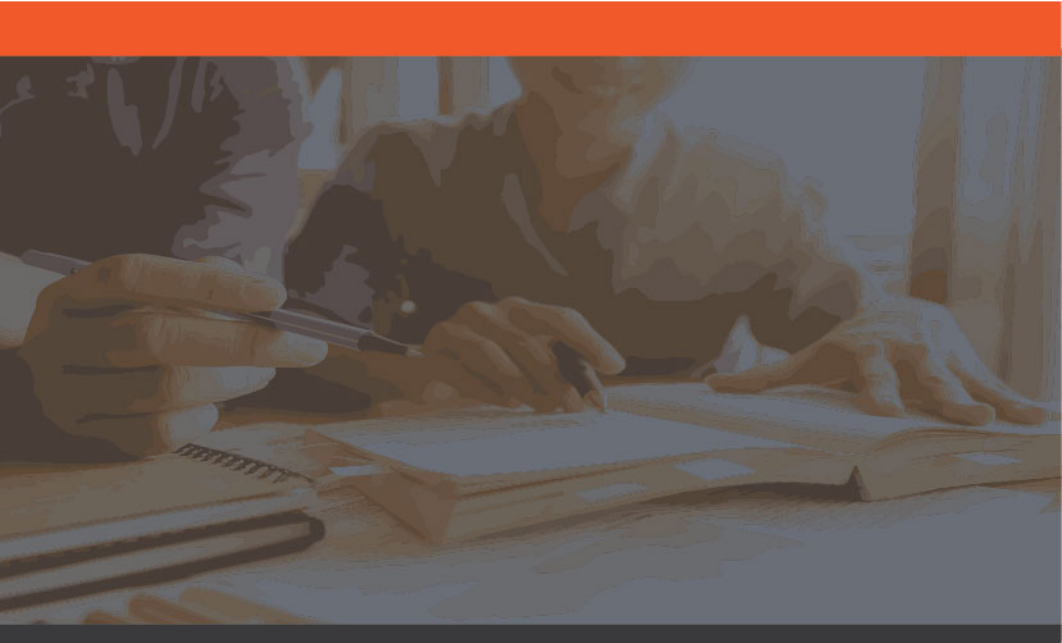




Government of the Republic of Trinidad and Tobago



Legal Barriers that affect Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago

A Qualitative Study

This Study was conducted by the
National AIDS Coordinating Committee (NACC)
in the Office of the Prime Minister,
with financial and technical support
provided by the
United Nations Population Fund (UNFPA)

Institutional Review Board Approval granted by the
Ministry of Health, Government of Trinidad and Tobago

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Acronyms

| | |
|--------|---|
| CI | Co-investigator |
| COMBI | Communication for Behavioural Impact |
| CRC | Convention on the Rights of the Child |
| CREDI | Catholic Religious Education Development Institute |
| CSE | Comprehensive Sexuality Education |
| FPATT | Family Planning Association of Trinidad and Tobago |
| GSHS | Global School-based Student Health Survey |
| HIV | Human Immunodeficiency Virus |
| IPPF | International Professional Practices Framework |
| LGBTQI | Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex |
| NACC | National AIDS Coordinating Committee |
| NCP | National Child Policy |
| PAHO | Pan American Health Organization |
| PI | Principal Investigator |
| SRH | Sexual and Reproductive Health |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infections |
| THA | Tobago House of Assembly |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| UWI | University of the West Indies |
| WHO | World Health Organization |

Glossary Of Terms

Sexual Health: A state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Reproductive Health: refers to the diseases, disorders and conditions that affect the functioning of the male and female reproductive systems during all stages of life.

Sexual Activity: Sexual activity includes sexual acts and sexual contacts.

A sexual act means (A) contact between the penis and the vulva or the penis and the anus, and for purposes of this subparagraph contact involving the penis occurs upon penetration, however slight; (B) contact between the mouth and the penis, the mouth and the vulva, or the mouth and the anus; (C) the penetration, however slight, of the anal or genital opening of another by a hand or finger or by any object, with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person; or (D) the intentional touching, not through the clothing, of the genitalia of another person.

Sexual Consent: Sexual consent is an agreement to participate in a sexual activity.

Sexual Violence: Sexual activity when consent is not obtained or not freely given. It is 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.

Mandatory Reporting: The legal requirement to report any suspicion of child abuse or neglect to the relevant authorities.

Evolving Capacity of Adolescents: An interpretation in international law, recognizing that, as children acquire enhanced competencies, there is a diminishing need for protection and a greater capacity to take responsibility for decisions affecting their lives. This allows for the recognition that children in different environments and cultures, and faced with diverse life experiences and will acquire competencies at different ages.

Minor: A person who is still legally a child i.e. persons under the age of eighteen (18).

Adolescence: A transitional phase of growth and development between childhood and adulthood.

Transcendental/Psychological Phenomenological Research: A philosophical approach to qualitative research methodology seeking to understand human experience.

Contents

| | |
|---|-----------|
| Executive Summary | 1 |
| 1. Introduction | 3 |
| 1.1 Study Background | 4 |
| 1.2 Justification for Conducting Research among Adolescents | 5 |
| 1.3 Research Objectives | 6 |
| 1.4 Research Questions | 7 |
| 1.5 The Research Team | 7 |
| 1.6 Study Limitations | 9 |
| 1.7 Organisation of this Report | 9 |
| 2. Research Methodology and Design | 10 |
| 2.1 Study Design | 10 |
| 2.2 Sampling Strategy | 11 |
| 2.2.1 Recruitment Approach – Adolescent Participants | 11 |
| 2.2.2 Actual Sample Recruited – Adolescents 10 - 19 | 12 |
| 2.3 Data Collection Methods – Adolescent Participants | 14 |
| 2.3.1 Semi-structured In-depth Individual Interviews with Adolescents | 14 |
| 2.3.2 Focus Group Discussions with Adolescents | 14 |
| 2.4 Participatory Mapping | 15 |
| 2.5 Data Collection Method – Service Providers/Key Informant Participants | 15 |
| 2.5.1 Recruitment Approach – Service Provider/Key Informant Participants | 15 |
| 2.6 Study Procedures | 16 |
| 2.6.1 Obtaining Informed Consent | 17 |
| 2.6.2 Conducting the Interview/Focus Group Discussion | 17 |
| 2.6.3 Data Entry and Data Management Procedures | 18 |
| 2.6.4 Audio Recording | 18 |
| 2.7 Ethical Considerations in the Study | 18 |
| 2.7.1 Protection of Privacy and Confidentiality | 18 |
| 2.7.2 Reporting and Referral Protocol | 19 |
| 2.8 Data Analysis | 20 |
| 2.9 Research Challenges | 20 |
| 3. Findings | 21 |
| 3.1 Engaging and Disengaging Agency | 21 |
| 3.2 Adolescents and Sexual Reproductive Health | 22 |
| 3.2.1 Key Sources of SRH Information | 22 |
| 3.2.2 Public/State-Sponsored Access to SRH | 24 |
| 3.2.3 Condoms, Contraceptives and Access to Care | 24 |
| 3.2.4 Emotional Response Dimensions of Access | 25 |
| 3.3 Legal Barriers, Knowledge & Perceptions about the Law | 25 |
| 3.3.1 Age of Consent | 25 |

| | |
|--|----|
| 3.4 Positive Adult –Adolescent Relationships | 26 |
| 3.5 SRH and Gender | 27 |
| 3.6 Younger Adolescent vs. Older Adolescent Experiences | 27 |
| 3.7 Experiences of Adolescent Parents | 27 |
| 3.8 Experiences of Marginalised Adolescents | 28 |
| 4. Service Providers' Knowledge, Perceptions and Interpretations of the Laws Regarding Minors' Access to SRH Information and Services | 29 |
| 4.1 Policing the Gap: Between Policy and Legislation | 29 |
| 4.2 Adolescent Profiles | 30 |
| 4.3 Defining SRH | 31 |
| 4.3.1 Sexual Health vs. Reproductive Health | 31 |
| 4.3.2 Condoms, Contraceptives and Access to Care | 32 |
| 4.4 Adolescents' Access to SRH Services | 33 |
| 4.5 Process for Minor Access | 33 |
| 4.6 Assessing Competence | 34 |
| 4.6.1 Cultural Realities and Sexual Relationships | 34 |
| 4.7 Legal Barriers and Implications for Service Provision | 35 |
| 4.7.1 Identifying Discrepancies | 36 |
| 4.7.2 Contravening Legal Parameters | 37 |
| 4.8 Confidentiality | 38 |
| 4.9 Assessment of Trends | 39 |
| 4.9.1 Lack of Data Collection | 40 |
| 5. Discussion | 42 |
| 5.1 Filling Research Gaps and Broadening an Understanding of our Local Context | 42 |
| 5.2 Understanding the Adolescent Experience in Trinidad and Tobago | 43 |
| 5.2.1 Views, Knowledge and Experiences of Adolescents and Service Providers | 43 |
| 5.2.2 Curiosity among Adolescents about SRH | 44 |
| 5.2.3 Responsible Decision-making for Consensual Sexual Relationships | 45 |
| 5.2.4 Willing Participation in Illegal Sexual Acts with Adults | 45 |
| 5.2.5 Coercive Sexual Acts, Sexual Assault/Rape by Adults | 45 |
| 5.3 Knowledge, Perceptions and Interpretations of the Law | 46 |
| 5.4 Health Care Workers and Minors' Access to SRH Services and Information | 46 |
| 5.5 Interaction of Legal Barriers with Social and Cultural Barriers | 48 |
| 5.5.1 The Need for Adolescent-friendly Services | 49 |
| 5.6 Recommendations | 49 |
| 5.7 Conclusion | 51 |
| References | 52 |

Tables

| | |
|---|----|
| Table 1: Research Team | 7 |
| Table 2: Targeted Participants Profiles – Adolescent In-depth Interviews | 11 |
| Table 3: Targeted Participants Profiles – Focus Group Discussion | 12 |
| Table 4: Actual Sample - In-depth Interviews – Adolescent Participants | 12 |
| Table 5: Actual Sample - Focus Group Discussion – Adolescent Participants | 13 |
| Table 6: Actual Sample - Service Providers/Key Informants | 16 |

Figures

| | |
|--|----|
| Figure 1: Recruitment of Potential Participants: Adolescents and Service Providers | 17 |
|--|----|

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Executive Summary

Trinidad and Tobago's legislative framework, which establishes the age of sexual consent as 18, prevents adolescents under the age of 18 from accessing Sexual and Reproductive Health (SRH) services and information. *Legal Barriers that affect Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago* is a qualitative study of minors and service providers undertaken to generate evidence on the legislative gaps and on the factors that facilitate as well as hinder adolescents' access to SRH services and information. This research has been conducted with the intent of building knowledge and capacity to respond to adolescents' SRH needs, as well as informing policymakers in developing policy and legislative reform.

The research showed three underlying themes in the context of Trinidad and Tobago:

- (1) adolescents are aware of the legal barriers to accessing SRH services and information;
- (2) adolescents can circumvent the law; and
- (3) some adults, including SRH service providers, may also contravene the law to facilitate services for the youth.

Throughout the research, both adolescents and service providers had identified legal barriers to adolescents' access to SRH services and information. Participants in the research asserted that the age of consent (18 years old) to sexual activities had, at times, caused more harm than good by preventing service providers from effectively assisting adolescents without the knowledge of their parents and/or guardians.

The service providers elaborated that the law on age of consent and mandatory reporting as well as the lack of policies to meet the demand for adolescents' access to contraceptives, STI testing and SRH information, had prevented them from effectively providing the necessary services to adolescents. The fear of violating the law often led service providers to take a deterrence-oriented approach to adolescents' SRH. Even where the service providers were sympathetic to the adolescents' needs and wished to assist them, the restrictive and one-dimensional agency policies on SRH and the lack of resources including commodities prevented them from providing the needed services.

Adolescents identified the “Law” and the “Church” as the most significant barriers to accessing SRH information. They would thus turn to online resources and peer groups for such information instead of seeking professional assistance.

Shame, fear, and anxiety were the primary emotions connected to seeking SRH services, and adolescents identified both external and internalised shame associated with accessing SRH services. Particularly, adolescents stated that, in their experience, society responded more harshly to adolescent girls who are sexually active than to adolescent boys who are sexually active.

Participants had also expressed the opinion that it was easier to access the “morning-after pill”, emergency contraception, at private pharmacies than other contraceptives, and many sexually active adolescent girls reportedly used it as the only source of birth control measure. Many adolescents noted that they were not offered reliable, easy-to-use birth control through State health care services.

Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex (LGBTQI) and other sexually diverse adolescents explained that they were largely ignored and/or invisible in the health or legal sector. LGBTQI adolescents have reportedly felt overwhelmed by the shame that society associated with their sexual orientation or gender identity, and were often reluctant to approach adults about their SRH needs due to fear of being “outed”. Moreover, adolescents living with HIV noted that they had not received any accurate SRH information, and did not feel prepared to live healthy, satisfying sexual lives.

In accordance with Sustainable Development Goals 3 (Good Health and Well-Being) and 5 (Gender Equality), the research suggests that the current legislation is not in line with adolescents’ needs to access SRH services and Comprehensive Sexuality Education. Legislative changes with regard to mandatory reporting and age of consent, as well as the development of clear policy guidelines for duty bearers (e.g. legal guardians and health workers) are necessary. The research highlights the importance of raising awareness of policymakers and other stakeholders in regard to adolescents’ SRH needs, and ensuring that adolescents are engaged and empowered to contribute to the design, implementation and monitoring of their own SRH services.



Introduction



Legal Barriers that affect Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago was a qualitative study undertaken to generate evidence on the factors that facilitate as well as hinder adolescents' access to Sexual and Reproductive Health (SRH) information and services in the current legislative context. The study adopted a transcendental/psychological, phenomenological, qualitative research design which undertook a systematic exploration of the lived experiences of adolescents in Trinidad and Tobago between the ages of 10 and 19 years. The study sought to provide evidence of the impact of having no access to SRH information and services has on minors under the age of 18. The results of this study can assist policymakers in developing policy and legislation reform.

For millions of adolescents around the world, the onset of puberty brings not only changes to their bodies, but also exposure to additional human rights abuses. Millions of girls are coerced into unwanted sex or marriage, putting them at risk of sexually transmitted infections (STIs) including HIV, unwanted pregnancies, unsafe abortions, and dangerous childbirth.

Research evidenced that adolescents in the Caribbean continue to be sexually active, despite parental, school and community-based, governmental, and various national programmatic efforts to delay sexual activity. The Caribbean regional context is marked by early sexual debut with a mean age of 14 years for the first sexual encounter, as well as disproportionately high rates of HIV and STI infections among adolescent and other vulnerable groups (Allen, 2013; WHO/GSHS, 2017).

The World Health Organization (WHO) Global School Based Student Health Survey (GSHS) indicates that in Trinidad 28.8% of adolescents between the ages of 13 and 17 were sexually active, with 55.9% found to have had first sexual intercourse before age 14 (GSHS 2017).

The GSHS results for Tobago evidenced that 38.8% of adolescents between 13 and 17 were sexually active, with 56.3% found to have had their first sexual experience before the age of 14. In both Trinidad and Tobago, there was a higher incidence of sex among boys than girls (WHO, 2017). Furthermore, there is an estimated 330,000 people living with HIV in the Caribbean (UNAIDS 2019 regional data, captures 2017 data). Five countries account for 96% of all people living with HIV in the region: Cuba, the Dominican Republic, Haiti, Jamaica and Trinidad and Tobago. Adolescents—both boys and girls—are disproportionately affected by HIV, and accounted for approximately one third of all new infections in the Caribbean in 2016 (UNAIDS, 2017).

1.1. Study Background

Trinidad and Tobago's legislative framework, which establishes the legal age of sexual consent as 18, denies adolescents under the age of 18 universal access to SRH services, information and commodities. The Children Act of 2012, driven by a commitment to child protection, stipulates mandatory reporting requirements that may, in effect, make health care providers reluctant to provide SRH information and services to minors. Additionally, mandatory reporting requirements may reasonably make adolescents with SRH service-needs fearful of punitive actions from parents and other authority figures. The impetus for this Study was the need to examine these limitations in our local and regional context.

In 2015 and 2016, key stakeholders in Trinidad and Tobago participated in a review of the Children Act with regard to its implications for minors seeking access to SRH information, commodities and services. In keeping with Sustainable Development Goal five (5) of ensuring healthy lives and the promotion of well-being for all at all ages, these stakeholders had a mandate to fulfil target 3.7 of ensuring 'universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programme by 2030'. As such, an amendment was proposed geared at balancing child protection from sexual abuse and their right to access health care services. These stakeholders concurred that an amendment should be supported by empirical evidence.

Improving adolescent health outcomes necessitates a balance between protecting children and maintaining the autonomy of adolescents in light of their evolving capacities (IPPF, 2014; Sotolongo et al, 2017; Folayan et al, 2015).

The challenge of minors lacking access to SRH information and services is not unique to Trinidad and Tobago, and there is a range of strategies and guiding principles based on regional and international models which can be adapted to our context to facilitate the best outcomes for adolescents. An amendment to the Children Act can provide a means of ensuring that both child protection and improved SRH outcomes are safeguarded.

Cultural factors such as religion and social relationships, and their intersection with and influence on the legislation and policy, guide the adolescents' comfort level in accessing SRH services and information without the scrutiny and criticism of the society. A policy development in line with the legislative change that opens up discussion on adolescents' sexual health and capacity to consent is also much needed. For example, the 2009 National HIV Testing and Counselling Policy by the Ministry of Health espouses principles that recognise the evolving capacities of adolescents to understand their diagnosis and treatment such as the Gillick Competency Test and Fraser Guidelines, as outlined further in this study, even though the service providers still have to adhere to the law on age of consent to medical treatment, and abide by the mandatory reporting requirement. In this regard, the findings of this Study will be instructive.

1.2. Justification for Conducting Research among Adolescents

The dilemma on minors' access to SRH information and services are not unique to the Caribbean, and the literature highlights numerous empirical studies. At the core of the literature analysis are extrapolations around the balance between protecting the child and recognising the "evolving capacities" of adolescents that justify measures of autonomy. International law recognises adolescents' "evolving capacities" to make decisions in matters affecting their lives (CRC, 2012). Yet legislative frameworks that limit access to adolescents who are sexually active and health-seeking are, in essence, imposing punitive sanctions on individuals who are demonstrating maturity as they seek protection from, and/or treatment for, serious health risks (Center for Reproductive Rights, 2006). According to this argument, limitations on minors' access to SRH information and services are violations of their right to physical integrity as well as their right to be protected from sexual violence and abuse.

Rigid laws and policies barring minors' access to SRH information and services are characteristically justified by the obligation of adults to protect adolescents. The crux of this argument hinges on the position that adolescents are not sufficiently competent to make sexual decisions, specifically to consent to sexual acts.

In response to laws that limit minor access to SRH services, there have been provisions made in certain countries to permit health care providers to offer services (IPPF, 2014; Burke et al, 2014). The two criteria used are:

- Gillick Competency – which assesses the minor's ability to understand treatment and consent to receiving SRH services.
- Fraser Guidelines – which stipulates that health workers should attempt to persuade minors to inform parents, and ensure that the risks connected to treatment are understood prior to providing SRH services.

In the global context, there is extensive literature on barriers to accessing SRH services that include a lack of public belief in their confidentiality and privacy as well as flawed facility design. There is also an evident need for provisions of services that respond to the needs of vulnerable adolescents, including adolescents with mental illness, HIV, drug and alcohol dependency, LGBTQI adolescents and those living in poverty (Uberoi, and Galli. 2017).

There are a number of situational analyses and adolescent health research studies in the English-speaking context as well. These analyses address access to SRH services as an important aspect of the larger psychosocial and biological risks and vulnerabilities faced by adolescents. Notwithstanding, there has not been any previous research that specifically addresses minors' access to SRH information and services.

This study, *Legal Barriers that affect Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago*, offers an opportunity to (1) generate context-specific evidence that can elucidate the lived experiences of adolescents with regard to access to SRH services; and (2) offer legal, policy and programmatic measures that are responsive to the needs of adolescents in our context.

1.3. Research Objectives

This study aims to generate new evidence on how perceptions, knowledge, and understanding of legislative factors can facilitate, as well as hinder, adolescents' access to SRH services and commodities in Trinidad and Tobago. This study also aims to inform policy decisions. Specifically, the objectives of the study are to:

- identify adolescents' views and experiences in accessing SRH information and services;
- generate an understanding of how adolescents' experiences with accessing SRH services have affected them across a diverse socioeconomic spectrum, including but not limited to education and family; and

- build an understanding of how lack of access to SRH services, information and commodities have impacted sexual and reproductive health outcomes.

1.4. Research Questions

Four (4) research questions determined the methodology, and guided all stages of inquiry, analysis and reporting:

1. What are the views, knowledge and experiences of adolescents related to accessing SRH information and services?
2. How have adolescents' experiences of access to SRH services and information shaped their expectations, choices and decision-making regarding their SRH?
3. How do legal barriers interact with social, cultural or other barriers to accessing SRH services?
4. What are the service providers' knowledge, perceptions and interpretations of the laws regarding minors' access to SRH information and services?

1.5. The Research Team

The study was operationalised by the following personnel: Principal Investigator (PI), Co-Investigators (CIs), Field Interviewers/Data Collectors and a Research Advisory Board. The roles and responsibilities of the aforementioned are outlined in Table 1.

| Table 1: Research Team | |
|--|--|
| Title | Outline of Roles and Responsibilities |
| <i>Principal Investigator (PI)</i> Ayanna Sebro, M.B.B.S, MPH Technical Director, NACC | <ul style="list-style-type: none"> • Ultimately accountable for the ethical conduct of the study and study outcomes to the Institutional Review Board (IRB), policy makers and other stakeholders; • Obtained IRB approval, and was responsible for strict compliance with the IRB-approved research protocol and the protection of the human research subjects; • Led the multidisciplinary research team and provided oversight throughout the entire research endeavour. The PI delegated tasks to members of the research team, but (s)he retained the ultimate responsibility for the conduct of the study. • Approved all final reports; |
| <i>Research Consultant</i> Tracie Rogers, PhD. | <ul style="list-style-type: none"> • Responsible for field research tasks and activities; works closely with other CIs to engage key stakeholders and the advisory group throughout the research process; |

Table 1: Research Team (cont'd)

| Title | Outline of Roles and Responsibilities |
|--|---|
| | <ul style="list-style-type: none"> • Prepared the operational manual and data collection documentation and worked closely with other CIs to recruit study sample and lead the data collection team which consisted of field interviewers; • Initiated the hiring/assignment process of field interviewers; oriented and trained field interviewers; observed, monitored, and evaluated fieldwork and provided guidance for quality improvement; • Ensured the completion, accuracy and timeliness of raw data reports; ensured the integrity and safeguarding of audio and written data. Responsible for communicating any changes or adverse incidents to the PI and other CIs; • Led data analysis and drafted final report; conducted data analysis validation activities; planned and coordinated dissemination workshop; |
| <p><i>Co-Investigators (CIs)</i> Pilar de la Corte Molina MD, MPH SRH Technical Advisor UNFPA Sub-regional Office for the Caribbean</p> <p>Aurora Noguera-Ramkissoon Liaison Officer UNFPA Sub-regional Office for the Caribbean</p> | <ul style="list-style-type: none"> • Assisted the PI with oversight, coordination, and facilitation for planning and implementation of the study. CIs brought Liaison RH complementary skill sets to the assessment, planning and implementation process; • Provided technical guidance on the overall conduct of the study; monitored data collection activities and closely reviewed the design, planning, implementation, and all fiscal spending related to the MPA conduct of the study; • Reviewed and supported implementation of data collection activities; • Vetted all study reports and final data analysis and dissemination presentations; |
| <p><i>Co-Investigator (CI)</i> Dona Da Costa Martinez MBA, Executive Director, Family Planning Association of Trinidad and Tobago</p> | <ul style="list-style-type: none"> • Reviewed and supported implementation of data collection activities; assisted with engaging stakeholders to generate study sample, acquired permission for use of research sites, and negotiating access to the participants and other study resources with relevant gatekeepers; • Worked closely with other CIs to engage key stakeholders and the advisory group throughout the research process; |
| <p><i>Field Interviewers</i> Nadine Lewis-Agard Claudia Joseph Akilah Riley-Richardson Onika Henry Mark Lawrence</p> | <ul style="list-style-type: none"> • Conducted and moderated in-depth interviews, focus group discussions and participatory mapping; • Assisted in data collection and summation, produced field notes to include observations; • Produced detailed data summary reports and safeguarded data and participants' confidential information; • Reported adverse events immediately and directly to PI and CIs; |

Table 1: Research Team (cont'd)

| Title | Outline of Roles and Responsibilities |
|--|--|
| <i>Research Assistant</i> Renessa Ramlochan | <ul style="list-style-type: none"> • Established contact with persons and external agencies who met the demographic criteria of the study; • Monitored interview scheduling, dates, times and cancellations; • Updated the interviewers as necessary on progress of the research as well as any delays; |

1.6. Study Limitations

Legal Barriers that affect *Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago* was a qualitative research endeavour, and as such statistical representativeness was not sought. The sampling strategy utilised for this study was therefore purposive instead of probability based, as it gathered data from participants selected to facilitate a complex and nuanced understanding of the phenomena under study.

The study holds as its primary objective expanding the understanding of minors' access to SRH information, services and commodities in Trinidad and Tobago and seeks to produce in-depth and illustrative information in order to understand the various dimensions of the problem under analysis. Hence, its focus is on uncovering explanations of social dynamics, meanings, motives, beliefs, values and attitudes related to the phenomena under study.

This study does not seek to investigate causality, and as a result cannot determine the cause-and-effect relationship between phenomena. Replication of findings is not a measure of reliability for this study. Alternatively, transferability, credibility and repeatability are key markers of validity and reliability, as this study seeks to analyse the thoughts, demographic behavioural patterns, and emotional reasoning processes of its participants.

1.7. Organisation of this Report

The report is organised in four main sections. This introductory section outlines the impetus, justification and research questions that informed the conduct of the study. The following section presents the methodology and methods utilised in this study. The third section of the report presents the findings generated from fifty-two (52) adolescents and ten (10) adult service providers/key informants. The final section of this report presents the conclusions and recommendations arising from the study.

2

Research Methodology and Design



Phenomenology is a qualitative research method that seeks to describe how human beings experience a given phenomenon. A phenomenological study investigates human experiences, feelings, and responses to a particular situation by allowing the researcher to delve into the perceptions, perspectives, understandings and feelings of individuals who have lived the phenomenon or the situation of interest. Phenomenological research is typically conducted through the use of in-depth interviews with small samples of participants. By examining the perspectives of multiple participants, generalisations can be made regarding the quality of experiences of a certain phenomenon from the perspective of those who have lived the experience.

This study adopted a transcendental/psychological, phenomenological and qualitative methodological research design. It did not seek to test hypotheses, but rather to generate hypotheses through a systematic exploration of the lived experiences of adolescents and service providers. Hence the research will provide evidence to inform policy makers of the impact of lack of minor access to SRH services. The purpose of the research evidence is to inform proposed policy and legislation reform.

2.1. Study Design

The proposed research design for this phenomenological study included 60 participants (10 adult service providers/key informants and 50 adolescents). The study drew on a sample of 62 participants in the following categories:

- 10 in-depth interviews with adult participants in the role of service providers/key informants
- 13 in-depth interviews with adolescents
- Eight (8) focus group discussions with 39 adolescents
 - Six (6) groups consisting of five (5) participants per group
 - One (1) group discussion in South Trinidad with six (6) participants
 - One (1) group discussion in Tobago with three (3) participants.

Although the study drew a larger sample than proposed, the target of 15 in-depth interviews with adolescents was not attained. The sample was also not achieved within the two-month period proposed. Instead, the target sample size was attained in five months—data collection commenced on July 8, 2019, and was terminated on November 22, 2019 (See the “Research Challenges” segment in this section for further discussion).

2.2. Sampling Strategy

A purposive, non-probability sampling strategy was selected. This qualitative sampling strategy identified and selected information-rich cases that offered insight into the phenomenon of minors’ access to SRH services. There were two cohorts of participants:

1. Adolescents between ages 10 and 19, and
2. Professional health care providers and key informants.

2.2.1. Recruitment Approach – Adolescent Participants

Targetted profiles of potential participants were created, based on stakeholder consultations and as stipulated in the IRB-approved protocol to guide participant recruitment. These targetted profiles are illustrated in Tables 2, 3, 4 and 5. It was anticipated that adolescent participants would be drawn from both urban and rural communities (a total of seven), and from diverse socioeconomic, religious and geographical categories. The inclusion criteria for adolescent participants in the study were ages 10 – 19 years, and resident in Trinidad and Tobago for more than six months. The exclusion criteria were participants younger than 10, and older than 19.

Table 2: Targeted Participants Profiles - Adolescent In-depth Interviews

| | Adolescent Participant Characteristics | Age | Geographic Location |
|----|--|---------|---------------------|
| 1 | Teen Parent (Male) | 16 - 19 | Rural Trinidad |
| 2 | Teen Parent (Female) | 10 - 19 | Rural Trinidad |
| 3 | Residential facility (Male) | 16 - 19 | Rural Trinidad |
| 4 | Teen Parent (Male) | 10 - 19 | Suburban Trinidad |
| 5 | Residential facility (Female) | 16 - 19 | Suburban Trinidad |
| 6 | Teen Parent (Female) | 16 - 19 | Tobago |
| 7 | Newly Diagnosed HIV positive (Female) | 16 - 19 | Tobago |
| 8 | Differently abled adolescent (Female) | 10 - 19 | Tobago |
| 9 | Differently abled adolescent (Female) | 10 - 19 | Trinidad |
| 10 | Homeless/Socially displaced (Female) | 16 - 19 | Urban Trinidad |
| 11 | Newly Diagnosed HIV positive (Female) | 16 - 19 | Urban Trinidad |
| 12 | LGBTQI Identified (Female) | 16 - 19 | Urban Trinidad |

Table 2: Targeted Participants Profiles - Adolescent In-depth Interviews (cont'd)

| | Adolescent Participant Characteristics | Age | Geographic Location |
|----|--|---------|---------------------|
| 13 | Substance User (Female) | 10 - 19 | Urban Trinidad |
| 14 | Residential facility (Female) | 10 - 15 | Urban Trinidad |
| 15 | Residential facility (Male) | 10 - 15 | Urban Trinidad |

Table 3: Targeted Participants Profiles - Focus Group Discussion

| | Adolescent Participant Characteristics | Age | Geographic Location |
|---|---|---------|---------------------|
| 1 | Community-Based Mixed In-School and Out of School Same-Sex Females | 15 - 17 | Rural Trinidad |
| 2 | Institutionalised Adolescent Males | 13 - 14 | Suburban Trinidad |
| 3 | Adolescent Mothers' Programme | 10 - 19 | Tobago |
| 4 | HIV-Positive Adolescent Clinic | 16 - 19 | Tobago |
| 5 | LGBTQI Identified Same-Sex Females | 16 - 19 | Trinidad |
| 6 | Institutionalised Adolescent Females | 10 - 12 | Urban Trinidad |
| 7 | De Living Room – Family Planning Association of Trinidad and Tobago | 17 - 19 | Urban Trinidad |

2.2.2. Actual Sample Recruited – Adolescents 10 - 19

Participants were drawn from both urban and rural communities and from diverse socioeconomic, religious and geographical contexts. The sample of adolescents included vulnerable or marginalised groups where it was safe to do so, including members of LGBTQI communities and socially displaced adolescents. Participants were selected to participate in in-depth individual interviews and focus group discussions of same-sex groups. Where data was gathered from participants who belong to marginalised groups, focus group discussions were limited to members of that group and discussions were conducted in a protective environment. Focus group discussions with adolescents limited participation to members of a similar age range, to ensure that discussions were not intimidating and were age-appropriate. Table 4 depicts the sample of adolescents who participated in the in-depth interviews.

Table 4: Actual Sample - In-depth Interviews - Adolescent Participants

| Type | Participant Characteristics | Date of Interview | Location of Interview |
|--------------------------------------|---------------------------------------|-------------------|---|
| In-Depth Adolescent Interviews (IDI) | 18-year-old in-school female | 15-08-19 | UN House, Port-of-Spain |
| | 18-year-old LGBTQI female | 24-10-19 | UWI St. Augustine |
| | 19-year-old out-of-school male | 15-08-19 | UN House, Port-of-Spain |
| | 10-14-year-old institutionalised male | 11-10-19 | St. Mary's Children's Home |
| | 20-year-old youth church member, male | 12-11-19 | Wholeness & Wellness Counselling Services, San Juan |

Table 4: Actual Sample - In-depth Interviews - Adolescent Participants (cont'd)

| Type | Participant Characteristics | Date of Interview | Location of Interview |
|--------------------------------------|---|-------------------|---|
| In-Depth Adolescent Interviews (IDI) | Homeless/socially displaced female | 25-10-19 | St. Jude's Home for Girls |
| | 16-year-old teen parent, female | 29-10-19 | St. Jude's Home for Girls |
| | 17-year-old differently abled female | 25-10-19 | St. Jude's Home for Girls |
| | Socially displaced female | 19-10-19 | Economics Department, UWI, St. Augustine |
| | 17-year-old institutionalised female | 20-10-19 | St. Jude's Home for Girls |
| | 19-year-old youth church member, female | 12-11-10 | Wholeness & Wellness Counselling Services, San Juan |
| | 15-year-old institutionalised female | 20-10-19 | St. Jude's Home for Girls |
| | 18-year-old LGBTQI male | 22-11-19 | UWI St. Augustine |

As illustrated in Tables 4 and 5, the study participants represented a wide range of demographic, socioeconomic and cultural characteristics. Although this study did not endeavour to draw a representative sample, the purposive sample reflected the diversity of the adolescent population as recommended by stakeholder consultations convened to guide research strategies. The study was able to capture vulnerable youth in institutional care, as well as migrant populations, differently abled youth and socially displaced youth. Data was also drawn from a combination of in-school and out-of-school youth.

Table 5: Actual Sample - Focus Group Discussion - Adolescent Participants

| Type | Participant Characteristics | Date of Interview | Location of Interview |
|------------------------------|--|-------------------|--|
| Focus Group Discussion (FGD) | 10-15 years old, Institutionalised Males | 21-08-19 | St. Mary's Children's Home |
| | 17-19 years old, Mixed Community - Based Adolescents | 29-08-19 | FPATT, De Living Room. Port-of-Spain |
| | 10-15 years old, Mixed Migrant Youth | 31-10-19 | CREDI, Belmont |
| | 10-15 years old, Institutionalised Females | 20-09-19 | St. Jude's Home for Girls |
| | 15-19 years old, Community-Based Mixed In-School/Out-of-School Males | 19-09-19 | UN House, Port-of-Spain |
| | 15-19 years old, Community-Based Mixed Group | 10-10-19 | Signal Hill Youth Centre |
| | 10-19 years old, Institutionalised Mixed Group, South Trinidad | 23-11-19 | Dar-ul-Aman Children's Home, Freeport |
| | 10-19 years old, Institutionalised Mixed Group, Central Trinidad | 23-11-19 | Ezekiel Home for Abandoned Children, Preysal |
| | | | |

2.3. Data Collection Methods – Adolescent Participants

2.3.1. Semi-structured In-depth Individual Interviews with Adolescents

Given the sensitive nature of this research, individual interviews were conducted in private and confidential settings. These environments were conducive to adolescents discussing/sharing opinions about their behaviours, choices, perceptions and experiences related to access to SRH services. Although the data collection instruments were developed to facilitate a degree of standardisation in data collection, the tools were used as guides.

Interviews included a combination of life history questions, and questions that focused on perceptions of law and access to SRH services. This facilitated a connection between demographic data (e.g. gender, age, ethnicity, sexuality etc.) and data on participants' backgrounds and life circumstances. There was a particular focus on perceptions about the law and experiences relating to seeking of, and access to, SRH information and services.

2.3.2. Focus Group Discussions with Adolescents

Table 5 depicts the sample of adolescents who participated in the Focus Group discussions. These discussions consisted of groups of 3 – 6 adolescents. During focus group discussions, adolescents were separated according to gender and/or sex due to the sensitive nature of the issues under discussion. Participants were encouraged to discuss issues in a general, hypothetical, or scenario-based format, to avoid pressure to reveal information about personal experiences. Focus group discussions provided a useful method for exploring issues concerning different contexts of access to SRH information and services.

There were two focus group instruments: one instrument was used for participants aged 10 – 14, and another for participants aged 15 – 19. The first instrument presented participants with a scenario in which they were invited to explore a hypothetical adolescent's experience with the interviewers. The scenario drew on their views regarding the situation of a 13-year-old adolescent who was sexually active, as well as their perceptions of how the law applies to the situation (e.g. different circumstances in which an individual may seek contraceptive or abortion services). Exploring these issues through a focus group discussion was particularly useful as participants had the opportunity to respond to the ideas and opinions of others. Researchers considered the implications of social pressure and other group dynamics, which have the potential to skew opinions and information.

2.4. Participatory Mapping

Participatory mapping was used with the younger adolescents during the focus group activities. It involved the use of visual techniques in order to ensure that adolescents who are less inclined to engage verbally with researchers were able to share their views and experiences. During the focus group discussions with adolescents younger than 15 years, participants were first asked to develop drawings or maps which represented SRH services they accessed (or could not access). Secondly, the drawings or maps were to also depict safe spaces where they could get advice or support on SRH matters, and thirdly, a depiction of the barriers to accessing SRH information and services. Maps give insightful information about both the local environment and the adolescents' perception of their place in their communities. This activity generated further conversation about behaviour of individuals in the community, and the adolescents' views on and interpretations of these behaviours.

2.5. Data Collection Method – Service Providers/Key Informant Participants

Semi-structured, in-depth interviews were also used for data collection among service providers. Interviews were conducted in public locations, which facilitated a measure of privacy to engage in confidential discussions. Although the data collection instruments were developed to facilitate a degree of standardisation, the tools were used as guides.

2.5.1 Recruitment Approach – Service Provider/Key Informant Participants

The study set a target of ten (10) individual interviews with health care providers who provide SRH information and/or services, and who routinely come into contact with adolescents in the course of service provision. These practitioners were anticipated to be general practitioners, district nurses from the Regional Health Authority, clinic nurses, staff members of Queen's Park Counselling Centre and Clinic, the nation's public sexually transmitted disease (STD) clinic and youth clinic staff members. Key informants such as youth leaders, youth officers and technical officers from governmental and non-governmental agencies were also included in this target group. Potential participants were solicited from members of the Research Advisory Group. The inclusion criteria for this cohort were contact with a minor who has attempted to access SRH information and/or services within the last two (2) years.

The actual sample recruited met the research targets and is illustrated in Table 6 below:

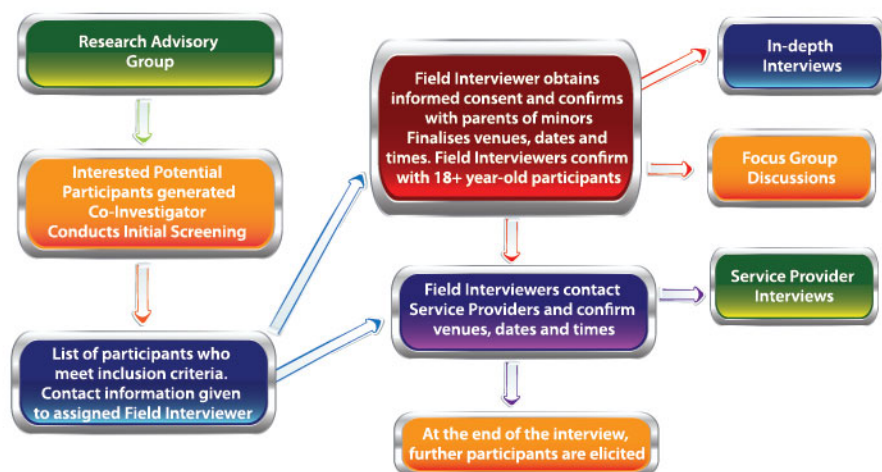
Table 6: Actual Sample - Service Providers/Key Informants

| Type | Participant Characteristics | Date of Interview | Location of Interview |
|---|--|-------------------|--|
| Key Informant Interviews/Service Provider Interviews (KI) | Guidance Officer | 28-07-19 | Restaurant, San Fernando |
| | Youth Officer | 26-07-19 | Restaurant, Trincity |
| | District Nurse, RHA | 07-08-19 | Port-of-Spain General Hospital |
| | Bilingual Counselor | 08-08-19 | Public Venue, East Trinidad |
| | Youth Clinic Staff Member | 14-09-19 | Youth Clinic |
| | Medical Doctor | 02-09-19 | Public Clinic, North East Trinidad |
| | Nursing Assistant/Social Worker | 27-09-19 | Private Clinic, St. Clair, Port-of-Spain |
| | Social Worker | 19-09-19 | Government Clinic, Port-of-Spain |
| | Nurse at the Adolescent Clinic | 10-09-19 | Scarborough General Hospital, Tobago |
| | Technical Officer at the Adolescent Clinic | 14-09-19 | Government Programme Office, Tobago |

2.6. Study Procedures

Figure 1 illustrates the overall recruitment strategy for the study. The data collection team made initial contact with potential participants by phone to determine their eligibility for participation in the study. Participants who were deemed to be eligible for participation in the study were sent an electronic version of the Participant Information Sheet for completion or had it read out to them over the telephone.

Figure 1: Recruitment of Potential Participants: Adolescents and Service Providers



Five (5) Field Interviewers were trained on data collection procedures for this study. All field staff followed procedures documented in an Operational Manual created specifically for the study. Field Interviewers had responsibilities in two (2) areas—data collection and data entry.

2.6.1. Obtaining Informed Consent

Interviewers ensured that all participants under age 18 submitted a signed parental/guardian consent form prior to participation in any data collection activity. Once parental consent forms were verified, field interviewers gave participants a copy of the Minor Assent Form. Participants were invited to follow along while the form was read aloud. Interviewers asked participants if they had any questions or concerns and responded to them as appropriate.

All interviews were recorded. Recording of interviews did not commence until the signed informed consent and assent forms were obtained.

2.6.2. Conducting the Interview/Focus Group Discussion

As indicated earlier, all service provider/key informant interviews, in-depth interviews, and focus group discussions used semi-structured interview guides, with follow-up questions and probes. Interviewers used interview skills gained during training sessions, brainstorming, role-playing and practice scenarios to facilitate these activities in an efficient and thorough manner.

Data collection instruments were designed to ensure that concepts were clearly explained and developed in an engaging and adolescent-friendly manner. Data collection tools were pilot-tested with a group of adolescent volunteers to determine their accessibility, effectiveness and 'adolescent-friendliness'.

2.6.3. Data Entry and Data Management Procedures

After the interview/focus group discussions, interviewers reviewed and transcribed interview data into data collection templates within two (2) business days of the recording. Detailed data, which included summarised responses to each question, direct quotations and field notes for each interview/discussion conducted were also produced.

2.6.4. Audio Recording

The audio recordings of all interviews and focus group discussions were downloaded from the audio recorder within three (3) hours of recording. These recordings were saved on password-protected files on a USB memory stick issued to each field interviewer.

2.7. Ethical Considerations in the Study

2.7.1. Protection of Privacy and Confidentiality

The confidentiality and privacy of all participants were safeguarded throughout data collection and data analysis activities. No information that could potentially identify participants was included in this report. Data obtained during the study was kept on a password-protected file and only the researchers had access to the records. Neither participant names nor other details that could describe them were made available in this report. All opinions recorded have been kept strictly confidential. Participants were informed that they could refuse to answer any question and stop the conversation at any time for any reason.

Anonymity: Ensuring confidentiality and anonymity was of the utmost importance in this study. The participants were told that their identities will be kept confidential throughout the process of data collection as well as in the analysis and write-up of the study findings.

‘Do no harm’ and ‘best interests of the child’ approach to research with adolescents: The welfare and best interest of the participants were the primary consideration in data collection. The research was guided by the UN Convention on the Rights of the Child, specifically Article 3.1 which states: “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts or legislative bodies, the best interests of the child shall be a primary consideration.” Due to the sensitivity of the research topic, particular care was taken to ensure that questions were asked sensitively, and in an adolescent-friendly manner appropriate to the age of the participants. Clear language was used, and great effort was taken to avoid blame and judgement.

Addressing child protection concerns: During the interviews and the focus group discussions, a procedure was put in place if participants disclosed information that raised child protection concerns (i.e. information indicating that they were currently at risk of, or were, experiencing violence, exploitation or abuse). Before the commencement of an interview or a focus group, participants were advised that should any information they provided indicate that they are at risk of abuse or exploitation, researchers would need to follow the relevant child protection procedures, which they did. These procedures were explained to the participants. Participants were interviewed with at least two (2) persons present.

Adolescent participants were informed that they would be asked questions about their thoughts, feelings and experiences. Participants were reassured that information shared would be kept private with one exception: if researchers became aware that the participant(s) were being hurt, they would be obligated to inform the relevant people/authorities who are responsible for keeping children safe. If informed that participant(s) or another child was being hurt, researchers were to first have a formal conversation with the child regarding their disclosure, and have the follow-up procedures explained to them at a level at which they could understand. There were no such disclosures during data collection activities.

2.7.2. Reporting and Referral Protocol

Participation in the study was on a voluntary basis. No incentives were provided. Researchers explained to participants in clear, age-appropriate language that they were not required to participate in the study, and that they could refuse to answer any questions and could stop the interview, or stop participating in the focus group discussions at any time. Researchers carefully explained that refusal to participate would not result in any negative consequences.

2.8. Data Analysis

The study adopted a psychological phenomenological qualitative research design that engaged in a systematic exploration of the lived experiences of adolescents. Moustakas' (1994) transcendental/psychological phenomenological approach focuses on creating thick descriptions of the experiences of participants. Textural (what they experienced) and structural descriptions (how they experienced it in terms of the conditions, situations or context) of the experiences of the participants were created to convey an overall sense of the experiences of adolescents around access to SRH information and services.

The analysis phase used horizontalisation to reduce the data by describing the essence of the phenomenon (Moustakas, 1994). Data collected included perceptions and feelings of the phenomenon. Significant statements or quotes were identified through bracketing, and subsequently combined into themes. This is called clustering. Textural description (what) and structural description (how) were used to describe the ultimate essence of the experience or phenomenon (Moustakas, 1994).

2.9. Research Challenges

The most formidable challenge encountered during the research project was the difficulty of recruiting adolescent participants for the study.

Accessing Adolescents: Stakeholder consultations were conducted prior to commencement of the study, and the research team engaged with key gatekeepers with the aim of securing 'buy-in'. Notwithstanding, when the data collection activities began, the research team experienced great difficulties negotiating access to adolescent participants. Many gatekeepers exhibited paternalistic behaviour, citing that "exposing adolescents to research questions about sex, sexuality and SRH services could cause harm". It took twice the anticipated time to attain the sample size for this study.

Obtaining Parental Consent: Several parents withheld consent for participation in the study. This challenge is reflective of the research problem and is indicative of the fear and the stigma that exist around engaging adolescents and learning from them when addressing issues involving sex. Sex and sexuality-related topics are difficult issues to talk about for many adults. Many parents appeared suspicious of the "researchers' agenda" and how the study may impact their parenting.



Findings



This section will proceed with an examination of the data sets produced from the perspective of the adolescent participants, followed by an examination of the data that emerged from discussions with service providers and key informants.

3.1. Engaging and Disengaging Agency

The consent process for this study gave participants the ability to assent or refuse to participate. Over the data collection period, there were 11 participants who had received parental consent to participate in the study and chose not to give assent and opted out of participating in the study. Potential participants usually expressed shock and disbelief when offered the option to refuse assent to participate. Interviewers were repeatedly asked if they (the interviewers) were certain adolescents had the right to decline. Participants who declined were not asked to provide a rationale or reasoning for their decision but they were asked how they felt about being able to decline. The adolescents offered similar sentiments: they indicated that it was gratifying to be able to decide whether they participated in an activity. Furthermore, this was not an option that adolescents were often given.

The participants who agreed to participate were extremely co-operative and enthusiastic about engaging in the discussion. About half of the sample reported that they were not sexually active. They possessed diverse levels of knowledge about SRH; while some participants were very knowledgeable, others had not heard the term SRH before the interview or the focus group discussion. It was noted that those participants who indicated that they were not sexually active were less knowledgeable about SRH issues.

There were evident differences between the experiences of the focus groups and the in-depth interviews. In the in-depth interviews, participants would begin answering the questions tentatively and within 10 – 15 minutes ease into dialogue with the interviewer.

The focus group discussions provided an opportunity to observe the dynamics of interaction between adolescents when discussing an emotionally charged and—for most of them—tabooed topic. In the groups with younger members, adolescents were visibly uncomfortable; on occasion, one or two persons covered their ears or giggled every time the word ‘sex’ was mentioned.

In these groups, it was very important to let the participants know that the adults were able to hear their thoughts and experiences without judgement. Interviewers had to reinforce that adolescents would not be punished in any way for information discussed.

3.2. Adolescents and Sexual Reproductive Health

3.2.1. Key Sources of SRH Information

The Internet and peer groups were the primary sources of SRH information among the participants in the study. The adolescents who could be categorised as being more vulnerable and at higher risk seemed to be most reliant on these primary sources for information—namely, participants who were in institutionalised care, socially displaced or identified as members of sexual minority groups. With that said, it is noteworthy that several participants who identified as having positive relationships with parents also manifested discomfort in speaking with them about sex.

In response to the question “How does an adolescent get SRH information?”, one participant responded, “She must have belly like an alligator.” This metaphor aptly describes the difficulties participants indicated about accessing SRH information and services. Participants shared that adolescents who were curious about SRH often met judgement, harshness and ridicule from adults in family, school and service settings.

Religious institutions were also named as another entity that presented barriers to accessing SRH information. To face this type of judgement, ridicule and scrutiny, being tough and formidable were necessary traits.

"A young person who is sexually active can feel very alone when trying to access information." Participants shared that parental disappointment was often faced by sexually active teens. Furthermore, social institutions often silenced these adolescents in both subtle and blatant ways. In the experience of participants, this was often done by creating barriers to engaging in conversations about sex. The lack of emotional and physical safety in their curiosity about SRH was an evident theme in nearly every interview and focus group discussion.

Perception about lack of safety when reaching out to parents for information and support was connected with corporal punishment for adolescents. It was shared that if an adolescent approached, or questioned a parent about SRH information, services and or commodities, he or she was also putting themselves at risk to be beaten. Fear of being beaten, however, did not feature prominently if the participant was male. Both male and female adolescents were clear about the double standard that exists in how girls and boys are treated with regard to information seeking, as well as reporting, sexual behaviours.

The experience of "having nowhere young people can go to have conversations about SRH" creates anxiety and uneasiness for the adolescent. It was identified as a major push factor towards seeking information on the Internet. The Internet emerged as playing a critical role in providing SRH information. "You may not get the right information but you get something and then you can try and figure out rightness and wrongness after that." Moreover, the participants expressed the view that the adolescent had a desire to be informed, and "not rely heavily on hearsay."

Participants noted that they had encountered adults willing to have conversations about SRH. However, the information they received was often based on the adult's personal experiences. As a result, the adolescent often received, in their view, biased, questionable and/or incorrect information. In their view, the key sources of correct information on SRH were identified as teachers and parents.

The sentiment that it is easier to go online to access SRH information than to speak to an adult or a professional, and that young people trust information from their peers who have had more experience than they did, were strong themes running through the data. There was mixed feedback about the openness of medical and social service providers to assist adolescents with accessing SRH services, information and commodities.

3.2.2. Public/State-Sponsored Access to SRH

There were a number of stigmatising and painful experiences shared by adolescents through both in-depth interviews and focus group discussions. Nevertheless, there were participants who explained that they had “good experiences” within the public health care system. Several participants shared that they were provided with useful information and commodities from nurses and doctors in these settings, describing them as helpful and supportive.

Participants expressed surprise and shock about positive experiences at public health clinics. One older participant, a 19-year-old university student, detailed her experience of receiving information and services via both the public and private health care systems. This participant was very aware of the services and various avenues to receive both information and services relating to SRH, having had a need to access them at an early age. Her access to SRH services had arisen from a sexual assault and a resultant pregnancy. She shared that she would not have been aware of these free services if she had not been assaulted and furthermore, she was confident that her peers were unaware that they could access these services.

Another participant offered that in her experience of accessing public service health care as a teen, she felt “taken care of”. She reported that her questions were answered, and the medical staff was warm, patient, kind and supportive to her. The “most nerve-wracking” aspect of her experience, was when she heard a nurse’s response, “You wouldn’t be the first and you wouldn’t be the last,” as she awaited the results of her STI test. She shared that what she anticipated to be judgement laden was instead an empathetic and destigmatising response. She also indicated that as an “underage adolescent”, the mandatory presence of parents in receiving services made it difficult to access SRH services. While she understood the need for parents to be present for consent, she wished that there was “...an avenue where the law is up-held but minors and adolescents can have privacy and confidentiality” when discussing topics of a sensitive nature.

3.2.3. Condoms, Contraceptives and Access to Care

The fear of “getting in trouble” and being under the age of 18 were both highlighted as barriers to accessing SRH services and information. However, in a highly restrictive environment, adolescents have found ways to access SRH through adults such as older siblings, older intimate partners and peers. Adolescents managed to secure contraceptives with varying degrees of ease. Female adolescents were able to negotiate access by not wearing school uniforms when engaging pharmacies where prescriptions were not required.

A minor can access contraceptives if (s)he can pose as an adult. Older female adolescents (16 – 19) felt confident that they could access pap smears by withholding their ages and tapping into the access of older persons in their social circles.

Participants expressed the view that it was easier for adolescents to access ‘the morning-after pill’ than a prescription for other contraceptives. Among the sexually active adolescent girls, the ‘morning-after pill’ was often reportedly used as the sole source of birth control protection. It was noteworthy that many of the sexually active adolescent participants were not offered reliable, easy-to-use birth control after routinely using State health care services.

3.2.4. Emotional Response Dimensions of Access

Participants articulated shame, fear and anxiety as primary emotions connected to the access of SRH services.

In addition to the anticipated public shaming and reactions adolescents imagined encountering, participants also identified internalised shame about accessing SRH as one of their emotional responses.

Participants identified a number of ways in which lack of access to SRH services impact adolescents. Female adolescents often do not use contraceptives to avoid the anxiety, shame and judgement associated with attempting to secure these commodities. As a result, in the words of one participant, “they just ‘wing it’ and rely on their partner to get it.”

3.3 Legal Barriers, Knowledge & Perceptions about the Law

3.3.1. Age of Consent

There was no ambiguity among the study’s participants that the legal age of sexual consent in Trinidad and Tobago is 18 years of age. Participants were also unequivocal in their belief that the legal age of consent neither dissuaded adolescents from engaging in sexual interactions nor offered protection to young people.

“The people who abuse children don’t care about how old they are. They are sick people. The law about age [age of consent] is not going to stop them. It only stopping me from getting help I need to take care of me.”

—17-year-old participant.

Participants explained that the taboo generally placed on sexual information for teens is a hindrance to their knowledge and safety. Participants overwhelmingly agreed that adolescents are placed at risk because they are “concerned about being judged for being involved in sexual activity, but without the necessary knowledge they will have sex anyway.” The “Church” and the “Law” were identified as the most significant barriers to SRH access for adolescents. Participants experienced the cultural context in Trinidad and Tobago as an area where sexually active adolescents are largely ignored by the law.

Generally, beyond knowing that it was illegal for people under 18 to have sex, participants seemed to know very little about the laws that pertain to minors and sexual behaviour. They were not able to cite any legislation, nor were they able to speak to any specific dimensions of the law that relates to their ability to access SRH.

“At 17, the government gives us a license to drive; but we don’t have access to sexual and reproductive health information or services.”

—16-year-old male participant.

Most participants expressed the belief that the law “harms persons who are under the age of 18 and sexually active”. They reasoned that any law that prevented access of information that can impact health was harmful. Information was articulated as a means of enabling adolescents to engage in confident and responsible sexual decision-making.

One interview participant and participants in one focus group held a different perspective. They offered that one way the law may influence decision-making was with reference to adolescent females who are in relationships with adults. It was suggested that young people who are in relationships with adults may be fearful that their adult partner could be imprisoned.

A participant in the focus group reasoned that in this light perhaps the law protects young people from early sexual initiation and sexual exploitation by adults. It is noteworthy that these participants indicated that they were not sexually active.

3.4. Positive Adult –Adolescent Relationships

Among the participants was a small cohort of adolescents who identified having a positive relationship with parental and authority figures with regard to sexuality.

It was notable that they expressed that guidance from these persons were not only useful but quelled desires to engage in sexual relations. These types of supportive approaches appear to be a protective factor for young people in relation to sexual decision-making. One adolescent shared that his father showed him how to use a condom despite the conservative Christian ethos of his family. Strong parental bonds appear to be associated with decreased sexual behaviour.

There was an expressed sense that adolescents would be willing to connect with adults for guidance for gaining more SRH information *"if adults were more open ... or if I could have those conversations with my mother ...if the Church could talk about it."*

3.5. SRH and Gender

Among the participants, there were clearly articulated notions that gender played a vital role in the need for and access to SRH information, services and commodities. Male participants repeatedly articulated that the female adolescent experiences more shame, anxiety and fear around access to SRH services, information and commodities. Male participants shared accounts of purchasing pregnancy tests and condoms for female siblings and female friends at a pharmacy due to their siblings and friends' fear of embarrassment.

Adolescents stated that in their experience, society responded differently to an "underage male" who was sexually active versus an "underage female" who was sexually active. They were also able to articulate that females were more affected by social perceptions of themselves than males.

3.6. Younger Adolescent vs. Older Adolescent Experiences

When examining experiences of younger and older adolescents, it was apparent that shame and anxiety while addressing issues surrounding sex and sexuality extended into adulthood. The 19-year-old participants were as averse to the thought of discussing SRH issues with their parents as the younger ones. This would suggest that failing to talk to children and young people about sex fosters a sense of shame, and can lead to adults who are silent and who continue to struggle in terms of negotiating sex, looking after their sexual health and disclosing issues around sexual exploitation and violence.

3.7. Experiences of Adolescent Parents

Adolescent parents noted the importance of having family care to support young people through traumatic events.

Moreover, the importance in having parental support to attend to SRH needs was overwhelmingly seen as a requisite to survive the experience of parenthood and thrive thereafter. There was also satisfaction with the care received from the State's facilities. One participant articulated that the SRH services she received after being sexually assaulted was instrumental in developing her belief that her traumatic initiation into sex should not affect her sexual enjoyment in the future.

3.8. Experiences of Marginalised Adolescents

There were a number of study participants with marginalised identities. Included in the research was an adolescent with developmental delays, a few LGBTQI adolescents, HIV positive young persons and a socially displaced adolescent. Most of these participants were not sexually active and all openly shared their perceptions and experiences about accessing/attempting to access SRH services, information and commodities.

It was noteworthy that neither of the two adolescents living with HIV seemed to have received any sex-positive (i.e. information about consensual sexual behaviour articulated as fundamentally pleasurable and healthy), accurate SRH information designed for children and young people living with HIV. These participants were about to transition out of institutional care and seemed unprepared to lead healthy, satisfying sexual lives in their adulthood.

LGBTQI-identified adolescents offered that while heterosexual adolescents were stigmatised and judged by the law and adult circles of care, gender non-conforming and sexual minority adolescents were ignored and/or invisible. Lesbian participants expressed that they were not clear about what their sexual and reproductive health needs were and which service providers could help them figure it out. There was only one LGBTQI-identifying male participant who shared that he had no difficulty accessing condoms and did not think beyond condom use with regard to his SRH. The shame about being homosexual felt overwhelming for these adolescents and they admitted that they were often reluctant to approach adults about sexual health issues for fear that they would be "outed".

4 Service Providers' Knowledge, Perceptions and Interpretations of the Laws Regarding Minors' Access to SRH Information and Services



4.1. Policing the Gap: Between Policy and Legislation

"We are the face. We are expected to create safety for them [adolescents] but expected to violate it to keep them safe." These were the words used to capture the difficult position in which most service providers who serve youth find themselves. Service providers who agreed to participate in this study did so with a great deal of apprehension and caution. There were five (5) providers/key informants who refused to engage in the study because they questioned/doubted that the research could keep their identities confidential. Study participants articulated that throughout their interviews, they battled inwardly with the need to protect their agency/workplace by being limited in their responses. There were questions that some participants refused to answer, citing the need to protect their clients and their agencies. To ensure their confidentiality, as with the adolescent findings, this section includes limited verbatim quotations and seeks to give a composite sketch of the experiences of service providers without inadvertently disclosing their identities.

The approach of service providers/key informants to the care of adolescents tended to fall on one of three points on a continuum. At one end, there were participants who engaged in a fear-based, deterrent-oriented approach where minors were told not to engage in sexual activity, and to avoid sexually transmitted disease because "sex is for grown people". These participants seemed to use a 'guilt-and-shame' approach to crafting their intervention strategies. While these participants come across as harsh and unwavering, what was evident beneath this outer layer was a pronounced fear/concern about being found culpable of circumventing the law and/or agency policy.

The other end of the continuum is populated by service providers/key informants who perceive the restriction of adolescents' access to SRH information, services and commodities as harmful, and an infringement of their human rights and the providers' duty to provide care. These participants have and will contravene the law and policy to provide SRH care to minors who are at risk, and/or in need of urgent attention. There was a high degree of fear amongst this group, and they did not make these decisions without due consideration for the consequences.

Most of the adults interviewed as part of this study tended to operate somewhere between the two extremes of the continuum, where they alternated between denying access and negotiating access for adolescents to SRH services, commodities and information. These participants also exhibited a deep sense of frustration and deep disappointment with the lack of SRH services for youth, as well as the inability or reluctance of parents to provide sex education for their children.

Regardless of where the providers fell on this continuum, it is evident that they often found this role overwhelming due to the lack of sufficient resources to manage the SRH issues of adolescents. Participants were united in their hope that the results of this research could contribute to changes in the health care system that would address the needs of adolescents.

4.2. Adolescent Profiles

While the providers/key informants in this sample served a wide cross-section of adolescents, their service provision was often much targetted. The majority of the participants interviewed served females between the ages of 16 – 19—mostly out of school and unemployed. Providers in public health care facilities rarely served teens under 16. Females under the age of 16 were usually referred to the public health care system after being sexually assaulted. Many of these adolescents were living with their parents. That being said, some participants noted that they often received adolescents as young as 13 years old in community-based settings.

One participant noted that male adolescents tended to come to their agency clinic motivated by curiosity, while female adolescents were mainly motivated by pregnancy. From their experience, males tended to be more interested in HIV testing. Another provider offered that males appeared to be more “empowered” to proactively seek services, and noted that they sometimes sought services as a result of curiosity after viewing a programme or accessing some information on the Internet.

Across the sample of participants, it was often lamented that they could only offer qualitative/anecdotal responses since there was a lack of data collected in a structured or systematic manner. One participant offered their perception that one of the reasons for this emerged from a difference in approaches to serving adolescents by health practitioners. It was noted that some health practitioners did not refer pregnant adolescents to hospitals for care, and these adolescents were only captured in the system during delivery and post-natal care. This was offered as an indication that there are providers who are not reporting these breaches of the law.

4.3. Defining SRH

Service providers/key informants generally had very broad and holistic definitions of SRH. One nurse practitioner offered the following definition:

"Being able to educate the adolescent on any aspect of their sexuality. Sexuality is being male, being female, being undefined. Their sexuality in terms of sex, in terms of growth and development, their sexuality in terms of understanding who they are; in terms of family planning and not contraceptives only, but planning when they see themselves or how they see themselves functioning in the family; when they would like to have children, in what context they would like to have children, whether as a single parent, whether as a married [person]. That is how I see our role should be or how I see we should function in terms of sexual and reproductive health."

Most participants subscribed to this holistic understanding of SRH and juxtaposed it to the restrictive, often one-dimensional definition imposed by their agencies. Participants' views of SRH as involving much more than sexual activity included understanding of internal influences (mental, emotional, physical well-being) as well as external influences ("toxic persons" in one's environment, unhealthy relationships, stress etc.). The theme that emerged from this data was the need for SRH services for adolescents to address ways that providers can help or support a healthy sexuality.

4.3.1. Sexual Health vs. Reproductive Health

One agency's policy defined SRH services as solely biological and relating to the anatomy; others defined them as a mental health issue. One participant argued that the major shortcoming of SRH care offered to the adolescents lay in its failure to understand that sexuality does not only stem from our physical arousal but mental arousal as well. Other participants noted that many entities do not differentiate between sexual and reproductive health.

This failure to distinguish between the two often created a blind spot to gender issues, and left segments of the population unserved or underserved as well as denying young people access to a comprehensive service.

It was also noteworthy that many of the participants suggested that deficiencies existed in terms of how their respective agencies defined SRH. Moreover, providers often identified conflicts between their personal understanding of SRH and the perspective of their respective agencies. Reflecting on the conflict, one provider at a clinic that treats adolescents offered,

"I think sexual is what we do more than reproductive. Yes, we do pap smears in terms of reproductive but reproductive also has a family planning component ... We do more sexual health rather than sexual AND reproductive health... but I would define sexual reproductive health as the total package—both the STI and the sexual health and management, treatment, and follow up... going beyond looking towards a healthy reproductive system. But we can't do that here."

4.3.2. Condoms, Contraceptives and Access to Care

While providers in medical settings were clear about the difference between services and commodities, community-based providers were not. Services included treatment, assistance, advice or guidance around SRH. It was apparent that what constitutes SRH is not consistent across entities/institutions that are designed to serve adolescents. A provider working in a school context noted that neither commodities nor services were afforded for adolescents in this context.

This provider offered,

"Nothing for adolescents. We have some health literature, but since they [Ministry of Education] scaled down on their financing of health literature, we are not getting as much. And we are not producing health literature as before."

Adolescents were described as "a totally forgotten population" by one participant. Reflecting on their community-based organisation, they offered that commodities for this population are very limited not just in number, but in variety as well: there might be some literature on STIs, pregnancy and abstinence, but definitely no condoms or other contraceptives.

Among the providers interviewed, there was a vast difference in knowledge and perception about the laws pertaining to minor access to SRH services and commodities.

Some participants disclosed that they can provide information about contraceptives but they cannot distribute contraceptives. Other service providers offered that they can refer a minor for services at a hospital without reporting interaction with the minor.

Yet other participants offered that they can provide information but not services. Another indicated, "The law is clear that no commodities and services outside of information about contraceptives can be given to adolescents."

4.4. Adolescents' Access to SRH Services

Most of the service providers indicated their understanding that sexual exploration was a part of adolescent development. There was a universal understanding that minors should not have access to services unless they were accompanied by an adult relative. Participants conveyed that their challenges with service provision emerged from the fact that they must also acknowledge that often adolescents do not feel safe to speak to their parents about sexual health issues. To meet this challenge, many participants disclosed that they are often willing to exercise as much flexibility as possible to legally safeguard themselves while serving their adolescent clients in these situations.

4.5. Process for Minor Access

The official policy for most agencies regarding how a minor may access their services includes accompaniment by a parent or legal guardian; however, some providers worked in agencies with "unofficial policies" that would facilitate services to a minor who was accompanied by "a trusted adult." The adult/guardian cannot be the client's older/adult intimate partner. Most of the participants indicated that they had denied services to unaccompanied adolescents (in these instances they informed the adolescents about their limitations).

One participant at a clinic shared,

"...we've had instances where the adolescent came with their boyfriend which is one year or two years older than them ... and we have turned them away. Because you want to give the adolescent um... as professional treatment as possible and I think speaking to a boyfriend is not really as professional so we tend to tell them 'listen we don't have to come back with your mother if you don't want to, but you need to get a relative.'"

4.6. Assessing Competence

The major difference between adolescent and adult access to services surfaced in terms of assessing competence. There were significant disparities amongst providers in terms of their methods for assessing competence to consent to receiving services. One provider indicated they used the Gillick Competency Test for HIV testing while it was not required for STI testing. This practitioner volunteered that while the agency's policy approved the Gillick, they felt conflicted about its use:

"The Gillick is a tricky thing and I don't really advocate it because it is not the best thing to test a minor. You are asking someone under 19 to say I am prepared to get a positive diagnosis. NOBODY is prepared to get a positive diagnosis.... So even if this minor sits up and say 'I could and I understand' ... then we go ahead so we will tend to do that on the 17, 18, 19 year olds. The younger ones we will hardly do that Gillick for the HIV testing."

In the case of young adolescents and HIV testing, if service was denied due to the absence of an adult, the provider ensured that the adolescent was seen by a social worker or medical doctor who would consent on behalf of the adolescent. Other providers shared that they struggled with conflicts between policy and law: *"Yes. There is talk about the Gillick [competency] and using one's discretion, but this does not take away from what the law says."*

A youth worker noted their perception that there were significant gaps in parental education about sex and sexuality for young people. Furthermore, parents were either hesitant to engage in such discussions or viewed their adolescents as insufficiently competent to make sexual decisions. These were flagged as the basic impediment to parental consent for access to services. In the providers' experiences, adolescents were reluctant to approach their parents to accompany them for services. These dynamics often resulted in the adolescent not receiving services since providers were often resistant to the idea of providing services without parental consent. Providers repeatedly spoke of the need to "protect" or "cover themselves" with parental consent.

4.6.1. Cultural Realities and Sexual Relationships

Several participants shared their observations that "some teen (16+)/adult relationships are based on cultural norms and involving the law can break up relationships and families." This participant clarified that with many families it is not uncommon for a 16 year old to be involved with a 20 year old.

Parents in those families may not have any difficulties with this “set-up” and as a result they are “blind to what we consider a violation.” The participant continued that if she reported this behaviour, the family may be devastated and discourage access to SRH services. Ignoring this reality, in the perspective of this participant, “makes our service a blunt instrument.”

Participants rejected the notion of withholding SRH information, services and commodities to adolescents based on a concern that this would lead adolescents to placing themselves at risk of sexual and other forms of harm.

One of the main themes emerging from the data is the lack of services legally allowed to be provided to adolescents. Participants offered that there is a high demand for the service in particular regard to contraceptives and STI testing, but there are no policies put in place by law and/or government health agencies to meet this demand. Providers in public settings identified that the Ministry of Health’s main policy is abstinence, and they are expected to give advice along these lines to adolescents seeking services.

Many service providers found a source of contention with agencies’ policies that do not discriminate between the older and younger sexual partners of adolescents. Most minors seek the service after already engaging in sex, when there is a concern such as the possibility of contracting an STI. Hence, it was perceived as irresponsible at that point for any public service agency to endorse an abstinence-based approach to service. Participants proffered that if access is dependent on the consent of an adult parent/guardian, then adolescents do not have ‘real’ access to SRH services.

4.7. Legal Barriers and Implications for Service Provision

“We don’t get involved with adolescents.”

“The focus is on abstinence only.”

“They [adolescents] are a neglected population; we behave as if they don’t exist.”

“We pretend as if they are not sexually active, or don’t want to believe they are sexually active.”

“Nothing planned and ongoing from Health Authorities, no routine provision of services for sexual health for adolescents.”

“Cannot offer any protection to children until 18.”

“These issues of lack of services for adolescents have been flagged many times over the many years I have worked here.”

In terms of legal limitations, all participants understood that adolescents under the age of 18 do not have access to SRH services unless accompanied by an adult/guardian. As alluded to earlier, many of the participants expressed frustration that the law regarding sexual behaviour with minors is not nuanced. While participants expressed varied ideas around how nuanced the law should be, they all agreed that adolescents should have access to SRH information, especially if they are very open to receiving the services. Some participants required consent to provide information while others did not.

More than half of the providers and key informants interviewed concurred that there is a need to lower the age of consent to enable access to SRH services. However, similar to adolescents in this study, service providers and key informants had incongruent opinions beyond those on the age of consent, and were lacking in information on what the law dictates regarding adolescent access to SRH. While some participants understood that they could respond to emergency care, such as botched abortions without parental consent, others insisted that such action must be disclosed to parents and authorities. There were also gaps in the reporting chain for mandatory reporting.

The participants' knowledge about the law appeared to be limited to reporting being mandatory, and that there were penalties when reporting was not done. Other details about the current legislation were generally unclear to them. However, the laws were perceived to be inadequate, and not oriented toward the physical well-being of adolescents.

4.7.1. Identifying Discrepancies

There was one participant who articulated a clear understanding of the law pertaining to adolescents who seek SRH services. This participant addressed discrepancies in the law and policies that govern adolescents' access to SRH services. For example, this participant identified that the National HIV Testing & Counselling Policy produced by the National AIDS Coordinating Committee (NACC) advises health practitioners to administer the Gillick test to minors who are between 14 – 18 years of age. As long as it was believed that the minor was mentally capable of understanding the processes, the HIV test could be administered. However, this policy is no longer in place, and the current Children's Act states that if a health practitioner is made aware of any sexual acts being committed by a minor, then that case has to be reported to the officials because it is a criminal act to have sex under the age of 18.

Providers also disagreed with laws preventing minors' access to SRH;

"Laws keep adolescents away and many opportunities are lost for education and supporting services around healthy sexuality and SRH. I think that if a child is of the age where they can understand and make an informed decision then that child can consent to receive services."

Many of them thought that they could be jailed for providing services and that the recent laws and policies were not fully implemented at their workplaces. At one participant's workplace, employees do engage in conversation with adolescents about sexuality and sexual health when they come in seeking help for particular situations. There was no "hard-and-fast" rule as it relates to the national laws or policies.

4.7.2. Contravening Legal Parameters

A few participants unequivocally indicated that they would personally help an adolescent get help or services, since usually the parent(s) were not open to conversations about sex. These participants indicated that they take action in whatever form needed, and a conversation with the parent(s) would eventually take place. Participants explained that because parents are resistant to, or not understanding of, the situation, and because a timely intervention was sometimes needed, they would take action.

On the other end of the continuum, there were a number of participants who stated that beyond information regarding abstinence, STIs and pregnancy prevention, nothing could be provided to adolescents for SRH. Outside of this parameter, a health care provider could face criminal charges and be jailed. They acknowledged that the law prevented access to SRH services and information, and many opportunities for education and supporting services around healthy sexuality and SRH were lost. One such participant shared,

"The law states that if any practitioner knowingly or knows that a minor is having sex and does not report it, then that practitioner can be charged and possibly jailed. So no one wants to go down that road. So this conversation is not had. Parents do come in and complain about the child's sexual behaviour, and it's usually a female teen, and health care providers may intervene and talk to the child, but we are supposed to push abstinence. There is never talk about or information shared about prevention or condom use."

Mixed views about legislative mandates rest on the perception of some participants that sometimes adolescents are developmentally capable of making decisions. Participants felt strongly that the needs of knowing children's sexual behaviour, who are at greater risk of harm, should be differentiated from the needs of knowing sexual behaviour amongst adolescents. The constant balancing act between offering protection for a child, and knowing or thinking they are sexually active and having to report it, is a source of frustration for most participants.

"We are literally telling the children go out and have sex, we know you're having sex and come back when you're pregnant or come back when you have HIV and we will attend to you then."

Service providers expressed a profound sense of powerlessness as they often have to act against their will and against their better judgement and medical training with regards to minors' SRH.

4.8. Confidentiality

While participants acknowledged that confidentiality is a necessary component of service delivery, they are clear that a minor simply cannot receive confidential services if they must be accompanied by an adult.

"Then you have the dilemma where you have already developed this rapport with a client and this relationship where there is trust. You going to report her, yes it's against the law, you going to report her. That is the dilemma that health professionals face, and sometimes we make a decision in the best interest of the child which may be detrimental to the child."

One mental health professional discussed at length the importance of confidentiality with this population. The participant reported navigating "a fine line" between alerting parents to the adolescents' sexual activity and maintaining the bond of trust with the individual. The participant expressed frustration with systems that are not supportive of healthy sexuality in youth and hoped that research like this will help make things better for young people.

Another participant shared that the current legal restrictions,

"forces us to breach confidentiality for sexual health. If an adolescent comes in and reveals that he/she is sexually active, the law forces me to listen to what the child has to say and call the police even when the parties involved in sexual activity are both/all minors."

Breaking confidentiality will create a situation in which there is a lack of trust, and the adolescent will no longer share their issues and challenges with providers. Participants shared that these restrictions force minors to turn to the Internet, peers and older, often predatory, adults for guidance.

Several participants intimated that there is a need for nuance and discretion when addressing confidentiality around minors. One participant shared that they distinguish between dangerous situations and breaks confidentiality upon determining if there is bodily harm, or if there is a predatory adult involved. Similarly, another participant shared that they utilise a list of considerations that determine how, and if, confidentiality is broken. The list is as follows:

- Is there sexual abuse and sexual exploitation apparent?
- Is my decision to disclose going to cause harm?
- Is another health care provider needed to assist with care?
- Can I refer this case to someone else who can better help?

Participants generally had no misgivings about breaching confidentiality and reporting information to the Children's Authority and Child Protection Unit if the child was at risk. That said, many participants understood that they were operating outside of legal limits with some of the information they kept confidential.

4.9. Assessment of Trends

Participants noted that there was often an increase in requests for services by adolescents after Carnival and long holiday weekends. One provider noted that their agency, which served out-of-school youth, required adolescents enrolled in their programmes to have blood tests done to meet entrance requirements. In this setting, the provider noted that when adolescents received the test results, there was a large uptake in the demand for SRH services, information and commodities. The provider identified that this trend of increased demand for services is noted annually when a new cohort is accepted.

Participants also identified some novel approaches to increasing adolescent access to commodities. Carnival bands, especially the J'Ouvert bands, have been increasingly requesting condoms from health institutions. Participants shared that they are aware that adolescents are accessing SRH commodities by these means. It has also been noted that contraceptives at walk-in clinics are often taken by adults for adolescents.

"They (adolescents) know you have to provide ID. What I found, too, we have 3-4 clients who are around 70 years old and they come in for condoms and they tell you that is for their grandchildren, but we can't tell them 'no' outright, but they tell us it's for their grandchildren. And the grandchildren, some of them are not adults."

Providers also noted that they have observed increased numbers of adolescents from sexual minority groups attempting to access services;

"They are confused and most of us (providers) confused ... is a whole missing generation of information. It is not something that is taught or they've received training for. But we have not addressed that."

4.9.1. Lack of Data Collection

Several service providers concurred that in their experience no data collection mechanism exists to systematically capture data about adolescents' access to SRH services with the exception of data related to adolescents who have delivered babies. Commenting on the paucity of data on demographics of adolescents who access SRH services in a public health setting, one service provider commented:

"Nothing is provided for adolescents in our health care system. On average, 15 to 16-year-old girls access pregnancy care, more boys (14 – 15 years old) access HIV testing. Those who try to get contraceptives are given advice, we push abstinence, but we are most definitely not giving commodities. There is not even a discussion nor is [there] information given about the types of contraceptives, the best methods to use, or how to store and use the contraceptives."

Three (3) themes were abundantly clear when discussing legal barriers to accessing SRH information, services and commodities among adolescents. Firstly, adolescents are aware that legal barriers exist. Secondly, adolescents can circumvent the law and, thirdly, there are adults (some of whom are service providers) who will contravene the legal barriers and facilitate service.

While the legal context presents an obstruction to adolescents accessing SRH information and care, it effectively increases their susceptibility to a myriad of risks including, but not limited to, unscrupulous adults and inaccurate, potentially harmful information from Internet sources.

Adolescents' inability to access SRH information is a risk factor for negative SRH outcomes. With that said, legal barriers are not solely responsible for increasing the vulnerability of adolescents. These barriers fuse with sociocultural barriers to producing a judgement-laden and shame-based environment with heightened potential for negative SRH outcomes for adolescents.



Discussion



The discussion section of this report will use the research questions crafted at the outset of the study to examine adolescents' views and experiences in accessing SRH information and services in Trinidad and Tobago. The qualitative evidence from this study paints a nuanced picture of how adolescents' experiences with accessing SRH services have affected them across a diverse socioeconomic spectrum. Based on the understanding of how SRH services, information and commodities access—or lack thereof—have impacted adolescent reproductive health outcomes, this section will conclude with recommendations aimed at improving adolescent SRH outcomes.

5.1. Filling Research Gaps and Broadening an Understanding of our Local Context

Reviews of the research literature pertaining to adolescent health in general, and their access to SRH services and information in particular, highlight the need to generate empirical data to support decision-making and to promote novel and innovative initiatives for effective programming. While the need for research and the benefits to be derived are evident, the data and research gaps are overwhelming. Darroch J et al (2016) points out that "Filling these gaps will require efforts that include basic data collection, in-depth research to increase understanding of adolescent behaviours and evaluations of interventions to enable decision-makers to scale up promising programs". The data accrued from this study has certainly filled gaps in our understanding of the service provision context for adolescents' access to SRH services in the Caribbean, and more concretely, in Trinidad and Tobago.

The qualitative evidence reinforces previous programme reviews that highlighted numerous service barriers that adolescents encountered when seeking SRH information and services, such as judgemental attitudes of some providers, a lack of confidentiality, limited contraceptive options, and a lack of policy and guidelines for protecting adolescents' rights to information and services (USAID, 2015).

Similar to Cook and Dickens' (2009) findings, our data suggested that the gatekeepers, such as service providers and parents, made adolescent access most difficult. These findings mirror the experiences of the research team in collecting data—gatekeepers contributed significantly to the challenges faced in data collection. The study also produced findings in keeping with Remez, Woog and Mhloyi, (2014), who found that barriers to adolescent access to SRH are attitudinal, educational/informational and infrastructural/economic in nature.

5.2. Understanding the Adolescent Experience in Trinidad and Tobago

The findings of this study support the view that minors' access to SRH services must be addressed as an aspect of the larger psychosocial and biological risks and vulnerabilities faced by adolescents. There is a range of structural factors that affect the sexual and reproductive health outcomes of adolescents. The evidence confirms Allen's (2013) analysis of a range of structural factors that contributed to poor outcomes for adolescents in the Caribbean. Using an ecological systems analysis, Allen discusses risk and protective factors that are key markers of vulnerability among adolescents in the region. This analysis surmises that both risk and protective factors have a far more significant impact on girls than boys in the region. Moreover, a "clustering" of risk factors is apparent for certain categories of young people, including adolescents who are female, who are LGBTQI, and who are living with HIV and/or disabilities.

5.2.1. Views, Knowledge and Experiences of Adolescents and Service Providers

The data garnered from the adolescent participants corresponded with the data garnered from the service providers. This triangulation lends credibility to the qualitative evidence produced, which overwhelmingly supports the premise that there is a critical need for SRH information, services and commodities among the adolescent population. Although this qualitative study does not seek to quantify the scope of this problem among the study population, with a diverse sample it has given insight into the meanings and understanding of the experience of SRH access for adolescents.

There are diverse circumstances under which adolescents may need to access SRH services (including commodities). Sexual violation by an adult is only one of a myriad of reasons that may trigger a need to access these services. Reasons for a need to access include, but are not limited to, adolescent curiosity, attempts to make responsible and informed decisions to engage in consensual sexual relationships with other adolescents, willing participation with adults who break the law by engaging in illegal sexual behaviour with minors, and coercive sexual interactions with adults (including sexual assault or rape).

While the need for accessing services can arise from a multitude of reasons, the law pertaining to sexual behaviour among minors presupposes that the need for access is always as a consequence of sexual violation. While the rationale of legal barriers is child protection, the view of most of the study participants is that the legal barriers as it currently exists functions contrarily to its intent and instead, it increases adolescents' vulnerability to harm. Furthermore, it punishes adolescents who are attempting to engage in positive health-seeking behaviours.

5.2.2. Curiosity among Adolescents about SRH

One of the hallmarks of the adolescent stage of development in human beings is curiosity. Decades of research have reinforced that inquisitiveness in adolescence is the gateway to healthy adult development. Notwithstanding, the responsibility of adult circles of care, including family members and duty-bearers with the mandate of child protection, is to scaffold adolescent curiosity in supportive, nurturing environments. The entity that appears least supportive and nurturing to adolescents is the State in terms of the restrictive environment created by the legislation. The policy underlying section 20 of the Children Act, providing relief to adolescents who engage in a sexual relationship within the same age groups under certain circumstances, suggests that the legislators understand the curiosity, experimentation and sexuality that drive adolescents' sexual relationships, albeit not same-sex relationships. Where this provision is only for heterosexual relationships, as many minors are not aware, and although not criminalised, there is still a reporting requirement once sex has occurred among the minors.

Notably, the majority of adolescent participants in this study expressed that their adult circles of care were not nurturing or supportive with regard to their curiosity (and needs) surrounding SRH. The participants in this study who expressed that their adult circles of care were supportive and nurturing appeared to have more accurate SRH information and reported more willingness to delay sexual behaviours.

Both adolescents and service providers/key informants posited that, based on their experience, seeking information was not necessarily an indication of intent to engage in sexual activity. Both groups of participants noted that access to information could result in delayed sexual activities.

5.2.3. Responsible Decision-making for Consensual Sexual Relationships

Adolescents often seek out SRH information and services because they wish to engage in responsible decision-making regarding consensual sexual relationships. Among the participants, the preferred source of information was the Internet, followed by peers they considered to be more experienced than themselves. There was an intense fear of seeking information from parents and other authoritative sources of information. Corporal punishment as a means of dealing with adolescent sexual behaviour was one of the reasons cited by adolescents who feared talking to parents about SRH. Going online to get SRH information and services was the preferred alternative to interfacing with a social and legal environment that created such shame around SRH issues, that adolescents became uncomfortable addressing their own SRH needs.

5.2.4. Willing Participation in Illegal Sexual Acts with Adults

Moreover, many of the adolescent and adult participants concurred that adolescents should be afforded confidentiality as well as the ability to access SRH information and services, even while the need to protect adolescents from exploitative relationships was acknowledged. Participants agreed that there were adolescents who often willingly entered into sexual relationships with adults. Willing participation should be distinguished from consensual acts. Adolescents in the sample study concurred that the law could certainly function to protect adolescents from these relationships.

A couple of service providers struggled with the notion that adolescents could not give consent to engage in sexual encounters with adults. These providers cited that some adolescents live in cultural contexts where relationships between adults and minors were a norm and attempting to regulate such was a futile practice. This was not a perspective that surfaced among the adolescent participants.

5.2.5. Coercive Sexual Acts, Sexual Assault/Rape by Adults

There were two survivors of sexual assault among the participants and they were able to lend insight into their experiences of accessing SRH services in the aftermath of the assault.

Both of their experiences in accessing public facilities were positive, and they spoke of feeling “taken care of” by service providers. The guidelines around service provision for adolescents who have been sexually assaulted were clear for service providers.

5.3. Knowledge, Perceptions and Interpretations of the Law

With regard to the legislative context that limited the ability of adolescents to access SRH services and information, Allen (2013) highlighted a number of issues that mark the reality of the adolescent’s experience in the Caribbean context. These included, but were not limited to, inadequate privacy and confidentiality when accessing SRH services and information, judgement-laden approaches to discussing sexuality, the absence of protocols for the management of adolescents attempting to access SRH services, lack of adolescent-friendly services—especially for adolescents with disabilities, minimum mobile outreach services, and low adolescent involvement in service delivery. Adolescents shared their beliefs that the current laws are a hindrance to truly edifying young people about their sexual health. Based on their experiences, and the experiences of their peers, adolescents characteristically sought access to SRH services, information and commodities after they had engaged in—or had been forced to engage in—sexual activity. As a result, denying access to SRH for these adolescents did not safeguard them from sexual activity—the exposure to sexual activity had already occurred.

5.4. Health Care Workers and Minors’ Access to SRH Services and Information

Empirical studies cite that young people’s care-seeking behaviours are often restricted due to fear of breach of confidentiality that may result in violence, embarrassment, lack of knowledge, misinformation and myths, stigma, and shame (Blanc, Tsui, Croft, & Trevitt, 2009). The literature highlights the fear that their peers, parents, family members, teachers, and health care workers would judge them for their sexual activity and the possible results of it. Some argue that the single most important barrier to care is provider attitude (Morris & Rushwan, 2014).

Rigid laws and policies barring minor access to SRH information and services are characteristically justified by the obligation of adults to protect adolescents. The crux of this argument hinges on the position that adolescents are not sufficiently competent to make sexual decisions, specifically to consent to sexual acts. In response to laws that limit minor access to SRH services, there have been provisions made in certain countries to permit health care providers to offer services (IPPF, 2014; Burke et al, 2014).

Service providers interviewed struggled with the ethical dimension of not providing service to adolescents. These ethical dilemmas emanated from the conflicts between duty to care and duty to do no harm, and the obligation to abide by the law.

Service providers/key informants have very little knowledge about the law beyond (1) the stipulated age of sexual consent, (2) that they are mandated to report sexual activity among minors, and (3) that there is some penalty attached to failure to report. Conflicting knowledge, perceptions and interpretations of the law was a significant finding of this study. There are several factors that seem to have contributed to the muddled and somewhat haphazard understanding of the legal context that should govern service provision for adolescents. Firstly, services providers and key informants often work in environments where there is incongruence between policies and the law as it relates to SRH information and services (including commodities). This is a major factor that drives the lack of conformity among providers in terms of adolescent access to SRH services. A second contributing factor is the absence of a unified understanding of mandatory reporting. There were different interpretations of what was “reportable” and what was not.

Thirdly, incongruence in service provision across service providers and key informants also occurred because there was ambiguity about the legislation that governs SRH access for adolescents.

While there was unanimity in the understanding that adolescents younger than 18 years old cannot engage in consensual sexual activity, there is little else that was agreed upon. For example, some providers provided SRH information but not services, some provided services with the consent and physical presence of a parent or guardian, while others would provide services in the presence of a trusted adult.

A fifth factor which emerged as contributing to incongruent practices was the dissonance between the providers’ assessment of the adolescents needs and what was in their best interest, and the prescription of legislation that stipulates mandatory reporting of minors who are sexually active. Simply put, many service providers and key informants are attempting to conform to practices that are counter to their experience in service provision.

Finally, it was also apparent that service providers had inadequate, if not disparate training, in assessing the competence of adolescents to receive SRH services, as well as the legal requirements expected of them.

With contrasting practices seen across private and public service providers, adolescents are receiving conflicting messages from different institutions with a mandate to provide for their care. These include, but are not limited to, educational and health care institutions. Mandatory reporting does not equate to service provision, and discomfort around reporting emanates from this position. Many service providers/key informants understand that reporting is not a treatment plan and while it may expose sexual predators, more often than not it further victimises the adolescents and functions as a deterrent to engaging in help-seeking behaviours. Without treatment planning, mandatory reporting may increase the vulnerability of adolescents. First-responders like nurses and medical doctors are not adequately trained to make reports. Furthermore, it is not their mandate to assess the ecological systems in which an adolescent is functioning. It was apparent that while the nurses interviewed were routinely counselling sexually active minors and parents of sexually active/pregnant minors, they were doing so without any apparent theoretical framework. This research raised key questions such as:

- Are nurses kept abreast of details surrounding legislation that guide their practice?
- Whose responsibility is it to keep them up-to-date with any legislative changes?
- What is the relationship between the disciplines of nursing and social work in dealing with adolescent SRH?
- What framework guides disclosure to the minor's (adult) next of kin when pregnancy or sexual activity is discovered?
- Do patriarchal/conservative norms shape the ways in which sexually active minors are engaged?

5.5. Interaction of Legal Barriers with Social and Cultural Barriers

Adolescents perceive that there is a refusal by adults in positions of authority to accept that adolescents/minors are sexually active, and need SRH services and commodities. It is a strong perception among adolescents and service providers/key informants that the Government's unilateral approach in promoting abstinence for adolescents in educational and health policy increases adolescents' risk to negative SRH outcomes, because they are engaging in sexual activity without adequate knowledge or protection.

In spite of the law, adolescents will find ways to access the information, commodities and services that they need. Young women will access SRH commodities on their own to prevent pregnancy.

Furthermore, what was irrefutable for the participants in this study was that adolescents' comfort in accessing SRH was very much influenced by their perceptions of public opinion/public condemnation i.e. the social and cultural perceptions of acceptability. Social and cultural barriers have a greater impact on adolescent decision making than legal barriers.

The law interacts with social, cultural or other barriers to create an atmosphere of judgement, shame, guilt or fear around a normal human activity. The interaction creates psychological and physical harm by blocking access to services and information (for treatment and testing, or conversations and advice), which leads to poor SRH outcomes. Where policy decisions have been made to facilitate the provision of SRH services and information, legal barriers and cultural factors play an influential role in adolescents' capacity to access them.

5.5.1. The Need for Adolescent-friendly Services

Although there were positive experiences of feeling "cared for" when accessing SRH services, adolescents highlighted that services were often not adolescent friendly. They questioned the requirements of adult accompaniment for minors who received services, citing that adolescents do not have 'real access' to SRH service if they only have access through an adult.

5.6. Recommendations

In keeping with Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all, at all ages) and target 3.7 (ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes) as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences, the WHO/PAHO Plan of Action for Women's Children and Adolescent Health 2018 – 2030, the Convention of the Rights of the Child, and in addition, other global frameworks and human rights instruments:

- Adolescents should be granted access to age appropriate Comprehensive Sexuality Education information and Sexual and Reproductive Health (SRH) services. In this context, legislation should be amended to facilitate minors' access to SRH, by only requiring mandatory reporting for those minors who are coerced or forced into sexual activity. This could be achieved by introducing legislation to lower the age of consent to medical treatment to 16, and introducing the principles of the Gillick Competency Test in legislation. Further, rules and regulations related to health care practitioners (for example in the Medical Practitioners Rules) and policies could be implemented to address any remaining gap.

- Comprehensive sexuality education programmes targeting in and out-of-school children should be implemented nationwide in line with the UN technical guidance and empirical support. From this perspective, Trinidad and Tobago should not continue investing in abstinence-focused programmes, as evidence has proved that they are not effective in delaying sexual initiation, reducing frequency of sex, or reducing the number of sexual partners.

Where the adolescents are situated in religious schools and religious households that continue to instil abstinence-focused programmes, developments should be made to reach them with SRH information and services through facilities such as booklets, adverts and programmes.

- Mandatory reporting of consensual sexual activity among minors within the same age group, which has already been decriminalised through the Children's Act, should not be understood to be compulsory, as it inhibits access to services.

While a service provider is only obligated to report when there are reasonable grounds for believing that a sexual offence has been committed, both adolescents and service providers have understood this to mean a mandatory reporting requirement, thus inhibiting the adolescents' access to SRH services.

- Lower the minimum age of consent to sexual intercourse to 16 years as existed prior to the coming into effect of the Children Act No. 12 of 2012 in 2015. Setting an appropriate age of consent to sexual activity requires a balance of rights to protection and the recognition of the evolving capacity and autonomy of adolescents and young people as they age.

- SRH is a biopsychosocial need that requires an integrated and holistic treatment approach. Addressing the SRH needs of adolescents therefore requires integration of psychosocial care in service delivery. A professional with requisite professional training should be tasked with the responsibility of conducting ecosystems and biopsychosocial assessments for adolescents who access SRH services and commodities. Reporting must not be substituted for treatment planning.

- The legislative provisions must be accompanied by clear policy guidelines for duty bearers that outline the laws and regulations governing minors' access to services and step-by-step procedures for reporting minor-abuse. For example, the 2019 National Child Policy supports the notion that children should be provided with physical and mental health services. Further and more elaborate protocols should be developed, reviewed, updated and widely disseminated.

- Right holders, duty bearers and other adults in a position of trust also need to be clearly informed about the laws and regulations pertaining to their access to SRH and rights.

- Engage and empower adolescents and youth to contribute to the design, implementation and monitoring of sexual and reproductive health services. On account of this, active involvement of adolescents is critical in designing sexual health spaces and services that target this population, and is strongly recommended.

In fact, a Communication for Behavioural Impact (COMBI) strategy was developed to accompany the National Child Policy (NCP) with the goal of ensuring that children's views are included in all major government and public initiatives by the year 2025. Such services will involve selecting venues, times and days for services that are best suited for adolescents. The adolescents in this study recommended training for health care providers and suggestions for the physical environment and the way providers are dressed in these spaces as a necessary component of an adolescent friendly service. Health care providers should be aware of the importance of confidentiality; not only in structuring the physical space, but also in building a sense of safety and confidentiality within the community.

- Heightened awareness is needed among stakeholders, including policy makers on the findings of this report to inform appropriate legislative changes. The development of an advocacy and communication road map is therefore suggested.

- An Adolescent Online Web Portal that offers 24-hour access to SRH information. This online mechanism can be essential in disseminating accurate information to counteract inaccurate information that adolescents are readily accessing on the World Wide Web.

5.7. Conclusion

Despite the restrictive legal environment, adolescents are able, to some extent, to access both public and private sector SRH services, which suggests that current legislation has not effectively prevented access to SRH care. However, it is clear that barriers to access exist.

It was also evident that service providers and key informants are conflicted by, if not opposed to, the parameters of care stipulated by the current legislation. That the adults in a position of trust do not strictly adhere to the prevailing approach of not offering SRH services and information beyond abstinence is also indicative of the ineffectual nature of the law. It is also of note that service providers are challenged by the restrictions of the current legislation because its directive runs counter to the evidence that they encounter in the field.



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