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Caribbean Centre for Health Systems Research and Development
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Evidence Brief for Policy

Providing targeted access to Sexual and Reproductive Health Services to Adolescents in Trinidad and Tobago

APRIL 2021

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CARIBBEAN CENTRE FOR HEALTH SYSTEMS RESEARCH AND DEVELOPMENT

EVIDENCE BRIEF FOR POLICY

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Caribbean Centre for Health Systems Research and Development

The University of the West Indies, Caribbean Centre for Health Systems Research and Development (CCHSRD) is a Research Centre at The University of the West Indies, St. Augustine. The Centre was established to pursue a program of work in Health Policy and Systems Research (HPSR) to address pressing policy and system issues faced by decision-makers in the Caribbean region.

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Merit Review

CCHSRD Evidence Briefs for Policy undergo a merit review process by internal and external reviewers.

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Conflict of Interest

CCHSRD declares it has no actual or potential conflict of interest in relation to this evidence brief for policy and the stakeholder dialogue.

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Key Messages

KEY MESSAGES

What is the problem?

Many adolescents in Trinidad and Tobago (T&T) face legal, organisational and societal barriers when accessing quality sexual and reproductive health (SRH) education and services. This results in undesirable outcomes such as risky sexual behaviours, a high incidence of sexually transmitted infections, unwanted teenage pregnancy and subsequent school dropouts.

What do we know about elements of an approach to addressing the problem?

Element 1: Legislative Review to remove legal and policy barriers to Sexual and Reproductive Health services and protect and promote adolescents' sexual and reproductive health and rights

- Use of the Gillick Competence Model by health care workers (HCWs) to assess the knowledge levels of adolescents when providing care: Gillick Competence refers to a child or adolescent's ability to consent to medical treatment without parental consent, based on their knowledge level and understanding of the treatment involved;
- Implementation of the UNFPA's model legislation "Reproductive Health Care Services and Protection Bill" to treat with the legislative barriers that prevent adolescents from accessing care: Most notably, persons below the age of 16 cannot access any medical care without parental consent and health care workers are legally required to report any incidence of sexual activity in persons below the age of 18 to the police.

Element 2: Implementation of adolescent-friendly facilities; training for health care workers; and strengthening of the Health and Family Life Education Programme

- Implementation of adolescent-friendly facilities or specialised adolescent health clinics;
- Pre- and in-service training for health care workers on treating with adolescents and adolescent health issues;
- Strengthening of the Health and Family Life Education Programme in collaboration with the Ministry of Health to include updated, relevant SRH information;
- Implementation of multi-component interventions (school education programmes, parent involvement, community engagement, training for health care workers).

Element 3: SRH sensitisation and training for parents and community; societal awareness; and utilisation of digital platforms

- Sensitisation for parents and community members on the SRH issues adolescents face;
- Utilisation of social media and digital platforms to increase availability of SRH education and counselling to adolescents.

What implementation considerations need to be kept in mind?

To ensure targeted access to sexual and reproductive health services to adolescents in T&T, a variety of implementation considerations need to be kept in mind at the level of systems, organisations, health care workers and patients/ communities. These include political will, collaboration between the Ministries of Education and Health, in-service training for HCWs, equitable geographic distribution of adolescent-centred clinics, sensitisation for parents and community members, public education campaigns, and the use of digital platforms for the provision of SRH education.

Executive Summary

EXECUTIVE SUMMARY

The Problem

While Trinidad and Tobago provides free healthcare for all its citizens, adolescents face significant barriers when attempting to access adequate sexual and reproductive health (SRH) information and services. Trinidad and Tobago's Sexual and Reproductive Health Policy (1) noted that the main issues being faced by adolescents in accessing SRH were: stigma and discrimination towards sexually active teenagers; limited access to health care; and limited access to and use of contraceptives. This often results in adverse outcomes, most notably, risky sexual behaviours, teenage pregnancy, school dropouts and a high incidence of sexually transmitted infections (1–4).

The Magnitude of the Problem

A 2017 World Health Organisation (WHO) survey uncovered that 29% of children in Trinidad and Tobago between the ages of 13 and 17 were engaged in regular sexual activity, and only 50% of these children made use of contraceptives (5). A 2020 Joint Select Committee Report noted that between 2014 and 2018, 3,577 teenage mothers were admitted to public hospitals (6). This is of significant concern due to the fact that teenage mothers and their babies are more likely to experience negative health outcomes (3,7). Babies born to adolescent mothers are more likely to be born premature, with congenital malformations, with a low birth weight or experience perinatal death (4). Teenage mothers themselves were prone to increased health risks such as abortion, urinary tract infections, hypertensive disorders and premature rupturing of foetal membranes (7). Additionally, emotional and psychological support is needed in cases of teenage pregnancy in which both parents still attend school. They face stigmatisation, which usually results in decreased focus in school, mental health challenges and increased dropout rates or transfers to new schools (8).

Research also found that adolescents were prone to high incidences of STIs, as the incidence rate of HIV infections in persons below the age of 19 in Trinidad and Tobago was 70.2 per 100,000 (9). Additionally, 12% and 15% of new infections of gonorrhoea and trichomoniasis respectively occurred in persons below the age of 19 (9).

Underlying Factors

At the *Governance arrangement* level, current legislation does not allow persons below the age of 16 to access some health care services without parental consent, and this includes SRH services (10). Additionally, HCWs are legally required to report incidents of sexual activity in persons below the age of 18 (1). Both of these legal requirements result in a scenario whereby adolescents avoid seeking SRH care at health facilities, leaving them to pursue alternative sources of medical care. This often results in HCWs' reluctance to treat adolescents. Additionally, in schools, especially in smaller communities, teachers are hesitant to report student pregnancies, leading to decreased perpetration and enforcement of the law (8).

Secondly, there is a national committee (the Sexual, Reproductive, Maternal, Neonatal, Children, Adolescent Health (SRMNCAH) Committee), which was convened to monitor the implementation of the National Sexual and Reproductive Health Policy. However, this policy includes recommendations for improving access to adolescent SRH services, which are yet to be actioned (11). Subsequently, healthy school initiatives and new policies are still in the development stage. This is tied to the fact that there is no dedicated unit or department at the governance level which deals with adolescent health, and as such, adolescent health issues are rarely given the appropriate level of attention required (12).

Another major factor at the governance level is the fact that the national programme dedicated to providing SRH education in schools, the Health and Family Life Education Programme (HFLE), should be reviewed to ensure it is medically accurate and age-appropriate (1,12). There is a working relationship between the Ministry of Education (which delivers the programme) and Ministry of Health in this regard. In particular, the Ministries collaborated on the revision of the HFLE curriculum in 2013. There is, however, need for a stronger partnership and this has also been highlighted by several joint select committees convened to address SRH issues. The Ministry of Social Development and Family Services should also play a critical role (8).

Additionally, there have been school programmes (through the Regional Health Authorities, communities and health centres) such as the Ministry of Health's *RapPort Programme* that provides information, education and counselling to youth on the prevention of sexually transmitted infections and "managing self, sexuality and safe sex practices" (6). The Ministry indicated, however, that the execution of its projects and programmes has been adversely affected by challenges of inadequate human and financial resources (6).

Additionally, the HFLE programme is not institutionalised and as such, not provided in every school as the programme intended. This is because there are no dedicated teaching positions for the HFLE programme, which means it is only delivered if a teacher volunteers. In primary schools, this is an even greater challenge as teachers are only expected to cover the "basics", which excludes information on reproductive health and adolescent wellness which are pertinent to students of Standards Four and Five (8).

At the *Financial arrangement* level, there is no dedicated health expenditure focused on training for health care workers on treating with adolescent SRH needs. As such, staff at health facilities have limited training in techniques to deal with the SRH needs of youth. Furthermore, while health care is free for all citizens, there is no targeted programme for adolescent health care.

At the *Delivery arrangement* level, there are limited youth-friendly facilities or specialised clinics whereby adolescents can access SRH services which are suited to their specific needs. This limits the accessibility and uptake of contraceptives among adolescents, leading to negative health outcomes (1). Additionally, some SRH services, particularly HIV and STI testing, are only available at select facilities and may not be easily accessible to adolescents. Lastly, adolescents often face discrimination and negative attitudes from health care workers, due in part to the societal conventions in Trinidad and Tobago which still considers sexual activity in adolescents as taboo (1,12).

Elements of a comprehensive approach to address the problem

The following three elements form part of a comprehensive approach to improve access to SRH care to adolescents in T&T.

Element 1: Legislative Review to remove legal and policy barriers to SRH services and protect and promote adolescents' sexual and reproductive health rights.

The Gillick Competence Model is utilised by HCWs to determine an adolescent's level of understanding when providing SRH care. This model may reduce adolescents' need for parental consent when attempting to access SRH care at health facilities. Additionally, the UNFPA conducted a gap analysis of adolescent SRH rights in the Caribbean, and emanating from this, they developed draft legislation particularly targeted at removing these legislative barriers (13).

Element 2: Implementation of adolescent-friendly facilities; training for health care workers; and strengthening of the HFLE Programme.

Evidence demonstrated that multi-pronged approaches (training for health care workers on adolescent needs and health, school-based SRH education programmes, and parent involvement in SRH education) were the most successful in improving adolescents' access to SRH care. Research found that youth-friendly family planning services had a positive effect on adolescent reproductive health outcomes, notably reductions in teenage pregnancy, increased knowledge levels and increased contraceptive use (14). A systematic review also found that interventions to improve the attitudes of health care workers was likely to improve the utilisation of health facilities by adolescents (15).

The importance of SRH school-based education programmes cannot be overstated. Five systematic reviews demonstrated that school-based health programmes resulted in improved SRH knowledge levels in adolescents (16–20). One systematic review also noted that school-based SRH education programmes were not associated with increased sexual activity as previously thought (21).

There was strong evidence to indicate that the most effective approaches to improve adolescent sexual and reproductive health were multi-component interventions (22,23). These interventions included school intervention programmes, parent involvement, community engagement (24,25), adolescent-friendly facilities, and training for health workers (17).

Element 3: SRH sensitisation and training for parents and community; societal awareness; and utilisation of digital platforms.

There was abundant research evidence demonstrating the effectiveness of parent-involvement in influencing adolescent sexual behaviour. Strong evidence in six systematic reviews indicated that programmes tailored towards increased parent-child communication resulted in improved adolescent sexual knowledge and behaviours (22,26–30). Two reviews also found that parent communication resulted in decreased unprotected sex, delayed sexual initiation and decreased sexual activity in adolescents (29,30).

Digital and new media platforms are emerging as a novel avenue for the proliferation of SRH education and the promotion of safe sexual practices. When considering the use of digital platforms to influence adolescent SRH, two reviews found evidence of improved attitudes towards contraceptive use (31,32), while two other reviews found evidence of increased SRH knowledge levels in adolescents when using new media (33,34).

Implementation Considerations

At the *System level*, there may be a lack of political will to adopt the model legislation that removes the barriers (parental consent requirement) which prevent adolescents from accessing SRH services and care. Public education campaigns may serve to change societal perception towards adolescents accessing SRH (25,35).

Additionally, there is inadequate collaboration between the Ministry of Health and Ministry of Education, which hinders the provision of relevant and comprehensive SRH education in schools. Greater collaboration is needed between the Ministries, to improve the HFLE Programme.

At the *Organisational level*, some health facilities may already be so heavily utilised that they may be unable to find/schedule time to host adolescent-only clinics. Selecting some health facilities with an equitable geographic distribution to offer adolescent-centred clinics may be an effective strategy to address this constraint.

Also, the Ministry of Health may be of the view that there is insufficient funding to hire new staff to manage and monitor digital platforms to spread awareness on SRH services for adolescents. However, existing platforms such as one previously offered by the Family Planning Association of Trinidad and Tobago (FPATT) can be used.

At the *Health Care Workers level*, there may be unwillingness by established HCWs to attend/utilise adolescent-specific training. This can be addressed by making in-service training for HCWs on adolescent health mandatory (14).

At the *Patient/Community level*, parents may oppose the removal of mandatory parental consent, and religious bodies, their respective schools and parents may be unwilling to have the HFLE programme taught in their schools. This can be addressed by strong political will to adopt new legislation or remove legislative barriers to care.

Additionally, while SRH training and sensitisation may be offered to parents and the public, there may be unwillingness by the public to participate. This barrier may be counteracted by offering sensitisation for parents and community members through NGOs and CBOs as they already have expansive community networks (36).

Main Report

MAIN REPORT

The Problem

While Sexual and Reproductive Health (SRH) services are easily accessible to adults in Trinidad and Tobago, significantly less focus has been placed on the SRH rights of adolescents. The World Health Organisation (2014) defines adolescents as persons between the ages of 10 and 19, and in Trinidad and Tobago, adolescents make up an estimated 13% of the total population (11). Despite representing a significant portion of the population, many adolescents in Trinidad and Tobago face barriers in accessing adequate SRH information and care, and this often results in undesirable outcomes such as risky sexual behaviours, a high incidence of Sexually Transmitted Infections (STIs), teenage pregnancies and school dropouts (1–3).

Box 2: Definition of Sexual and Reproductive Health Services

The United Nations Population Fund (UNFPA) in a 2014 publication, stated that it was imperative to support the sexual and reproductive health of adolescents. The publication noted that adolescents had a right to comprehensive sexuality education, family planning counselling and services to prevent, diagnose and treat sexually transmitted infections. These amenities are the basic Sexual and Reproductive Health (SRH) services that should be made available to adolescents to foster healthy development into adulthood (36).

Box 1: BACKGROUND TO THE EVIDENCE BRIEF FOR POLICY

CCHSRD's evidence briefs bring together both global and local research evidence about a problem, options for addressing the problem, and key implementation considerations. Whenever possible, the evidence is drawn from systematic reviews of the research literature. A systematic review is a summary of research studies addressing a clearly formulated question. Systematic reviews use explicit methods to identify, select, appraise, and synthesise findings from research papers. CCHSRD's evidence briefs do not include recommendations, as these would require the authors of the brief to make judgments based on their values and preferences. Recommendations should emanate from deliberations among stakeholders after considering the evidence provided in the brief.

The preparation of the evidence brief involved six steps:

1) Convening a Working Group comprising key stakeholders;
2) Developing and refining an outline framing of the problem and viable options for addressing it;
3) Conducting consultation with the Working Group and several other key informants and reviewing the outline based on feedback;
4) Identifying and synthesizing relevant research evidence about the problem, options to address it and implementation considerations;
5) Drafting the evidence brief in such a way as to present, in plain language, the evidence found;
6) Finalising the evidence brief based on the input of several merit reviewers.

This evidence brief was prepared to inform a stakeholder dialogue at which research evidence is one of many considerations. Participants' views and experiences and the tacit knowledge they bring to the issues at hand are also important inputs to the dialogue.

The Magnitude of the Problem

Recent studies conducted in Trinidad and Tobago found that 29% of children between ages 13 and 17 were already engaged in sexual activity, and only 50% of these children utilised protection (5). The incidence rate of HIV infection for persons in Trinidad and Tobago below the age of 19 was 70.2 per 100,000 (9), while 12% and 15% of new infections of gonorrhoea and trichomoniasis infections respectively occurred in persons below 19 (9). A 2020 Joint Select Committee (JSC) Report found that 3,577 teenage mothers were admitted to public hospitals between 2014 and 2018 (6) and this is especially alarming as teenage mothers are more likely to experience negative health outcomes (3,7). Pregnancy-related death is the second leading cause of death in females aged 15-19 years (38) and girls under 19 have a 50% increased chance of stillbirths and neonatal deaths (22). Additionally, children born to adolescent mothers are more likely to be born premature, have low birth weight or experience other negative outcomes such as perinatal death (4).

The JSC Report also indicated that within the same period, 211 males younger than 18 years fathered children of teenage mothers, while 2,381 fathers were aged 18 years or older (6). These figures, however, only represent the instances in which paternity was disclosed/reported.

Trinidad and Tobago's Vision 2030 is the national guide for development across both islands. Although Vision 2030 was developed in accordance with several International Agreements that relate to and influence universal access to SRH services (including the Programme of Action of the International Conference on Population and Development (ICPD), the Montevideo Consensus on Population and Development, and the Sustainable Developmental Goals (SDGs)),Trinidad and Tobago has not yet achieved the following SDG targets related to universal access to SRH services for men and women over the age of 15, notably:

1) SDG target 3.7 – "By 2030, 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".

2) SDG target 5.6 – "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences".

While the Government of Trinidad and Tobago provides free healthcare for all citizens, the current health system arrangement does not promote adequate access to SRH education and services for adolescents. Trinidad and Tobago's Sexual and Reproductive Health Policy (2016) states that limited use of contraception, stigma, and discrimination towards sexually active teenagers as well as limited access to health services were the main issues faced by adolescents (1). If the status quo is maintained, Trinidad and Tobago may be in danger of failing to meet the Sustainable Development Goals related to adolescent health.

Underlying Factors

At the **Governance arrangement** level, current legislation does not allow persons below the age of 16 to access SRH services without parental consent or attendance. Some adolescents therefore never access these services, and this heavily influences their use of contraceptives (10). Additionally, the Trinidad and Tobago Children's Act of 2012 mandates that health care workers (HCWs) are legally required to report incidences of sexual activity in persons below the age of 18, and this often results in a scenario where HCWs are reluctant to treat adolescents (1). These barriers are significant enough to bar numerous adolescents from seeking SRH care at health facilities, leaving them to pursue alternative sources of medical care which can result in undesirable or even dangerous outcomes (12). Studies have shown that prohibitive legislation is a significant barrier to the uptake of SRH by adolescents (39,40).

The National Sexual and Reproductive Health Policy (finalised in August 2020) recognises that SRH services should be adolescent-friendly, responsive to their needs, and delivered by trained providers in a confidential, stigma-free environment (1). However, the policy includes targets to achieve by 2025, and many of the recommendations have not yet been implemented.

There is no dedicated unit or department at the governance level tasked with addressing adolescent health issues. The Population Programme Unit at the Ministry of Health is the division tasked with oversight of Family Planning and Sexual and Reproductive Health of citizens throughout the life cycle. However, this unit does not have a specific focus on adolescents, and as such, this means that adolescent issues are rarely given the attention they require and often major shifts in adolescent behaviour or health challenges go unnoticed (12). The absence of a dedicated unit for adolescent health also means that surveillance in the area of adolescent SRH is lacking and there is great potential for the under-reporting of adolescent issues such as teenage pregnancy and STI transmission. Limited data on adolescent health issues makes it difficult to analyse, monitor and plan for the health needs of adolescents (41).

Another important issue at the governance arrangement level relates to SRH education, which is provided in the primary and secondary school setting by the Ministry of Education (MoE) through the Health and Family Life Education (HFLE) programme, albeit with lack of involvement from the Ministry of Health (MoH). Since there is no dedicated unit tasked with dealing with the SRH needs of adolescents at the MoH, the content of SRH education in the HFLE programme is prepared by the MoE and in many cases is not age-appropriate (1) or aligned to the current SRH needs of adolescents (12). Inadequate collaboration and communication between the two Ministries hinders the provision of relevant and comprehensive SRH education in schools.

Notably, there are severe challenges with the implementation of the HFLE programme in schools across the country. As the programme is not institutionalised, the provision of the HFLE curriculum is left to the discretion of the individual schools. There are also no dedicated HFLE teachers, so the programme is only taught if a teacher volunteers to do so. The consequence of this is that SRH is not taught at all in some schools and there is no oversight on what is being taught at the institutions that have adopted the HFLE curriculum.

At the **Financial arrangement** level, there is no dedicated funding or expenditure on training for health care workers on adolescent SRH needs. SRH services are provided to the general population at public health facilities across the islands, as part of the provision of primary health care, which is free to all nationals. While the SRH needs of adults are met through government expenditure, adolescents do not receive specialised or targeted care.

At the **Delivery Arrangement** level, there are currently limited youth-friendly facilities or clinics for adolescents to access SRH services which are tailored to their unique needs. The FPATT offers a youth-focused clinic, "The Living Room" which was designed by and for adolescents, and targets sexual health. Additionally, Health Visitors from the Regional Health Authorities (RHAs) have arrangements with schools to provide education and services; and several RHAs have adolescent health clinic services (8). However, staff at existing health facilities have limited training in techniques to treat with the specific SRH needs of adolescents. This may be a significant factor that limits the accessibility, uptake and use of contraceptives in teenagers. The Ministry of Health noted that health system-related issues such as limited access to health services and the consequential limited use of contraceptive methods were a contributing factor to adolescent pregnancy (1,12).

Some SRH services (such as HIV and STI testing) are only available at select locations and are not easily accessible for adolescents. The MoH's 2018 Statistical Report noted that 1% of all new HIV infections occurred in persons below the age of 15, while 12% and 15% of gonorrhoea and trichomoniasis infections respectively, occurred in persons below the age of 19 (9). These statistics may be an underestimation since the testing for these services is limited to a few locations and may not be readily accessible to adolescents.

Lastly, **societal conventions** in Trinidad and Tobago still predominantly consider sexual activity in teenagers/adolescents as taboo and forbidden (due in part to a heavily religious society). The vast majority of the population believes that children (persons under 18) should not be engaging in sexual activity at all. As such, adolescents face discrimination (1), scorn, or negative attitudes from health care workers (12) and adult patients when presenting at a health care facility for SRH care. At the individual level, they may experience a sense of shame or feeling of loneliness in obtaining SRH services as this is still frowned upon in society. This taboo manifests itself in a number of ways:

- parents being reluctant to teach their children about SRH and their reluctance to have SRH education provided to their children, either in schools or health facilities;
- policymakers being reluctant to make the necessary changes to address the growing negative outcomes of early sexual activity;
- health care workers being reluctant to treat adolescents for SRH issues (42).

Policy Elements to Address the Problem

Below, we propose elements of a comprehensive approach to providing targeted access to sexual and reproductive health services to adolescents in Trinidad and Tobago.

Element 1 – Policy Level - Legislative Review to remove legal and policy barriers to SRH services and protect and promote adolescents' sexual and reproductive health and rights

Legislative barriers are a significant contributor to the poor utilisation of SRH services by adolescents at public health facilities. The age of consent for sexual intercourse in Trinidad and Tobago was raised to 18 in 2015, by virtue of the Children Act No. 12 of 2012 (43). This legislation presumes that persons below the age of 18 are not sexually active, and based on the 2017 GSHS study, this is an incorrect assumption. Legislative changes would require amendments to several other policies and acts, such as the Sexual Offences Act and the Marriage Act. The former is important to address as many adolescent girls have sexual relationships with adults. For example, between 2014 and 2018, 869 male offenders 18 years or older were charged for sexual offences against minors (6). Regarding the latter, child marriage was only criminalised in 2017, which meant that underaged marriages before that time contributed to teenage pregnancies.

Legislative changes would also impact curriculum amendments, so education curricula would need to be updated to reflect legal updates. Trained and experienced persons are needed to guide such a process.

With the age of consent at 18, HCWs are mandated to report suspected sexual activity among younger persons to the relevant authorities, and this prevents some HCWs from providing much needed SRH services to adolescents. Additionally, the law states that children under the age of 16 must be accompanied by a parent or guardian when accessing healthcare at any health facility in Trinidad and Tobago. This precludes some adolescents from ever accessing SRH services at a health facility. While legislative change is often a long process, this evidence brief for policy proposes two pathways to reduce the effects of these legislative barriers and improve adolescent access to SRH services at health facilities.

The following can be considered for the removal or easing of these legislative barriers:

1) The use of the Gillick Competence Model:

   Gillick Competence refers to the right of a child to consent to medical examination and treatment without parental consent, if the child has demonstrated sufficient maturity and understanding of the nature of the requested treatment (44). A PAHO report in 2013 suggested that health care workers in countries with restrictive SRH policies can utilise the Gillick Competence Model to assess the knowledge levels of adolescents and provide SRH care accordingly (45), thereby eliminating the need for parental consent to access care in some instances. In this way, those adolescents who are in need of SRH care can be treated, thus increasing the usage and uptake of SRH services by adolescents and potentially reducing the adverse effects of poor/lacking SRH education.

2) The implementation of the UNFPA's model legislation, "Reproductive Health Care Services and Protection Bill" which is specifically tailored to treat with legislative barriers to adolescent's access to SRH services:

   The UNFPA (13) conducted gap analyses of the adolescent SRH and rights within the Organisation of Eastern Caribbean States (OECS) in 2012. Emanating from this, the UNFPA developed draft legislation for use in the OECS, which was specifically focused on adolescents' rights to SRH with an aim of improving adolescents' access to SRH services. This model legislation was presented to Ministers of Legal Affairs and Attorney Generals in the region in 2015, but to date has not been adopted by Trinidad and Tobago.

Table 1 provides a summary of the evidence related to these interventions.

Table 1: Key Findings from Primary Studies and International Reports

Category of finding	Legislative Review to remove legal and policy barriers to SRH services and protect and promote adolescents' sexual and reproductive health and rights
Benefits	In studies conducted in 2004 and 2005, it was determined that mandated parental consent for access to contraception would likely result in risky sexual behaviour with a resulting increase in teenage pregnancy (46,47). Additional studies (48) found that 59% of girls would completely stop using SRH services if parental consent was necessary. A PAHO report (2013) suggested that in dealing with adolescents and SRH services, the Gillick Competence Model be used, whereby physicians assess the competence level of the adolescent and provide medical care based on the patient's level of understanding around the issues (45). The UN Committee on the Rights of the Child (CRC) in 2016 stated UN member states should introduce legislation to recognise the rights of adolescents, specifically the right of adolescents to make decisions in respect of their health. The report also noted that there should be no barriers to SRH information and counselling such as third-party consent (49). Further, a WHO publication (50) noted that member states are obligated under human rights laws to provide comprehensive SRH education and contraceptives to all adolescents and that barriers to uptake (such as third-party authorisation) should be removed. The recommendations went on to state that laws and policies to support adolescent access to SRH services without parental notification are critical. Three countries in Africa have made legislative provision for the age of consent to HIV testing and counselling from 12 years. The UNFPA noted that where laws support adolescent SRH rights, this can delay sexual debut by encouraging and enabling informed decision-making (51). In South Africa, SRH rights are outlined in section 27 of their Constitution. This legislation states that "everyone has the right to have access to health care services, including reproductive health care". As such, HIV

Category of finding	Legislative Review to remove legal and policy barriers to SRH services and protect and promote adolescents' sexual and reproductive health and rights
	testing, medical treatment (inclusive of PreP: pre-exposure prophylaxis) and contraceptives can be provided to persons 12 years and older (52). Literature notes that through legislative reform, South Africa has provided an enabling environment for adolescents to access SRH and HIV prevention interventions (53). The UNFPA (13) noted that there were significant barriers to the uptake of SRH services by adolescents in Caribbean countries, particularly, legislative barriers. Following this, model legislation was developed specifically to reduce these barriers and increase uptake of services. This model legislation was developed for use in OECS states and can be used to inform legislative change in Trinidad and Tobago.
Potential Harms	None identified
Cost and/or cost-effectiveness	None identified
Uncertainty regarding benefits and potential harms (monitoring and evaluation would be warranted if the element is pursued)	None identified

Element 2 – Organisational Level – Implementation of adolescent friendly facilities; training for health care workers; and strengthening of the HFLE Programme

At the organisational level, the following interventions have been identified to enhance access and availability of adolescent SRH services and improve the SRH outcomes of adolescents:

3) The implementation of adolescent-friendly facilities/clinics:

   Reviews demonstrated that youth-friendly family planning sites or services were effective in improving adolescent sexual health outcomes (14,22). It is proposed that existing health facilities should implement specialised clinics or visiting hours to treat with adolescent health needs. It is expected that this would increase adolescent utilisation of public health systems. Health facilities already have functional SRH clinics on specific days. These clinics can be tailored to allow specific hours or areas (rooms) to deal with adolescent SRH services. This is a much more cost-effective method of providing SRH care to adolescents rather than developing new facilitates to address adolescent-specific needs, as existing facilities and staff can be utilised.

   Additionally, it is important to consider the accessibility of adolescent-friendly facilities to the persons living with disabilities. Accessibility is not limited to infrastructure but also includes existing policies and specific challenges these persons face when accessing SRH services.

4) Training for health care workers:

   Pre- and In-service training is strongly encouraged as this could greatly reduce the stigma faced by adolescents when attending public health facilities. Systematic reviews noted that increased training on adolescent sexuality and needs improved the attitudes, behaviour and subsequent treatment meted out to adolescents by HCWs (15,35). Training can be integrated into existing programmes. Because human and physical resources are low, utilising current staff and materials may create more buy-in. Continuous training is also an avenue for HCWs to learn how to treat with the unique needs of adolescents.

5) Strengthening of the Health and Family Life Education (HFLE) Programme:

   Of all the elements reviewed, school-based education programmes were found to have the greatest positive effect on changing adolescent behaviour (16–20). The reviews also found that SRH education in schools did not increase sexual activity or decrease the age of sexual activity initiation (21) – a point which is frequently raised when advocating for the elimination of SRH education in schools. Educational programmes are the most significant tool that can be employed in any government's attempt to reduce the negative SRH outcomes being experienced by adolescents.

   The Health and Family Life Education Programme is currently undergoing a review by the Ministry of Education (body responsible for provision of HFLE in schools). The government can build upon the review by ensuring that medical professionals are engaged in setting the curriculum for the programme as well as ensuring that the programme is delivered in

all schools across the islands. Once this review has been completed, the MoE hopes to secure funding to create dedicated teaching positions in primary and secondary schools to deliver the HFLE programme.

In tandem with the HFLE review, the MoE is also developing Parental Guidelines which will be used to sensitise parents and guardians on the HFLE programme and its importance. It is hoped that with increased knowledge among parents, this will eliminate some resistance to the delivery of the HFLE programme that is currently encountered by teachers in the form of parents who are unwilling to have schools provide SRH education to their children.

Table 2 provides a summary of the evidence related to these interventions.

Table 2: Key Findings from Systematic Reviews

Category of Findings	Adolescent friendly facilities; training for health care workers; and strengthening of the HFLE Programme
Benefits	Adolescent Friendly Facilities One moderate-quality systematic review found that youth-friendly family planning services (defined as specialised clinic hours for youth, with providers with specialised training in adolescent health) had a positive effect on reproductive health outcomes, specifically reducing teen pregnancy, increasing contraceptive use and increasing knowledge levels (14). Training for HCWs One high-quality systematic review found evidence that interventions/ training to improve the attitudes and behaviours of health care workers was likely to improve healthcare facility/service utilisation by adolescents (15). The review noted that training should specifically cover adolescent SRH and contraceptive needs. Strengthening of HFLE Programme Five systematic reviews (including two moderate- and two high-quality) found that school-based programmes can result in increased knowledge levels of students about good sexual and reproductive health (16–20). One high-quality systematic review found that school-based health services were not associated with increased sexual activity or earlier initiation of sexual activity; additionally, there was a reduction in teenage births (21). Multi-Component Interventions Two high-quality reviews indicated that there was good evidence that multicomponent interventions (school education programmes, parent involvement and community engagement) were effective in promoting good sexual health, reducing teenage pregnancy and reducing risky behaviours (24,25). Two moderate-quality systematic reviews found that school-based interventions alone are ineffective in improving sexual and reproductive health outcomes (reducing the incidence of HIV, STI and pregnancy) in

Category of Findings	Adolescent friendly facilities; training for health care workers; and strengthening of the HFLE Programme
	adolescents (23), but rather that these interventions were successful when combined with other interventions such as youth-friendly health facilities (22). One systematic review found that a combination of approaches, particularly training for health workers, adolescent-friendly health facilities, and a community-wide SRH education campaign could improve health outcomes and positive behavioural changes in adolescents (17).
Potential Harms	None identified
Cost and/or cost-effectiveness	One review found that providing specialised youth-friendly clinical SRH services was expensive, because the uptake was lower than anticipated to be economically feasible (in cases where the facilities only provided services to adolescents, and no other clients) (54).
Uncertainty regarding benefits and potential harms (monitoring and evaluation would be warranted if the element is pursued)	<u>Adolescent-Friendly Facilities</u> One moderate-quality review noted that studies on the efficacy of youth-friendly facilities were prone to a high risk of bias due to low response rate and data being reported by facility managers rather than clients/ users (14). One high-quality review which focused on low and middle-income countries concluded that there were pre-existing obstacles to the uptake of SRH services provided at youth services, which resulted in low uptake of services. The review noted that these centres would be more successful if providing other services in tandem with SRH (54). One systematic review noted that there was uncertainty on what factors/ dimensions youth prioritised (would produce the most beneficial outcomes) in the development/utilisation of youth-friendly facilities, and as such, the impact of youth-friendly facilities on SRH outcomes was also uncertain (55). <u>HFLE</u> Uncertainty in one of the high-quality systematic reviews examined comes from the fact that this review drew on evidence exclusively from the United States (25). Three systematic reviews indicated notable uncertainty: One high-quality systematic review noted that there was uncertainty in the efficacy of school-based interventions as the follow-up assessments were short and did not track behaviours when adolescents became more sexually active (19). One moderate-quality systematic review noted that the only effective school-based programmes were ones that spanned a number of years and started when children/students were very young (17). Another review found that school-based interventions, while effective, did not have as large/consistent effects as previously expected (18).

Element 3 – Individual & Community Level - SRH sensitisation and training for parents and community; societal awareness; and utilisation of digital platforms

Societal taboo around SRH and adolescents ignores the facts which are reflected in local studies, in that children are engaging in sexual activity well below the age of 18. As such, much work needs to be done to change the views of society on adolescents and SRH, so that the negative SRH stigma and outcomes currently being experienced by adolescents can be addressed and eliminated. This policy brief acknowledges that shifting societal attitudes is an integral part of changing the current narrative with regards to adolescents and SRH, and as such, it is proposed that:

1) Parents and the general community need to be sensitised on the SRH issues facing adolescents, and there is a need for adolescents to access comprehensive SRH services.

   Research showed that theory-based, face-to-face interventions between parents and health care professionals yielded success in changing attitudes of parents towards adolescent sexual health (22). In most cases, these sessions not only taught parents how to treat with adolescent SRH needs, but additionally, parent-child communication (26,27), decision making, early-intervention at pre-adolescence, parental awareness, societal norms and setting family rules and boundaries (28). The programmes with the most success were ones that ran for multiple sessions (7-14 hours) and had opportunities for follow-up with clinicians or the HCW providing the intervention (22). The research clearly showed that parent-focused interventions resulted in significant positive changes in youth sexual behaviour (29,30).

2) Social media and digital platforms should be utilised as the key vehicles to transform the way adolescents can access SRH education and to assist in changing societal attitudes.

   One example of this is the use of apps to provide SRH education and counselling (31,32). The Family Planning Association of Trinidad and Tobago has an app called “Youth Connect” with a live chat feature that adolescents can use to get advice, information, educational material and counselling referrals for SRH issues. The existence of this app however, is not widely known. Public promotion and expansion of the scope of this app can increase adolescents’ knowledge level of SRH and eliminate the need for some adolescents to visit health facilities.

Table 3 provides a summary of the evidence related to these interventions.

Table 3: Key Findings from Systematic Reviews

Category of Findings	SRH sensitisation and training for parents and community; societal awareness; and utilisation of digital platforms
Benefits	SRH Sensitisation/Training for Parents Six systematic reviews (four moderate- and two high-quality) found that programmes geared towards increased parent-child communication resulted in improved sexual knowledge (22,26,27), and reduced risky sexual behaviours (29,56). Notably, parent training also resulted in decreases in unprotected sex, delay in sexual initiation and decrease in frequency of sexual activity (29,30). In the papers reviewed, the parent training interventions that were found to be most successful were on average 7 hours long and focused on increased parent-child communication, parental monitoring and supervision, family support,

Category of Findings	SRH sensitisation and training for parents and community; societal awareness; and utilisation of digital platforms
	improved youth decision-making and self-control, and increased comfort with sexual-health discussions. <u>Utilisation of Digital Platforms</u> Two high-quality systematic reviews showed modest results for behavioural change attributed to mobile interventions (texting services and use of apps) for contraceptive use (31,32). Two systematic reviews (one moderate-quality) indicated that SRH knowledge levels (on condom use, STI and HIV transmission, and pregnancy) were significantly increased when using new media, such as text-messaging and social networking sites (33,34). One moderate-quality review found that text messaging campaigns were not only successful in improving SRH knowledge, but also in decreasing the incidence of unprotected sex, and increasing STI testing (57).
Potential Harms	None identified
Cost and/or cost-effectiveness	None identified
Uncertainty regarding benefits and potential harms (monitoring and evaluation would be warranted if the element is pursued)	<u>Utilisation of Digital Platforms</u> Three reviews (including one moderate- and one high-quality) noted that research on the use of new media in promoting healthy SRH in adolescents was limited as it is an emerging field. Long-term studies to determine the change in behavioural outcomes was lacking, and sample sizes were smaller than ideal (32–34).

Implementation Considerations

Barriers to implementation of each element have been identified at the system, organisational, professional (health care workers) and patient/community levels. Counterstrategies are proposed.

Level	Barriers	Counterstrategies
System	There may be a lack of political will to adopt the model legislation that removes the barriers (parental consent requirement) which prevent adolescents from accessing SRH services and care.	Changed societal perceptions can encourage/ facilitate the government or ruling political party's willingness to make the necessary legislative changes. This can be achieved through public education campaigns that highlight the extent of the current problems being faced with respect to adolescent SRH and the subsequent negative outcomes. These campaigns may reduce the public's aversion to allowing adolescents to access safe SRH services and care (25,35).
	Inadequate collaboration between Ministry of Health and Ministry of Education hinders the provision of relevant and comprehensive SRH education in schools.	The HFLE Programme should be revised to reflect collaboration between the Ministries of Health and Education, to ensure materials are updated and aligned to the needs of adolescents.
	In the utilisation of digital platforms to spread awareness, the MoH may be of the view that there is insufficient funding to hire new staff to manage and monitor these social platforms.	As aforementioned, the Family Planning Association of Trinidad and Tobago has an app which focuses on adolescents and SRH. Research indicates that apps such as these should at minimum include: correct usage of contraceptives to prevent pregnancy, pregnancy risk of sexual activity, and SRH communication (including negotiation and refusal) for successful outcomes (58). The Ministry of Health can collaborate with the FPATT to expand the scope and offering of this app. to provide more comprehensive SRH education and care to adolescents. As this app was previously in use, the cost to expand its scope would be significantly lower than formulating a new app or platform. Additionally, the management of the app can be shared between the FPATT and the Corporate Communications Department of the MoH, who is already responsible for all social media and digital campaigns. The use of mobile apps has been shown to be effective due to its ability for widespread dissemination and the privacy provided (59).
Organisational	Some health facilities may already be so heavily utilised that they may be unable to find/schedule time to host adolescent-only clinics.	Local health system research or utilisation reports may be of use in determining which facilities can offer adolescent-only clinics. Only selected facilities (not all) should offer these clinics with an equitable geographical distribution, to ensure all adolescents are able to attend these clinics if necessary.

Level	Barriers	Counterstrategies
Professional / Health Care Workers	With the replacement of mandatory parental consent by the Gillick Competence Model, some HCWs may still be unwilling to provide SRH services and care to adolescents (stigma and discrimination).	Pre- and in-service training for HCWs that focuses on the specific needs of adolescents will serve to counter negative attitudes towards adolescents and can make HCWs more willing to care for adolescents and their SRH needs (14). HCWs are an essential aspect of improving adolescent access to SRH services, but in some research HCWs noted discomfort with their competence level in dealing with adolescent health; however HCWs also noted that this may be mitigated with appropriate training (36).
	There may be unwillingness by established HCWs to attend/ utilise adolescent-specific training.	In-service training can be made mandatory by the regulatory body (MoH) or health facility as part of the HCW's continuing education. Research has shown that HCWs with more education on adolescent health and those who had received continuing education on adolescent sexuality had more youth-friendly attitudes and were in support of SRH care for youth (15).
Patient / Community	Parents may oppose the removal of mandatory parental consent and its replacement by the Gillick Competence Model.	Strong political will and public education campaigns on adolescent SRH needs/ issues can serve to change parental views on their children accessing selected services at public health facilities. Research demonstrated that interventions involving parents led to improved knowledge levels and attitudes towards adolescent SRH (27). Other reviews noted that both parent involvement and community education programmes were effective in changing attitudes towards adolescents accessing SRH services (35).
	Religious bodies, their respective schools and parents may be unwilling to have the HFLE programme taught in their schools.	Political will is needed to enforce the teaching of HFLE in all schools in Trinidad and Tobago. Additionally, public education campaigns on the current scenario regarding adolescents and SRH, the issues faced by adolescents in accessing SRH services and the SRH needs of adolescents may go a long way in removing the resistance to having SRH education taught in schools (especially for parents). Research indicated that public education campaigns improved community acceptance of adolescents' access to SRH (35).
	While SRH training and sensitisation may be offered to parents and the public, there may be unwillingness by the public to participate (low uptake). Societal norms may be difficult to change (36).	These trainings may be offered through NGOs and other CBOs in the first instance. Numerous organisations have existing training programmes for parents and this can be an avenue to reach these individuals until the training is more widely accepted. Improving uptake of SRH services by adolescents can be achieved not only by improving the quality of health care but also by improving community support for adolescent SRH access (36). In tandem, while training sessions are ongoing, public education campaigns, through print, television and radio can be utilised to both: get by-in for the training

Level	Barriers	Counterstrategies
		sessions and to educate the population on the issues and steps being taken to correct them.

Next Steps

The aim of this evidence brief is to foster dialogue informed by the best available evidence, and thereafter inform policy on improving access to adolescent SRH services in Trinidad and Tobago. The intention is not to advocate specific policy elements or forego discussion. Further actions will follow review of this evidence brief, and will include:

- Deliberation among policymakers and stakeholders regarding the problem, policy elements and implementation considerations described in this policy brief, in the form of a Stakeholder Dialogue.

- Refining elements based on the Dialogue, for example by adding, removing or modifying components.

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Evidence Brief for Policy

Providing targeted access to sexual and reproductive health services to adolescents in Trinidad and Tobago

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