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Caribbean Centre for Health Systems Research and Development
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Stakeholder Dialogue Summary

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

APRIL 2022

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REPORT:
STAKEHOLDER DIALOGUE SUMMARY

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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 (The UWI), 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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Dialogue

The Stakeholder Dialogue on *Providing targeted access to Sexual and Reproductive Health Services to Adolescents in Trinidad and Tobago* was held virtually on February 24, 2022. The Stakeholder Dialogue was co-facilitated by Professor Donald Simeon, Director (CCHSRD), Ms Shelly-Ann Hunte, Research Fellow (CCHSRD), and Ms Kershelle Barker, Junior Fellow, Evidence Synthesis (CCHSRD).

The views expressed in the Dialogue Summary are the views of the Dialogue participants and should not be taken to represent the Evidence Brief for Policy (EBP) Team or CCHSRD.

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Preamble

PREAMBLE

The CCHSRD's Stakeholder Dialogue was convened virtually (via the *Microsoft Teams* platform) on February 24, 2022, to discuss providing targeted access to Sexual and Reproductive Health Services to adolescents in Trinidad and Tobago. The dialogue hosted 13 diverse stakeholders from different sectors and multi-disciplinary backgrounds to ensure richness of discussions. These included representatives from:

- Ministry of Health
- Ministry of Education
- Faculty of Medical Sciences, The University of the West Indies (The UWI)
- Trinidad and Tobago Medical Association (TTMA)
- Trinidad and Tobago Unified Teachers Association (TTUTA)
- Family Planning Association of Trinidad and Tobago (FPATT)
- Concerned Parents Movement of T&T (CMPTT)

The Stakeholder Dialogue was facilitated by Professor Donald Simeon, Director (CCHSRD), Ms Shelly-Ann Hunte, Research Fellow (CCHSRD), and Ms Kershelle Barker, Junior Fellow, Evidence Synthesis (CCHSRD).

Prior to the deliberations, an animated video was presented, summarising the findings of the pre-circulated Evidence Brief for Policy (EBP), i.e., the problem, policy elements to address the problem, and implementation considerations.

Box 1: BACKGROUND TO THE STAKEHOLDER DIALOGUE

The Stakeholder Dialogue was convened to facilitate a full discussion of relevant considerations (including research evidence) about a public health issue to inform action.

Key features of the dialogue were:

1) Addressing a high priority health issue being faced in Trinidad and Tobago;
2) Informed by a pre-circulated Evidence Brief for Policy that synthesised both global and local research evidence about the problem, underlying factors, policy elements and key implementation considerations;
3) Informed by a discussion about the full range of factors that can inform how to approach the problem and ways to address it;
4) Brought together parties who would be involved in or affected by future decisions related to the issue;
5) Ensured fair representation among policymakers, researchers and stakeholders;
6) Engaged facilitators to assist with the deliberations;
7) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
8) Did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the Dialogue. The Dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The Dialogue was also designed to generate action by those who participated in the Dialogue and by those who receive the Dialogue Summary.

Deliberations about the Problem

Framing the Problem

Dialogue participants discussed the overall framing of the problem of legal, organisational, and societal barriers faced by adolescents when accessing quality Sexual and Reproductive Health (SRH) education and services. Participants acknowledged the existence of the problem in Trinidad and Tobago (T&T) and agreed on the need to address it. The following are key points from the discussions on the research evidence presented in the Evidence Brief for Policy (EBP) and stakeholders' suggestions for strengthening the framing of the problem, including its magnitude.

Some participants highlighted that some of the data/information used to inform the magnitude of the problem was dated and agreed to share updated statistics. For example, one stakeholder stated that the Central Statistical Office (CSO) released statistics for the period 2012 to 2018, which revealed a decline in adolescent pregnancies and related deaths. One participant suggested that the decrease in recorded teenage pregnancies might be due to home deliveries among younger adolescents, resulting in unregistered births (until the child was ready to enter primary school). Another participant speculated that an increase in abortions might have also contributed to the decline.

One participant suggested that younger adolescents (10-15-year-olds) should not be grouped with older adolescents i.e.,16/17-year-olds and "adults" – 18/19-year-olds. The latter were able to consent to SRH services, and there was dialogue surrounding the legal barriers faced by 19-year-olds.

Participants suggested that terms like "a lack of" and "there is no" should be avoided, as work was being done to develop plans/policies for adolescent health. Additional resources were shared, including the:

(i) National Sexual and Reproductive Health Policy for Trinidad and Tobago;
(ii) Legal Barriers that affect Adolescent Access to Sexual and Reproductive Health Services in Trinidad and Tobago;
(iii) National Child Policy 2020-2030;
(iv) National Policy on Sustainable Community Development 2019-2024; and
(v) Social Sector Investment Programme 2022 – Resilience in the Face of a Global Pandemic.

Stakeholders agreed that there was no specific **adolescent** sexual reproductive health plan or strategy, however, there was 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. Additionally, one stakeholder mentioned that healthy school initiatives and new policies were being developed.

One stakeholder shared the progress made by other Caribbean countries regarding access to adolescent SRH services. Guyana adopted the Gillick Competence model, while St. Lucia and St. Vincent and the Grenadines explicitly set the age for autonomous access to SRH services at 16. Internationally, countries in Africa (such as Malawi, South Africa, and Uganda) had set the

age of consent for HIV testing at 12. It was suggested that the successes on an international and regional level should be used as examples to bolster action in our local context.

Several stakeholders suggested additional related issues – not mentioned in the EBP – that should be considered when discussing the problem:

- There was no mention of adolescent fathers. These boys and their needs and challenges should also be addressed.
- With teenage pregnancy, the fathers were not always teens, which had its own challenges and legal considerations.
- Emotional and psychological support was needed in cases of teenage pregnancy in which both parents still attended school. They faced stigmatisation, which usually resulted in decreased focus on school, mental health challenges and increased dropout rates or transfers to new schools.
- Socio-economic trends (in outcomes, barriers etc.) among adolescents should be explored.

Underlying Factors

Participants then proceeded to discuss the factors underlying the problem, at the governance, financial, and delivery arrangements levels. Stakeholders expanded on the multi-level underlying factors:

- Legislation restricted persons below the age of 16 from accessing SRH services without parental consent or attendance. Stakeholders expressed that changing this legislation would also require amendments to other existing laws and policies.

- The Trinidad and Tobago Children's Act of 2012 mandated that health care workers (HCWs) were legally required to report incidents of sexual activity in persons below the age of 18, and this often resulted in HCWs' reluctance to treat adolescents. One stakeholder added that in schools (especially in smaller communities) teachers were hesitant to report student pregnancies, leading to decreased perpetration and enforcement of the law.

- There was no specialised document/agenda/plan/policy to address the issues faced by adolescents in accessing SRH services. One participant referred to the National Sexual and Reproductive Health Policy, which was finalised in August 2020, however, this policy included only one paragraph on SRH that addressed adolescents.

- SRH education was provided in schools by the Ministry of Education (MoE) through the Health and Family Life Education (HFLE) programme. The EBP mentioned a lack of involvement from the Ministry of Health (MoH), however, stakeholders assured that there was a working relationship between the MoE and MoH in this regard. In particular, the Ministries collaborated on the revision of the HFLE curriculum in 2013, and had been

working on school programmes (through the Regional Health Authorities). There was still need for a stronger partnership and this had also been highlighted by several joint/collective committees convened to address SRH issues. One stakeholder suggested that the Ministry of Social Development and Family Services should also play a critical role.

- Additionally, there were no existing teaching positions for the HFLE programme, so it was only delivered if a teacher volunteered. Dialogue participants agreed that this was a barrier to the institutionalisation of the HFLE programme in secondary schools. One stakeholder shared that in primary schools, this was an even greater challenge as teachers were expected to cover the 'basics', which excluded information on reproductive health and adolescent wellness that was pertinent to students of Standards Four and Five.

- The EBP stated that there were no youth-friendly facilities or clinics for adolescents to access SRH services tailored to their unique needs. However, one stakeholder suggested rephrasing the status of service delivery locations from "no" to "limited" as:
  (i) The FPATT had a youth-focused clinic, "The Living Room" which was designed by and for adolescents, and targeted sexual health;
  (ii) Health Visitors from the RHAs had arrangements with schools to provide education and services; and
  (iii) Several RHAs had adolescent health clinic services.

- Societal conventions in T&T still predominantly considered sexual activity in adolescents as taboo. One stakeholder stressed the need for further national dialogue in terms of destigmatising sexual and reproductive health. A societal 'paradigm shift' was necessary to diminish existing challenges around the delivery of SRH programmes in secondary schools.

Deliberations

Deliberations about the Policy Elements to Address the Problem

Dialogue participants discussed the three elements that were examined in the Evidence Brief for Policy (EBP).

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

Stakeholders deliberated on the evidence for removing or reducing the effects of legislative barriers to improve adolescents' access to SRH services at health facilities. Two pathways were highlighted in the EBP: i.e., (i) the use of the Gillick Competence Model; and (ii) the implementation of the UNFPA's model legislation "Reproductive Health Care Services and Protection Bill", which was presented to Ministers and Attorney Generals in the region in 2015, but was yet to be adopted by T&T.

Dialogue participants agreed there was a need for legislative changes, and this would require amendments to several other policies and acts, such as the Sexual Offences Act and Marriage Act. The latter was important to address due to the issue of underaged marriages (supported by some religious organisations) that contributed to teenage pregnancies. Several participants agreed that trained and experienced persons must be brought in to guide such a process.

Another stakeholder noted that legislative changes would also impact curriculum amendments, so revisions would have to coincide, i.e., education curricula would need to be updated to reflect legal updates.

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

Dialogue participants deliberated on the second policy element and agreed on its importance and relevance.

<u>Adolescent-friendly Facilities</u>

One stakeholder shared that it was important to consider the accessibility of adolescent-friendly facilities to the differently-abled and persons living with disabilities. They added that accessibility was not limited to infrastructure but also included existing policies and specific challenges these persons face when accessing SRH services.

Training for Healthcare Workers

One participant stated that the HIV/AIDS Coordinating Unit (HACU) had delivered HIV training to sensitise HCWs about stigma and discrimination. However, they stated that the target audience was limited, and such training should be expanded to include social workers, guidance counsellors, and auxiliary staff (security, administrators, etc.). HACU expressed interest in collaborating with other units within the MoH or even MoE to establish training in adolescent health within health and education systems.

Stakeholders suggested integrating training into existing programmes. Because human and physical resources were limited, utilising current staff and materials might create more buy-in.

Strengthening of the HFLE Programme

One participant shared that the results of a Needs Assessment (NA) in private secondary schools indicated that the implementation of a comprehensive sexual education programme was best placed within the HFLE curriculum. Additionally, the NA highlighted the importance of preparing academic and administrative staff to serve/interact with adolescents seeking SRH services.

Participants also highlighted the need to demystify the HFLE Programme to address the common misconception that it was sexual education. More accurately, there were four modules of the programme, and SRH is only one part. Addressing this misconception through sensitisation/education could potentially improve the programme's rollout and uptake.

Participants also noted that some teachers lacked the confidence to deliver the SRH topics, and therefore required more support. Additionally, given there were no teachers officially assigned to deliver the HFLE Programme, one participant suggested that health officers, officers from the Student Support Services Division (MoE), school social workers, and guidance officers needed to be empowered to deliver the curriculum. This required lobbying for increased manpower in student support services, and consequently, ensuring they were equipped to provide support to students.

Element 3: Individual & Community Level – SRH sensitization and training for parents and community; societal awareness; and utilization of digital platforms

The stakeholders deliberated on the evidence for policy element 3, highlighting work that had been done locally.

SRH Sensitisation and Training for Parents and Community

Stakeholders proposed that SRH sensitisation and training should also include training for teachers and Faith-Based Organisations. They indicated that Draft Parental Guidelines had been prepared for the HFLE Programme in collaboration with Faith-Based Organisations, and was under review by the Central Executive Team of the MoE. One stakeholder stated that the Student Support Services Division also engaged in sensitising parents, making this Division well-suited to collaborate in implementing the guidelines.

One stakeholder also highlighted FPATT's ongoing work in adolescent SRH education. It was thought to be the organisation best poised to lead civil society engagement.

Stakeholders identified the Ministry of Social Development and Family Services (with its National Parenting Policy) and the Ministry of Sport and Community Development (which was implementing community parent programmes) as key stakeholders to improve SRH service use.

Utilisation of Digital Platforms

Stakeholders agreed that social media platforms would be ideal for reaching the target population, due to their popularity among young people. Stakeholders suggested the use of a communication blitz (non-stop messaging) to provide SRH education and resources to adolescents.

The FPATT's Youth Connect App, which was developed by the UNFPA, approved by the Ministry of Health, and further endorsed by the Ministry of Education, had a number of critical features which would help address many SRH issues. These included a live chat where adolescents could receive information in real time, as well as location finders for clinics. There were challenges to the optimal functionality and utilisation of the app, namely:

- The hosting subscription had expired and needed to be renewed;
- The app required further development;
- Marketing was needed to increase awareness of the app; and
- Internet access was required to use the app, which limited use by adolescents without data/ internet connection.

Stakeholders confirmed that all three policy elements adhere to the UNFPA'S eight standards for adolescent health care and as such, could be endorsed.

Implementation Considerations

Following the policy elements, the stakeholders deliberated on and agreed with the barriers and counterstrategies identified in the EBP.

One stakeholder suggested that continued networking and communication/ additional dialogue was necessary to review and agree on actioning the policy elements. Another suggested engaging school groups to obtain adolescents' perspectives would be critical to determine next steps, discuss strategies and obtain solutions to address barriers related to SRH.

Participants also shared the following additional potential barriers to implementation of the policy elements:

- Parents' fear/concern that they were losing control over what information was presented/taught to their children – To overcome this, collaboration between educators and parents was needed. Public education campaigns should focus on parents' attitudes and feelings toward SRH and the importance of understanding adolescents' SRH needs.

- Schools governed by religious organisations were reluctant to allow SRH workers to address students – Faith-Based Organisations should be included in training and sensitisation efforts.

Next Steps

Recommendations & Next Steps

The deliberations around the policy elements were successful in obtaining agreement among the different stakeholders for the need for action. All three policy elements were considered to be appropriate, feasible and necessary to address the problem.

When asked to set priorities on which elements to focus on, there were two views:

(i) Existing policies do not take precedence over legislation, and legislative changes would inform the curriculum and other changes, so this must come before programs are rolled out. Therefore, Policy Element 1 should be prioritised to ensure other efforts are not wasted.

(ii) Alternatively, legislative review would be the most difficult and time consuming to address. Therefore, Policy Elements 2 and 3 should be prioritised as they could be implemented more quickly.

The recommendations and next steps covered a few actions that could be implemented immediately and others that could be considered for implementation at a later stage. These included:

Recommended Action	Stakeholders Involved
System (Regulatory and Policy) Level	
Obtain legal expertise to initiate/guide the process to adopt the model legislation that removes the parental consent requirement for adolescents to access SRH services and care	→ Ministry of Attorney General and Legal Affairs → Ministry of Health (MoH)
Collaborate to expand the scope and offering of the Family Planning Association's "Youth Connect" app to provide more comprehensive SRH education and care to adolescents	→ MoH → Family Planning Association of T&T (FPATT) → NGOs
Organisational Level	
Institutionalise the HFLE Programme by addressing misconceptions and hiring dedicated teachers	→ MoH → Ministry of Education (MoE) → Associations
Expand the distribution of adolescent-only SRH clinics	→ MoH → Regional Health Authorities (RHAs) → NGOs
Professional (Health Care Workers) Level	
Implement/Offer pre- and in-service training for HCWs that focuses on the specific health needs of adolescents	→ HIV/AIDS Coordinating Unit (HACU), MoH → RHAs

Recommended Action	Stakeholders Involved
Patient/Community Level	
Increase SRH training and sensitization to parents, educators, and the public	→ FPATT → MoH
Obtain the voice of adolescents (e.g., school groups, youth groups) on the EBP content, to understand the perspective and lived experiences of those directly affected	→ MoH → Children's Authority of Trinidad and Tobago → NGOs → Associations → Academic Institutions

The CCHSRD Dialogue Summary along with the revised Evidence Brief for Policy would be shared with stakeholders for use by each stakeholder organisation as a road map for action to improve the provision of targeted access to SRH services to adolescents in T&T. Stakeholders to communicate internally and externally with relevant Ministries, agencies, departments, and NGOs to advocate for improvements to SRH service delivery and public education through the proposed policy elements and actions. Relevant stakeholders and experts would be engaged in the process.

An implementation plan is to be developed to operationalise the recommendations that were agreed upon and accepted by the key stakeholders. Joint ownership of the plan was required to move forward.

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