Reaching Poor Adolescents in Situations of Vulnerability with Sexual and Reproductive Health

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Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

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Preface

Young people face a myriad of obstacles which exclude them from health and which are closely linked with poverty, marginalization, and discrimination. Today, 40% of youth live in poverty in the Latin America and the Caribbean Region. This situation has a direct impact on their health and well-being, ultimately limiting their capacity to realize their full potential.

The health of poor and vulnerable adolescents is a priority for the Pan American Health Organization (PAHO), reflected by the mandates of the Member States, through the adoption—in 2008 and 2009—of the Regional Strategy for Improving Adolescent and Youth Health and the Plan of Action on Adolescent and Youth Health. At that time, Member States were encouraged to strengthen the response capacity of policy-makers, program directors, and health providers to expand policies and programs that promote community development and provide effective health services that address the health of excluded adolescents and youth.

Further, these resolutions are a call to promote the participation of adolescents and youth, their families, and communities to implement culturally sensitive and age-appropriate health promotion and prevention programs as part of a comprehensive model to improve the health and well-being of young people.

Within this context, PAHO, in collaboration with the Royal Norwegian Embassy and the Spanish Agency for International Development, are pleased to present *Reaching Poor Adolescents in Situations of Vulnerability with Sexual and Reproductive Health*. With many vulnerable youth living in the Region, it is important to understand the impact that poverty has on these young people in order to develop evidence-based health programs.

This document is intended to inspire and guide leaders responsible for shaping social policies and decision-makers concerned with the comprehensive health and development of adolescents and youth. It is our hope that, by reflecting upon this document, the countries of Latin America and the Caribbean will make significant advances toward improving the health and well-being of poor and excluded adolescents.

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Acknowledgments

Acronyms

ASRH
Adolescent sexual and
reproductive health

CDC
Centers for Disease Control
and Prevention

CSC
Consortium for Street Children

DHS
Demographic and Health Surveys

ECOSOC
Economic and Social Council

GWG
Global Working Group on HIV and
Sex Work Policy

HDI
Human Development Index

HOI
Human Opportunity Index

HRP
Special Program of Research,
Development and Research Training
in Human Reproduction

IDU
Injection drug users

IOM
U.S. Institute for Medicine

International Organization for
Migration

IPPF
International Planned Parenthood
Federation

LAC
Latin America and the Caribbean

LGBT
Lesbian, gay, bisexual, and
transgender people

MDG
Millennium Development Goals

MSM
Men who have sex with men

MSSM
Modified Social Stress Model

NGO
Nongovernmental organization

NSWP
Network of Sex Work Projects

POA
Adolescent and Youth Regional
Strategy and Plan of Action
2010-2018

SRH
Sexual and reproductive health

STI
Sexually transmitted infections

UNAIDS
The Joint United Nations Program
on HIV/AIDS

UNDP
United Nations
Development Program

UNESCO
United Nations Educational,
Scientific and Cultural Organization

UNFPA
United Nations Population Fund

UNGASS
United Nations General Assembly
Special Session on HIV/AIDS

UNICEF
United Nations Children's Fund

UNODC
United Nations Office on Drugs
and Crime

USAID
United States Agency for
International Development

WDR
World Development Report

YFS
Youth friendly services
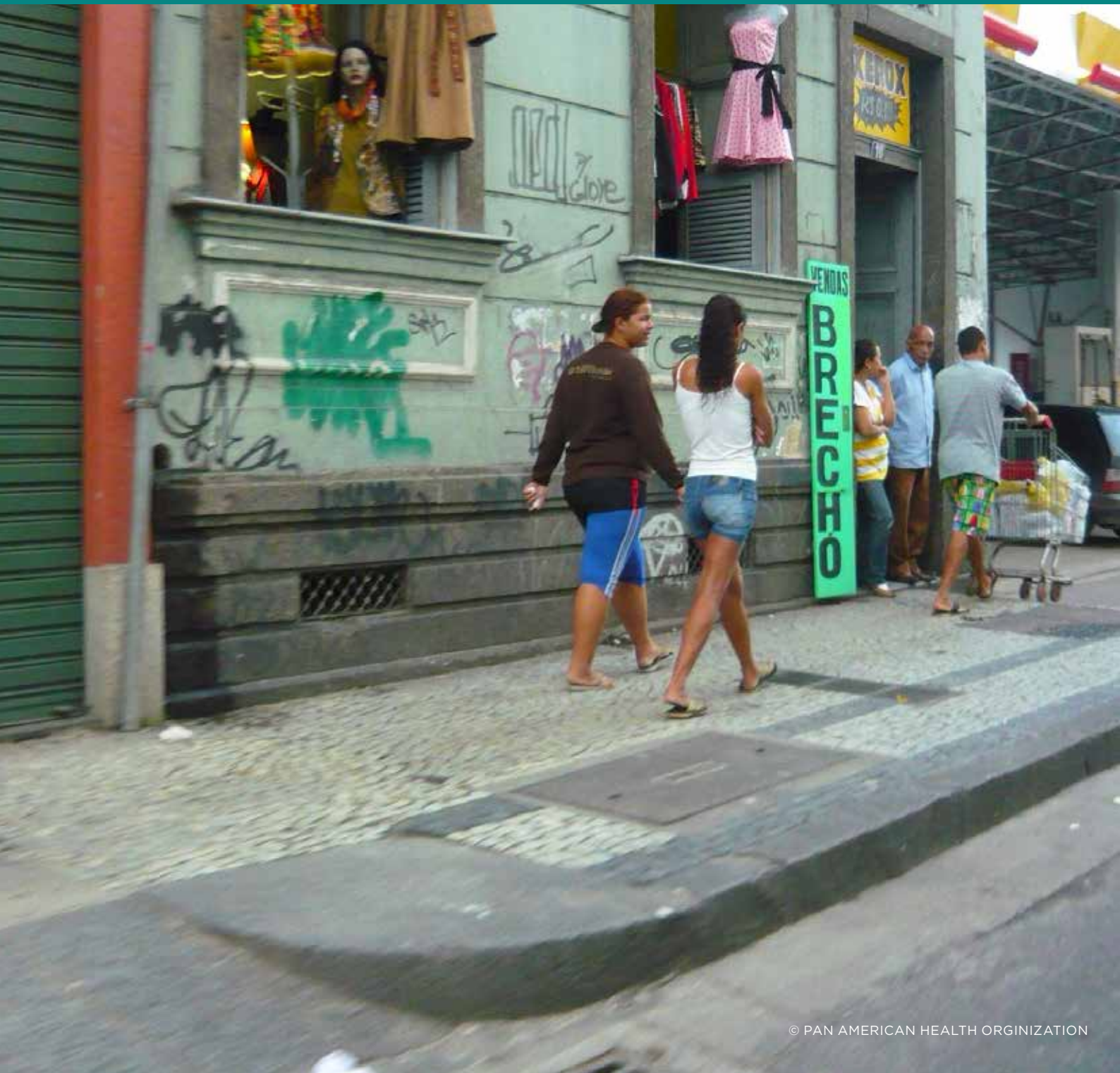
Introduction

Reaching Poor Adolescents in Situations of Vulnerability with Sexual and Reproductive Health is a document on how best to attain optimum sexual and reproductive health amongst poor adolescents in situations of vulnerability in Latin America and the Caribbean (LAC) using evidence based tools and strategies. "Poor adolescents in situations of vulnerability" includes concepts of exclusion, invisibility, and susceptibility to circumstances and life events that negatively impact young persons not only during adolescence but also in adulthood. The Pan American Health Organization (PAHO) defines adolescence as the period between 10–19 years of age, youth as 15–24 years of age, and young people as individuals between 10 and 24 years of age.

In PAHO's Adolescent and Youth Regional Strategy and Plan of Action (POA) 2010–2018, seven strategic areas are provided as guidelines in order to meet the needs of young people in LAC. While significant results may only become apparent at sub-national levels, achieving changes in these strategic areas will help reach the most vulnerable young people. As outlined in the first strategic area, **improving strategic information and innovation** is critical to identifying strategies and interventions that can improve adolescent sexual and reproductive health (ASRH). When developing health programs, underlying factors such as household poverty, gender, ethnic membership, and age, must be explicitly addressed; baseline data must be transformed into usable and relevant information; and targeted interventions should determine whether poor, ethnic minority, young, and gender excluded adolescents have been reached.

Environments that enable the health and development of adolescents and youth by using evidence-based policies is the second strategic area in the POA. It emphasizes local and national contexts when reaching the poor, given that marginalized adolescents make up small and often invisible sub-populations. Latin America and the Caribbean is a heterogeneous region in which contexts vary tremendously. For example, marginalized young people in one country may not be marginalized in another. Further, the characteristics of a group in situations of vulnerability in one region (such as, migrants), may not be the same in another. In order to improve ASRH in the Region, the epidemiological, institutional, and social context of each country should be taken into consideration.

Despite increasingly sophisticated information technologies, health systems are failing to reach marginalized adolescents as social and health data on this population are still difficult to obtain and often incomplete, inaccurate, and inconsistent in many countries. This may be due to the fact that marginalized adolescents are sometimes identified as out-of-school; street children; migrants (such as domestic workers or victims of trafficking); disabled persons; minority ethnic groups; and/or those at risk of HIV infection. What these groups have in common is that they are invisible, stigmatized, and may be engaged in illegal activities; all challenges to meeting their needs. Moreover, these are groups that often suffer human rights violations, such as lack of access to information and services, lack of protection against violence, and lack of privacy. The third strategic area in the POA addresses these issues by recommending **integrated and comprehensive health systems and services**.

Difficulty in obtaining information on marginalized youth may also be due to the following:

• While individual programs or projects may have found significant results, lessons learnt are often not scaled up to reach larger populations. For example, certain projects or programs may be effective due to carefully designed efforts using locally appropriate resources to meet the needs of a particular group, and thereby only effective for one group and not others, even though labels such as "street children," "migrants," or "sex workers" may be similarly defined.

• The HIV/AIDS epidemic spreads at varying rates in different countries and regions. For example, the Caribbean has a higher HIV prevalence in comparison to Latin America; however, HIV/AIDS work in Latin America is concentrated in key populations. Therefore, not only is addressing the most-at-risk HIV populations critical to how HIV develops in a country, but also the effective approaches that provide guidance on how to reach adolescent groups in situations of vulnerability.

- Oftentimes, politicians have little direct experience in living and working with groups of invisible, marginalized young people and as a result these groups are often not on the political agenda. It is important to, therefore, raise awareness and increase participation among policy makers to ensure that marginalized youth are put on the political agenda.

Not only is access to health services critical but the quality of services is critical too. Poor and marginalized adolescents may not seek health services, as they face stigma and discrimination and less-than adequate care from health personnel. Strategic area four supports the development and strengthening of **human resources capacity building** in order to improve the quality of adolescent and youth health promotion, prevention, and care.

Poor and marginalized groups have, at best, fragile connections to their families, schools, and communities. The fifth strategic area supports **family, community, and school-based interventions**. Although initiatives to reach marginalized groups through families and schools may be of limited help, efforts should be directed at increasing community institutions efforts to involve families and communities in reaching out to marginalized adolescents.

In order to reach poor and marginalized adolescents, it is important to facilitate dialogue and build alliances between strategic partners to advance an agenda for marginalized youth. This can be achieved through **strategic alliances and collaboration with other sectors (**the sixth strategic area) in order to avoid duplication and to ensure that there is a consistent, unified approach in reaching marginalized adolescents.

Little is known about the extent and use of new communication technologies and media among groups in situations of vulnerability. However, adolescents are among the first to take up recently developed social communication opportunities. **Social communication and media involvement**, the seventh strategic area in the POA, is an important outlet to use in order to reach poor and marginalized adolescents, as the extent of access to communication is growing rapidly and this provides opportunities for sharing information in a confidential manner.

The first part of this document is intended for policy and decision-makers in the countries, including the Ministry of Health. It provides a literature review on the work that has already been done to reach marginalized adolescents in various international organizations (including PAHO, UNICEF, the World Bank, among others), and at the policy level, and recommends four priority tasks in order to reach marginalized adolescents. The second part of this document builds on the literature review, and identifies additional sources of information and tools that may be useful for policy makers. The POA's seven strategic areas provide a framework for how to pursue these efforts.

Literature Review

Vulnerability

According to PAHO, vulnerable populations are defined as:

Groups that, due to biological, environmental or socio-cultural factors, have limited or no control over exposure to hazardous or risky situations. These people may not be frequently exposed to risk, but if they are exposed they have less power to avoid it or to lessen its damaging effects (2).

Vulnerability affects the ability that young people have to successfully transition into adulthood in terms of the roles they will play as parents, participants in the wider society, and as responsible citizens. Their evolving capabilities need to be cultivated and protected.

Sexual and reproductive health (SRH) decisions and behavior during the adolescent years have long lasting consequences on a young person's life chances and their vulnerability. Due to age, adolescents have limited control over exposure to risky situations, as it is a period defined by physical, emotional, and social changes. It is a time of exploration and a time for personal and gender identity development and expression. A number of situations can threaten this transition: weak family and school ties; an insecure economic base that leads to decisions that further weaken ties to established communities; participation in risk-taking activities; and poor SRH decision-making.

Ultimately, adolescents are often overlooked, as they are no longer children and not quite yet young adults. Attempts, therefore, to meet the SRH needs of young people under 18 can be hampered by their status as children. As a result, they are often given little say in the circumstances that directly affect them.

Underlying Factors of Vulnerability

Poverty

Poverty is multi-dimensional, dynamic, and includes subjective dimensions such as powerlessness and voicelessness. It includes a lack of access to meeting basic needs such as food, shelter, clothing, sanitation, education, and health. Although poverty has been defined as living on less than US$ 2 per day and "extreme poverty" as under US$ 1 per day, it includes dimensions beyond income. The importance of income should be considered within the context of family and social support, inclusion in social, political, and economic institutions, access to other assets, and opportunities available. Gender, ethnicity, and age are important dimensions within poverty and should be seen as acting simultaneously with poverty.

Definitions

The Human Development Index (HDI) measures social and economic development based on life expectancy, educational attainment, and income (*3*).

The Gini Index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. The index ranges from 0 (total equality) to 100 (greatest possible inequalities) (*4*).

The Human Opportunity Index (HOI) measures the percentage of available opportunities needed to ensure children's universal access to basic services and their equal allocation. The index ranges from 0 (absolute deprivation) to 100 (universality) (*5*).

Income inequality denotes the unequal distribution of household or individual income across the various participants in an economy (*6*).

Poverty is measured in different ways at the national level through indicators, such as, social and economic development; inequalities and inequities; and opportunity (as outlined below).

The Human Development Index (HDI) measures social and economic development based on life expectancy, educational attainment, and income. Table 1–1 lists PAHO member countries in order of their HDI rank along with their HDI value and the percentage of populations living in poverty. The table shows that while all (except Haiti) of the countries in Latin America and the Caribbean are considered by UNDP to have achieved medium or high human development, people living in poverty make up significant sub-populations of the Region. Even by a country's own definition of poverty, approximately half of many of the countries' population live in poverty.

Another way to determine poverty is to examine inequalities and inequities. Health indicators often fail to take into account the wide disparities that are found between the lowest and highest income groups in a country. One of the best ways to measure income inequalities is to use the Gini Index. Values for the coefficient range from 0 (total equality) to 100 (greatest possible inequality). Table 1–2 shows the Gini Index together with the shares of income or consumption of the highest and lowest 10% of a country's population. This demonstrates the relative disparity between the rich and the poor. Income and consumption inequalities relate to a person's or household's ability to access services and information. What is important to note however, is that although the Gini Index demonstrates inequalities, it may not be able to reach the poorest 10% of the population—risking, therefore, that many of the groups in situations of vulnerability discussed in this document, are not included in surveys that capture this data.

Poverty is also related to a lack of opportunity. The World Bank, together with Brazil's Instituto de Pesquisa Economica Aplicada and Argentina's Universidad de la Plata, have devised a Human Opportunity Index (HOI) as a way to measure the extent to which personal circumstances (such as, race, gender, birthplace, parental educational level, and father's occupation) during childhood affect adult income inequality. Table 1–3 shows 19 LAC countries ordered according to their HDI rank, together with their HOI and their Gini Index values. This table shows the complex nature of inequalities and poverty in a country. For example, Chile, Argentina, and Venezuela score higher on opportunity but have fairly robust income disparities.

Table 1–1. PAHO Member States, the Human Development Index (HDI) rank (2010) and income poverty indicators (2000–2008)

HDI rank	Country	HDI Value 2010	% population living under US$ 1.25 per day 2000–2008	% population living under national poverty line 2000–2008
Very High Human Development				
4	United States	0.902	--	--
8	Canada	0.888	--	--
42	Barbados	0.788	--	--
High Human Development				
43	Bahamas	0.784	--	--
45	Chile	0.783	<2	--
46	Argentina	0.775	3.4	--
52	Uruguay	0.765	<2	--
54	Panama	0.755	9.5	36.8
56	Mexico	0.750	4.0	47.0
59	Trinidad and Tobago	0.736	--	--
62	Costa Rica	0.725	<2	23.9
63	Peru	0.723	7.7	51.6
73	Brazil	0.699	5.2	21.5
75	Venezuela	0.696	3.5	--
77	Ecuador	0.695	4.7	38.6
78	Belize	0.694	na	--
79	Colombia	0.689	16.0	45.1
80	Jamaica	0.688	<2	18.7
Medium Human Development				
88	Dominican Republic	0.663	4.4	48.5
90	El Salvador	0.659	6.4	30.7
94	Suriname	0.646	--	--
95	Bolivia	0.643	11.7	37.7
96	Paraguay	0.640	6.5	--
104	Guyana	0.611	--	--
106	Honduras	0.604	18.2	50.7
115	Nicaragua	0.565	15.8	45.8
116	Guatemala	0.560	11.7	51.0
Low Human Development				
145	Haiti	0.404		

Table 1–2. Income inequality (2000–2010)

HDI rank 2006	Country	Gini index 2000–2010	Income/expenditure share 1992–2007	
			Poorest 10% of population	Richest 10% of population
Very High Human Development				
4	United States	40.8	1.9	29.9
8	Canada	32.6	2.6	24.8
42	Barbados	--	--	--
High Human Development				
43	Bahamas	--	--	--
45	Chile	52.0	1.6	41.7
46	Argentina	48.8	1.2	37.3
52	Uruguay	47.1	1.7	34.8
54	Panama	54.9	0.8	41.4
56	Mexico	51.6	1.8	37.9
59	Trinidad and Tobago	40.3	2.1	29.9
62	Costa Rica	48.9	1.5	35.5
63	Peru	50.5	1.5	37.9
73	Brazil	55.0	1.1	43.0
75	Venezuela	43.4	1.7	32.7
77	Ecuador	54.4	1.2	43.3
78	Belize	59.6	--	31.4
79	Colombia	58.5	0.8	45.9
80	Jamaica	45.5	2.1	35.6
Medium Human Development				
88	Dominican Republic	48.4	1.5	38.7
90	El Salvador	46.9	1.0	37.0
94	Suriname	52.8	1.0	40.0
95	Bolivia	57.2	0.5	44.1
96	Paraguay	53.2	1.1	42.3
104	Guyana	43.2	1.3	34.0
106	Honduras	55.3	0.7	42.2
115	Nicaragua	52.3	1.4	41.8
116	Guatemala	53.7	1.3	42.4
Low Human Development				
145	Haiti	59.5	0.9	47.8

Source: United Nations Development Program. The Real Wealth of Nations: Pathways to Human Development. New York; UNDP; 2010. Available at: *http://hdr.undp.org/en/media/HDR_2010_EN_Complete_reprint.pdf*. Accessed on 10 June 2010.

Table 1–3. Human Opportunity Index (2002–2009) and other indicators of income poverty (2000–2008)

HDI rank	HOI	Country	Gini Index	% Population living below US$ 1.25 a day 2000–2008
45	92	Chile	52.0	<2
46	88	Argentina	48.8	3.4
75	87	Venezuela	43.4	3.5
62	88	Costa Rica	48.9	<2
52	90	Uruguay	47.1	<2
56	86	México	51.6	4.0
77	76	Ecuador	54.4	4.7
79	79	Colombia	58.5	16.0
80	81	Jamaica	45.5	5.8
73	76	Brazil	55.0	12.7
88	73	Dominican Republic	48.4	15.1
-	73	LAC HOI Average	--	--
54	69	Panama	54.9	17.8
96	71	Paraguay	1.1	14.2
63	69	Peru	50.5	18.5
95	69	Bolivia	0.5	30.3
90	53	El Salvador	46.9	20.5
106	48	Honduras	0.7	29.7
116	51	Guatemala	1.3	24.3
115	46	Nicaragua	1.4	31.8

Source: The World Bank. Human Opportunity Report for Latin America and the Caribbean 2010. Washington DC: World Bank, 2010.

Sexual and reproductive health is related to poverty. Studies have found that lower household economic status is associated with poorer SRH indicators. Demographic and Health Surveys (DHS) (*7*) that have examined household wealth status with a number of reproductive health indicators have found that:

• A larger percentage of young women, aged 15–24, in the lowest wealth quintile were more likely to become pregnant at least once in their lives than those in higher wealth quintiles.

• Young women, aged 15–24, in the lowest wealth quintile had a greater unmet need for contraception than their sisters, who were better off, in the highest household wealth quintile.

• Among currently married young women, those in the highest household wealth quintiles were more likely to use a modern contraceptive method compared with women in lower wealth quintiles.

Table 1–4. Reproductive health indicators in relation to household wealth status (2001–2005)

	Wealth status (quintiles)				
	Lowest	**Second**	**Middle**	**Fourth**	**Highest**
Percentage of adolescents age 15–19 who had children or are currently pregnant, by household wealth index					
Bolivia 2008	31	23	18	16	8
Colombia 2010	29	28	19	14	7
Dominican Republic 2007	37	30	20	14	8
Guyana 2009	38	21	20	9	4
Haiti 2005-06	22	16	18	13	7
Honduras 2005–06	31	24	27	20	10
Nicaragua 2001	38	31	25	20	15
Peru 2004–05	30	18	14	9	4
Percentage of currently married young women who use a modern method of contraception, by household wealth status					
Bolivia 2003	25	29	33	40	51
Colombia 2005	45	58	61	64	69
Dominican Republic 2002	40	46	47	47	49
Guyana 2004	42	32	(32)*	(25)*	(46)*
Honduras 2005	34	43	49	57	59
Nicaragua 2001	53	59	62	66	65
Peru 2004–05	33	44	42	69	51
Percentage of currently married young women with an unmet need for family planning, by household wealth status					
Bolivia 2003	40	31	31	29	19
Colombia 2005	18	13	9	9	4
Dominican Republic 2002	27	22	20	20	26
Guyana 2004	--	--	--	--	--
Honduras 2005	30	24	24	20	19
Nicaragua 2001	22	19	17	17	14
Peru 2004–05	18	17	8	3	15

Source: Khan S, Mishra V. Youth Reproductive and Sexual Health. DHS Comparative Reports No. 19. Calverton (Maryland): Macro International Inc.; 2008.
*Figures in parentheses are based on 25–49 unweighted cases

Gender

Adolescence is a period when young people begin to explore what it means to be male and female and to establish their gender identity. In the Special Rapporteur on the Right to Health, the United Nations General Assembly Human Rights Council provides the following definitions (*8*):

Definitions

Gender describes those characteristics of women and men that are socially constructed, while **Sex** refers to those which are biologically determined.

Gender identity is defined as each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the person's sense of the body and other expressions of gender.

Gender equality in health means that women and men have equal opportunities for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results.

Gender inequity in health refers to those inequalities between women and men in health status, health care, and health work participation, which are unjust, unnecessary, and avoidable. Equity is the means, equality is the result.

Gender analysis in health examines the interaction of biological and socio-cultural factors to highlight how they positively or negatively affect health behaviors, risks and outcomes, access and control over health resources, and contribution to care.

People are born female or male but learn to be girls and boys who grow into women and men. This learned behavior makes up gender identity and determines gender roles.

Among men and adolescent boys, traditional expectations related to masculinity are often associated with behaviors that increase their risk of HIV infection. Male attitudes towards sexuality and risk-taking behavior increases adolescent boys' vulnerability to accidents and homicides, STIs, and early fatherhood. Further, the role of alcohol and illegal drug use, the secrecy of same-sex activities, inconsistent condom use, prestige associated with having multiple sexual partners, and attitudes towards interpersonal violence create vulnerabilities among certain groups of adolescent boys.

Sexual violence and sexual coercion are often rooted in male notions of entitlement, control, and dominance. For example, violence among adolescent males is socially accepted in many cultures. There is a widely held belief that sexually aroused males are not able to control themselves and it is the girl's responsibility to not act in a provocative manner.

Among women and adolescent girls, cultural and social gender norms often restrict their access to basic information, prescribe an unequal and more passive role in sexual decision-making, undermine autonomy, and expose them to sexual coercion. Adolescent females are at an increased risk of early pregnancy, unsafe abortions, early motherhood, sexual exploitation, sexual abuse, and are less able to negotiate safe sex. Studies in the Dominican Republic and Guyana have found that fewer young women reported condom use on the last occasion of sex with a non-spousal, non-cohabitating partner in the previous 12 months (7). The situation is further compounded by an insecure economy, leading to forced migration and/or transactional sex. When combined with low levels of schooling, adolescent girls have limited resources for asserting and ensuring their sexual and reproductive rights to self-protection, services, and information; thus, motherhood can be tempting for some as it confers adult status - a strong motivation for having a child at a young age.

Gender differences have also been found in sexual behavior. While there is little difference in never being sexually active among girls in urban and rural areas and between girls who have completed primary school or secondary school, such differences are found among males. Studies have found that adolescent boys in higher household wealth quintiles are more likely to have ever had sex than those in lower household wealth quintiles.

As in other parts of the world, LAC is experiencing a feminization of the HIV/AIDS epidemic. In Jamaica, for example, among 10–19 year olds, the male to female infection ratio is 1: 2.84—making young adolescent girls three times more likely to become infected than adolescent boys of the same age (9).

Gender identity is each person's internal and individual experience of gender. Transgender persons are those whose sense of themselves as male or female differs from that usually associated with their sex at birth. Transgender adolescents may be heterosexual, homosexual, or bisexual. Adolescence is also a period when individuals become aware of their sexual attraction. Understanding the factors associated with young people's sexual attraction and sexual orientation is also important to reaching populations in situations of vulnerability as defined below (*8*).

Definitions

Sex: Characteristics of women and men that are biologically determined.

Sexual orientation: Each person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.

In December 2008, 66 countries signed a statement that was presented at the UN General Assembly that affirmed that international human rights protections include sexual orientation and gender identity, condemning rights abuses against LGBT persons. Fourteen of PAHO member countries are signatories to this statement (*10*). Additionally, in June 2009, the Organization of American States (OAS) adopted the Resolution on Sexual Orientation, Human Rights and Gender Identity in its 39th General Assembly session to reaffirm that all human beings are born free and equal without distinction of any kind.

Ethnic diversity
Indigenous and Afrodescendants make up nearly a quarter of the Region's total population. In Peru, Guatemala, Bolivia, and Ecuador, indigenous groups make up more than 40 percent of the population (*11*). In LAC it is estimated that they account for approximately 45–50 million people who belong to more than 400 ethnic groups making up 40% of the rural population. In Brazil, Colombia, Venezuela, the English-speaking Caribbean, Haiti, and the Dominican Republic Afro descendants account for more than 45% of the population. Altogether, they approximately account for 150–200 million people in the Region (*12*), however

information on their living conditions and health is sparse, which greatly deters efforts to meet their needs (as outlined in Table 1–5).

Definitions

Ethnicity: refers to a construction of a collective identity. It describes a series of relationships between groups within a social order but also a type of changing awareness in time (*13*).

Ethnic groups: Clusters of people who share common cultural traits that distinguish them from other people. By virtue of sharing a common language, values, beliefs, food habits, place of origin, geographic location, religion, tradition, and a sense of history they view themselves, and are perceived as an ethnic group (*13*).

Indigenous populations: People who self-identify as indigenous adhere to social, cultural, and economic conditions that distinguish them; they are governed completely or partially by their own customs, traditions, or by special legislation. They are descendants of people who inhabited lands before conquest, colonization, or the establishment of national boundaries (*14*).

Race: A sociological concept based on social, cultural, and political differences among individuals. There are no genetic or biological bases for classifying individuals but even though race may be a biological fiction it is an important determinant of health status and health care quality (*15*).

The lack of information on the living conditions and health of minority ethnic groups is largely due to the fact that these populations are often invisible and overlooked in studies and national surveys. This deficit causes ethnic diverse populations to be omitted from national health plans, strategies and policies, and neglected by national health systems and their services. Other barriers preventing ethnic diverse populations to access health services include large geographical distances to services, inconvenient opening hours of health services, and the lack of cultural sensitivity among providers and health services. As indigenous populations often make up many separate ethnic communities that

Table 1–5. Total indigenous population estimates in the Americas as a percent of the total of the population in selected countries (2002–2004)

Percent	Total indigenous population		
	<100,000	100,000 to 500,000	> 500,000
More than 40			Peru Guatemala Bolivia Ecuador
5 to 40	Guyana Belize Suriname	El Salvador Nicaragua Panama	Mexico Chile Honduras
Less than 5	Costa Rica Guyana Jamaica Dominica	Argentina Brazil Paraguay Venezuela	Canada Colombia United States of America

Source: Inter-American Development Bank. Reports on the Evaluation of the International Decade of the Indigenous Peoples of the World. Washington, DC: 2002. Pan American Health Organization. Health of the Indigenous Peoples of the Americas. Washington, DC: PAHO; 2006 (CD47/13).

often live in remote areas and do not share a common bond or language, countries should acknowledge and provide for the diverse nature of indigenous populations.

Ethnic background, together with low socio-economic status, rural residence, and lower educational levels are associated with lower contraceptive use, lower coverage of prenatal and delivery care, and shorter intervals between first and second births. For example, the contraceptive use among married Guatemalan women is higher among the non-indigenous than indigenous. In addition, the maternal mortality ratio among Guatemalan indigenous women is three times higher than among non-indigenous Guatemalan women (*16*).

Indigenous youth often face social and institutional discrimination impeding their access to health services that are due to the following (*17*):

a) Marginal political and legal status
b) Lower literacy levels and educational achievement
c) Barriers to economic opportunities and employment
d) Limited access and barriers to health and other services
e) Limited knowledge on Sexual and Reproductive Health and Rights (SRHR)

Adolescents in Situations of Vulnerability

Adolescents, in general, face difficulties accessing health information and care; these challenges are exacerbated for adolescents in situations of vulnerability whose needs are not being met by available services. Populations in situations of vulnerability have received increased attention in recent years, although international institutions differ on who they consider to be most vulnerable. While these differences reflect the primary focus of each institution's work, together they present a consistent picture, as demonstrated below.

The UN Special Program of Research, Development and Research Training in Human Reproduction (HRP)

The HRP was established by the World Health Organization (WHO) in 1972. Between 1998 and 2003, it supported over forty studies on ASRH in developing countries. In a review of these studies, the WHO identified adolescents in situations of vulnerability as those living in poverty and amidst social conflict, out-of-school, refugees, and migrants (*18*):

> *"Although all adolescents typically have reduced perceptions of personal risk from unsafe sexual activities, social context is an important marker of the extent of risk-taking. In every social setting in the studies that were reviewed, adolescents with strong family ties and educational achievement were more likely to have the life skills to better be able to cope with the challenges of negotiating safe sexual activity."*

Collectively, it was found that adolescents in situations of vulnerability were less likely to have a basic knowledge of contraception and reproduction; more likely to experience or initiate risky sexual behavior; more likely to be involved in transactional sex; less able to protect against sexual coercion, including the inability to negotiate contraception and protection for STIs and HIV.

   Regarding condom use, the review article notes, that "…condoms may be used for initial sexual encounters but use fades if the seriousness of the relationship increases; a stronger emotional bond creates the perception that risk of infection or unwanted pregnancy is reduced."

The World Health Organization (WHO)
A 2004 WHO literature review of over 11,000 documents reported on risk and protective factors related to ASRH behaviors (*19*) including age of sexual debut, pregnancy occurrence, HIV infection, contraceptive use, condom use, early childbearing, multiple sexual partners, and STI infections; concluding that the factors that put young people at risk for and protect them from compromising sexual health behaviors are multifaceted.

United Nations Children's Fund (UNICEF)
According to UNICEF, exclusion is an integral component of vulnerability whereby children may be excluded from access to essential goods and services and rights protecting them from violence, abuse, and exploitation. This lack of protection threatens their ability to fully participate in a future society. Closely linked to exclusion is invisibility and includes: a lack of or loss of formal identity; inadequate State protection for children without parental care; exploitation through trafficking and forced labor; and premature entry into adult roles related to marriage, hazardous labor, and combat (*20*).

The World Bank
In its 2007 *World Development Report (WDR)*, the World Bank determined that young people's transition to adult life is a critical period as this is when they develop the tools and resources for continuing education, employment, developing a healthy lifestyle, forming families, and exercising citizenship. The report concluded that adolescence is a period of investment for the future (*21*).

In *Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential,* a number of studies on at-risk youth was conducted in order to determine the characteristics of at-risk youth in LAC while providing evidence-based guidelines to inform policy makers. Using a conceptual framework based on the life-cycle approach, risk factors were grouped by risky behaviors and negative outcomes, ranging from the micro to the macro level. Feeling disconnected from home, not feeling that one has a parent who cares, and poverty are underlying factors to risky behavior. The report found that youth who are most at-risk are from the poorest households and characterized as being inactive and illiterate, as well as, having dropped out of secondary school. Among young women at-risk, seventy-five percent have children. Indeed, risky sexual behavior, including early sexual debut, unprotected sex, and forced sexual initiation is a significant component for groups in situations of vulnerability. For example, ten percent have experienced abuse in their homes. Education also plays a role in being at-risk.

Adolescent boys are more likely to drop out of school, enter the job market prematurely, become violent, and abuse substances. Adolescent girls are more likely to engage in early and risky sexual activity, enter marriage at an earlier age, and leave school early (*22*).

The Institute of Medicine (IOM)
Growing up Global (2005) is the National Research Council and Institute of Medicine of the National Academies report on the transitions to adulthood in developing countries. The report views education and health as necessary for a successful transition to adult roles that involve work, citizenship, marriage, and parenthood. Young people most vulnerable to risky behavior are those with loose ties to schools and families. Attention is given to SRH as an integral component for a healthy transition to adulthood, including age of sexual debut, risky sexual behavior, sexual violence and coercion, contraceptive knowledge and use, and abortion.

Specific Groups in Situations of Vulnerability

In addition to increasing awareness about adolescents in situations of vulnerability, there is a need for further information on groups such as street children, victims of trafficking, and those at-risk for HIV. Among these groups one finds a nexus of factors related to vulnerability: poverty, gender, invisibility, low educational achievement, and risky sexual behavior. Stigma continues to remain a barrier which contributes to the underreporting of these groups. The paucity of data often impedes the identification of groups at risk within and among countries, as well as the risk and protective factors for health behaviors and outcomes.

There are no internationally agreed definitions for many groups in situations of vulnerability discussed in the following section. Current working definitions are often vague and subject to debate. In reviewing the literature, it is apparent that terms have been conflated. In some settings, "sex workers" include migrant laborers; "street children" are confused with "out-of-school"; "at-risk for HIV" includes people who are living with HIV and AIDS. Further, labels may not include groups that are overlooked. For example, "sex workers" may not include young males or transgender people; "victims of sexual abuse" may not include sex workers or people with disabilities.

Given the paucity of data, marginalized groups are invisible, and adolescents within marginalized groups tend to have heightened invisibility. Indeed, determining group composition is difficult as many groups are fluid, with young people moving in and out of them at different times and places.

As mentioned earlier, the period of adolescence is defined as 10–19 years of age, however, many studies qualify that those under 18 years of age are children. Oftentimes, available literature refers to children or adults and not adolescents. This is further compounded by illegal activities that some marginalized groups partake in, such as sex work and illegal drug use – all multiple reasons for remaining hidden. Groups in situations of vulnerability often face stigmatization and discrimination. As a result, individuals are reluctant to be identified with a group. In addition, groups may overlap and co-exist, so that adolescents are likely to suffer multiple forms of stigma and discrimination. This, coupled with their age means that young people who are out-of school, on the street,

disabled, migrants, and/or are at-risk for HIV, lack the protection from violence, exploitation, and other human rights violations.

Addressing the needs of each of these groups requires knowledge about the local context. How to reach them depends on the political landscape of each country. There is no single set of policies and/or services that can best reach marginalized adolescent groups.

The following section is not intended to provide a comprehensive review of each group. Rather, the descriptions will clarify issues pertaining to each group and stimulate ways of thinking about them so that PAHO officers and national policy makers are better able to implement the Adolescent and Youth Health POA.

Out-of-school youth

No formal definition of "out-of-school" exists for adolescents. The United Nations Educational, Scientific and Cultural Organization (UNESCO) states that 'out-of-school' refers to primary school and to some extent the adolescent period. The situation is further complicated by the country; in countries that have a compulsory school requirement (such as the United States), young people who are not attending may be considered "out-of-school", however, in countries that have universal schooling policies where access to basic schooling (usually between 6–9 years) is considered a right, those not registered can be considered "out-of-school."

Net enrollment ratios are the best indicators for school enrollment and are defined as the proportion of children of a relevant age group enrolled in school. The *gross enrollment ratio* counts the number of people enrolled in a given education level regardless of age, expressed as a percentage of the population in the theoretical age group for the same level of education. This means that gross enrollment ratios may be above 100%, as older persons may be attending school at a level that is designed for younger students (e.g. 17 year olds in 5th grade).

Based on UNESCO's *Education for All Global Monitoring Report 2009,* Table 1–6 shows the net enrollment ratios for selected countries ordered according to their HDI index rank. At the primary school level girls' enrollment is equal to that of boys in the Region overall. There is a slight differential in the Caribbean with fewer girls enrolled in primary school. At the secondary school level, more girls are enrolled in schools than boys indicating that they successfully transition from primary to secondary school more often. As with other population based national statistics, data quality can vary considerably. Importantly, school enrollment does not mean school attendance or educational achievement.

Table 1–6. Primary and secondary net enrollment ratio in selected countries of the Americas, school year ending in 2006

HDI rank	Country	Net primary school enrollment ratio %		Net secondary school enrollment ratio %	
		Female	Male	Female	Male
4	Canada	--	--	--	--
13	United States	--	--	--	--
37	Barbados	96	97	89	88
49	Argentina	98	99	82	75
44	Chile	--	--	--	--
50	Uruguay	100	100	--	--
54	Costa Rica	--	--	--	--
52	Bahamas	89	87	85	83
51	Cuba	97	96	88	86
53	Mexico	97	98	70	71
62	St Kitts and Nevis	78	64	61	70
47	Antigua and Barbuda	--	--	--	--
64	Trinidad and Tobago	85	85	66	64
60	Panama	98	99	67	61
75	Brazil	95	93	83	75
73	Dominica	79	75	85	77
69	Saint Lucia	97	99	80	65
58	Venezuela	91	91	71	62
77	Colombia	88	89	68	61
90	Dominican Republic	78	76	57	47
93	Belize	97	97	69	64
74	Grenada	83	84	--	--
97	Suriname	98	95	79	57
78	Peru	97	96	72	72
80	Ecuador	97	96	58	57
91	St Vincent & the Grenadines	88	92	71	57
101	Paraguay	95	94	59	56
114	Guyana	--	--	--	--
100	Jamaica	90	90	80	76
106	El Salvador	94	94	55	53
124	Nicaragua	90	90	47	40
112	Honduras	97	96	--	--
113	Bolivia	95	94	72	70
122	Guatemala	92	96	37	40
149	Haiti	--	--	--	--
	Latin America and the Caribbean	94	94	73	68

Source: United Nations Educational, Scientific, and Cultural Organization. Education for All Global Monitoring Report. Paris: UNESCO; 2009.

Reasons for leaving school are varied. In a World Bank report (*22*), young people leave school due to the following reasons: financial, personal, and poor school quality.

Given that out-of-school is a vague and poorly defined term it is difficult to determine poor ASRH according to out-of-school status. Studies have found that lower levels of schooling are associated with poorer ASRH outcomes. For example, according to the most recent DHS studies, a smaller percentage of young women (aged 15–24) with secondary education have ever been pregnant compared to those with no or only primary education. Among married young women, a larger percentage of those with secondary education use a modern method of contraception compared with married women with no or only primary education (*23*). Additionally, studies have found that women reporting physical or sexual violence have fewer years of schooling than women who have not reported abuse (*24*).

The World Bank (*22*) links school dropout with crime and violence, risky sexual behavior, substance use, and unemployment. Not being in school deprives young people from the benefits of national sexual education programs.

Street children

The Convention on the Rights of the Child (CRC) (Article 1) defines a "child" as a person below the age of 18, unless the relevant laws recognize an early age of majority. "Street children", on the other hand, is defined by the Inter-American Commission on Human Rights as children, under the age of 18, who live in the streets in a risky situation (*25*). The term "Street children" is sometimes used interchangeably with "young people living or working on the streets". The Inter-Agency Task Team on HIV and Young People identifies young people living or working on the street as one of the most at-risk groups. Everyday these young people are subjected to the risk of sexual abuse and violence at the hands of their peers, parents, and police, among others. Many do not have access to appropriate services, abuse drugs, and exchange sex in order to survive to meet their basic needs (*26*).

According to UNICEF "street children" is a stigmatization, as it denotes that children are seen as threatening and are a source of criminality (*20*). One of the ways in which children become street children is when they run away from home, often in response to abuse. The majority of street children are males, as girls endure abusive situations longer. However, when girls do runaway, they are less likely to return. UNICEF has developed categories to group street children: a) *street-living children*: those who sleep in public places without their families; b) *street-working*

children: those who work on the streets during the day and return to their family home to sleep, and c) *street-family children*: those who live with their family on the streets. However, in practice and research, UNICEF has found that children's life conditions vary and overlap tremendously. Most street children are not orphans but remain in touch with their families, and provide an important contribution to household income.

Attempts to quantify the number of street children have been difficult due to the reliability and validity of the data collected (*27*). UNICEF maintains that although street children are among the most physically visible due to the nature of living and working in public spaces, they are also among the most invisible in terms of reaching them with education and health services and the most difficult to protect (*20*).

The Consortium for Street Children (CSC) is a worldwide network that works collectively to promote the rights, development and protection of street children. Violence is a constant companion for children on the streets, shaping their experiences in public spaces and influencing their lives. The CSC uses an ecological framework to analyze factors that affect street children at the individual, family, community, social and political level.

In 2000, the WHO produced a 10 module Training Package on Substance Use, Sexual and Reproductive Health Including HIV/AIDS and STDs for Street Children to determine the vulnerability associated with risky behaviors and situations associated with substance use and sexual behavior. The modules were intended to give practitioners tools for learning about street children in local contexts. In the introduction to the training package, the WHO describes street children as:

"… the casualties of economic growth, war, poverty, loss of traditional values, domestic violence, physical and mental abuse. Every street child has a reason for being on the streets. While some children are lured by the promise of excitement and freedom, the majority are pushed onto the street by desperation and a realization that they have nowhere else to go. In many countries, street children are named after their main survival activities, such as 'vendors,' 'street gangs,' and 'juvenile prostitutes.' What is obvious is that street children are poverty-stricken and their needs and problems are a result of wanting to meet basic needs for survival. Street children go through the struggle of providing themselves with basic things such as food, shelter, health and clothing. Providing targeted interventions that meet the needs of street children require an understanding of who they are, what they need, what they do and how they can be identified" (*28*).

In addition, studies have found that a large percentage of street children abuse a wide variety of psychoactive substances, depending upon geographic region, gender and age. According to the MSSM, child vulnerability to substance use increases when (*29*):

  - The child's stress level is high
  - The child experiences positive or desired effects from substances
  - The child has few positive attachments
  - The child has limited skills and coping strategies
  - Few internal or external resources are available to the child
  - Substance abuse is common in the child's community

The abuse of these substances leads to adverse consequences for the street child and the community as a whole. The WHO has found that substance abuse among street children often includes sexual activity, including unprotected intercourse, sex work or survival sex, same-sex activity, and sexual violence. The report found that street children attach meanings to sexual experiences including: sex as comfort, sex for power, initiation sex, and sex for punishment. Conclusions from the Training Package include the following (*30*):

• Street children often lack information on SRH including HIV/AIDS, even though sexuality is part of normal development.
• Street children are less likely to seek timely professional medical help and are more likely to undertake dangerous self-treatment, with resultant SRH consequences.
• Many myths and fears surround the issue of HIV/AIDS. Street educators need to help each other and the community to identify these myths and provide correct information.
• Children's vulnerability to risky sexual behaviors is associated with substance abuse.

Young people with disabilities

It is estimated that 10% of the world's population lives with a disability, however, a definition of disability has only recently been developed. The Convention on the Rights of Persons with Disabilities and Optional Protocol (*31*), which was implemented in 2008 by seventeen countries in LAC, states:

Definitions

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

There is a growing awareness regarding the neglected needs of people with disabilities. In 2007, UNFPA declared that the SRH of persons with disabilities was an important and emerging issue (*32*). In April 2009, UNAIDS produced a *Disability and HIV Policy Brief*. (*33*). In July 2009 the *Realizing the MDGs for Persons with Disabilities* document noted the absence to the needs of people with disabilities in the MDG targets, indicators, guidelines, policies, programs, and conferences (*31*).

UNICEF estimates that 30% of street youth are disabled and that 90% of children with disabilities in developing countries do not attend school (*34*). Due to active stigmatization and a lack of policies, programs, and facilities, people with disabilities experience exclusion from social, economic, and political life. Indeed, the World Bank estimates that twenty percent of the poorest people are disabled. People with disabilities are more likely to be victims of rape and violence and less likely to obtain police protection, legal protection, or preventive protection; women and girls with disabilities are particularly vulnerable to these circumstances.

Young people with disabilities may be particularly vulnerable to sexual abuse as a result of the following (*35*) (*36*):

• Physical impairments which make it difficult to protect themselves, ask for help, and/or disclose abuse
• Limited power to make choices for themselves
• Limited personal care which can make it difficult for them to set boundaries that respect their integrity
• Isolation which increases the likelihood that sexual abuse will go undetected and create barriers to disclosure

• A lack of protective policies and enforced practices in the institution or organization

Young people with disabilities have considerable difficulties accessing SRH information and services. Although there may be an occasional SRH initiative for persons with a specific disability, few countries have systematically adapted materials and services to meet the needs of a range of disabilities. Further, few health workers are trained to work with adolescents who have disabilities. In addition, HIV is a concern among disabled populations as some engage in risky sexual behavior, or are victims of sexual violence; many encounter barriers to accessing HIV prevention and care services. There are few studies on HIV prevalence among persons with disabilities although the studies that have been conducted indicate that hearing-impaired populations have higher HIV prevalence rates than the rest of the community (*33*).

Migrant laborers

Under the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families:

Definitions

Migrant worker refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.[1]

[1] The 1990 International Convention came into force in 2003 after the required 20 countries ratified the agreement.

More than any other term "migrant laborer" has been confused with other groups of adolescents in situations of vulnerability as it is too general a label. For example, adolescent migrant workers whose SRH and rights are often overlooked include domestic workers, victims of trafficking, sex workers and agricultural or day laborers. Furthermore, there is a severe lack of age-disaggregated data on migrants. Oftentimes, migration studies are grouped into children (under 18) and adults, with no reliable data on adolescents.

While there has been increased interest in international migration over the past five years, there is little information available in all of PAHO's 35 Member States. The Population Division of ECOSOC, however, has produced useful information on various international migrant indicators, such

as: net migration, international migrant stock refugees, migrant remittances, as well as government views and policies on international migration.

Oftentimes, the decision to migrate is a family-made decision. Families may consider not only who will benefit the most but also the household functions that person performs and the amount of remittances that he or she is likely to send. Given that in many cultures women are viewed as caregivers, young women are often selected. In fact, in the *State of the World's Population, 2006,* (*37*) UNFPA reported on the feminization of migration – from LAC to Europe – noting that in 1990, immigrant women in Latin America were the first in the developing world to reach equivalent numbers to male immigrants. For example, Caribbean women have outnumbered males in migration to North America since the 1950s (37), and an Argentinean study found that women made up 65% of the migrants to Argentina.

There are both positive and negative sides to migration. Migrants contribute a high level of skills, labor, and education to the receiving country. However, they are often found in the most poorly paid, dangerous, and insecure jobs, and face a number of adverse circumstances that jeopardize their health, such as exploitative working conditions, poor housing, and barriers to accessing health care. Migration may be voluntary or forced, however, not all migrants are the poorest or least educated and have some resources and networks that enable them to move.

The revolving and sometimes seasonal nature of migration impacts the health system in source and receiving countries. Migrants may encounter obstacles to health services in receiving countries, as well as similar problems when they return home as they may not have established links to a community. In general, migrants' mobility may result in loose connections to local networks, as well as loneliness and isolation. When migrants are unable to find ways to make money, they often turn to sex work (*38*). Migrants may also become clients of sex workers given the isolation from family and friends.

Among young people migrating to other developing countries, the ratio of men to women is equal (*39*). Approximately 80% of 12–14 year olds accompany a parent compared to less than 20% of 18–24 year olds. Although studies indicate that most young migrants (aged 10–12) attend school, the figures for adolescents and youth between 18–24 years of age are more worrisome: in a study conducted in Argentina among recently arrived 18–24 year old male migrants, 20% were neither working nor in school (*39*). Male migrants are most commonly employed in construction and agricultural work while females find work as domestic workers, cashiers, sales clerks, and in the food catering industry.

Children also migrate by themselves. In a systematic review of independent child migrants in developing countries that included data from El Salvador, Mexico, Costa Rica, and Argentina, the review found that:

"…… movements by children to live without parents or adult guardians is a major issue in developing countries, involving poor, rural children, in some cases as young as 7–10 years. Often it is motivated partly by the children themselves, with their own reasons, resources and mechanisms, inter-linked to family ones, to such an extent that many children's independent movements would be difficult to consider adequately with a trafficking/ criminal lens, rather than a broader migration/ development lens" (40).

Importantly, day laborers and young agricultural workers are groups whose SRH needs have been overlooked. For example, in Mexico, the review found that:

"Most attention has been on Mexico as a migrant source or transit country to the USA. However, Mexico is a major destination as well. Agricultural production in Mexico depends on both international and internal migration, and involves children. Rural-rural migration across Mexico's 1000 km southern border sustains a range of fruit and other production. Sin Fronteras (2005) estimate [that] 10 per cent of agricultural migrants are 14–17 years old, mostly boys.

Younger children are involved – Sin Fronteras cites official Guatemalan statistics on independent Guatemalan children repatriated from Mexico, and around 1.5 per cent were below 11 years of age and nearly 23 per cent aged 11–15 years (April 2004–April 2005). Artola (2007) cites official Mexican data for January to July 2007 that 15 per cent of children with and without families repatriated to Guatemala, Honduras, El Salvador and Nicaragua, were under 12 years of age" (40).

These statistics coincide with the International Organization for Migration (IOM). In 2008, there were approximately 5,200 boys and girls from Central America who were intercepted on the southern Mexican border. The figure, however, does not include Guatemalan girls whose homes are near the border and who are domestic workers in Mexico (*41*). Moreover, it is estimated that as many as 20,000 young people migrate on their own or join families already in the USA.

Domestic workers

Domestic workers represent up to 60 percent of all internal and international migrants from Latin America with the majority found in North America and Europe. Given the feminization of internal and international migration, large proportions of women are found in this service, while many are young and from indigenous or Afrodescendant groups. As domestic workers, they are vulnerable to abuse and exploitation as they are often unseen in homes, isolated due to language, unprotected by labor laws, and restricted due to residency status (*37*). In a study done in 2000 on intra-regional migration, receiving countries for domestic workers were Argentina, Brazil, Chile, Costa Rica, and Venezuela while source countries included Bolivia, Colombia, Guatemala, Nicaragua, Paraguay, and Peru (*42*).

Victims of trafficking

According to the United Nations, trafficking is defined as:

Definitions

(a) "**Trafficking in persons** shall mean the recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of prostitution of others or other forms of sexual exploitation, forced labor or services, slavery, servitude, or the removal of organs";

(b) "The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used";

(c) "The recruitment, transportation, transfer, harboring, or receipt of a child for the purpose of exploitation shall be considered 'trafficking in persons' even if this does not involve any of the means set forth in subparagraph (a) of this article";

(d) "Child' shall mean any person under 18 years of age".

Source: United Nations Office on Drugs and Crime. Human Trafficking. Vienna: UNODC: 2010. Available at: http://www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html. Accessed on 10 June 2010.

Trafficking also includes forced domestic and agricultural labor, although these are often overlooked and not included in the definition.

Compared to Asia and Europe, there is little information about victims of trafficking in LAC. In 2004, the United States Agency for International Development (USAID) commissioned a literature review on trafficking for labor and sexual exploitation in LAC focusing on prostitution and domestic servitude in Argentina, Brazil, El Salvador, Guatemala, Guyana, Jamaica, Mexico, and Paraguay (*43*). The review covered more than 140 studies in English, Spanish, and Portuguese from 1995–2004. Many of the documents on sexual exploitation of children (those under 18 years of age) included adolescents. The review notes that the underlying reasons for trafficking in LAC are the same as in other regions: poverty, lack of economic opportunities, and gender discrimination with some specific characteristics for the LAC region related to gang affiliations, substance abuse, and adolescent pregnancy. Some victims of trafficking engage in prostitution in order to provide for their children, while a large proportion of youth live with their families and engage in prostitution to provide household income. The increase in trafficking is associated with an increase in sexual tourism (*43*).

The Inter-Agency Standing Committee defines sexual exploitation as: "...any abuse of a position of vulnerability, differential power, or trust for sexual purposes; this includes profiting monetarily, socially or politically from the sexual exploitation of another"(*44)*. Child sexual exploitation includes prostitution, pornography, and exploitation of child domestic workers.

In a two year study on health and trafficking in Europe, the London School of Hygiene and Tropical Medicine (LSHTM), found that trafficked women are often in other overlapping groups in situations of vulnerability including: migrant workers; female sex workers; and exploited women laborers. The report determined that the health consequences of trafficking are inter-linked, synergistic, and complex.

Victims of sexual abuse
UNICEF and the Inter-Agency Standing Committee have defined sexual abuse as: "...an actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or under unequal or coercive conditions"(*44*). Indeed, sexual abuse has been cited as a risk factor for all of the groups in situations of vulnerability discussed in this document.

Intrafamilial sexual abuse is one of the most invisible forms of violence as it often goes unnoticed. Girls are more likely to be victims than boys, and the perpetrator is usually a family member in a position of trust. Studies have shown that between 40–60% of known sexual assaults within the family are committed against girls aged 15 or younger (*45*).

In the WHO multi-country study on *Women's Health and Domestic Violence against Women,* it was found that in Brazil, 12% of the women in Sao Paulo and 9% of the women in Pernambuco had experienced sexual abuse before the age of 15 (*46*). In Peru, approximately 20% of women in Lima and Cusco reported being sexually abused as children (*47*). The study found that in both Brazil and Peru, the abusers tended to be family members.

A CDC/USAID review of studies in El Salvador, Guatemala, and Honduras, found that between 7–13% of women reported being sexually abused (*48*). According to the review, the average age of first sexual abuse in Guatemala was fourteen while the average age of sexual abuse in El Salvador and Honduras was fifteen. Between one-half to two-thirds of women reported that their first abusive experience occurred before the age of fifteen. Similarly, women that had experienced childhood sexual abuse before the age of 15 were found to have experienced intimate partner violence in the past year. Indeed, childhood sexual abuse has been linked with subsequent sexual abuse, intimate partner violence, increased risk of unsafe sex, and poor mental and psycho-socio outcomes.

The WHO has defined "sexual violence" as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (*49*).

In a multi-country study in nine Caribbean countries the WHO found that nearly half of sexually active adolescent women reported that their first sexual intercourse was forced, compared with one-third of adolescent men. In Lima, Peru the percentage of young women reporting forced sexual initiation was almost four times that reported among young men (40% against 11%, respectively) (*49*).

In Brazil, the younger a woman's age at first sex, the greater the likelihood that her first sexual experience was forced. A study found that 14% and 11% of all women in São Paulo and Pernambuco respectively, who had sexual intercourse before the age of 15, reported it being forced (*46*).

Sexual abuse also includes intimate partner violence. This is pertinent to adolescents, given the sizable proportion of girls under the age of eighteen who are in couples. Bolivia, the Dominican Republic, and Haiti were included in a review of intimate partner violence in ten DHS countries. The review found a high prevalence of physical violence (52%) and sexual violence (14%) in Bolivia among women aged 20–44 (*50*). The 2005–2006 DHS in Haiti found that 11% of adolescents aged 15–19 said they had been victims of sexual violence by their partners (*51*). Indeed, forced sex starts early in young marriages. It was reported that in Nicaragua, half of partner violence among married adolescents aged 15–19 started within two years of marriage. In Haiti and Nicaragua, most young women who experienced sexual coercion in the past twelve months had been victims of coercion three or more times during that period (*52*). Sexual coercion in childhood or early adolescence has been linked to increased likelihood of sexual activity in adolescence and multiple partners later in life (*53*). However, more research is needed.

At–risk groups of HIV

Definitions

The **populations most-at-risk to HIV** are defined as:

"…groups of people who more frequently engage in behaviors that lead to HIV transmission. These behaviors include unprotected sex (particularly anal sex), sex with multiple partners, and use of the same piercing or injecting equipment. Such populations include men who have sex with men (MSM), female sex workers and their clients, and injection drug users (IDUs) "(*54*).

At the end of 2008, there were an estimated 240,000 people living with HIV in the Caribbean and 2 million in Latin America. The main mode of transmission in the Caribbean is unprotected vaginal or anal heterosexual intercourse, although unprotected anal sex between men is also a risk factor. In Latin America, the main modes of transmission are through MSM, sex workers, and IDUs (*55*). While the Latin American countries face concentrated epidemics among key at-risk populations, Haiti and the Bahamas are considered to have generalized epidemics. Evidence from other countries in the Caribbean however indicate a "mixed epidemic" (*56*).

The observations below are gathered from materials that cover all age groups as there is little information about adolescents among these at-risk groups. Despite the well-accepted fact that at-risk groups are integral to the propagation of the HIV epidemic, few resources have been devoted to them: only 1% of HIV global funds are directed towards sex workers and their clients while 10% are directed to MSM. This attests to the invisibility and the extent of "voicelessness" among these groups.

Populations at-risk for HIV face considerable stigma and discrimination that only serve to heighten their vulnerability. Social norms, along with legal and policy barriers, often prevent their access to services and information. Where illegal activities are involved (such as, illegal drug use, trafficking, and sex work), violence at the hands of the police and within the family and community is not often reported. People at risk of HIV are often met with hostility and occasionally violence from precisely those who should help and protect them: health workers, teachers, family members, and the police. Given that the groups often co-exist and overlap, adolescents among them experience multiple vulnerabilities.

Men who have sex with men (MSM)

Definitions

The UNAIDS Policy Brief on "HIV and Sex Between Men" (*57*) notes that:

"Sex between men occurs in diverse circumstances and among men whose experiences, lifestyles, behaviors and associated risks for HIV vary greatly. It encompasses a range of sexual and gender identities among people in various socio-cultural contexts. It may involve men who identify as homosexual, gay, bisexual, transgendered or heterosexual. MSM are often married, particularly where discriminatory laws or social stigma of male sexual relations exist. Sex between adolescent males can also be a part of sexual experimentation."

In studies conducted on HIV prevalence in LAC, results indicate that HIV prevalence amongst MSM populations is high: 10–25% in some cities of Colombia; 14% in Buenos Aires, Argentina; 15%, in four Bolivian cities and Quito, Ecuador; 18–22% in Peru; and 22% in Montevideo, Uruguay. Indeed, research has found hidden epidemics

of HIV among MSM in several Central American countries including Belize, Costa Rica, El Salvador, Guatemala, Mexico, Nicaragua, and Panama (*58*). These studies also demonstrate that 12% of all HIV infections in the Caribbean occur amongst MSM. Sex between men is criminalized in a number of Caribbean countries, which is a serious obstacle to prevention, treatment, care, support, and stigma reduction. Discrimination against MSM discourages them from seeking services, and if they do seek STI diagnosis and treatment, they are likely to conceal their sexual history which can result in undiagnosed and untreated STIs. Given that many MSM have sex with women, these risks extend to the general population as well.

Sex workers and their clients

The 2002 UNAIDS Technical Update *Sex Work and HIV/AIDS* (*59*), defines sex workers as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating." The Technical Update further notes, "...the majority of sex workers do not define themselves as such and consider the work to be a temporary activity." Sex work may vary in the degree to which it is formally organized and the degree to which it is distinct from other social and sexual relationships and types of sexual-economic exchange. The reasons for entry into sex work range from free choice to force and trafficking. Many people become involved in sex work due to conditions that do not involve direct coercion and/or deceit but rather poverty, gender inequality, indebtedness, low education level, lack of employment opportunities, family breakdown and abuse, dependent drug use, humanitarian emergencies, and post conflict situations (*60*).

Sex workers have an increased risk of HIV infection due to a large number of partners and inconsistent condom use. This group also includes IDUs, which adds to their at-risk status. As noted earlier, migration may be linked with sex work, thus making sex work mobile.

Given the above definition, transactional sex (defined as the exchange of gifts or money for sex) (*61*) and cross-generational sex (between young girls and older male partners) often overlap, which is highly pertinent to adolescent girls. Save the Children Federation USA has developed a model (figure 1–1) that addresses the reasons as to why young people are involved in cross-generational sex. It views transactional sex along a "continuum of volition" beginning with voluntary participation for emotional reasons to coercion (*62*).

This model recognizes negotiated areas for transactional sex. Identifying different types of "drivers" can help develop different responses.

Compared to other regions, there are few in-depth studies about sex work and transactional sex in LAC.

Due to the stigmatization of sex work, sex workers may be victims of discrimination due to gender-based attitudes, sexual exploitation, and belonging to other groups in situations of vulnerability, such as MSM and IDUs. Sex workers are vulnerable to sexual violence, including violence from law enforcement officers. When they are able to control their working environments and insist on safe sex (such as consistent use of condoms and non-penetrative sex), vulnerability to HIV can be reduced (*60*). As victims of sexual violence, sex workers require access to services providing safe abortion and emergency contraception. Medical abortion is a safe method that should be known and available to sex workers. In LAC, Barbados, Cuba, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Mexico, Panama, Bolivia, Brazil, Colombia, Guyana, and Uruguay allow abortion when pregnancy is a result of rape.
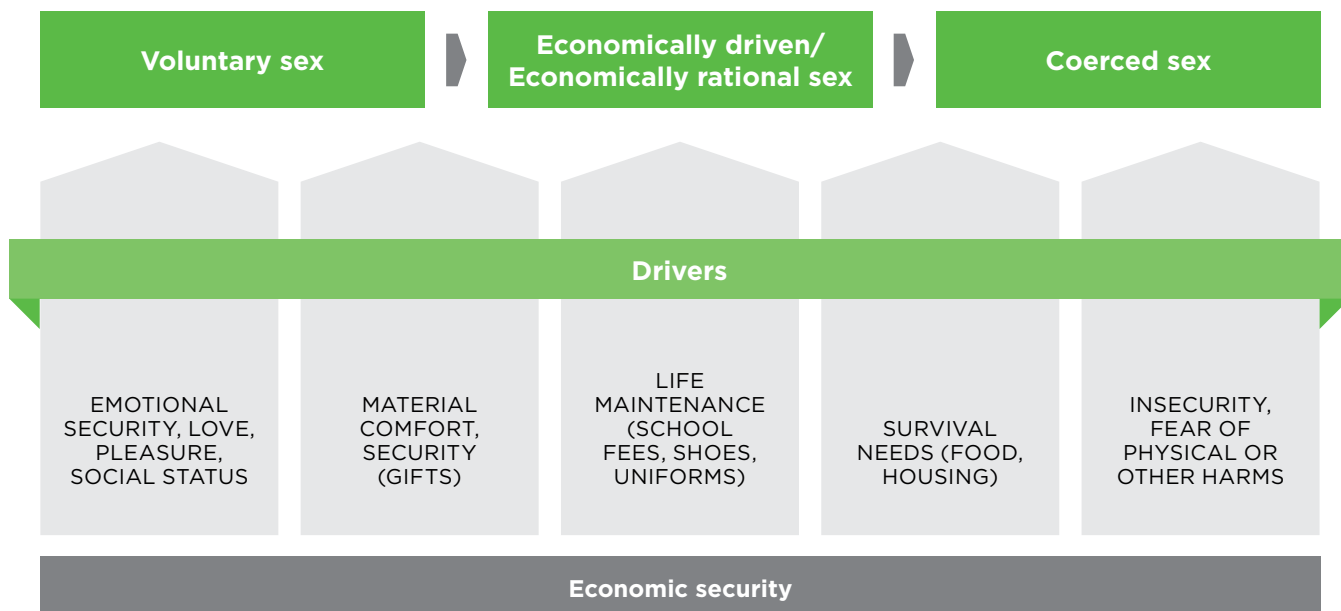
Injection drug users (IDU)

It is estimated that between 5–10 percent of HIV infections globally are due to injection drug use. It is a major source of HIV transmission in countries from the Southern Cone, Brazil, and Mexico. In fact, in Argentina, HIV prevalence among IDUs is estimated at 40%, however information on HIV and drug use in rest of the Region is limited. A *Lancet* article on the global epidemiology of injection drug use and HIV found only four LAC countries with drug prevalence estimates (*63*). Injection patterns vary from location to location; although cocaine is the most commonly injected drug in some countries (*64*), research must be conducted to determine the patterns of injection in each country and local area. The sharing of infected equipment, especially needles, is a common way of transmitting HIV.

Recently non-injection drug use of crack has been reported to be a risk factor for HIV. Some crack smokers suffer from burns and open sores on their lips and the linings of their mouths caused by the heat from smoking devices. Infected blood can contaminate shared smoking pipes (*65*).

Most IDUs begin injecting in youth by sniffing or smoking opioids and then switch to injection. First injections usually take place in a social situation when a young person is injected by a friend, relative, or sexual partner. Young IDUs are more likely to share needles and syringes than older IDUs but are less likely to be in contact with needle exchange programs, NGOs, or outreach workers. Drug treatment programs often overlook the needs of young IDUs, especially those who do not consider themselves addicts (*66*).

Figure 1–1. A continuum of volition: reasons and drivers for sexual activity

Voluntary sex	Economically driven/ Economically rational sex	Coerced sex

Drivers

EMOTIONAL SECURITY, LOVE, PLEASURE, SOCIAL STATUS	MATERIAL COMFORT, SECURITY (GIFTS)	LIFE MAINTENANCE (SCHOOL FEES, SHOES, UNIFORMS)	SURVIVAL NEEDS (FOOD, HOUSING)	INSECURITY, FEAR OF PHYSICAL OR OTHER HARMS

Economic security

Source: Weissman A, Cocker J, Sherburne MBP, Lovich R, Mukaka M. Cross-generational relationships: using a 'Continuum of Volition' in HIV prevention work among young people. *Gender & Development* 14 (1); 2006.

Concluding Remarks of the Literature Review

This review has attempted to emphasize the fact that marginalized adolescent groups are vulnerable in different settings. Importantly, the labels used to identify the most marginalized groups can be misleading as groups overlap and co-exist. Their composition may differ in terms of gender, age, ethnicity, and geographic location. Therefore, the first task in reaching adolescents in situations of vulnerability is to carefully determine the characteristics of the group one wishes to focus on.

Marginalized groups have many central common features. They are invisible and voiceless. They experience stigma, discrimination, violations of basic human rights, and violence. They need specially designed services and information. Moreover, they are loosely connected to wider community institutions, such as families and schools and are often disconnected from health care and protection agencies. Further, health policy-makers and health care professionals generally have little direct experience living and working among them.

In order to address these issues, the following four priority tasks are recommended:

1) To make invisible groups visible
2) To protect the human rights of young people in situations of vulnerability
3) To design service activities that take into account marginalized adolescents' circumstances
4) To seek participation from excluded adolescents

The next part of this document looks at how the seven strategic lines of action in the Adolescent and Youth Regional Strategy and Plan of Action 2010–2018 contribute to these priorities while highlighting the interventions that are most relevant to adolescents in situations of vulnerability.

Reaching Poor Adolescents in Situations of Vulnerability

Strategic Area 1: Improving strategic information and innovation

Strategic Area 2: Enabling environments and evidence-based policies

Strategic Area 3: Integrated and comprehensive health systems and services

Strategic Area 4: Human resources capacity-building

Strategic Area 5: Family, community, and school-based interventions

Strategic Area 6: Strategic alliances

Strategic Area 7: Social communication and media involvement

Introduction

PAHO's Adolescent and Youth Regional Strategy and Plan of Action 2010–2018 identifies seven strategic areas for promoting adolescent and youth health. While these strategic areas are not only critical for improving the overall health of adolescents and youth, they also provide a basis for reaching those most at risk. This section provides guidance and tools in order to respond to marginalized groups organized according to each of the POA's strategic lines of action.

Conclusions made from the literature review in the previous section indicate that:

1) There is a paucity of information on the most at-risk adolescents. It is imperative, therefore, for countries to identify adolescents most at-risk, their geographic location, and risk factors associated with belonging to an at-risk group.

2) Marginalized adolescents are repeatedly exposed to threats that increase their vulnerability to victimization and limit the ability to reach their full potential. It is important, therefore, to protect young people in situations of vulnerability while strengthening institution and community obligations towards them.

3) Poor people "...rarely speak of income, but focus instead on managing assets – physical, human, social, and environmental – as a way to cope with their vulnerability" (*67*). Adolescent coping strategies in situations of vulnerability may not work as well in mainstream society, however, this opens up the opportunity to reach adolescents. It is important to give voice to 'the voiceless'. Engaging adolescents in decisions on how best to reach them is key to improving not only their health overall but their SRH more specifically.

As mentioned in the previous section of this document, four priority tasks are recommended to reach marginalized groups. The first three directly relate to the first three strategic areas of the POA, which include:

1. To make invisible groups visible
2. To protect the human rights of young people in situations of vulnerability
3. To design service activities that take into account marginalized adolescents circumstances

The fourth priority task is cross-cutting and seeks participation from excluded adolescents.

In order to effectively reach groups in situations of vulnerability, it is essential that decision-makers understand the composition and characteristics of the group they are attempting to reach. Once established, the decision-makers can then offer legal and political protection, which is necessary to reduce the multiple risks that marginalized adolescents face. Moreover, services should be accessible, appropriate, affordable, flexible, tailored to users, and based on evidence. Reducing stigma and discrimination that marginalized groups face are critical to giving them a voice, and ensuring their rights to protection. Adolescents, and the NGOs working with them, should be fully involved in promoting adolescent needs. Furthermore, personal contact should be established with marginalized adolescents to build networks among groups; and technologies should be embraced and adopted in order to allow users confidential access to information and protection.

Further sources of information on reaching marginalized groups are provided below, along with tools that have been found useful in different settings. Each country has a different starting point for defining groups in situations of vulnerability and a different context for meeting their ASRH needs. Most of the tools were designed for a specific group; however, these tools can be adapted to several groups in situations of vulnerability.

STRATEGIC AREA 1:
Improving Strategic Information and Innovation

All groups in situations of vulnerability share a common characteristic: invisibility. The lack of information that exists about these groups makes identification for better programming difficult.

In order to improve strategic information, data should be disaggregated by five-year age groups, gender, ethnicity and socio-economic indicators. The Health Metrics Network's *Framework and Standards for Country Health Information Systems* provides guidelines on transforming data into information and evidence (*68*).

Today, countries are implementing household surveys such as the Demographic and Health Surveys (DHS), Reproductive Health Surveys (RHS), and other national surveys to collect information on socio-economic status, residence, age, and gender. These surveys also provide information on contraceptive use, maternal care, HIV knowledge, and domestic violence. In addition, The Global School-based Student Health Survey (GSHS) and other family planning surveys include questions on sexual behavior and substance use.

Within the next few years, censuses will take place in all of the PAHO Member States. Given that ethnicity is one of the most overlooked factors in household surveys, PAHO country offices will be given an opportunity to actively collaborate with governments to ensure that information about ethnicity is collected. Supporting this process is important since collecting information on ethnicity requires careful planning, resources, and sensitivity. For example, the ethnicity of indigenous populations may be collected according to the way each person or group identifies themselves.

While household surveys help establish underlying factors of vulnerability, marginalized adolescents are still likely to be overlooked and under-represented. In order to identify marginalized adolescents and to develop interventions and programs, further studies are needed. With PAHO's influence and support, invisible groups can be put on the national agenda through the commission of *ad hoc* studies from academic institutions, NGOs, and special interest groups that are willing to map basic demographic characteristics of these groups and their needs. For example, NGOs may have locally based studies that are reported as "grey literature" that can provide information on interventions and programs for marginalized adolescents. Moreover, information from national and international advocacy organizations or interest groups can help to identify relevant issues.

Key populations at-risk for HIV are among the most difficult to reach. Family Health International's *Behavioral Surveillance Surveys: Guidelines for repeated behavioral survey in populations at risk of HIV* gives detailed guidance on how to collect information on marginalized groups and how to use it for program monitoring. The UNAIDS', *A framework for monitoring and evaluating HIV prevention programs for most-at-risk populations*, provides an overview of information needed to plan an intervention for female sex workers, issues to explore in a rapid assessment of sexual behavior and HIV for MSM, and criteria to be examined before developing interventions. It covers different methodologies on gaining information about the HIV epidemic and provides an overview of the UNGASS indicators.

Qualitative data collection methods, such as in-depth interviews and focus group discussions, are required in order to gain a deeper understanding of the target group's needs. For example, participatory rapid appraisal methods can help determine attitudes and knowledge. This is especially useful for communities that are more comfortable with visual representations than verbal analysis and rely more on making comparisons than on measuring. CARE International in Zambia has produced a book entitled *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents* that shows how participatory rapid appraisal methods, pioneered by Robert Chambers, have been adapted to a participatory learning and action methodology applied to ASRH (*69*).

In addition to developing and informing programs, information can be used for advocacy purposes. PAHO supports NGOs in building advocacy capacity by emphasizing the public health benefits, such as, reductions in teenage pregnancies pregnancy, HIV transmission, violence, and substance abuse. Further information about using data for advocacy purposes can be found in the UNAIDS/WHO's *Guidelines for effective use of data from HIV surveillance systems*.

Tools for data and information

World Health Organization. Framework and Standards for Country Health Information Systems. 2nd ed. Geneva: WHO; 2008.

Joint United Nations Program on HIV/AIDS, World Health Organization. Guidelines for effective use of data from HIV Surveillance. Geneva: UNAIDS, WHO; 2004.

⊕ Tools for data and information

World Health Organization. Working with Street Children, Module 1: A Profile of Street Children. Geneva: WHO; 2000 (WHO/MSD/MDP/00.14).

Thompson MP, Basile KC, Hertz MF, Sitterle D. Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2006.

Family Health International. Behavioral Surveillance Surveys: Guidelines for repeated behavioral surveys in populations at risk for HIV. New York: FHI; 2000.

Joint United Nations Program on HIV/AIDS. A framework for monitoring and evaluating HIV prevention programs for most-at-risk populations. Geneva: UNAIDS; 2007.

Joint United Nations Program on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2010 reporting. Geneva: UNAIDS; 2009

📓 Information sources on groups in situations of vulnerability

Cunningham W, McGinnis L, Verdu RG, et al. Youth at Risk in Latin America and the Caribbean: Understanding the Causes, Realizing the Potential. Washington, DC: World Bank Report; 2008.

United Nations Educational, Scientific and Cultural Organization. EFA Global Monitoring Report 2009, Overcoming inequality: why governance matters. Available from: *http://www.streetchildren.org.uk/*. Paris: UNESCO; 2008.

UN Department of Economic and Social Affairs. Population Division. International Migration Report 2006: A Global Assessment. New York: DESA; 2009.

Ribando C. Trafficking in Persons in Latin America and the Caribbean. Congressional Research Service Report for Congress. New York: Cornell University; 2007.

Sumner Coffey P, Vallance Phariss A, Renaud T. Washington, DC: OAS [cited 2009 Jul 31]. Literature Review of Trafficking in Persons in Latin America and the Caribbean (2004). Available at: *http://www.oas.org/ atip/Regional%20Reports/USAID%20LAC%20TIP%20Literature%20 Review.pdf*. *http://www.oas.org/atip/Regional%20Reports/USAID%20 LAC%20TIP%20Literature%20Review.pdf*

STRATEGIC AREA 2:

Enabling Environments and Evidence-Based Policies

Groups in situations of vulnerability often experience stigma, discrimination, and violence. A human rights approach (including, the right to life, the right to privacy, the right to health care services, the right to freedom from discrimination, and the right to information) reduces marginalized groups vulnerability and improves their ASRH.

Creating an enabling environment in Brazil:

Human rights, strategic alliances, and partnerships

Brazil is considered a model for addressing HIV/AIDS. In 1988 the Brazilian Constitution set that healthcare was a right to all and a duty of the state. When antiretroviral drugs became available, the Ministry of Health decided to make them available to all who required them, free of charge. The human rights movement that emerged in the 1980s was active in reducing AIDS-related discrimination. At the beginning of the epidemic, MSM were the most infected. The Ministry of Health partnered with LGBT organizations to defend their rights. A series of legislative acts now protect MSM and people living with AIDS. Private health plans are prohibited from discriminating against partners of the same sex, while discrimination on the basis of orientation is prohibited, and violence on the basis of gender identity is criminalized. To demonstrate Brazil's commitment to reduce discrimination, President Luiz Inacio Lula da Silva launched a program "Brazil without Homophobia". Further, a national plan to promote citizenship and humans rights for LGBT people has been issued.

Providing an enabling environment for marginalized groups of adolescents requires working with sectors outside of health such as, education, policy, and internal security. Within countries, a close working relationship is needed if separate ministries for women, gender, youth, and/or ethnic minorities exist. It also requires decision-makers and health care professionals to be aware of the different issues that affect these groups. Protective policies are important but not sufficient – they must be adequately resourced and implemented.

Further, there is a need for policy coherence, with a clear understanding that within the health sector the provision of services and information is necessary to improve the health of at-risk adolescents. Protection of individual service users is of utmost importance and health workers need to understand that they will not be punished for providing preventive, diagnostic, treatment, and care services for "underaged" young people, or those engaged in illegal activities. Moreover, a pragmatic and public heath approach to preventing the spread of HIV should be pursued.

Education is also important to strengthening adolescent resiliency. Policies that encourage adolescent pregnant girls, teenage mothers, and adolescent fathers to continue their education should be implemented and enforced.

Migrants

An environment that improves ASRH among migrants should be promoted regardless of their legal status. In some countries, the State only protects the rights of its citizens, or makes a distinction between documented and undocumented migrants. Access to education and health care are critical for migrants. Moreover, protecting the work environment, as required in the International Convention on the Protection of All Migrant Workers and their Families, helps to strengthen the position of migrants overall.

Disabled adolescents

Regarding adolescents with disabilities, there is not enough evidence as to how many LAC countries have ratified the Convention on the Rights of Persons with Disabilities and Optional Protocol and have included the definitions for disabled persons in their national and legal frameworks and policies. The majority of LAC in 2004 was using an outdated definition of disability that was established in 1980. This definition, for example, does not take into account the social context in which disabled people live.

Sex work

The legal status of sex work varies throughout LAC. For example, prostitution is illegal in nine countries and of limited legality in one country. One international report found that as of September 2009, legal protection for prostitution exists to varying degrees in nineteen PAHO member countries. PAHO's six impact countries, together with three of PAHO's priority countries for adolescent health are among those where prostitution and activities associated with it are legal. Since

various aspects of sex work are legal in many LAC countries, health care professionals and decision-makers are able to secure a safe working environment for sex workers. Protection from violence and coercion is fundamental to negotiating safer sex, including condom usage and resisting non-penetrative sex.

Tools for creating an enabling environment

International Planned Parenthood Federation, United Nations Population Fund, World Health Organization, Joint United Nations Program on HIV/AIDS, Global Network of People Living with HIV/AIDS, International Community of Women with HIV/AIDS, and Young positives: Rapid assessment tool for Sexual & reproductive Health and HIV linkages: a generic guide. New York: UNFPA; 2009.

Sources for creating an enabling policy environment

The International Gay and Lesbian Human Rights Commission (IGLHRC) is a leading international organization dedicated to human rights advocacy on behalf of people who experience discrimination or abuse on the basis of their actual or perceived sexual orientation, gender identity or expression. Their website is: *http://www.iglhrc.org/cgi-bin/iowa/home/index.html*

The Global network of sex work projects provides a good starting point for links to sex workers' organizations: *http://www.nswp.org/*

Integrated and Comprehensive Health Systems and Services

Effective health services for adolescents in situations of vulnerability share common features. For example, it is essential that services are accessible, appropriate, affordable, and flexible, as well as, evidence-based. The tools in this section emphasize programs designed for groups in situations of vulnerability. Routine services seldom are planned in ways that attract hard-to-reach users, and considerable time and resources are required to train staff in reaching out to young people in order to make them feel welcome.

Outreach

Outreach is a way of providing services and information in places that marginalized adolescents frequent and has shown to be an effective way of working with marginalized groups. Collaborating with academic institutions and NGOs to offer outreach services is recommended as they are often more liberal in the way they provide services.

The purpose of outreach is to provide:

• A range of services, commodities, and information for prevention, harm reduction, testing, treatment, and care
• Referrals to other services
• Information on violence
• Increased awareness of rights

The WHO reports that outreach-based interventions, such as behavior change interventions, are effective in reaching out-of-treatment IDUs (*70*). Interventions need to be tailored to each community and should only be developed after establishing a level of trust with the communities. Sex workers and IDUs are especially difficult groups to reach, but the principles of confidentiality, respect, inclusion, and professionalism together with the right balance of activities are essential. In addition, including people as participants and/or facilitators in group discussion has been found to be effective.

The UK Network of Sex Work Projects (NSWP) discusses several types of outreach for sex workers (*71*):

• On-the-street outreach
• Off-the-street outreach, such as bars and clubs
• Outreach within another institution, such as vocational education, or livelihood efforts
• Home-based outreach
• Internet-based outreach

Observers of outreach programs have found that it can be challenging to maintain the technical quality of services offered outside the premises of routine care. Further, outreach programs that are specifically targeted to a small group may have difficulties scaling up to a wider range of services. It is critical, therefore, that routine services are designed to sensitively receive adolescents in situations of vulnerability as many outreach program users may need to be referred to routine service facilities.

Tools and information sources on outreach

UK Network of Sex Work Projects. Working with Sex workers: Outreach. London: UKNSWP; 2008.

World Health Organization, Joint United Nations Program on HIV/AIDS, United Nations Organization on Drugs and Crime. Policy Brief: Reduction of HIV Transmission Through Outreach. Geneva: WHO, UNAIDS, UNODC: 2004.

Quality health services for adolescents
Comprehensive and integrated quality health systems and services for groups in situations of vulnerability call for youth friendly services (YFS). The International Planned Parenthood Federation (IPPF) briefly describes comprehensive YFS as those that:

• Have convenient opening hours for young people and do not require appointments in order to be seen
• Have staff who are specially trained to meet the needs of young people

- Offer comprehensive SRH services for STIs including HIV, contraception (emergency contraception), and safe abortion(*72*)

Important features to YFS include confidentiality and privacy, geographical accessibility, services free-of-charge, and post-exposure prophylaxis for HIV. These features should be included in services specifically designed for groups in situations of vulnerability and should be provided through outreach, bringing services to where marginalized adolescents meet and work. Given that many adolescents in situations of vulnerability experience sexual violence, the decision to terminate a pregnancy should be supported by YFS providers in countries where abortion is permitted.

Integrating and strengthening SRH and HIV services in primary health care as well as in services for: maternal, newborn, and child health; TB; and nutrition increases the venues where youth in situations of vulnerability may seek care. IPPF and partners have prepared a rapid assessment tool to assess HIV and SRH integration at the policy, system, and service levels in order to identify gaps and strengthen ties.

Although YFS have long been used as a means to reach adolescents, many countries do not offer such services due to financial reasons and thus opt to offer only mainstream services. Mainstream services are unlikely to appeal to out-of-school youth and marginalized adolescents as many fear that they will be met with unsympathetic providers.

Tools for youth friendly and integrated services

International Planned Parenthood Federation. Provide: Strengthening youth friendly services (a guide and tool with checklists for clinic self-assessment, provider needs, management, and client satisfaction).

YouthNet produced a series of tools for assessing and planning YFS based on a project that ended in 2001.

Tools for youth friendly and integrated services

International Planned Parenthood Federation, United Nations Population Fund, World Health Organization, Joint United Nations Program on HIV/AIDS, Global Network of People Living with HIV/AIDS, International Community of Women with HIV/AIDS, and Young positives. Rapid assessment tool for Sexual & reproductive Health and HIV linkages: a generic guide. New York: UNFPA; 2009. Available at: _http://www.ippf.org/en/Resources/Guides-toolkits/Rapid+Assessment+Tool+for+Sexual+Reproductive+Health+and+HIV+Linkages.htm_

Family Health International. Increasing Access to Contraception for Clients with HIV: A Toolkit. Available at _publications@fhi.org_; 2008.

Information sources on youth friendly services

The Kenyan Ministry of Health has produced national guidelines for YFS and is an example of what could be included in a national provision.

WHO has produced a generic guide to YFS, _Adolescent Friendly Health Services,_ (WHO/FCH/CAH/02.14) Distribution GENERAL Original ENGLISH.

Senderowitz J, Solter C, Hainsworth G. Clinic Assessment of Youth Friendly Services; A Tool for Assessing and Improving Reproductive Health Services for Youth. New York: Pathfinder International; 2002.

Out-of-school youth
Substantial effort should be made at keeping young people in school, particularly in rural areas where access to education may be limited or attendance costly. Moreover, policies for pregnant girls should be

implemented and enforced. Informal education, literacy programs, second-chance education, and vocational education can assist in preparing out-of-school adolescents to take advantage of opportunities for more formal education and employment.

When providing information to out-of-school adolescents, care should be taken to not rely on written materials, given that some youth may be illiterate. Information, therefore, should be disseminated through radio and television.

Out-of-school youth empowerment

YouthNet reported on an initiative to bring education to rural youth in Colombia, Honduras, Guatemala, Costa Rica, and Ecuador. The purpose of Sistema de Aprendizaje Tutorial (SAT), or Tutorial Learning System program is to prepare students for their future livelihoods, which are mainly agricultural, through a combination of formal curriculum and applied practical activities in health, agriculture, and micro-enterprise. With a trained tutor, a group of 10 – 30 students study for a period of six years, graduating with a diploma that is equivalent to a high school diploma. They take what they've learned from the classroom to their communities, sharing information about HIV/AIDS and other topics.

YouthNet, 2004, *Reaching Out-of-School Youth with Reproductive Health and HIV/AIDS Information and Services,* Youth Issues Paper 4 Family Health International ISBN 0-939704-89-7

Street children

ASRH services for street children should focus on the prevention of risky sexual behavior and the diagnosis, treatment, and care of unplanned pregnancies, unsafe abortions as well as STIs, including HIV. Services should also address violence protection, including counseling for those who have experienced violence, as well as educational and empowerment techniques to protect against future violence. In addition, free and accessible primary health care services are also needed. As well, outreach services should facilitate access to safe shelters and emergency and other supportive services (*27*).

Tools for services for street children

World Health Organization. Working with Street Children, Module 4: Understanding Sexual and Reproductive Health including HIV/AIDS and STDs Among Street Children. Geneva: WHO; 2000 (WHO/MSD/MDP/ 00.14).

Information sources on street children

Thomas de Benítez S. State of the World's Street Children: Violence. London: Consortium for Street Children; 2007.

Migrants
All information and services for migrants should be available in their maternal language. As with other groups, migrants need SRH services for contraception, pregnancy care, and the diagnosis and treatment of STIs, including HIV. This is particularly important when migrants include minority, ethnic groups.

Trafficking of women
Although, there is a paucity of data on sexual exploitation trafficking in LAC and services provided to these victims there have been a couple of reports that are worth mentioning: The London School of Hygiene and Tropical Medicine (LSHTM) provides a report on the physical, sexual, and mental health consequences of trafficking; substance abuse; social, economic, environmental well-being; security; and service utilization and delivery on the five stages of trafficking (*73*).

In addition, the IOM, together with the UN Global Initiative to Fight Human Trafficking and the LSHTM, have published a book, *Caring for Trafficked Persons: Guidance for Health Providers* (*74*). It provides

information on various aspects of patient care, protection and security, and law enforcement interaction for trafficked persons. Moreover, it outlines ten principles to ensure ethical and safe interviews with trafficking victims, which include:

1) Do no harm
2) Know your subject and assess the risks
3) Prepare referral information – do not make promises that you cannot fulfill
4) Adequately select and prepare interpreters and co-workers
5) Ensure anonymity and confidentiality
6) Get informed consent
7) Listen to and respect each person's assessment of their situation and risks to their safety
8) Do not re-traumatize individuals
9) Be prepared for an emergency intervention
10) Put information collected to good use

Tools for services for trafficked persons

International Organization for Migration, UN Global Initiative to Fight Human Trafficking, London School of Hygiene & Tropical Medicine. Caring for Trafficked Persons: Guidance for Health Providers. Geneva: IOM; 2009.

Information sources on health and trafficking of women

Zimmerman C, Yun K, Shvab, I, et al. The health risks and consequences of trafficking in women and adolescents: Findings from a European study. London: London School of Hygiene & Tropical Medicine (LSHTM); 2003.

Young people with disability

Disabled youth face the same issues of invisibility, stigma, violence, and a need for specially designed outreach services. More so than other groups, their sexuality is often overlooked due to a lack of accessibility to information and services. For example, some services do not take into account mobility restrictions and physical access issues. Further, confidentiality may be compromised due to a need for others to interpret or assist. The box below provides further information on service needs for adolescents with disabilities.

Information sources on service needs of adolescents with disabilities

Joint United Nations Program on HIV/AIDS. Disability and HIV: Policy Brief. Geneva: UNAIDS; 2009.

Eastgate G. Sexual health for people with intellectual disability (Salud sexual para personas con discapacidad intelectual). Salud Publica Mex 2008: 50 (suppl 2:S255 – S259).

Sex workers

As a group, sex workers are perhaps the most organized and vocal about the range of services needed. Sex workers should be included as active participants in service planning and provision, as well as monitoring and evaluation of services provided to them. For instance, there are certain SRH commodities and services that are essential to protecting sex workers, including: high quality male and female condoms, contraceptives and emergency contraceptives, post-exposure prophylactics, HIV anti-retroviral treatment, water-based lubricants, and safe abortion.

The 2009 UNAIDS *Guidance Note on HIV and Sex Work* posits that human rights is the cornerstone to effectively respond to HIV and sex work and recommends three pillars: 1) ensure universal access to HIV prevention, treatment, care, and support; 2) build supportive environments, strengthen partnerships, and expand choices; and 3) reduce vulnerability and address structural issues (*60*).

Protecting sex workers against violence and discrimination while creating a safe work environment are interventions that will enhance

their SRH. The Global Working Group on HIV and Sex Work Policy (GWG) asserts that one of the most significant ways to protect sex workers from violence is to decriminalize sex work.

A comprehensive and integrated package of services to broaden the choices of sex workers includes:

• Meaningful alternative employment and livelihood opportunities, such as jobs and cash grants
• Micro-credit and microfinance, banking services, and debt repayment
• Assistance in obtaining secure housing
• Continued education, including literacy classes and vocational and skills training
• Control of family assets
• Support to return home for documented and undocumented migrant sex workers, whose circumstances often restrict their ability to leave sex work

Information sources on services for sex workers

Joint United Nations Program on HIV/AIDS. UNAIDS Guidance Note on HIV and Sex Work. Geneva: UNAIDS; 2009.

AVERT, an international AIDS charity available at: *http://www.avert.org/aids-hiv-charity-avert.htm*

Update on sex workers available at: *http://www.avert.org/sex-workers.htm*

The Network for Sex Work Projects, *http://www.nswp.org*

Research for Sex Work, an annual publication intended for sex workers, health workers, researchers, NGO staff, and others. Available at: *http://www.researchforsexwork.org*

Injection drug users (IDU)

In addition to ASRH outreach services specifically designed for young drug users, there are three service areas important for IDUs that include: a) harm reduction interventions, or the provision of clean needles and syringes, b) the prevention of non-injection drug users from switching to injection, and c) the provision of an opiate substitute treatment. Needle and syringe exchanges are not sufficient on their own. In areas where there is no possibility of needle exchange programs, the provision of bleach to clean equipment should be considered. Harm reduction programs should be integrated into drug- treatment and primary health care services, as well as, HIV risk-reduction education, testing, counseling, treatment, and care. Moreover, studies have found that when drug services provided transportation, the use of HIV prevention and care increased (*70*).

Information sources on services for drug users

Interagency Youth Working Group, 2008, "Youth and Injecting Drug Use" Youth Lens on Reproductive Health and HIV/AIDS, no. 26 available at: *http://www.infoforhealth.org/youthwg/pubs/IYWGpubs.shtml*

World Health Organization, Joint United Nations Program on HIV/AIDS, United Nations Organization on Drugs and Crime. Policy Brief: Reduction of HIV Transmission Through Outreach. Geneva: WHO, UNAIDS, UNODC: 2004. WHO, 2005, *Policy and programming guide for HIV/AIDS prevention and care among injecting drug users,* ISBN 92 4 159295 8

AVERT, "Injecting Drugs, Drug Users, HIV & AIDS" available at: *http://www.avert.org/injecting.htm*

Men who have sex with men (MSM)
A framework for achieving universal access for MSM and transgender people has been developed and identifies the following required interventions (*75*):

- Information and education about HIV and other STIs, and support for safer sex and safer drug use through appropriate services (including peer-led, managed and provided services)
- Condoms and water-based lubricants
- Confidential, voluntary HIV counseling and testing
- Detection and management of STIs through the provision of clinical services
- Referral systems for legal, welfare and health services, and access to appropriate services
- Safer drug-use commodities and services
- Appropriate antiretroviral and related treatments where necessary, together with HIV care and support
- Prevention and treatment of viral hepatitis
- Referrals between prevention, care, and treatment services
- Services that address HIV-related risks and needs of female sexual partners

Information sources on services for men who have sex with men

The Joint United Nations Programme on HIV/AIDS. UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People. Geneva: UNAIDS; 2009.

STRATEGIC AREA 4:

Human Resources Capacity Building

A concerted effort to reach poor adolescents in situations of vulnerability requires capacity building among policy makers, PAHO staff, strategic partners, and community institutions that include:

1) Improved knowledge on groups in situations of vulnerability at the national and local setting
2) Improved knowledge on how to protect the rights of adolescents in situations of vulnerability
3) Service efforts most relevant to the needs and preferences of poor adolescents in situations of vulnerability
4) Skills for seeking out the participation of excluded adolescents

Policy-makers and health care professionals generally do not have direct contact with poor adolescents in situations of vulnerability. One approach is to build the capacity of human resources to increase the visibility of marginalized young people through face-to-face situations. By working with youth in situations of vulnerability, policy-makers and health care professionals should begin to understand the needs of adolescents in situations of vulnerability, their daily lives, and their coping strategies when exposed to risks. Another approach is to train strategic partners, such as NGOs, human rights organizations, other UN agencies, and social services, on adolescent sexual and reproductive health and rights (ASRHR).

Family, Community, and School-Based Interventions

The groups discussed in this document have at best fragile connections to families and schools, and in some cases, are distinctly at odds with them. Although they may form their own tightly knit communities, they are almost by definition, outside the mainstream community. Thus, initiatives to reach them through families and schools are of limited help. However, community institutions are excellent places for efforts to strengthen community and family obligations. Efforts should be directed at increasing an understanding of how stigma and discrimination evolve and how they adversely impact the health of marginalized adolescents.

Lessons learned from previous experience in reaching groups at risk of HIV include the participation and ownership of interventions by marginalized adolescents themselves. At the international level, sex workers and MSM are perhaps the groups most willing to speak out. However, at local levels and among young people, this is difficult to achieve. Not only is there stigma attached to most of these groups, but the threats that these adolescents experience are such that many shy away from coming together.

The first task is to establish initial contact. Organizations that have expanded their work to new target groups have reported that it often takes only one or two initial contacts to begin to form a network.

Participatory learning is well suited for people who are overlooked in community assessments. What is particularly challenging for facilitators is what Chambers calls, "handing over the stick", or turning over the facilitation of the sessions to participants so they can present and analyze the information which they collected themselves.

The report, *Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs* provides guidance on how to work with a difficult to reach group, specifically people living with HIV/AIDS and people who use drugs. Among the tools provided is a list

of forty-four "do's" and "don'ts". For example, do invite a user group to select representatives; don't always hand-pick the same user you know and are comfortable with; do acknowledge that you may have needs too, and that unfamiliarity may make you uncomfortable (*76*).

Moreover, participation requires more than dialogue. Groups may need training on how to speak in formal settings with local authorities, how to read and prepare documents, and how to present information. People seeking to create greater involvement among groups in situations of vulnerability should be sensitive to the costs of participation, as participation is expensive in terms of time and money.

Finally, involvement of potential service users requires that decision-makers switch from providing "for" a group with special needs to planning and providing "with" a group.

Collective action is a demonstration of genuine participation. For example, the reduction in HIV prevalence among homosexual men in the '80s and '90s could be credited to the active engagement of gay men's groups in Europe and North America. The Network of Sex Work Projects is another recent example of collective international action. Sex workers felt that the first version of UNAIDS' recent *Guidance Note on HIV and Sex Work* did not sufficiently emphasize the importance of human rights protection and workplace safety, and placed too much emphasis on reducing the demand for sex work and the rehabilitation of sex workers. Their work helped to ensure a more prominent place for these issues in the revised guidance note.

⊕ Tools for participation

Jurgens R. "Nothing about us without us" Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative. Canadian HIV/AIDS Legal Network; 2005.

Shah, Meera Kaul, 1999, *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents* CARE International in Zambia, FOCUS on Young Adults

Strategic Alliances

Reaching adolescents in situations of vulnerability with ASRH services requires collaboration with different actors. It is important that health care professionals collaborate with other UN agencies to avoid duplication and to ensure that there is a consistent, unified approach with clearly defined roles. If there is a national policy regarding one or more of the groups discussed, it is important that PAHO's Regional efforts are aligned with country efforts.

There are three potential resources for establishing alliances with marginalized groups.

1) NGOs: Personal contacts may be facilitated by NGOs working with the intended target group. For example, women's groups have been found to help make the initial contacts with LGBT communities.

2) Faith-based organizations: Faith-based networks are another potential source for collaboration. Working in the field of HIV and with indigenous, youth, and poor groups are important areas for many churches. Some churches are working in more sensitive sexual and reproductive health areas, as well as with LGBT groups.

3) Human rights groups: In preparing reports, human rights groups gather evidence on human rights violations with information often provided by grass roots organizations.

The International HIV/AIDS Alliance is a global partnership of nationally based organizations working to support community action on AIDS in developing countries. The Alliance has regional programs and partners in Bolivia, the Caribbean, Ecuador, Mexico, and Peru.

Moreover, the International Lesbian and Gay Human Rights Commission is an organization dedicated to human rights advocacy on behalf of people who experience discrimination or abuse on the basis of their actual or perceived sexual orientation, gender identity, or expression. It regularly produces country and regional reports on human rights violations together with national organizations.

Forming strategic alliances with the police is also recommended. PAHO has considerable convening power at the country level. Given that many adolescents in situations of vulnerability experience violence, it is important that health care professionals collaborate with police to ensure the protection of marginalized young people.

Sources of information for establishing strategic alliances

International HIV/AIDS Alliance Website: http://www.aidsalliance.org/

Consortium on Street Children website: *http://www.streetchildren.org.uk/*

Network of Sex Work Projects website: http://www.nswp.org/

Catholics for a Free Choice
email: cfc@catholicsforchoice.org
Catholics for Choice 1436 U Street NW, Suite 301, Washington, DC 20009-3997, USA
Tel: Office: +1 (202) 986-6093, Fax: +1 (202) 332-7995
Católicas por el Derecho a Decidir (CDD) in *Latin America*

International Gay and Lesbian Human Rights Commission
Website: *http://www.iglhrc.org/cgi-bin/iowa/home/index.html*
phone/fax: +54.11.4665.7527
Email: *mferreyra@iglhrc.org*

STRATEGIC AREA 7:

Social Communication and Media Involvement

Little is known about the extent and use of new communication technologies and media among groups in situations of vulnerability. However, adolescents are among the first to take up recently developed social communication opportunities. While it has been observed that sex workers are highly dependent on cell phones, accessing new technologies requires resources. The extent of access to communication technologies changes quickly. For example, within LAC there is a considerable range of access. In 2005, telephone mainlines ranged from 17 per 1000 people in Haiti and 43 per 1000 in Nicaragua to over 500 per 1000 in some Caribbean countries. Internet users ranged from 17 per 1000 in Cuba to 594 per 1000 in Barbados (*77*). By the end of 2010, the region's mobile phone use had grown to approximately 620 million mobile telephones, a density of 100.6 cellular devices for every 100 residents in 98% of the countries in the Region.

New technologies and social communication provide opportunities for sharing information in an anonymous manner. It is important, therefore, that new technologies are made accessible and available to marginalized adolescents. It would be beneficial to use social communication networks so that assistance is readily available to a young person who needs information about their SRH or has been threatened by violence. Technology could foster self-help social networks so that young people in situations of vulnerability could assist someone in need of protection.
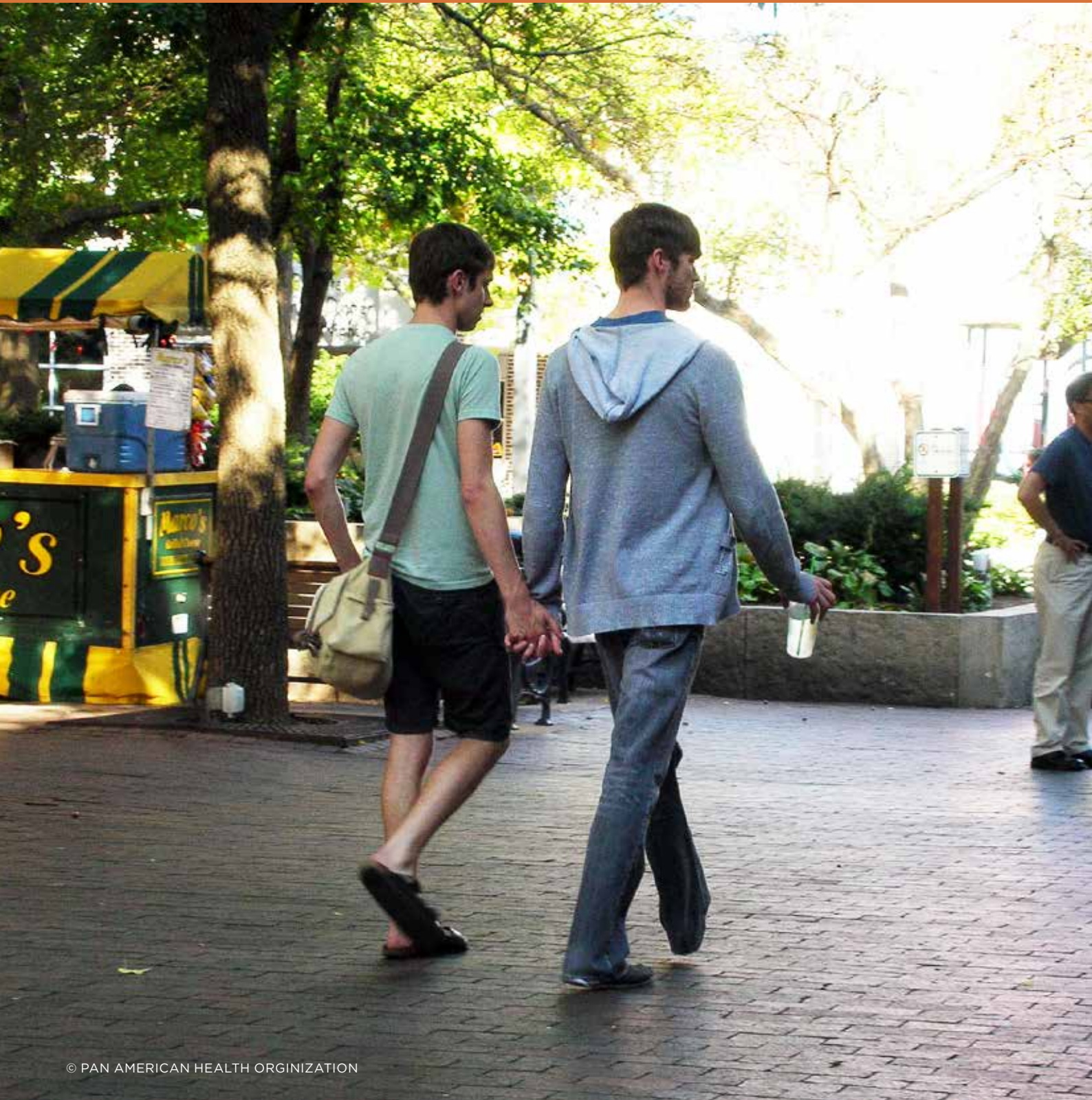
SECTION 3:
Concluding Remarks

Marginalized youth and groups in situations of vulnerability are often invisible, voiceless, and victim to stigma and discrimination. Providing them with SRH services requires designing interventions that take into account circumstances that shape their daily lives.

The Strategic Areas from the Adolescent and Youth Health's POA provide a starting point for reaching these groups and individuals. Four priority tasks that link the action areas are recommended to help policy makers and health care professionals focus on groups in situations of vulnerability. These can be considered as 'guiding principles' for deciding which interventions are most relevant and include:

1) To make invisible groups visible
2) To protect the human rights of young people in situations of vulnerability
3) To design service activities that take into account marginalized adolescent circumstances
4) To seek participation from excluded adolescents

Improving strategic information and monitoring systems will allow for improvements in ASRH. Note that this is easier to achieve if information on poverty, gender, ethnicity, and age are consistently collected and used; for example, there needs to be information collected at the national and local levels on the characteristics of marginalized groups.

Reducing stigma and discrimination is critical to developing evidence-based policies and creating youth-friendly environments. Specially designed interventions for groups in situations of vulnerability must be part of comprehensive health systems and services.

Further research on marginalized groups is necessary for policy makers, health care professionals, and community institutions. Human resource capacity building should be directed to a) increasing awareness about groups in situations of vulnerability, b) strengthening the competence of health personnel, among others, to provide protection for adolescents in situations of vulnerability, and c) increasing competence on how to gain greater participation by adolescents.

Efforts to increase excluded adolescents participation is especially relevant in the areas of service design, while working with families and community institutions, strategic alliances, and involving social communication and media.

Table 3–1 is a summary of the conclusions drawn from the literature review. This summary attempts to tie together information from the literature review with the PAHO's Adolescent and Youth Regional POA and the list of tools and guides provided, with the purpose of providing policy makers and health care professionals a guide to better reach and improve the SRH of poor adolescents in situations of vulnerability.

Table 3–1. The Plan of Action for Adolescent and Youth Health to Reach Groups of Adolescents in Situations of Vulnerability

	Shared characteristic of the groups in situations of vulnerability	Response	Priority task
Improving strategic information and innovation	Invisibility	Know your group in situations of vulnerability–its composition and characteristics. Use available 'grey literature' and information for advocacy.	Make "invisible groups" visible.
Enabling environments and evidence-based policies	Voiceless. Experience stigma, discrimination, and violence	Develop legal frameworks and policies that protect groups and reduce their vulnerability. Increase awareness of vulnerable groups' rights and obligations of family and community.	Protect the rights of adolescents in situations of vulnerability.
Integrated and comprehensive health systems and services	Need specially designed services and information	Services should be accessible, appropriate, affordable, and flexible. Outreach has been shown to be an effective approach. Gain the participation of intended service users in designing service interventions. If possible include them as service providers.	Design services adapted to the circumstances of intended users. Seek participation & voices of excluded adolescents.

Human resources capacity building	Little direct contact with ASRH service decision-makers and health care professionals	Increase the knowledge of policy makers, health care professionals, strategic partners, and communities in situations of vulnerability, their rights to protection, and their ASRH needs. Build skills in these groups to better seek the participation & voices of excluded adolescents. Increase health care professionals experience working with marginalized groups. Build ASRH capacity in strategic partners.	All priority tasks.
Family, community, and school-based interventions	Have loose connections with families, the mainstream community, and schools	Use community institutions to strengthen the protection of marginalized adolescents. Actively engage adolescents in situations of vulnerability and their representatives in decisions regarding interventions designed to improve their ASRH.	Protect the rights of adolescents in situations of vulnerability. Seek participation & voices of excluded adolescents.
Strategic alliances and collaboration with other sectors	Loose, if any at all, contact with organizations	Work with NGOs that have established networks among adolescents in situations of vulnerability, human rights organizations, and other UN agencies. Aim to build trust and credibility and to develop wider networks among the groups.	Seek participation & voices of excluded adolescents. Make "invisible groups" visible.
Social communication and media involvement	They use new media and are better able to take up new technologies	Provide information that can be accessed anonymously and without cost. Design initiatives to improve protection.	Seek participation & voices of excluded adolescents.

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