services, community health workers and adolescent involvement in service delivery should be scaled up and emulated.
6. In the development of training and guidelines for health care workers there is the need for greater focus on STIs other than HIV, adolescent pregnancy, understanding of risk factors and vulnerabilities and processes of behavioral and environmental change.

Educational approaches

1. Institutional barriers to the implementation of HFLE should be addressed. It should be a required part of the educational curriculum. Resources such as videos and print materials should be developed to support teachers in generating discussion and interactive teaching sessions.
2. Evidence-based interventions such as the Trinidad and Tobago Family HIV Workshop and Focus on Youth Caribbean should be used as models for the development of parenting and teacher skills.
3. Communication campaigns targeting vulnerabilities such as violence, substance abuse and gender norms should be strengthened.
4. Organizations conducting ASRH outreach, edu-tainment and peer education should be strengthened.
5. Faith-based organizations should be brought into the multi-sectoral response to ASRH.

Services for vulnerable adolescents

1. A multi-sectoral response to ASRH should be developed, along the lines of the expanded response to HIV. At national and regional level, the activities of various agencies should be coordinated to assure a coherent response both to the needs of the general adolescent population and vulnerable groups.
2. Counseling and psychosocial support should be available and accessible to all young people with HIV/ STI or who have experienced a pregnancy or abortion.
3. The proportion of ASRH resources dedicated to interventions with vulnerable populations should be increased. This includes supporting organizations working with adolescents on mental health, poverty, HIV stigma and discrimination, drug and alcohol abuse, sex work, transactional sex, LGBTI issues and gender issues including masculinities. The technical skills of people working in these agencies should be enhanced via a coordinated human resource development strategy.
4. ASRH services should be integrated with initiatives to increase vocational skills and youth employment.
5. Agencies addressing alcohol and drug abuse should increase their focus on adolescents and be included in ASRH interventions and strategies.