A Legal Gap Analysis of Adolescent Sexual and Reproductive Health and Rights in Barbados

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Though early sexual debut and activity are by no means encouraged, the statistics show that this is a reality we in the Caribbean have to face. In fact, the region is often quoted as having one of the lowest ages of early sexual debut in the world[i]. This creates the need for contraceptives and other medical sexual and reproductive treatment and services to be available to adolescentsat the same age that they can legally have sexual intercourse, without the need for parental permission.

The age of sexual consent in Barbados is 16; however it is necessary to ascertain whether at this age, adolescents are legally able to access medical sexual and reproductive services and treatment. For further insight into the legal framework and perspectives on this topic, a Legal Gap Analysis was conducted from June – August 2011.

The Legal Gap Analysis included the following components**:**

- Analysis of Legislation in Barbados on Health, Children, Youth, Adolescence and Gender Equality.
- Analysis of Legal and Medical Perspectives on Adolescent Sexual and Reproductive Health and Rights in Barbados.

The Analysis of Legislation involved a review of commentators, case law and legislation in the Faculty of Law library, research in the Queen Elizabeth Hospital library, Internet research, and reviews of previous related studies, done within the UN system. The Analysis of Legal and Medical Perspectives comprised interviews with judicial officers, lawyers, law students and medical practitioners, using an Interview Guide.

The respondents included:

- The Honourable Madam Justice Jacqueline Cornelius, Supreme Court of Barbados;
- Ms. Anya Kirton, Attorney-at-Law;
- Dr. Lisa Monrose, Medical Practitioner;
- Two final year LLB Law students from the Cave Hill Campus, University of the West Indies.

Analysis of Legislation

In the research conducted, there was found to be no legislation that explicitly prevents adolescents from accessing sexual and reproductive health services and treatment without parental permission, though there is legislation that sets varying ages for a child becoming an adult. The rule setting out the medical age of consent is actually found in government policy- a fact unknown to any of the respondents to the interviews conducted as part of this Legal Gap Analysis. The consequences of non-compliance with the policies sometimes involve penalties, which are however not enforceable in a court of law, and are merely seen as a convention, setting out what "should" happen, but not what "must" happen.

The UN defines adolescence as encompassing ages 10 to 19 and youth as encompassing ages 15 to 24, and statistics show that these two groups do carry the burden of HIV infections, STIs and unwanted pregnancies. The region has the second highest rate of HIV/AIDS outside of Sub-Saharan Africa[ii]. In the UNGASS country progress report for Barbados 2010 it was reported that 19.6% of young women and men aged 15-24 have had sexual intercourse before the age of 15. At that time, 0.24% of young people aged 15-24 were HIV infected. By the end of 2008 the cumulative total of HIV cases was 3166 and the total number of AIDS related deaths was 1,436. In the early 1990s AIDS was the leading cause of death in the age group 15-49 years.

The confusion and insufficiency of the legislation has contributed to young people being refused and deterred from even enquiring about sexual and reproductive health treatment and services with fear of the consequences, on the basis that the legal age at which children become adults is eighteen. The result of lack of clarity in the legislation then is that some teenagers have unprotected sex and become susceptible to STIs, STDs, and teenage pregnancies.

In her interview, Dr. Lisa Monrose, a doctor who practices at the Polyclinic and the QEH Hospital, stated that from her experience in the community setting, most doctors operate on the basis that the legal age of majority is 18, and so "children" cannot receive treatment without their parents' permission until that age. She stated that though the law does not explicitly state that they cannot distribute this treatment to minors, neither does it state that they can. She says physicians must operate within a strict code of ethics and conduct, and be able to justify any actions that they take. However, in the Minors Act, which sets out the age of majority, there is no reference to the age of medical consent, and therefore this Act cannot be said to apply to the that.

The law is an essential and necessary medium for the protection of the rights of adolescents

and youth. They are a highly vulnerable group of citizens and have the smallest voices, yet their contribution and potential contribution to society is great, given the demographic reality. In 2007, in the UNFPA Framework for Action on Adolescents and Youth, it was noted: "the case for investing in young people now is more than clear. Almost 1.5 billion people in the world today are between 10 and 25 years old." In the Caribbean, youths make up more than 30% of the population[iii], a phenomenon known as the "youth bulge", where the cohort of youths is large relative to the total population. As such, the UNFPA projects that the greatest "demographic dividend" for Latin America and the Caribbean, will be created in the space between 2018 and 2020[iv].

It is clear then, that what is done with the huge potential lying in such a large proportion of the population is determinative of this country's success or failure. Stability and prosperity are contingent on the opportunities afforded to this generation. Without the right guidance and acknowledgement of their rights, especially the right to sexual autonomy and access to medical sexual and reproductive treatment and services, youths and adolescents would turn to the easier options of crime, drugs and unprotected sex. It has been suggested that the countries with unharnessed "youth bulges" are those most prone to civil unrest because this demographic is prevalent in developing countries with high levels of unemployment and poverty.[v]

How the issue has been addressed so far

George Griffith, executive director of the Barbados Family Planning Association, noted in March 2011, at a UN conference in New York, that the Association was pushing government for the change in legislation. He noted that currently there is an anomaly where the age of consent to sex in Barbados is 16 but one becomes an adult at 18. However before you reach that age, you are not permitted in any of the Government clinics to have reproductive services or any services without parental consent. This reiterates the fact that though there is no concrete legislation preventing access to this treatment and services, adolescents are still prevented.

In 2008, during a debate on two resolutions before the Lower House on HIV/AIDS- one looking at the National Strategic Plan For HIV Prevention And Control 2008-2013-and the other dealing with the Barbados National HIV Policy, a policy suggesting the change in legislation was tabled, and received general support but went no further than this.
Also in 2008, Minister Esther Byer-Suckoo during her address to a two-day high level meeting of the United Nations General Assembly Special Session on HIV, pointed out that lowering the age of medical consent from 18 to 16 was but one of the policies which the Barbados Government was pursuing. She further noted that evidence suggests that this action will facilitate greater access to

sexual and reproductive health services by those youth who are presently in need of such, but do not have the requisite parental support.

In March 2011, a draft National Youth Policy was created by The National Youth Policy Coordinating Committee. This committee includes persons from different organizations involving the youth, and persons from the Ministry of Family, Culture, Sports and Youth. In the preface by the Minister of Family, Culture, Sports and Youth, Stephen Lashley, he noted that the Manifesto of the Democratic Labour Party of 2008, and the Youth Manifesto are documents which gave clear directions for the formulation of a holistic National Youth Policy. Goal G of the Policy is "To enable young people to tackle lifestyle diseases, especially HIV/AIDS". Objective three of this goal is to: "Align the age of consent with the age of access so that young persons have the right to get tested for HIV/AIDS and other Sexually Transmitted Infections (STIs) without their parent's consent from age 16."

Most recently, on July 18th, 2011, 'Parliamentarians Leading on HIV Prevention Stigma and Discrimination' was launched. There, former deputy Prime Minister, Dame Billie Miller, suggested that Government must have the "intestinal fortitude to take legislative steps to address the issues of stigma and discrimination associated with HIV/AIDS". Ms. Miller also noted that it will be difficult to meet the Millennium goal by 2015 with respect to AIDS which is to halt and begin to reverse the spread of HIV/AIDS, and to achieve universal treatment for the disease.

It is thus clear, that the deficiency in our legislation and the necessity of clarifying it has been recognized by various parliamentarians, prominent leaders and youth advocates over the years. However it is important that these leaders and youth advocates remain prudent in attaining this change, and ensuring it as swiftly as possible. Also to be noted is that it appears to be general consensus among legislators and parliamentarians that the age of medical consent is truly 18, whereas the legislation does not make this clear.

Legislation

Past actions show that government has invested into the welfare of children via the many laws in place which show that the law protects the rights of children and adolescents. The Status of Children Reform Act of 1979, is an Act to reform the law relating to children to provide for their equal status. It recognizes and equalizes the status of children born outside and within the marriage and destroys reference to the term "illegitimate children". The Protection of Children Act 1990 speaks to the non-exploitation of children by video or photographic media, and makes it an offence to

commit such an act. The Family Law Act1981, also places much importance on the protection of children and speaks to their mental and physical well being in the breakdown of a marriage.

The age at which different Acts recognize that children become responsible for their action is also necessary to note, and the possible contradictions that lie within. Adolescents are deemed responsible enough to drive at sixteen under the Road Traffic Act 1949. The Protection of Children Act stipulates that for the purposes of that Act, children are not adults until 18 and are offered protection up to that age under that Act. This is the same as the Minors Act which recognizes children up to 18 for a number of purposes but recognizes children up to 17 for contracts relating to marriage, and settlement of property through such a union. The medical age of consent is not mentioned as one of the categories that this act refers to, yet this is the Act that most medical practitioners refer to due to lack of any other reference legislation.

The Marriage Act1978, allows marriage to occur with a sixteen year old given the permission of that person's parents. Otherwise it legally occurs at eighteen and older.
The Medical Termination of Pregnancy Act recognizes a general rule that persons under 16 cannot have abortions without parental permission. Further those persons requesting an abortion must fulfill the exceptions to the general rule that abortions are illegal. These exceptions however are very broad- that is- where continuance of the pregnancy would cause harm to mother or child, and where harm can be both mental and physical. Arguably, mental harm to the mother can almost always be established. This law can be seen as an acceptance that 16 year olds are having sex without contraception and getting pregnant, but are not being allowed to legally receive contraceptives at that age.

The law in Barbados that specifically relates to the sexual activity of the youth is the Sexual Offences Act 1992.Under this Act, a person under the age of fourteen is deemed incapable of committing the offence of rape. A person under 12 years old is deemed incapable of committing an offence under the entire Act.

The Drug Abuse (Protection and Control) Act 1990, prevents the distribution of controlled drugs to children, and recognizes children up to the age of 14. Under this Act, persons 15 years also older are able to receive controlled drugs without parental consent. Thus, whether or not contraceptives and other medical sexual and reproductive treatment and services fall under the category of 'controlled drugs', adolescents aged fourteen and older would still have access to these drugs.

These differences may indeed be seen as contradictions within the law. At different ages

children are recognized as adults and therefore may not be given access to contraceptives because of a healthcare service provider's own interpretation of what an 'adult' is.

Evolving Capacity

The advantage of the varying legislation is the recognition of the evolving capacity of human beings and the varying ages at which one could be responsible for different offences. Alternatively, standardization of the laws could also be advantageous in reducing the confusion of the law. Further, though the evolving capacity is recognized between offences, it is not recognized within each offence, and does not take account of the different levels of maturity that each child may exhibit. This also prevents the discretion of judges in certain cases when the law may be too liberal or too restrictive. Justice Cornelius felt that the way the law recognizes adulthood at different ages mostly has no rational basis and should in fact be standardized, and that this would help to clarify the position for the layperson that may be confused by the difference in ages. She spoke especially about the dichotomy that exists where one can have an abortion at 16, but cannot access contraceptives until 18, and the need for harmonization in that area. The other respondents felt that standardization of an age for adulthood was appropriate and took away much confusion, though expressing reservations about the potentially arbitrary consequences of this, and the need for the recognition of evolving capacity by allowing some discretion in the law, based on strict guidelines. One student noted that the recognition of evolving capacity allows for a wider safety net than the fixing of an age.

The sexual development of youth and adolescents is by no means fixed, and varies according to the different body and mental maturation rates, and personal experiences. It is a time of rapid physical, social and cognitive changes. Due to adolescent's vulnerability, and pressure from society to adopt risky behaviors, challenges are presented such as dealing with one's sexuality and finding one's identity. However, during this period, sexual behaviour is learned, therefore if young people adopt unsafe and unhealthy habits when young, these may continue into adulthood.

The concept of evolving capacities recognizes the need to respect this time of young peoples' lives and give them more responsibility where due. Evolving capacities also recognizes that as children and adolescents acquire enhanced competencies there is a greater possibility that they can take responsibility for decisions affecting their lives, with proper guidance and with appropriate guidance and support. Conversely, they need protection from decisions that they are not yet mature enough to make.

Analysis of Legal and Medical Perspectives

The term "adolescent" was interpreted differently by many of the respondents, however most of them believed it to encompass the teenage years of 11-19. Attorney-at-law Anya Kirton noted that the law made no distinction between child and adolescent, and noted that in Family law children are recognized up to 18. Using the UN definition of adolescents, all the respondents were of the opinion that adolescents in Barbados are a sexually active group, their opinion being based on personal experiences, and statistics that they were aware of. Personal experiences varied from legal and medical cases to community work. Dr. Monrose noted that the age of first intercourse is decreasing, while many of the cases she encountered involved force. Justice Cornelius was concerned about early sexualization in our culture promoted by many of the practices encouraged, and adult–led activity, using Crop Over as an example. She also expressed concern about the high levels of sexual and psychological abuse of children noting that at Summerville many of the girls there were sexually abused.

The obvious implications of this prevalence of sexual activity among our youth were echoed by all of the respondents: high teenage pregnancy rates, children parenting children and lacking the maturity and responsibility to be parents, an increase in abortion statistics, an increasing burden on social services where the adolescents do not have resources, influences on quality of life, adolescent's lack of awareness of their bodies from a medical perspective, and many young mothers seeking maintenance in the courts.

Proposed Legal Reasons for Lack of Access

In the interviews conducted among different members of the legal community, there were different interpretations of what legal reasons exist for preventing access to medical sexual and reproductive treatment and services without parental permission. The question however was one which many of the respondents were unable to answer, as their opinion was based on pure assumption prior to the interview. Justice Cornelius in her response noted that it could possibly be because of the rules of contract where minors cannot make contracts unless in times of necessity. However she also found that necessity can include medical treatment, but she was doubtful as to whether medical treatment could include reproductive services. Arguably there will be many cases where reproductive services can be of 'necessity'.

In response to a question about whether doctors do not offer that treatment on the basis of contract, Dr. Lisa Monrose noted that every time a doctor takes on a minor as a patient, they make a

contract with them based on confidentiality, and breach of this would be a violation of that contractual arrangement, and a code of ethics.
Attorney-at-law Anya Kirton interpreted the age of sexual consent to encompass the age of medical consent, and did not believe it is general practice to refuse treatment or services to persons 16 years and older. Both legal practitioners expressed surprise that there is no explicit legislation. One law student was aware of the lack of legislation while another was not.

The Gillick-Fraser Competency test

In Britain and in some other countries of the Commonwealth, the Gillick competency test and Fraser Guidelines are used to determine whether a child, sixteen years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. This test has been proposed for Barbados and places the discretion with the medical practitioner, or distributor's hands to decide whether the adolescent is mature enough. This removes the rigidity from the law and takes into account the concept of a human being's evolving capacity. The test requires the distributor to be able to answer yes to eight factors enabling them to determine if the adolescent or youth is competent to receive such treatment or services without parental consent.
The test was formed in 1982 in the case of Gillick v West Norfolk and Wisbech Area Health Authority in England, where a parent activist, Mrs. Gillick, protested against her local health authority distributing a circular to doctors advising them on the prescription of contraceptives and treatment for adolescents. The circular stated that the prescription of contraceptives was a matter of discretion for the doctors, and in some cases contraceptives could be prescribed to minors without parental consent. Mrs. Gillick brought the case on the grounds that such prescription of contraception would be illegal as it is encouraging sex with a minor. The case went all the way to the House of Lords, where it was held by the majority that doctors could have this discretion based on strict guidelines. Lord Scarman found that the notion of parental rights is only such as to protect the best interest of the child. He also found that the parents' right to prevent their underage child from seeking treatment ends when the child obtains a sufficient understanding and intelligence to fully understand the undertaking, in keeping with the concept of evolving capacity. Since then, the reasoning of this case has been applied beyond the prescription of contraceptives to other types of sexual reproductive health treatment and services, and not only to doctors but to other health care providers.
The case is binding in England and Wales and has been since followed in Australia, Canada and New Zealand, with similar provisions made in Scotland and Northern Ireland.

As it stands, there is no precedent in Barbados or indeed the Caribbean governing such

matters. The Gillick case did not occur in the Privy Council- the former final appellate court for Barbados, and notwithstanding this, the final appellate court is now the Caribbean Court of Justice (CCJ). However, though this court no longer relies on precedent from England, many of the decisions that come out of the CCJ, are based upon existing decisions in England- particularly so, where there is no precedent in the Caribbean to follow, and the cases from the House of Lords and the Privy Council governing the matter are persuasive. The credibility of this test has been further affirmed by the adoption in other countries, and its success so far.

The law, being an imperfect tool to protect such rights must maintain some degree of flexibility when it comes to this matter, and as such the Gillick competency test is a good solution. The test allows discretion whilst directing the use of this discretion along strict guidelines.

During the interview with Dr. Monrose, she displayed knowledge of the Gillick test, and explained that this formed part of her training, and she, along with other medical practitioners use this test, though it has not been made part of law in Barbados. Further, she noted that though the general principle is not to treat minors without parental consent, after an analysis of the case, a doctor may use their discretion to distribute the sexual medical treatment and services, depending on the maturity of the minor, and the type of treatment required among other factors. She added that this must all be very well documented, ensuring that all actions are well justified. She interpreted the Gillick test to be a test of the maturity of minors and ensuring that the minor understands what they are doing and the consequences. Dr. Monrose felt the test was very appropriate for the Caribbean and it was in fact a lifeline for them.

Justice Cornelius did feel that the Gillick test was a legislative policy decision that was necessary to be made, and was not an appropriate decision for the courts to make. She had serious doubts about the desirability and application in such a society as this where she felt there would be an outcry of such a liberal stance, and felt it was an area that needs reflection and consideration as a society. Both law students doubted the ability of the government to implement this test but felt it would be advantageous if the government did make that decision. One student further noted that societal attitudes also needed to be changed while the other noted that some level of counseling should be provided to compliment the test. Lawyer Anya Kirton did think that the test could be applied in the Caribbean, and felt that the age should be set to encompass the majority and then varied for a particular circumstance.

The Sexual Offences Act 1992

As noted previously, the law in Barbados that specifically relates to the sexual activity of the youth is the Sexual Offences Act 1992.
Under this Act, a person under the age of fourteen is deemed incapable of committing the offence of rape. This is perhaps contrary to the notion of evolving capacity, and it shows the unwillingness of the legislature to acknowledge that at 14, an adolescent may indeed be culpable for such an offence, and may have attained the maturity of mind and body to be aware of what they have done. Conversely, there must be an age limit at which adolescents can be deemed culpable for such offences. Also, according to the Act, no person 12 years or younger is deemed capable of committing an offence under the Act, which can potentially pose the same problems.

Further, under this Act, with consent, a person who has sex with someone between the ages of 14 and16 is deemed to have committed an offence unless they reasonably believed the person to be 16 years or over, or if that person is younger than 24 years old. This shows that there is some flexibility to the law, taking into account the varying levels of reprehensibility for certain acts given the age and the circumstance.

The implications of this are that it would be an offence for teenagers older than 14 to have consensual sex with anyone younger than 14. Thus a 15 year old could be charged for having sex with a 13 year old. Section 4 of the Act finds that regardless of consent, and regardless of the offender's honest belief, the offender, having sex with a person less than 14 years, is liable on conviction on indictment to imprisonment for life. Also, that consensual sex with any teen between 14 and 16, and a person under the age of 24 years, is legal. Given the difference in age of these potential victims, there is a huge jump in allotment of sexual responsibility.

In a comparison with Wisconsin, USA, where it is a felony for teens under 16 to have consensual sex, even if of the same age, all of the respondents felt this rule was too strict. Ms. Kirton was of the view that consensual sex should be allowed in persons between the ages of 12 and 18, and for ages 11 and under this should be deeply frowned upon. The two law students agreed with the 'close in age' exceptions used in Canada where individuals 14 and 15 are able to consent to non-exploitative sexual activity with individuals not more than 5 years older and 12 and 13- year olds are able to consent to non-exploitative sexual activity with adolescents not more than 2 years older[vi]. The law students felt that the close in age exceptions should not be more than 2 years in one student's opinion and 3 years in the others.

Under the law, 14 year olds are not deemed capable of committing rape, and 12 year olds are incapable of committing any offence under the entire Sexual Offences Act. Justice Cornelius commented on this point by saying she accepts this as the law, and she does doubt that at that age many 14 year olds can form the mensrea for rape. However she thought all the ages that are set by law should be reviewed, as many of them have no rational basis. All the other respondents felt that there are definitely cases where 14 year olds are cognizant of what they are doing. Ms. Kirton felt that the minimum age for culpability of rape should be perhaps lowered to 12, which was the age that most adolescents start going through puberty, but overall it should be on a case-by-case basis. She also felt that the minimum age for charge under the entire Act, which is 12, should stay but counseling should be provided for offenders who are younger. Both law students felt that all offenders should at the respective ages of 14 and under and 12 and under, receive some sort of rehabilitative counseling.

The entire Act recognizes the necessity to protect children from acts of those who may take advantage of them, or their lack of maturity to understand the consequences of their actions. This and the other Acts previously mentioned are indeed progressive in recognizing such.

However, what must be noted is the prominence that is placed in Barbadian legislation upon the protection of children and adolescents in many situations, and in turn the lack of acknowledgement of their responsibility and maturity in certain situations. This is evident in the lack of legislation permitting adolescents access to medical sexual and reproductive health care services.

What occurs in practice?

The cases that emerge from this research also reflect the predominance of rape, abuse and exploitation as the main themes addressed in the existing legislative framework on adolescents and youth. The questions of illicit and consensual sex between teenagers or the non-ability to access contraceptives at certain ages without consent never arise. Indeed it can be said there seems to be surrounding the said topic a level of stigma. This further compounds the problem and the necessity to clarify the legislation, because even though the law is silent, the statistics reflect that this is not because there is no problem. Ms. Kirton noted that she has never come across such a case, and most of the cases on this issue are rape related. However she did feel it was necessary to clarify the legislation. Both Ms. Kirton and Justice Cornelius felt that the lack of cases pointed to the fact that it is not much of an issue in Barbados.

Conversely, Dr. Monrose noted that in the polyclinic at least one to two cases are seen per

week, where minors come in requesting these treatment and services without parental consent. Whether they will be seen then depends on the urgency of the case, and the principles in the Gillick test. Most of the time however, the teenagers are asked to return with an adult or are sent to the Family Planning clinic by the health care provider and are given information. She noted the need for a legal framework in which adolescent health care is addressed so that health care providers would have something to follow- this also pertains to cases of rape and child abuse- where no protocols exist to follow.

Both law students highlighted the inadequate nature of their legal training in these matters noting that they are addressed briefly in Criminal Law, Human Rights and Constitutional Law courses- all which are mandatory. In terms of what needs to be done- they commented that counseling should play a bigger role and have a bigger relationship with the law. Along with standardization and clarification of the law, mandatory-reporting protocols should be enforced. One student thought that the holistic development of an optional course should be enforced that deals with adolescent sexual and reproductive health. The other student felt that there should be greater synergy between UWI and UN agencies as it relates to weaknesses in the law, allowing law students to be "think tanks" and construct model policies for potential implementation. Further he felt that there should be interactive human rights sessions outside of class that allowed for discussion on topics such as this one.

The Constitution

The Constitution, which is the supreme law of Barbados, prevents the discrimination against persons under section 13. However in the limited grounds under which discrimination is prohibited that are mentioned, the ground of age is not present. Thus the supreme law of Barbados does not in fact restrict such discrimination. Not only does this not offer protection to adolescents and youths who may want contraceptives, but also it allows the discrimination against the elderly and other persons on the basis of age. It is unfortunate that the law that is above all others in this country does not protect the rights of young people, or elderly people- two groups who are vulnerable in society and are often taken advantage of. Though the legislation offers protection to youths, it does not respect their need for sexual autonomy. Justice Cornelius agreed, and noted that the more prohibitions the greater. She was in favour of general anti-discrimination legislation, but did not think that age could be read into the Constitution by implication. One law student was not certain whether it should be there, and doubted that Caribbean jurisprudence would get there any time soon. The other law student though expressing his desire for it to be in the Constitution, echoed the belief that that step is a long way away for the Legislature. Ms. Kirton felt it was not necessary to go

through, as she thinks it could be read into the Constitution by implication.

The legislation and the Constitution of Barbados, the symbols of the order and fairness in society, in their lack of protection of this basic right of young people, have caused the country to move backward in the fight against HIV/AIDS and other demographical inconsistencies halting the progress of the nation.

Appropriate ages for sexual and reproductive health education and treatment

One must recognize that the lack of contraceptives actually just means that most adolescents will go without. This has negative results and consequences for society and the spread of diseases. When asked whether adolescents have the right to sexual and reproductive health education, all of the respondents responded in the affirmative. Most of the respondents felt that the age at which adolescents entered secondary school which usually corresponds with adolescence, is an appropriate one at which adolescents should be given this education, however some felt that it was necessary for younger children as long as the information is age appropriate. Reasons given included the fact that we need to face the realities of society head on, and knowledge leads to better behaviour, but at the same time we need to be weary of enabling sex offenders. When questioned if adolescents have the right to sexual and reproductive treatment and services, the responses varied. The students' views were quite liberal, where one student felt that after twelve adolescents should have access to contraceptives, while another felt that if adolescents are having sex then they should be provided with contraceptives. Dr. Monrose felt that at a young age, adolescents should be able to have a sexual and reproductive health consultation, and for those who are already active or making that decision a physical exam may be necessary. Justice Cornelius was of the view that sexual and reproductive services and treatment should not be available to anyone younger than 16, whilst Ms. Kirton felt that 14 was a more appropriate age.

Conclusion

Barbados has a responsibility to comprehensively address the unmet sexual and reproductive health needs of adolescents and youth. In fact, the country has made commitments under the various international conventions, which it has signed and ratified. In 1990, Barbados signed and ratified the Convention on the Rights of the Child, a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children. In 1999, in the feedback given by the Committee to the report submitted by Barbados, the Committee noted the inconsistencies that still remain in the definition of a child, noted the prevalence of physical abuse, and the unsatisfactory

amount of attention given to children's rights and compatibility with the Convention.

Further, though they recognized the efforts made by Barbados in the fight against adolescent pregnancy, the Committee noted that more should be done towards adolescent sexual and reproductive health care due to the high levels of adolescent pregnancies, abortion and the high levels of HIV/AIDS. They recommended involving the youth in the formulation of policies and treatment programs in accordance with their evolving capacity. Most importantly they recommended that it should be made possible for adolescents to have access to medical advice and treatment without parental consent in accordance with their age and maturity.

Barbados has also signed and ratified the Committee on the Elimination of Discrimination against Women in 1980. In Barbados' report of 2000, much is said of the progressive steps taken to equalize the status of women in society. In the area of health, the needs of adolescents are recognized in the adolescent health programs conducted at Polyclinics. They involve family life education, school outreach programs, self-esteem, and human sexuality, HIV/AIDS, budgeting, values and environmental health. It is said that adolescents are encouraged by medical personnel and parents to access the adolescent health programs. Though in theory this may seem to be so, the reality is that this does not occur and these programs are often not well attended.

Therefore, though through its international commitments Barbados recognizes the need for the protection of adolescent sexual and reproductive health, the reality is that there is no legislation that recognizes the need for adolescents to have access to contraceptives and sexual and reproductive health services. The contradictions throughout the laws of Barbados on what constitutes an adult further compounds the problem, where between 16 and 18, two years after adolescents can legally have sexual intercourse without their parents' permission, they are restricted access. The Gillick competency test is an appropriate test to determine whether adolescents should have access to contraceptives and sexual and reproductive health services because it recognizes the evolving capacity of adolescents. The policy is arguably not sufficient. Without legislation, there is no guide, authority or strict reinforcement mechanism for distributors and medical practitioners to follow and they will often impose their own opinion on whether an adolescent should have access to such, taking away an adolescents vital right to sexual autonomy and the right to make choices about their sexual and reproductive health.

Appendix

Table 1: Interview Guide for Lawyer and Judge

QUESTION GUIDE
Do you think there is any age difference in the term child and adolescent and if so, what is the difference?
Do you think adolescents are a sexually active group of individuals in the Caribbean?
If yes, what do you think are the implications of this?
Do you think that adolescents have the right to sexual and reproductive health and treatment? If not, why not?
Should there be a difference in the approach to sexual and reproductive health education among adolescents and the approach among children, why?
What legal barriers exist, if any, to prevent adolescents from accessing sexual and reproductive health services and treatment?
How do you interpret the age of majority for access to adolescent sexual and reproductive health?
Do you think the age of majority is the age of medical consent?
Are you aware that there is no Act in Barbados explicitly saying that the age of medical consent is the age of majority?
With knowledge of this, do you still think that the age of majority is the age of medical consent?
What are your thoughts on the different ages that Acts recognize adulthood, i.e. the age one is permitted to drive, the age one is permitted to get married, age one is able to access controlled drugs without parental consent?
What are your thoughts on the concept of evolving capacity as it relates to the fixing of an age of medical consent?
How do you interpret the Gillick-Fraser competency test?
Do you think that the test is an appropriate one to be applied in the Caribbean?
What are your thoughts on the fact that adolescents under 14 are not deemed capable of committing rape?
If you agree with that law, then how does that square with the concept of evolving capacity? If one is allowed to be responsible should they not also be accountable?
Further, what are your thoughts on the fact that no person under 12 years is deemed capable of committing an offence under the entire Sexual Offences Act?
How do you feel about the lack of age as grounds of prohibited discrimination in the Constitution?
Do you think that discrimination the grounds of age can be read into the Constitution by implication?
What are your thoughts on the law governing consensual sexual behavior between adolescents of the same age?
In Wisconsin, USA, it is a felony for teens under 16 to have consensual sex, even if of the same age.
In Canada, though the age of sexual consent is 16, there are 'close in age' exceptions, where individuals 14 and 15 are able to consent to non exploitative sexual activity with individuals not more than 5 years older and 12- and 13-year-olds are able to consent to non-exploitative sexual activity with adolescents not more than 2 years older.
In Barbados however, the law penalizes sexual intercourse with any person under 14 years, regardless of consent. Since the law states that those persons under 14 are incapable of committing rape, this means that though consensual sex among those of the same age under 14 is impliedly legal under the Sexual Offences Act 1990, sex between anyone 15 and up with anyone younger than 14, is impliedly illegal.
What are your thoughts on the law in Barbados as opposed to that of Wisconsin, and that of Canada?

Do you think that close in age exceptions should be employed in Barbados as well, or should the stricter approach of Wisconsin be used?
How often do you encounter cases on this matter, if at all?
How do you/would you deal with these cases?
How do you feel about the lack of precedent on this matter?
Do you have any recommendations for strengthening the legal framework in this area? [Probe specifically for recommendations on legislation on establishing an age for medical consent]

Table 2: Interview Guide for Law student

QUESTION GUIDE
Do you think there is any age difference in the term child and adolescent and if so, what is the difference?
Do you think adolescents are a sexually active group of individuals in the Caribbean?
If yes, what do you think are the implications of this?
Do you think that adolescents have the right to sexual and reproductive health and treatment? If not, why not?
Should there be a difference in the approach to sexual and reproductive health education among adolescents and the approach among children, why?
What legal barriers exist, if any, to prevent adolescents from accessing sexual and reproductive health services and treatment?
How do you interpret the age of majority for access to adolescent sexual and reproductive health?
Do you think the age of majority is the age of medical consent?
Are you aware that there is no Act in Barbados explicitly saying that the age of medical consent is the age of majority?
With knowledge of this, do you still think that the age of majority is the age of medical consent?
What are your thoughts on the different ages that Acts recognize adulthood, i.e. the age one is permitted to drive, the age one is permitted to get married, age one is able to access controlled drugs without parental consent?
What are your thoughts on the concept of evolving capacity as it relates to the fixing of an age of medical consent?
How do you interpret the Gillick-Fraser competency test?
Do you think that the test is an appropriate one to be applied in the Caribbean?
What are your thoughts on the fact that adolescents under 14 are not deemed capable of committing rape?
If you agree with that law, then how does that square with the concept of evolving capacity? If one is allowed to be responsible should they not also be accountable?
Further, what are your thoughts on the fact that no person under 12 years is deemed capable of committing an offence under the entire Sexual Offences Act?
How do you feel about the lack of age as grounds of prohibited discrimination in the Constitution?
Do you think that discrimination the grounds of age can be read into the Constitution by implication?
What are your thoughts on the law governing consensual sexual behavior between adolescents of the same age?
In Wisconsin, USA, it is a felony for teens under 16 to have consensual sex, even if of the same age.
In Canada, though the age of sexual consent is 16, there are 'close in age' exceptions, where individuals 14 and 15 are able to consent to non exploitative sexual activity with individuals not

more than 5 years older and 12- and 13-year-olds are able to consent to non-exploitative sexual activity with adolescents not more than 2 years older.
In Barbados however, the law penalizes sexual intercourse with any person under 14 years, regardless of consent. Since the law states that those persons under 14 are incapable of committing rape, this means that though consensual sex among those of the same age under 14 is impliedly legal under the Sexual Offences Act 1990, sex between anyone 15 and up with anyone younger than 14, is impliedly illegal.
What are your thoughts on the law in Barbados as opposed to that of Wisconsin, and that of Canada?
Do you think that close in age exceptions should be employed in Barbados as well, or should the stricter approach of Wisconsin be used?
Do you think your legal training thus far has been sufficient as it relates to these matters?
What course would you say it has been most addressed in?
Do you have any recommendations for strengthening the legal framework in this area? [Probe specifically for recommendations on legislation on establishing an age of medical consent]
Do you have any recommendation for how to strengthen legal training in this area?

Table 3: Interview Guide for Medical Practitioners

QUESTION GUIDE
Do you think there is any age difference in the term child and adolescent and if so, what is the difference?
Do you think adolescents are a sexually active group of individuals in the Caribbean? What is your opinion based on?
If yes, what do you think are the implications of this?
Do you think that adolescents have the right to sexual and reproductive health and treatment? If not, why not?
Should there be a difference in the approach to sexual and reproductive health education among adolescents and the approach among children, why?
What legal barriers exist, if any, to prevent adolescents from accessing sexual and reproductive health services and treatment?
How do you interpret the age of majority for access to adolescent sexual and reproductive health?
Do you think the age of majority is the age of medical consent?
Are you aware that there is no Act in Barbados explicitly saying that the age of medical consent is the age of majority?
With knowledge of this, do you still think that the age of majority is the age of medical consent?
Is the reason you do not distribute the treatment and services to minors because you cannot make a contract with a minor?
Are you aware that this rule is contained in a government policy?
What are your thoughts on the concept of evolving capacity as it relates to the fixing of an age of medical consent?
How do you interpret the Gillick-Fraser competency test?
Do you think that the test is an appropriate one to be applied in the Caribbean?
What are your thoughts on the fact that adolescents under 14 are not deemed capable of committing rape?
If you agree with that law, then how does that square with the concept of evolving capacity? If one is allowed to be responsible should they not also be accountable?

Further, what are your thoughts on the fact that no person under 12 years is deemed capable of committing an offence under the entire Sexual Offences Act?_
How often do you encounter persons younger than 18 requesting sexual and reproductive treatment and services?
How do you/would you deal with these cases? And where these persons do not have parental consent?
What reasons would one generally have for refusing treatment to persons under 18?
Do you think practice generally reflects something different to what the law requires?
In practice, are persons under 16 allowed to have abortions without parental permission?
Do you have any recommendations for strengthening the legal framework in this area? [Probe specifically for recommendations on legislation on establishing an age for medical consent]

Table 4: The Gillick Fraser Competency Guidelines

The following should be used as guidance for practitioners in determining and recording their decision as to whether a young person is able to participate in the CAF process without the involvement and support from their parent(s) / carer(s).
Consider: -
1. Has the young person explicitly requested that you do not tell their parents/carers about the common assessment and any services that they are receiving?
2. Have you done everything you can to persuade the young person to involve their parent(s)/carer(s)?
3. Have you documented clearly why the young person does not want you to inform their parent(s)/carer(s)?
4. Can the young person understand the advice/information they have been given and have sufficient maturity to understand what is involved and what the implications are? Can they comprehend and retain information relating to the common assessment and the services, especially the consequences of having or not having the assessment and services in question?
Can they communicate their decision and reasons for it? Is this a rational decision based on their own religious belief or value system?
Is the young person making the decision based on a perception of reality? E.g. this would not be the case for a chaotic substance misuser.
5. Are you confident that the young person is making the decision for themselves and not being coerced or influenced by another person?
6. Are you confident that you are safeguarding and promoting the welfare of the young person?
7. Without the service(s), would the young person's physical or emotional health be likely to suffer? (if applicable)
8. Would the young persons' best interests require that the common assessment is done and the identified services and support provided without parental consent?

You should be able to answer YES to these questions to enable you to determine that you believe the young person is competent to make their own decisions about consenting to and taking part in the Common Assessment, sharing information and receiving services without their parent's consent. You should record the details of your decision-making.

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