Socio-Cultural and Programmatic Contextual Influences on Adolescents' Sexual and Reproductive Health Help-Seeking Behaviour in Grenada

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Acknowledgements

Dedication

This thesis is dedicated to the memory of:

Nancy Swortzell, PhD – scholar, dear friend, and generous spirit

&

Louise and Sylvester Charles - my grandparents

You would have all been proud.

To my parents, Louisa and Bedell Frame

You keep me grounded. I love you.

Abstract

The response to ASRH has been *ad-hoc* in the Caribbean island of Grenada, with the exception of sexuality education offered by schools and a few non-governmental organizations. No SRH policy or services specifically for adolescents exist, and pertinent legislations have age and gender gaps. Additionally, adolescent sexuality is taboo and adolescents experience various negative SRH outcomes. Therefore, it is critical to understand adolescents' help-seeking behaviours to cope with their SRH concerns, to inform the design and implementation of adolescent-friendly services and policies

The aim of this thesis is to understand how adolescents aged 16-19 in Grenada perceive the socio-cultural and programmatic contexts as it relates to facilitating and hindering their help-seeking behaviour for sexual and reproductive health concerns. The research was guided by an ecological help-seeking framework and used an exploratory, qualitative constructionist approach. During 2009 and 2010, focus groups and semi-structured interviews were conducted among male and female adolescents in a rural and an urban community, and in two institutions for: 1) boys who are out-of-school, and 2) pregnant or adolescent mothers. Key informant interviews were conducted with organizational stakeholders, focus groups with key community members, and pertinent legislative, policy, and program documents were reviewed. Data were analyzed using framework analysis, managed in NVivo 8 software.

The study found that adolescents pathways to help-seeking involves the complex processes of a) identifying the SRH concern, b) identifying a need for help, c) seeking and accessing help and, d) assessing the help received. Mothers and other female relatives play an important role in all stages of the help-seeking. The socio-cultural and programmatic contexts interacted to primarily hinder adolescents' SRH behaviours at all stages of their help-seeking pathways. Desirable characteristic of sources of help are identified, and recommendations are suggested to improve ASRH help-seeking and help-giving in Grenada. It is hoped that by providing coordinated, comprehensive, and effective interventions, local stakeholders can address the key contextual factors to help adolescents cope successfully with their SRH concerns.

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Acronyms

AH	Adolescent Health
ART	Agency for Rural Transformation
ASRH	Adolescent Sexual and Reproductive Health
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community Based Organization
FBO	Faith Based Organization
GOG	Government of Grenada
GRENCODA	Grenada Community Development Organisation
GRCS	Grenada Red Cross Society
GSHS	Global School Health Survey
GYVS	Grenada Youth Volunteer Service
HCCS	Health Care and Counselling Services
HFLE	Health and Family Life Education
ICPD	International Conference on Population and Development
IE	Information and Education
LAC	Latin America and the Caribbean
PAHO	Pan American Health Organisation
PAM	Program for Adolescent Mothers
PTA	Parent Teacher Association
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social Development
NEWLO	New Life Organization
NGO	Non-Governmental Organization
NIDCU	National Infectious Disease Control Unit
NPP	National Parenting Program
RH	Reproductive Health
SRH	Sexual and Reproductive Health
UOL	University of Leeds
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organisation

Chapter 1 – **Introduction**

1.1   Introduction

This study explores the context of adolescent sexual and reproductive health (SRH) help-seeking behaviour in Grenada. This chapter serves as an introduction to the thesis by providing the background and rationale of the study. Section 1.2 provides a general overview of adolescent sexual and reproductive health (ASRH). In section 1.3 an overview of the Grenada context is provided as it relates to ASRH. In section 1.4 an overview of the main focus of the study including the research questions and objectives is provided. The chapter concludes with an overview of the structure of thesis in section 1.5.

1.2   Adolescent Sexual and Reproductive Health

The concept of adolescence is a social construction of modern society, and has cultural connotations (UNICEF, 2001). Adolescence is commonly understood to define the period of life between childhood and adulthood (Kaplan, 2004); however, adolescence can be defined differently in law, public policy or social perception (Bailey and Charles, 2008) within and between cultures. Although the United Nations define adolescents as persons between ages 10-19 years (UNICEF, 2012), adolescents are not a homogenous group. Each individual experiences the period of adolescence "differently depending on her or his physical, emotional and cognitive maturation as well as other contingencies" (UNICEF, 2011 p.8). While puberty can be viewed as a clear demarcation between childhood and adolescence, puberty occurs at different points for girls and boys, and may begin earlier for some girls than others (UNICEF, 2011). Therefore puberty as the marker of puberty can be a misleading demarcation; nonetheless, it can be usefulness for SRH.

Within Western culture adolescents are expected to achieve autonomy, identity and independence as a result of a culture of individuality. In contrast, in collectivist cultures such as those found in Asia, Africa, and Latin America and the Caribbean (LAC), values are placed on tradition, conformity, obedience, and fitting into family and society (Kaplan, 2004). However, not all countries or cultures have clear rites of passage to delineate the transition between childhood and adulthood. For example, there are different ages at which individuals are able to perform certain tasks associated with adulthood. The marriageable age without parental

consent in Grenada is 21 years, while the legal age for drinking alcohol and for voting is 18 years, the age for giving consent for sexual activity is age 16 for girls and not required for boys, and there is no legal age for consenting to medical treatment without parental consent. Although there is no cultural rite of passage in Grenada, graduation from secondary school appears to be the socially acceptable stage/transition (usually 16-18 years) for engaging in the above activities. This diversity in defining adolescence has implications for the SRH of adolescents.

Additionally, the diversity in definition, compounded by the interchangeable use of adolescents with youth (15-24) and young people (10-24) as defined by the World Health Organization (WHO) (WHO, 1998) has resulted in difficulties in making comparisons between studies among adolescent populations. This thesis uses the UN definition of adolescent, as an "assessable marker" (Spruitj-Metz, 1999) knowing that the period of adolescence is diverse as a result of biological, cognitive and socio-emotional changes experienced (Steinberg, 1999; Schutt-Aine and Maddaleno, 2003; Bailey and Charles, 2008).

Adolescents ages 10-19 currently comprise 1.2 billion of the worlds' population, with nearly 90% residing in developing countries (UNICEF, 2012). Within Latin America and the Caribbean (LAC), 19% of the population are adolescents (UNICEF, 2012). Although adolescence can be a period of vulnerability in the life cycle, it is generally a time of opportunities and growth (Barker, 2007; Breinbauer and Maddaleno, 2005; Senderowitz, 1995) when adolescents are generally strong and healthy, with mental acuity and remarkable information retention abilities (Breinbauer and Maddaleno, 2005; Senderowitz, 1995). However, for some globally, adolescence can be replete with problems, such as poverty, gender bias, illiteracy, violence, threats of trafficking and voicelessness, HIV and other SRH concerns (Bailey and Charles, 2008; Senderowitz, 1995). These problems are threats to the developing adolescent and serve to increase their vulnerability. Vulnerability as described by Couch *et al.* (2006), are factors that produce, construct or predict circumstances and situations in which people unwittingly find themselves. However, according to some authors research in developing countries on ASRH have mainly focused on the individual, and less on their circumstances – i.e. other contexts (Pilgrim and Blum, 2012; MacPhail and Campbell, 2001).

As a heterogeneous group (MacPhail and Campbell, 2001), adolescents experience different lived opportunities and disease burden (Flisher and Gerein, 2008; WHO, 2006) because of the

impact of their environment (Frydenberg, 1997; Ingham, 2006). Some authors (Schutt-Aine and Maddaleno, 2003; Senderowitz, 1995) have posited that, adolescents face some of their greatest challenges adjusting to sexual changes and protecting their reproductive health. For example, younger adolescents (Lule *et al.*, 2006), adolescents who are economically deprived (UNICEF, 2011; WHO, 2006; Flisher and Gerein, 2008) and gendered segment who may be subjected to different norms because of the interplay between sex and gender (Flisher and Gerein, 2008) may be more vulnerable and disenfranchised to access resources and negotiate for safer SRH practices.

According to Glasier *et al* (2006) most men and women become sexually active during adolescence, and in Latin America and the Caribbean, Demographic Health Surveys show that half of young women were between ages 18 and 19 at sexual debut (Khan and Mishra, 2008). However, early sexual activity, especially unprotected and/or coerced sexual activity can lead to negative reproductive health outcomes (Dixon-Muller, 2008). Outcomes can include, unintended pregnancy, unwanted childbearing and abortion, and human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) (Schutt-Aine and Maddaleno, 2003; Blum and Nelson-Mmari, 2004; Maharaj and Munthree, 2007). However, there is evidence from Sub-Saharan Africa (Wellings, 2006) and LAC (Norman *et al.*, 2007) suggesting that condom use at last sex is increasing. Still, one in five women worldwide are reported to have a child by age 18 (UNICEF, 2011; WHO, 2006).

As a result, adolescence is an opportune time to address issues of sexual health (Schutt-Aine and Maddaleno, 2003), so that adolescents can enjoy appropriate and healthy sexuality which will contribute to healthy adult sexuality. According to Schutt-Aine and Maddaleno (2003) evidence indicate that healthy sexual development leads to better decision-making, such as increased contraceptive use and delayed sexual debut leading to a decreased incidence of unwanted pregnancies. However, adolescents continue to face traditional barriers to information, contraceptives, and family planning services (Senderowitz, 1995). For example, SRH services in much of Sub-Saharan Africa have traditionally been designed for adult, married women, and there are often policies and social attitudes that restrict unmarried adolescents' access to services and information (Mmari and Magnani, 2003). These barriers persist despite increasing global awareness of the importance of adolescent sexual and reproductive health (ASRH) and rights (Rani and Lule, 2004), and recognition that adolescents need services that are sensitive to their unique stage of development (Tylee *et al.*, 2007).

However, there is also evidence suggesting that adolescents tend to keep away from individuals and institutions that should provide them with appropriate information and services (Senderowitz, 1995, Ingham, 2006; Hughes and MacCauley, 1998). Pearson and Makadzange (2008) argue that to provide appropriate SRH information and services, it is critical to understand how individuals manage their SRH, and have done so among men in Zimbabwe by examining SRH help-seeking behaviour. However, Barker *et al.* (2005) had previously identified adolescent help-seeking behaviour for SRH concerns as an underdeveloped field of research. And, in other fields, such as mental health where help-seeking has appeared to be more widely researched, Rickwood *et al.* (2005) point out the lack of unifying help-seeking theory. As a result, there is scope for this study to contribute to the body of knowledge on ASRH help-seeking behaviour.

1.3   Grenada Context

In this section, the aim is to discuss aspects of the Grenada context that is relevant to situate the study and it findings, and includes information on the geography and population, ASRH, socio-cultural context, and the health system. Table 1-1 contains some relevant population data for Grenada which will be referred to throughout this section.

Table 1-1 Population Data

	Grenada	St. Patrick	St. George
Human Development Index Rank (2011)	67		
Life Expectancy at birth	76 years		
Geographic size	344 km^2	42 km^2	65 km^2
Population (2008 est.)	109,436	11,281	36,290
Level of poverty as % of population (2008)	37.7%	56.7%	26.7%
− Level of poverty as % of 15-24 year old population (2008)	27%	-	-
Unemployment as % of population (2008)	24.9%	-	-
− Unemployment as % of 15-24 year old population	42%	-	-
Secondary school enrolment for ages 15-19 (2008)	63%	-	-
Secondary school drop-out(2008-2009 academic year)	1.91%	6.75%	1.44%

Sources of data: (GoG, 2009a, b, 2008c; UNDP, 2011)

Geography and population

Grenada is a small tri-island state (344 km^2) comprising of the islands of Grenada, Carriacou, and Petite Martinique. It is located in the southern-most region of the Anglophone Caribbean. The state is divided into seven parishes (i.e. geographic subdivisions comprising of main city/town centre and numerous village/communities), with Carriacou and Petit Martinique counted as one parish (GoG, 2007). See map of Grenada in Figure 1-1.
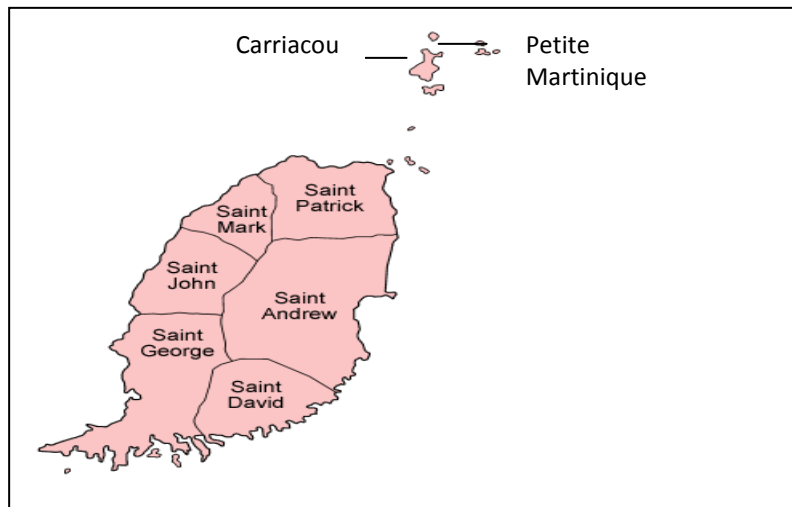
Source (Wikipedia, 2009)
Figure 1-1 Map of Grenada delineating parishes

In 2008 the population was estimated at 109, 436 with a growth rate of 1.8% (GOG, 2008c). The population is very youthful, with 20.8% under age 10, 23% between age 10 and 19, and 9.1% age 65 and older. See Figure 1-2 for population distribution by age and sex (GOG, 2008c). Investments in the health and education of this youthful population group can help to increase the country's economic potential (Schutt-Aine and Maddaleno, 2003).
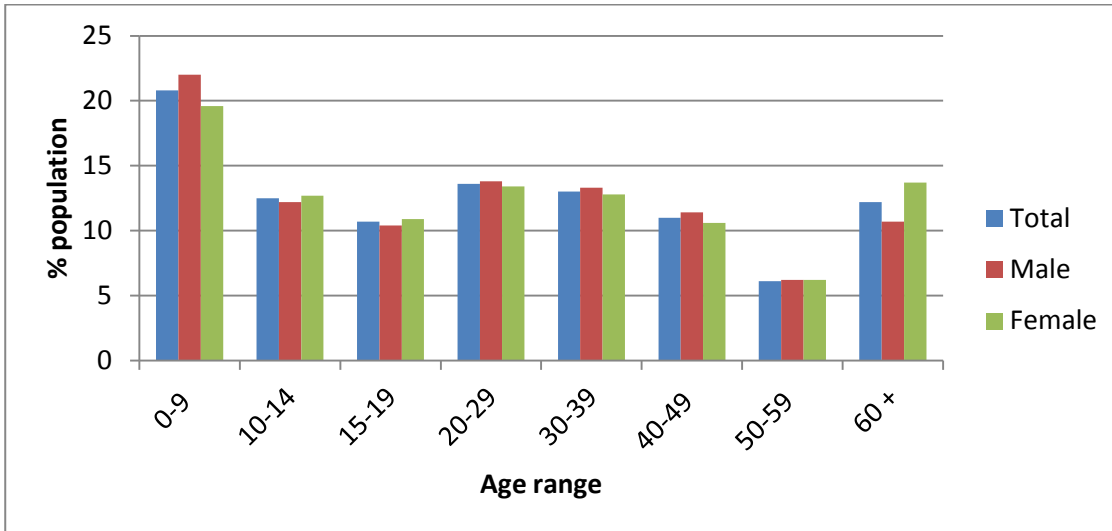
Source: (GoG, 2008c)
Figure 1-2 Estimated percent population distribution by age group and sex in Grenada

There is diversity among ethnic (Figure 1-3) and religious groups (Figure 1-4). However, the majority of persons are of African ancestry and identify as Christians (GoG, 2008b), which may have implications for SRH considering some Christian doctrine against premarital sex, homosexuality, abortion, and contraceptive use (Harris-Hastick and Modeste-Curwen, 2002).
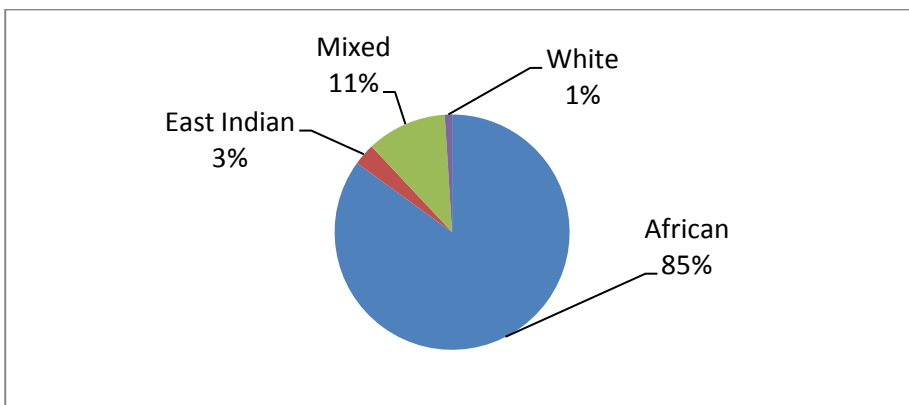
Source: (GoG, 2008b)
Figure 1-3 Percent race and ethnicity distribution in Grenada
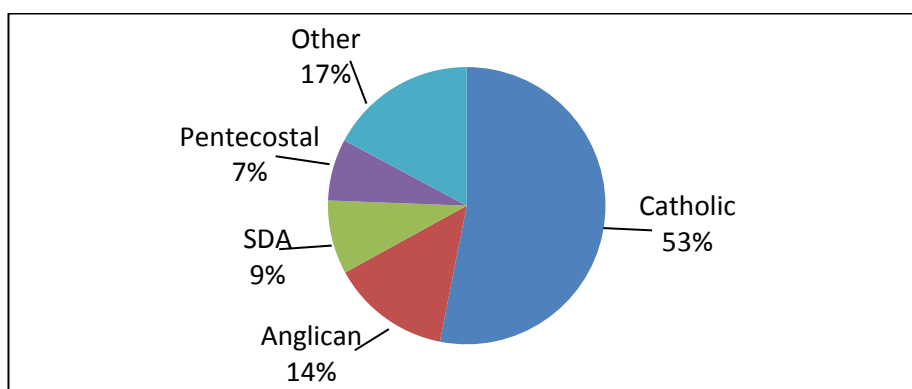
Source: (GOG, 2008b)
Figure 1-4 Percent religious affiliation in Grenada

ASRH in Grenada

What is known about ASRH in Grenada is based primarily on survey data (PAHO,2007a; GoG, 1998a; GoG, 2008a). However, standardised indicators have never been used across studies, and were school-based, although the HIV and AIDS Behavioural Surveillance Survey in 2006 (PAHO, 2007a) included adolescents in the general population. For these reasons, in addition to survey's reliance on self-report of behaviour, caution is taken in making definitive conclusions and generalisations about the results from past studies. Table 1-2 provides some of the data from the 2008 Global School Health Survey relevant to ASRH.

Table 1-2 Selected ASRH data from GSHS

	Total %	Male %	Female %
Ever had sex	30.8	47.3	18.3
Sexual debut before age 13	23.7	40.6	10.1
Sex w/ ≥ 2 people during lifetime	25.1	38.8	14.1
Sex during past 12 months	27.1	39	17.6
Sex during past 12 months & used condom at last sex	63.5	64.6	
Boyfriend/girlfriend who ever hit, slapped, or physically hurt them on purpose during past 12 month	17.8	20.3	14.3
Physically forced to have sex when they did not want to	14.5	14.7	14.1
Most likely get condom or protection from pharmacy, clinic, or hospital if they wanted one	30.5	29.1	32
Sex during past 12 months & they or partner most of the time used birth control method	18.9	19.4	18.3

Table 1-2 shows that among students who reported sexual activity, more than twice as many male students have had engaged in sexual activity compared to female students, and almost one-quarter of the students reported sexual activity before age 13, mainly male students. Although consistent contraceptive use was low, condom use at last sex among males were significantly higher compared to the negligible percentage of females, indicated by the missing value. Compared to other variables in the Table where more male than female were represented, *forced sex* and consistent contraceptive use in the past 12 months were the only two variables where almost equal percentages of male and female were reported. The sexual behaviours highlighted in the Table 1-2 can affect HIV and fertility outcomes.

HIV in Grenada is described as a low-level epidemic (348 HIV/AIDS cases between 1984 and 2007), because the estimated prevalence was under one percent (0.42%) at the end of 2003. However, the feminisation of the virus among 15-24 year olds is causing concern among health professionals in Grenada (GoG, 2008d). In 2003 prevalence among the 15-24 age group was 0.2% for both sexes, however, in 2007 the prevalence for females increased to 0.3% while it remained unchanged for males (GoG, 2009d). This suggests that while boys are engaging in more sexual activity, girls are experiencing more negative HIV outcomes, which may be related to adolescents' inconsistent contraceptive behaviour.

Additionally, the adolescent fertility rate in Grenada for 2010 (i.e. births per 1,000 girls ages 15-19) is reported at 38.2%, which is lower than the rate for LAC and Small Caribbean States (The World Bank, 2012) and represents a decline from the earliest year for which adolescent fertility rate data is available for Grenada (61.5 births/1,000 girls in 1997)However, as is shown in Figure 1-5, the fertility rate is still higher than other more developed countries in the Region, such as Trinidad and Barbados. Considering the findings on adolescent sexual behaviour above, it is surprising that the fertility rate among adolescents is not higher. However, induced abortion, which is restricted in Grenada (see section 4.2.3) is identified as a major issue by the Government of Grenada (GoG), and may help to explain the current fertility rate. The Grenada *National Strategic Plan for Health 2007-2012* report on a 1994 study in private clinics in Grenada where approximately 200 abortions for every 400 live births to teenagers were reported (GoG, 2008b). It can therefore be assumed that adolescents may be vulnerable to unsafe abortion practices, as well as negative health and psychological outcomes.
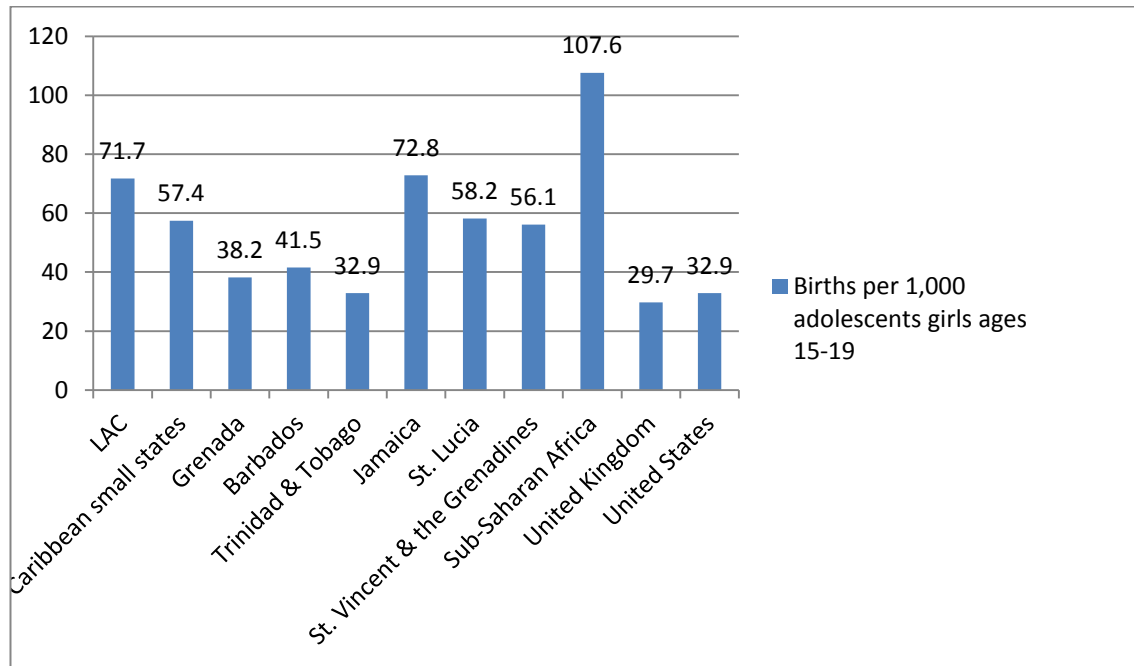
Source: (The World Bank, 2012)

Figure 1-5 2010 Adolescent fertility rate among selected countries and regions

Socio-cultural context

Grenada culture and society can be described as one based "within the context of specifically West Indian [Caribbean] social and cultural institutions" (Lowenthal, 1972 cited in Harris-Hastick and Modeste-Curwen, 2002). Lewis (2003) posits that notions of gender and sexuality in the Caribbean are based on hegemonic masculinity shaped by colonial and post-colonial history and economics. Sexual activity is said to be "treated casually" among adult men in Grenada, and "it is not uncommon for men to have multiple [concurrent] sex partners and father children with different mothers, or for women to have two or more children that have been fathered by different men" (Harris-Hastick and Modeste-Curwen, 2002 p.12). Additionally, heterosexual activity among boys is reported as an important marker of masculinity and the transition from boyhood to manhood (Marston and King, 2006 cited in Bombereau and Allen, 2008), while any sexual activity is stigmatised among adolescent girls (Kempadoo and Dunn, 2001). Pregnancy therefore is an objective indicator of sexual activity, and in 1998, the fear of pregnancy was reported by students in Grenada as one of the main reasons for abstaining from sexual activity (GoG, 1998a). In 2009, the fear of pregnancy was also one of the main reasons for drop-out among secondary school girls (GoG, 2009a). However, the highest percentage of school drop-out is reported in rural areas, in St. Patrick, which is also the parish with the highest incidence of poverty (see Table 1-1) (GoG, 2009a, b).

Women are reported to be emotionally and economically reliant on men due to high levels of poverty, which render women and girls powerless (Pan Caribbean Partnership on HIV/AIDS (PANCAP), 2002). The 2008 poverty assessment[1] conducted in Grenada revealed a poverty rate of 37.7% and unemployment rate of 24.9%. However, young rural females, and persons 15-24 years old are among those most affected (GoG, 2009b). As a result of this social reality, women and girls (and boys to a lesser extent) in the Caribbean are reported to engage in the transactional exchange of sex for money, food, school-related fees to meet basic economic needs, and also for fashionable clothes and gifts (Bombereau and Allen, 2008; Kempadoo and Dunn, 2001), which increases vulnerability to HIV transmission. Nonetheless, Goupal-McNichols (1993 cited in Harris-Hastick and Modeste-Curwen, 2002 p.14) notes that among West Indian families, "issues of a sexual nature are almost never discussed with young people, and feelings, such as love and tenderness, are almost never expressed or exhibited openly."

Grenada's Health System and ASRH

According to the World Health Organization (WHO), the health system comprises of "… all organizations, institutions and resources …whose primary purpose is to improve health" (WHO, 2000). Therefore the health system "reflects the wider holistic interpretation of health…to include other health related services" (Gerein *et al.,* 2009). The health system in Grenada consists of services delivered by the public and private sector and civil society including non-governmental organizations (NGOs). However, primary health services, which is the main form of health service delivery in Grenada is organized through the Ministry of Health (GoG, 2008b). Health services are decentralized and delivered from a network of 6 district health centres[2], 33 medical stations, and 2 maternity units (Figure 1-6) (GOG, 2008b). However, a 2003 UNFPA study (UNFPA, 2004) measuring progress toward the goals of the 1994 International Conference on Population and Development (ICPD 1994) in Cairo have highlighted some inadequacies in health services delivery regarding SRH. According to UNFPA (2004) a governmental framework to deal with reproductive health matters is lacking, and while adolescents have access to SRH services through health centres, there is a lack of adolescent-friendly services (AFS). Similarly, a 2006 HIV and AIDS Services Provision Assessment in Grenada found that only one of 17 health facilities with an HIV-testing system

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[1] The annual Poverty Line was estimated at Eastern Caribbean Currency (EC) $5, 842 per annum for 2008 (GoG, 2009b), which is approximately US$ 2,164 and GBP 1,403.
[2] Health Centres are located at the health district level, provide a wider variety of services, and are responsible for the administration of one or more medical stations within the district.

provided Youth Friendly Services (YFS), with at least one provider trained in YFS (USAID/MEASURE EVALUATION/SGU, 2007). Therefore, in Grenada there is a need for adolescent-friendly SRH services to improve ASRH outcomes.

St. Patrick Parish	St. Mark Parish	St. John Parish	St. George Parish	St. David Parish	St. Andrew Parish	Carriacou
1 Health Centre w/maternity unit		1 Health Centre	1 Hospital w/maternity unit	1 Health Centre	1 Hospital	1 Hospital
			1 Health Centre		1 Health Centre	1 Health Centre
3 Medical Stations	2 Medical Stations	2 Medical Stations	10 Medical Stations	4 Medical Stations	5 Medical Stations	1 Medical Station

*Green represents the parishes within which the community-based arm of the study was set.

Figure 1-6 Public health facilities by parish level

Furthermore, the scope of SRH promotion outside the health sector and the level of coordination among organizations and providers, such as the Health Promotions Unit in the Ministry of Health, Churches, and NGOs (PAHO, 2007b), if any, is unclear. Previous studies have not reported on the types of SRH services offered by these providers, or Grenadian adolescents' awareness and access to these organizations. However, poor access to primary care is reported, particularly in rural areas (UNDP, 2005), and increasing utilisation of private health services, due to the perception of better quality of care (GoG, 2008b). Some of these problems may be exacerbated by an unreported, but considerable number of general practitioners who work in government-run health facilities, but also maintain their private practice and the general shortage of health workers (GoG, 2008b). Additionally, the UNFPA study indicated that healthy living is also addressed within the school system through the *Health and Family Life Education Curriculum;* however, there is no special focus on reproductive health (UNFPA, 2004), which is disconcerting considering adolescent SRH outcomes discussed above. The above suggests there is a need to understand the scope of SRH promotion, including information, education, advice and services available to adolescents in Grenada, and how adolescents navigate available resources when they have SRH concerns.

The above discussion has provided insights into some of the ASRH behaviours, outcomes and services in the international and Grenada context. However, an in-depth understanding of ASRH is lacking, due to the heavy reliance of quantitative methods and in-school populations. As a result, it would be useful to know whether adolescents in Grenada interpret the above outcomes as problematic, and sufficiently so, as to warrant help-seeking. Help-seeking (section 2.2), is used as the mechanism through which to explore how Grenadian adolescents cope with concerns they have about their SRH. Therefore, this study will address research gaps in the Grenada context, giving adolescents a voice in the matters that affect their SRH, while contributing to the wider academic debate on ASRH help-seeking. Furthermore, there are implications for any future efforts by government to develop a framework to address ASRH.

1.4   Study Focus

The aim of this study is to investigate how adolescents in Grenada perceive the socio-cultural and programmatic contexts as it relates to facilitating and hindering their help-seeking behaviour for sexual and reproductive health concerns. The research objectives and corresponding research questions are presented in Table 1-3.

Table 1-3 Research objectives and questions

Research Objectives	Research Questions
1. To describe the ASRH promotion framework in Grenada.	1a. What ASRH-related programs, policies, and legislation exist in Grenada? 1b. What are stakeholders' perceptions of the adequacy of the current framework to meet the SRH needs of adolescents?
2. To explore Grenadian adolescents' perceptions of how the socio-cultural and programmatic contexts influence adolescents' help-seeking behaviour for their SRH concerns.	2a. What are Grenadian adolescents' help-seeking pathways for SRH concerns? 2b. How do the socio-cultural and programmatic contexts influence Grenadian adolescents' interpretation of their help-seeking behaviour for SRH concerns?
3. To recommend the most appropriate and potentially effective solutions to promote adolescents help-seeking for SRH concerns in Grenada.	3a. What are solutions emerging from the data and best practices that can be recommended to improve the current ASRH framework and address adolescents' help-seeking needs for SRH concerns in Grenada?

The research questions were explored among a cross-section of organizational-level stakeholders in ASRH, a cross-section of community members – subsequently referred to as community-level stakeholders – and adolescents in one rural and one urban community, and adolescents attending two alternative educational/vocational institutions. To gather the data, an exploratory qualitative approach was undertaken utilizing multiple methods (i.e. documentary review, focus groups and interviews). Thematic Framework Analysis was used to examine adolescents' SRH help-seeking pathways and the influence of the socio-cultural and programmatic influence on help-seeking behaviour. The research methodology is discussed later in Chapter 3.

1.5   Thesis Overview

This chapter provided the rationale and background to the study, outlining the study's aim, objectives and questions. Chapter 2 situates the study within the wider literature on adolescent help-seeking and the influence of context, and discusses the main theoretical perspectives informing the study. It concludes with the ecological help-seeking conceptual framework that guided the development of the research objectives and questions, which influenced data gathering and analysis. Chapter 3 provides an in-depth discussion of the methodology and methods used to achieve the research aim, objectives and questions. Chapter 4 to Chapter 7 discuss the study's findings in relations to the existing ASRH-related legislations, policies and services; adolescents SRH help-seeking pathways; and the socio-cultural and programmatic contextual factors affecting help-seeking behaviour, respectively. Chapter 8 concludes the thesis by discussing the key findings and the implications for ASRH in general, and specifically regarding Grenadian adolescents' SRH help-seeking. This is done in relation to the literature and existing framework of ASRH promotion in Grenada. The study's key contributions to knowledge are identified, and a revised conceptual framework is also provided based on the study's findings. The chapter concludes by discussing pragmatic recommendations for public health practice in the areas of: policy, programs and services, and research.

Chapter 2 – Reviewing the Literature: SRH Help-Seeking Behaviour & Context

2.1 Introduction

As stated in chapter one, the aim of this research is to investigate how adolescents in Grenada perceive the socio-cultural and programmatic contexts as it relates to the promotion and prevention of their help-seeking behaviour for SRH concerns. To understand such processes, and situate Grenadian adolescent SRH help-seeking within wider discourses on adolescent help-seeking behaviour, it is important to examine some of the existing literature on the topic. Therefore, this chapter will provide a critical analysis of the current literature to understand discourses related to adolescent help-seeking behaviour, and identify gaps in the literature as related to the topic and the Grenadian and/or Caribbean context, which were used to inform the development of the study.

In section 2.2, help-seeking is defined. In section 2.3 sources of help are discussed. Section 2.4 discusses the contextual factors that facilitate or inhibit ASRH help-seeking behaviour. Next, section 2.5 summaries gaps in the literature and indicates how the current research fits in. In section 2.6, the theoretical perspectives informing the study's conceptual framework and design are discussed. In section 2.7 the conceptual framework guiding the study is discussed. The chapter concludes with a summary in section 2.8.

The literature included in this thesis was found and reviewed as an on-going process throughout the PhD. However, using a search strategy (Appendix A), the main literature search was conducted in 2008 and was repeated in 2011 to identify any new literature on the topic. Additionally, keyword searches were conducted based on the study's findings to identify literature on emerging themes. The literature search was conducted using the following bibliographic databases: Global Health, Popline, and PsycINFO through Leeds University Library Catalogue. Additional literature was found by searching specific journals, reference list of relevant articles and books, and the grey literature. Literature is also included which offers theoretical perspectives on help-seeking and generic models of help-seeking processes, including those used in adult populations. The review strategy, however, is not exhaustive; rather it synthesizes accessible qualitative and quantitative literature on ASRH help-seeking

from developed and developing countries. This inclusive review strategy was used because there are few studies related to help-seeking in developing countries, especially in the Caribbean Region. As a result, some of the literature has limited applicability to the review, because they are based in Europe or the United States of America (USA).

2.2   Defining ASRH Help-Seeking

Within the literature, there are several definitions for the term "help-seeking". From the perspective of mental health research with adolescents, Rickwood *et al.* (2005) define help-seeking as a "process of actively seeking out and utilizing social relationships, either formal or informal, to help with personal problems" (Rickwood *et al.*, 2005 p.8), which is consistent with the "approach" style of coping described by Frydenberg (1997). From an adolescent health perspective, Barker *et al.* (2005 p.316) define help-seeking as "any action or activity carried out by an adolescent who perceives himself/herself as needing personal, psychological, affective assistance or health or social services with the purpose of meeting this need in a positive way." Both sets of authors acknowledge that help-seeking is initiated by the adolescent and that help may be sought from formal, as well as informal sources (see detail in section 2.3). However, implicit in these definitions is the assumption that health care or health service utilization is the ultimate goal of help-seeking.

The definition of help-seeking that drove this thesis is adapted from the above definitions. However, the assumption is that informal sources within adolescents' social networks can also be utilized as an adequate end-point for help-seeking based on the type of SRH concern the adolescent experiences. The following help-seeking definition is adapted for this thesis:

> *a process whereby an adolescent who perceives himself or herself as needing personal, psychological, or affective assistance, or health or social services related to their sexual and reproductive health, actively seeks and utilizes positive actions or activities from informal or formal resources.*

Although broad, this definition is important to account for the range of SRH concerns that arise during adolescent development (Barker *et al.,* 2005), and various sources adolescents may utilize for coping. Featherstone and Broadhurst (2003) argue that conceptualizing help-seekers as active agents, who negotiate pathways to a range of sources of help, forces researchers to

"consider problem definitions and solutions from the perspectives and experiences of the help-seeker" (p.342).

Notably, help-seeking behaviour for SRH concerns, particularly among adolescents is not a widely researched area. In fact, health-seeking behaviour, which Ward *et al.* (1997 p.21) define as "adolescents seeking health services to manage specific and predetermined SRH problems from the formal and/or the informal health sector", is better documented in the literature. However, a growing body of literature shows that adolescents tend to avoid individuals and institutions that are able to provide them with appropriate (or perceived to be appropriate) SRH information, counselling and services (Namisi *et al.,* 2009; Berhane *et al.,* 2005; Senderowitz, 1999; Hughes and McCauley, 1998). Avoiding help-seeking can further aggravate SRH issues, and qualitative and quantitative studies discuss a range of factors that affect adolescents' help-seeking decisions and behaviours (section 2.4). However, not all adolescents forego help-seeking. For adolescents who choose to seek help, a range of help sources are utilized. The next section focuses on the sources of help adolescents prefer and/or to utilize to manage their SRH concerns.

2.3   Sources of Help-Seeking

As indicated in the help-seeking definition above, sources of help can be categorized as formal or informal. Formal sources of help consist of counsellors and modern health care providers, in contrast, informal sources of help consist of parents, friends, school/teachers, traditional health care providers, and the media (Schonert-Reichl and Muller, 1996; Raviv *et al.*, 2000). Although these same categories are used in this thesis, they can at times be confusing. For example, Van der Reit and Knoetze (2004 p.233) argue that "while teachers are in 'formal' role relationships with youth, they do not necessarily have professional helping skills and their role as a potential help source is often closer to the 'informal' category of helpers." Similar to these authors, in the current study, a formal help source is those whose primary relationship to the adolescent is that of a help source, such as a health worker. In this thesis, informal sources of help are also referred to as social network sources, and sources of help are used interchangeably with "helpers" for ease of reading. Figure 2-1 shows the diversity of help sources that adolescents reportedly utilize to deal with their SRH concerns – the broken line indicates concurrent use of formal and informal sources.
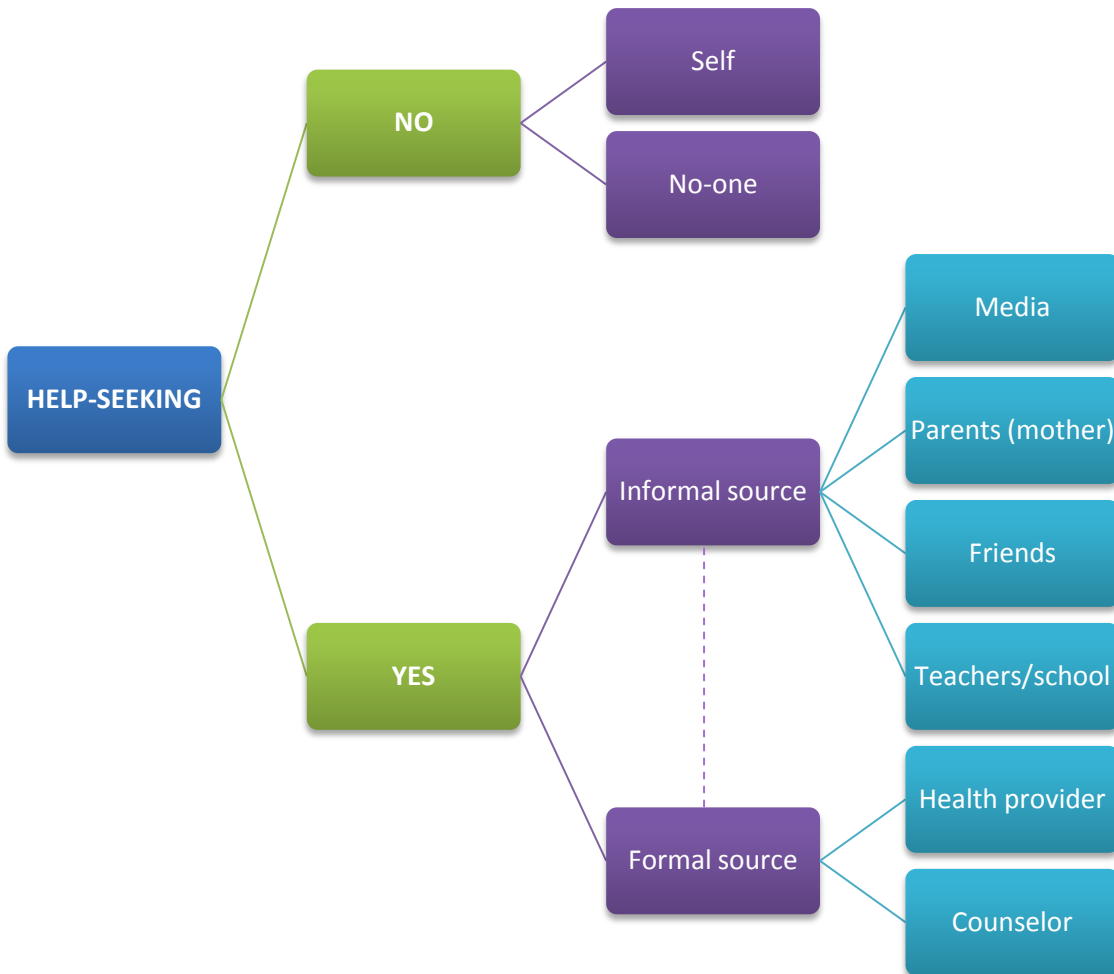
Figure 2-1 Sources from which adolescents seek help

2.3.1 Informal help sources

Although patterns of ASRH help-seeking are not always consistent, most studies indicate that adolescents prefer to seek and utilize help from informal sources (Marcell and Halpern-Felsher, 2007; Boldero and Fallon, 1995; Okereke, 2010; Bankole *et al.*, 2007; Char *et al.,* 2011; Tengia-Kessy and Kamugisha, 2006; Namisi *et al.,* 2009; Van der Reit and Knoetze, 2004; Ackard and Neumark-Sztainer, 2001; Berhane *et al.,* 2005). For example, in national household surveys among adolescents ages 12-14 in Burkina Faso, Ghana, Malawi and Uganda, the mass media, teachers and schools, other family members, and friends were the most dominant information sources reportedly utilized for information related to HIV, STIs and contraceptives (Bankole *et al.,* 2007). However, in the same study, health providers were also a dominant source of information for adolescents in Malawi.

Despite mixed findings regarding informal sources, parents, especially mothers appeared to be preferred and/or the most valuable informal source for SRH concerns, such as sexuality, HIV/AIDS, abstinence, condoms, and even general health concerns (Jones and Biddlecom, 2011; Berhane *et al.,* 2005; Namisi *et al.,* 2009; Ackard and Neumark-Sztainer, 2001). Furthermore, there was also indication of preference for same sex parental communication. For example, mothers were preferred by a majority of female adolescents in all three sites, while males in two (1 Tanzanian and 1 South African) of the three sites preferred to communicate with fathers (47% to 27%). Although, Namisi *et al.* (2009) did not separate the scale for measuring communication with parents for mother and father, among students in the United States of America (USA), Ackard and Neumark-Sztainer (2001) also found that mothers were the most used source by both male and female adolescents, and also the first source from which help was sought for health care information relating to general health concerns.

Only a few studies reported peers as an important source of help for adolescents with SRH concerns (Tangia-Kessy and Kamugisha, 2006; Van der Reit and Knoetze, 2004; Char *et al.,* 2011; Jones and Biddlecom, 2008). However, Masatu *et al.* (2003) pointed out that peers may not be a main source of information and advice for SRH concerns, because of their lack of credibility to provide accurate information. Similarly, a recent qualitative study (Jones and Biddlecom, 2011) among public high school students (ages 16-19) in the USA found that few students used the Internet as a source of SRH information related to abstinence and contraception, and majority were wary and distrustful of it as a source of SRH information. However, some studies reported that adolescents preferred to seek and utilize help (e.g. information) from media sources, such as television (Tengia-Kessy and Kamugisha, 2006; Char *et al.,* 2011) and the Internet (Borzekowski and Rickert, 2001; Pearson and Madkazange, 2008).

Teachers, who may be viewed as more credible sources of information, were only reported as the most popular source at sites in two studies (Bankole *et al.,* 2007; Namisi *et al.,* 2009). Interestingly, most of the students in Bankole *et al.* study reported not receiving family life or sex education in school, whereas teachers were not an important source of information for adolescents in Dar es Salaam, Tanzania where family life education is integrated into the school curriculum (Tangia-Kessy and Kamugisha, 2006). However, Van der Reit and Knoetze (2004) posited that teachers in their qualitative study among school age youth (14-22 years), were most often approached when other potential helpers were absent and if teachers were deemed trustworthy.

2.3.2   Formal help sources

Similar to the findings regarding informal sources, adolescents' utilization of formal sources for SRH concerns were inconsistent (Langhaug *et al.,* 2003; Berhane *et al.,* 2005; Kaipa-Iwa and Hart, 2004; Agampodi *et al.,* 2008; Biddlecom *et al.,* 2007; Miles *et al.,* 2001; Char *et al.,* 2011). For example, in Bankole *et al.*' (2007) surveys in four African countries, only in Malawi were health facilities a major source of SRH information for adolescents, and more girls (50%) than boys (36%) reported having gotten information from health professionals (Bankole *et al.,* 2007). Ackard and Neumark-Sztainer (2001) found that both female and male in-school adolescents reported doctors/nurses as the second source from whom they sought health care information. Among young men in rural India, only 23% of young men in the study reported health workers as a principal source of SRH information, however, 72% of young men reported a preference for talking to health providers face-to-face for SRH concerns (Char *et al.,* 2011). The authors suggest that this highlights the young men's wish for communication with credible sources, as was discussed by Masatu *et al.* (2003) in section 2.3.1.

Although Biddlecom *et al.* (2007) reported that the adolescents in their study underutilized STI services and HIV testing, those who obtained care did so from clinics, hospitals and doctors than from other sources, such as traditional healers. However, traditional healers and herbalists were also commonly mentioned as hospitals and public clinics. Interestingly, the majority of the adolescents in Biddlecom *et al.*' study preferred public over private clinics. One study reporting on access to contraceptives in Jamaica, indicated gender differences in access. Crawford *et al.* (2009) reported that about 12% of female adolescents in Jamaica accessed contraceptives from health centres compared to 3% of male adolescents. And that 20% of female adolescents accessed contraceptives from private pharmacies compared to 9% males (Crawford *et al.,* 2009). In Jamaica more female adolescents access contraceptives from public health facilities than males; however there appears to be a preference for private providers compared to public providers, as is assumed of adolescents in Grenada (section 1.3).

The above shows that there are variations in the sources of help that adolescents utilize. In the literature, these variations are attributed to many factors. These are discussed in section 2.4 below as contextual factors.

2.4   Contextual Barriers and Facilitators of ASRH Help-Seeking

Several factors have been identified as affecting help-seeking behaviour from formal and informal sources. Barker *et al.* (2005) categorize these factors into individual factors and exogenous factors. Considering the thesis is focused on contextual factors affecting help-seeking, which are essentially exogenous factors, and that the literature on adolescents' management of their SRH concerns identified primarily exogenous factors, this will be the main focus of sections 2.4.1– 2.4.3 below. Individual factors will only be discussed as they relate to exogenous factors, and existing gaps will be highlighted. Exogenous factors affecting help-seeking are categorized into socio-cultural, legal and policy, and programmatic contexts, based on the work of other authors (Barker *et al.,* 2007; Chalmers *et al.,* 2006; Couch *et al.,* 2006). Noteworthy, is that gender and stigma are conceptualized in this thesis as contextual factors, rather than individual factors as conceptualized by Barker *et al.* (2005). However, this is because at their core gender and stigma are socio-cultural factors (Ingham, 2006), based in patriarchal histories (Kempadoo, 2004; Van der Reit and Knoetze, 2004). Furthermore, gender inequalities in particular have been reported as commonplace in Grenadian society (UNDP, 2005), and warrant consideration as a contextual factor. Next is a discussion of the socio-cultural context, since it is believed to be the most influential on ASRH help-seeking behaviour, followed by the policy and legislative context, and then the programmatic context which is believed to have the least influence.

2.4.1   Socio-cultural context

Social and cultural factors "are often intertwined to impact health behaviours among a population" (Roberts *et al.,* 2005 p.1489). However, they vary within countries and cities (Couch *et al.,* 2006). The socio-cultural contextual factors discussed in this section pertain to norms and beliefs, gender, and stigma linked to adolescent sexuality, sexual activity and help-seeking.

Norms/belief about adolescent sexuality, sexual activity and help-seeking

Norms and beliefs pertaining to adolescent sexuality and sexual activity affect how adolescents view SRH issues, and by extension, how they deal with their SRH concerns. In much of Africa and the Caribbean, adolescents' sexual activity is taboo and not condoned (Kumi-Kyereme *et al.,* 2007; Kempadoo and Dunn, 2001). Some authors (e.g. Meekers *et al.,*

2001; Kumi-Kyereme *et al.,* 2007) have argued that in these contexts, adolescents may forgo or delay help-seeking to prevent accusations that they are sexually active, and other consequences for sexual involvement, such as stigma (see discussion on stigma in this section). For example, Meekers *et al.* (2001) reported that adolescents in urban Botswana did not want to be seen obtaining condoms because they did not want their parents to know they were sexually active. According to the authors, this was despite adolescent sexual activity being the norm in Botswana. This suggests potential tensions between subgroup norms and norms in the wider population that can affect help-seeking, and may be worthwhile to explore in the Grenada context. MacPhail and Campbell (2001) pointed out that adolescent boys in the two South African townships in their qualitative study viewed condoms as a waste of time and did not use condoms at all. This was attributed to the fact that parents did not condone adolescents' use of condoms, and discouraged its use by encouraging abstinence through gossiping and punishment.

However, some types of help-seeking appeared to be more acceptable and supported by different social networks than others. For example, in some contexts, adults may be supportive of adolescents seeking SRH information. Ouedraogro *et al.* (2007), cited in Biddlecom and collegues (2007) reported that adults in Burkina Faso were more supportive of adolescents accessing SRH information than RH services. And, in the Gambia the older people advise and refer young people in the traditional ways, such as drinking local herbs or going to traditional healers for treatment of STIs and other SRH concerns (Miles *et al.,* 2001). This may be indicative of a generation gap regarding preference for treating SRH issues, and may help to explain why adolescents in the study also use Western medical care alongside traditional treatments. Also, Kiapa-Iwa and Hart (2004) reported that nurses in Uganda were of the view that adolescent girls were encouraged by boyfriends and some schools to use the pill and injectable contraceptives rather than condoms. However, these beliefs still leave adolescents vulnerable to STIs/HIV, while providing some protection from pregnancy. Although Kiapa-Iwa and Hart (2004) did not provide sufficient background details about the site of the study for transferability for the Grenada context, they point out that these beliefs are common in reports of AIDS control in East Africa.

Additionally, some parents and health providers (e.g. nurses) believe that explicitly providing adolescents with sexual and reproductive health information will encourage sexual activity, which is deemed adult behaviour. This was reported among nurses in Zimbabwe (Langhaug *et*

al., 2003), nurse-midwives in Kenya and Zambia (Warenius *et al.,* 2006), and adolescents in Jamaica (Crawford *et al.,* 2009). For example, Langhaug *et al.* (2003) posit that nurses' beliefs, stemming from cultural beliefs about adolescent sexuality result in nurses being unwelcoming and judgemental, which consequently discourages adolescents from seeking help. However, referring to school-based sexuality education, research has shown that providing adolescents with sexuality information does not encourage or increase sexual activity (Kirby *et al.,* 1994; Kirby, 2007).

The above studies suggest that adolescents may be keen to seek types of help that are deemed more socially acceptable, in light of other barriers to access discussed in this chapter. Additionally, a few studies (Mmari and Magnani, 2003; Stephenson *et al.,* 2007) have shown that social acceptance (e.g. from community members, parents) of adolescents' utilization of SRH services increases adolescents' utilization of SRH services.

Gender norms

Adhering to strict gender norms can affect how adolescents cope with SRH concerns, and put them at risk for STIs/HIV (Rivers and Aggleton, 1999). Referring to mental help, Raviv *et al.* (2000) argue that help-seeking is a more socially acceptable and positive behaviour for females than males. Hence, the range of studies (e.g. Boldero and Fallon, 1995; Schonert-Reichl and Muller, 1996; Biddlecom *et al.,* 2007) show more females than males seek help for SRH health and other concerns. Van der Reit and Knoetze (2004), in their study among in-school adolescents in two South African Provinces, are among the minority of authors who report that gender did not play a significant role in adolescents patterns of help-seeking or sources of help utilized. The only significant difference Van der Reit and Knoetze (2004) found was that female participants accessed formal/professional sources while male participants did not. The authors attributed this to socializing factors, such as males being required to be strong and cope with problems without the help of professionals. An alternative explanation may be due to self-reporting bias, which may support the authors claim. However, claims about significance are unsubstantiated due to the qualitative nature of the study. Gender norms are also linked to stigma. Roberts *et al.*' (2005) study among adolescents in Mongolia indicated that boys can be stigmatized if they try to seek information about sexual activity, because they are "supposed to naturally know" (p.1494). This may therefore hinder help-seeking, and help explain some of the discomfort boys reported regarding discussing sexuality topics with health providers.

Nonetheless, male and female adolescents were reportedly uncomfortable discussing a range of sexuality and sexual health topics with health providers. According to Ackard and Neumark-Sztainer (2001), among in-school adolescents in the United States, although more girls than boys reported discomfort discussing issues related to puberty and sexuality, both boys and girls were uncomfortable as illustrated in Table 2-1. And, a study among adolescents in Thailand reported that the boys in their study often reported more positive experience of help-seeking than girls (Tangmunkongvorakul *et al.,* 2005). While findings from studies in Thailand and Mongolia may not be transferrable to the Grenada context, they are useful to highlight some of the tensions and complexities resulting from and perpetrating gender norms that may affect help-seeking.

Table 2-1 Summary of Responses by Gender for Topics Adolescents (Grades 5 through 12) Report They Would Be Too Embarrassed, Afraid, or Uncomfortable to Discuss With Their Health Care Provider

Sexuality & SRH issues	Percent boys	Percent girls	P-value
Sexuality	44	50	.001
Body changes	42	49	.001
menstruation	-	49	-
Physical & sexual abuse	34	40	.001
Contraception	23	40	.001
Pregnancy	21	30	.001
STD	26	25	.291
Private health	37	40	.145
Eating Problems	13.2	13.2	.962
Drug/alcohol use	16.7	9.9	.001
Other	5.8	2.6	.001

(Source: Ackard and Neumark-Sztainer, 2001)

P-value =.001 represent significant gender differences

Stigma related to the need for help

In Erving Goffman's theory of social stigma, stigma is defined as an attribute, behaviour, or reputation which is socially discrediting and undesirable, resulting in the devaluation of a person (Goffman, 1963). Several factors can result in adolescents, especially girls, being stigmatized as a consequence of having SRH concerns and seeking information

and/or services for SRH concerns. Actual or perceived stigma can hinder help-seeking for SRH concerns. Cross-cultural studies have shown that fear of being seen utilizing RH services by someone known to the adolescent (Langhaug *et al.,* 2003), embarrassment (Berhane *et al.,* 2005), and concerns about their reputation (MacPhail and Campbell, 2001) were major barriers to help-seeking. Stigma can be viewed as a cross-cutting factor resulting from beliefs and norms, including gender. For example, earlier girls were discussed as being uncomfortable procuring condoms because of norms against girls' sexual activity (Meekers *et al.,* 2001). However, the authors further stated that girls feared being stigmatized as prostitutes for engaging in sexuality activity, and as a result, girls in addition to boys preferred sources where they felt less embarrassed, such as retail outlets to procure condoms (males 77%; females 61%) compared to health facilities where they are provided freely. Atuyambe *et al.* (2009) also noted that pregnant adolescents in Uganda preferred to seek help from traditional birth attendants as a strategy to avoid encountering their in-school non-pregnant peers because they felt ashamed and stigmatized.

Fear of stigma also resulted in adolescents' hiding their SRH concerns, which result in delayed or forgoing help-seeking (Miles *et al.,* 2001; Kumi-Kyreme *et al*., 2007). For example, in Ghana there is stigma attached to premarital sex (Kumi-Kyreme *et al.,* 2007) and stigma attached to STIs (Miles *et al.,* 2001), which may result in adolescents and young people hiding the infections and finding it difficult to seek health care or to inform adults. Miles *et al.* (2001) also point out that stigma may result in a lack of full disclosure about the actual problem to health workers, which may affect treatment options. MacPhail *et al.* (2001) suggest that fear of stigma appeared to be more influential than fear of the progression of the disease as it relates to seeking treatment.

2.4.2   Legal and Policy context

The legal and policy context related to ASRH is complex, and according to Couch *et al.* (2006) their effects are sometimes unpredictable. The WHO (2006) notes that legislation and policies related to ASRH encompass health, education, transportation, social welfare, justice, and finance, among others. Furthermore, this context is closely related to the programmatic and socio-cultural contexts. Cook *et al.* (2003) argue that laws and policies often contain regulations and rules that are driven by outdated knowledge or long-standing community customs or religious practices, which have a harmful effect on SRH and disrespect basic human

rights. However, this section focuses on how enacting legislation and developing and implementing policies may affect adolescents' access to SRH information, advice and services.

International mandates and local implementation

For over 30 years international conventions, such as the 1978 Declaration of Alma-Ata, the 1986 Ottawa Charter for Health Promotion, the 1988 Adelaide Declaration, the 1990 Convention on the Rights of the Child (CRC), the 1994 Cairo Convention (ICPD 1994), and the 1997 Jakarta Principles have highlighted the importance of good public policy to create supportive environments, strengthen community action, and reorient health services to promote health and well-being (World Health Organization, 2009). At the 1994 Cairo Convention it was recognized that SRH are major cornerstones of health and development, and in its Program of Action a pledge was made to achieve universal access to reproductive health, including for adolescents. The Program of Action declared that "countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents" (United Nations, 2009, ICPD Paragraph 7.46). And in 2006 universal access to reproductive health (RH) information and services were explicitly included as part of the Millennium Development Goals.

However, many countries, lag behind in achieving the RH indicators among adults (Abrejo, Shaihk and Saleem, 2008) and adolescents (UN Millennium Project, 2006). For example, an analysis of adolescent health-related national legislation and policies passed between April 1976 and August 1996 in Latin America and the Caribbean was conducted by the Pan American Health Organization (PAHO) as part of their effort to respond to the concerns of adolescents. They found that in regards to rights and legal ages, youth in some countries may face significant barriers in accessing reproductive health services (PAHO, 1999). Although these findings may be considered outdated, more recent reports from the Caribbean indicate current relevance (Henry, 2011; Sealy-Burke, 2006).

Supportive versus unsupportive policies and legislation

Couch *et al.* (2006 p.39) argue that "legislative attempts to protect young people do not always work in their favour." English and Simmons (1999 cited in Couch *et al.et al.,* 2006) argue that fewer girls pregnant from older men will refuse to seek support services, as a result of many states in the USA including statutory rape as grounds for child abuse reporting in efforts to reduce teenage pregnancy. And in the Caribbean Island of St. Christopher (also

known as St. Kitts), the legal age for sexual intercourse was recently amended from age 16 to 18 to be consistent with the age of majority, and to protect adolescents from sexual abuse. However, stakeholders in various sectors are concerned that this will have a negative impact on the legal age for youth accessing SRH services, including effective HIV prevention, treatment, care and support (Government of St. Christopher and Nevis, 2010). These issues also raise concerns about the policy formulation process, the motive of policy makers, and whether all relevant actors were involved to arrive at the current legislative content (Walt *et al.*, 2008). However, these will not be discussed as they are outside the scope of the current research.

In contrast, there is evidence that legislation and policy may yield favourable results for adolescents (e.g. Braeken *et al.,* nd cited in De Bruin and Parker, 2004; Pathfinder International, 2005). For example, in the Netherlands, a supportive legislative and policy environment has contributed to ensuring that adolescents are able to access contraceptives (including emergency contraception), counselling, HIV/STI diagnosis and treatment, prenatal care and safe, legal abortions through their family doctors and special clinics (Braeken *et al.,* 2007). The authors argue that this has resulted in 85% of Dutch youth reporting using contraceptives during their first sexual experiences, a low pregnancy rate for girls aged 15-19 (14.1 per 1,000 women), and one of the lowest abortion rates in the world (8.6 per 1,000 pregnant women). However, it is important to point out that the Netherlands has a supportive socio-cultural context for ASRH and sexuality. In Tanzania, where the socio-cultural context is less supportive of ASRH and sexuality, a multifaceted intervention led by the African Youth Alliance (AYA) to integrate Youth-Friendly Services (YFS) into public health facilities, included a policy component and helped to increase service utilization, among other benefits (Pathfinder International, 2005).

Prioritizing ASRH

ASRH issues receive varied priority among policy makers and health care practitioners, which may affect their development and implementation. For example, studies (e.g. Bulatao and Ross, 2002; Wynter *et al.,* 2003) indicate that abortion and post abortion care receives relatively low policy priority compared to other SRH issues. A study carried out in 1999-2000 asked health professionals in 49 developing countries to rate 81 maternal and neonatal health services in their countries. The experts rated official approval for treatment of post-abortion complications as the second lowest policy priority (Bulatao and Ross, 2002). However, where

abortion is legal, the issue of parental consent has been raised, but countries such as France and South Africa have supportive legislations and policies for abortion that address the issue of parental involvement (see De Bruin and Parker, 2004). Nonetheless, parent involvement does extend to other SRH issues and will be discussed later in section 2.4.3, in relation to privacy and confidentiality.

An understanding of the legislative and policy context related to ASRH in Grenada would contribute to understanding ASRH help-seeking behaviour. However, as least one study (Silberschmidt and Rasch, 2001) showed that adolescents may not always be aware of the legislative and policy impact on their SRH. Silberschmidt and Rasch (2001) found that most adolescent girls in Dar es Salaam Tanzania were unaware that a policy existed that allowed young women access to family planning since 1994, although the service was not being provided.

2.4.3   Programmatic context

Chalmers *et al.* (2006) define the programmatic context as the context in which responses to young people's sexual health needs take place. In many developing countries, adolescents obtain SRH services in health facilities where services are primarily designed for adults, particularly adult women (Laski and Wong, 2010). Although research has indicated that most adolescents do not seek health services for sexual and reproductive health concerns (Biddlecom *et al.*, 2007), evidence also indicates that sexually active adolescents do utilize health services to some extent (Laski and Wong, 2010; Meuwissen *et al.*, 2006). This section will discuss (perceived) barriers and facilitators to adolescents' utilization of SRH and related services. While a range of factors are discussed in the literature, the programmatic factors below are broadly categorised as relating to matters of accessibility and acceptability, which are categories used by the WHO and others (e.g. Tylee *et al.,* 2007; Pearson and Makadzange, 2008; Berhane *et al.,* 2005; Barker *et al.,* 2005).

Accessibility

According to Maxwell (1992), accessibility of health care can be described in terms of whether "people are able to get treatment/services when they need it" and include factor such as "distance, ability to pay, and wait time" (p.171). Some studies (e.g. Berhane *et al.,* 2005; Booth *et al.,* 2004) capture accessibility as an aggregate measure whereas others (e.g.

Biddlecom *et al.,* 2007; Miles *et al.,* 2001; Atuyambe *et al.,* 2009) disaggregate the measure to include the factors discussed by Maxwell, in addition to other factors, such as knowledge of service. A cross-sectional survey using self-administered questionnaires was used to assess adolescents' health service utilization patterns, their attitudes and preferences towards existing health services in Ethiopia. The authors reported that one-third of 10-24 year old male and female secondary school students (N=2,647) reported that existing health services were inaccessible (Berhane *et al.*, 2005). Participants were reporting on access to service utilization for RH and other illnesses they had experienced in the last three months. Nonetheless, findings pertaining to adolescents' actual or perceived access to SRH services have been mixed.

Knowledge of service

Knowledge about places for getting SRH-related services is also used as an indicator of access and a contextual factor, because lack of knowledge may be due to lack of services or lack of marketing about available services (Char *et al.,* 2011). Biddlecom *et al.* (2007) found that significant proportions (see

) of adolescents ages 12-19 in some of the countries in their study did not know where to go to obtain contraceptive methods or STI diagnosis and treatment. However, most of the adolescents did not report having an STI or STI symptoms. The study relied on adolescents' self-report of STI and STI symptoms, therefore, there is the potential for under-reporting of both STI symptoms and treatment-seeking (Fortenberry, 2009).

Table 2-2 Percentage of 12-19 year olds knowledgeable about where to go or how to get there to obtain contraceptive or STI diagnosis and treatment among those who had sex in the last 12 months in 4 African countries in 2004

	Burkina Faso F = 654; M = 474	Ghana F = 274; M = 131	Malawi F = 339; M = 549	Uganda F = 536; M = 500
Does not know where to go or how to get there to obtain contraceptive methods	F = 15.1% M =20.7% *	F = 6.0% M =7.5%	F = 6.6% M = 13.2% *	F =22.2% M = 30.3% *
Does not know where to go or how to get there to get STI diagnosis and treatment	F = 5.6% M = 8.9%	F = 3.9% M = 1.2%	F = 6.9% M = 13.8% *	F = 11.8% M = 29.2% *

(Source: Biddlecom *et al.,* 2007)
*Chi-square p< 0.05

Booth *et al.* (2004) researched access to health care among 12-17 year olds in New South Wales, Australia. The authors found that across all groups, many adolescents were unaware of the range of available services from family practitioners and the range of skills that providers may have that could be relevant to their needs, which inhibited many adolescents from seeking health services. Interestingly, Booth *et al.* (2004) reported that out-of-school adolescents were far more likely to be aware of available services, especially youth health services. The authors attributed this to out-of-school adolescents being forced into health care by the Juvenile Justice (i.e. forced help-seeking).

Distance and transportation

The location of health services and the ability to reach them has also been recognized to affect adolescents' access to SRH services (Miles *et al.,* 2001; Kiapi-Iwa and Hart, 2004; Atuyambe *et al.,* 2009). Miles *et al.* (2001) conducted 12 focus groups with young men and women aged 15-25 in three rural villages in Gambia to understand the social processes that inform young people's health seeking behaviours for STI advice and treatment. The authors found that distance from the health centre and the lack of transportation to access STI advice and treatment was a recurrent barrier reported among young people. Similarly, Kiapi-Iwa and Hart (2004) found that distance was a barrier to obtaining condoms among adolescents in Uganda. However, distance and transportation was not always perceived or experienced as barriers to access (e.g. Biddlecom *et al.,* 2007; Kumi-Kyreme *et al.,* 2007). The majority of adolescents in Biddlecom *et al.* (2007) study thought they would be able to easily reach a clinic or hospital, especially those in Uganda (82% - 86%). The difference between these research findings could be a result of how the questions were asked, participants' place of residence (i.e. urban/rural), and availability of health facilities. Considering the network of public health facilities in Grenada (Figure 1-6), exploring whether distance and transportation affects ASRH behaviour can contribute to better understanding adolescent help-seeking in the Grenada.

Opening hours and wait times

Opening hours and wait times have also been reported as programmatic factors that hinder utilization among adolescents for SRH concerns. Among adolescents in Zimbabwe, Langhaug *et al.* (2003) found that clinics not being open during out of school hours hindered utilization of SRH services. In Berhane *et al.*' study (2005), the majority of respondents (70.1%) preferred designated service hours for adolescents (Berhane *et al.*, 2005). However, among Australian adolescents, Booth *et al.* (2004) found that opening hours and wait times were less

salient barriers to utilizing health services. The authors argue that these are likely to become more salient if adolescents' utilization of health services increased (Booth *et al*., 2004).

Cost of service

Another factor related to accessibility of services for adolescent populations is that of cost. Cost of transportation due to distance, and financial cost of diagnosis and treatment are two examples; social cost was discussed in section 2.4.1. High reproductive health service fees (Berhane *et al.,* 2005) and high cost of purchasing condoms at the clinic (Kaipi-Iwa and Hart, 2004) were reported as preventing access to health services and utilization of condoms. According to Kaipi-Iwa and Hart (2004), an 18 year old male participant in Adjumani district, Uganda stated, "In our locality condoms are not free of charge and therefore having no money means sex without condoms" (Kiapi-Iwa and Hart, 2004 p.344). Although, Biddlecom *et al.* (2007) found that between 60% and 86% of adolescents in their survey across four African countries felt that they would be able to pay for contraceptives and STI treatment, adolescents held the least favourable view regarding ability to pay for services.

Some studies (Meuwissen *et al.,* 2006; Berhane *et al.,* 2005) indicate that health services available to adolescents for free or at a reduced cost can increase utilization. For example, Meuwissen *et al.* (2006) reported that a voucher program offering free SRH services to low income female adolescents in Nicaragua has substantially increased the use of primary care clinics for contraceptives, STI and reproductive tract infections (RTIs), advice and counselling, and antenatal check-ups (Meuwissen *et al.*, 2006). Interestingly, nearly half of the sexually active girls who were neither pregnant or mothers and had not previously used contraceptives had redeemed their voucher. In contrast, Meekers *et al.* (2001) found that among in and out-of-school adolescents in Botswana, only out-of-school boys were satisfied and willing to access free condoms from public sector providers. These mixed findings suggest that free services may not be sufficient to improve service utilization for all groups of adolescents.

However, some adolescents do use alternative helpers when cost is a barrier to utilize Western health services (Miles *et al.,* 2001; Atuyambe *et al.,* 2009). For example, Miles *et al.* (2001) reported that female adolescents utilized traditional medical services for STIs, despite costing significantly higher than attending the health centre, because they were able to pay by exchanging goods for services. In contrast, Atuyambe *et al.* (2009) reported that pregnant adolescents were able to pay traditional birth attendants at a later date. The relevance of

financial cost in the Grenada context will be useful to explore, considering adolescents' preference for private providers and data showing that adolescent comprise one of the largest subgroup affected by poverty in Grenada (Table 1-1).

Acceptability of services

According to Maxwell (1992), acceptability of services can be described as "how humanely and considerately the treatment/service is delivered" (p.171). Literature on the acceptability of SRH services for adolescents indicate that there is a lack of specialized SRH services for adolescents (Tengia-Kessy and Kamugisha, 2006) and that specialized services mostly address the unhealthy consequences of unprotected sexual activity, although the majority of adolescents in most parts of the world need mainly SRH information and counselling (Hughes and McCauley, 1998). The literature further indicates that the factors that inhibit existing SRH information and services may be inadvertent and not deliberate (Senderowitz, 1999). Similarly to research on accessibility, acceptability is discussed in the literature as both aggregate and disaggregate measures. As an aggregate measure, Berhane *et al.*(2005) found that almost two-third of adolescents (students) in Ethiopia reported RH services as being unacceptable. As a disaggregate measure, other researchers discuss acceptability in terms of staffs' attitude and being able to meet adolescents' needs, and issues of confidentiality and privacy.

Attitude and behaviour of service providers

The lack of service providers, including receptionists who understand adolescents, as well as being sensitive to their needs and realities is reported as affecting adolescent help-seeking behaviour (Berhane *et al.,* 2005; Atuyambe *et al.,* 2009; Langhaug *et al.,* 2003; Meekers *et al.,* 2001). This has been reported extensively across Africa in both quantitative and qualitative studies. For example, 36% of high school students in Ethiopia perceived health providers as 'judgemental and unfriendly', which inhibited health service utilization (Berhane *et al.,* 2005). Similarly, adolescents experiencing teenage pregnancy in Uganda reported that "'don't care' attitude and rudeness and abusive behaviour of some health workers" discouraged them from seeking antenatal and delivery services (Atuyambe *et al.*, 2009 p.790). Additionally, Langhaug *et al.* (2003) interviewed both nurses and adolescents who attested to nurses "shouting at, mocking, labelling and judging young people" seeking RH information and services for prevention or treatment (Langhaug *et al.*, 2003 p.151).

Adolescents' perceptions and/or experiences also affect the source of help from which they chose to cope with their SRH concerns. For example, Meekers *et al.* (2001) reported that private sector providers were more willing to provide services to adolescents compared to public sector providers, but perceived that drug shop owners sometimes gave adolescents questioning looks when purchasing condoms. This might help to explain adolescents' preference for obtaining condoms from peers (Meekers *et al.,* 2001). However, not all adolescents perceived negative provider attitude and behaviour. Biddlecom *et al.* (2007) reported that between 75% and 95% of the sexually active adolescents in the four African countries examined reported they were likely to be treated with respect in clinics and hospitals.

Maintaining confidentiality and privacy

Confidentiality and privacy are often used interchangeably in the literature. However, in discussing adolescents' need for health care privacy, Britto *et al.* (2010) framed privacy as a multi-dimensional construct of which confidentiality is one type, referred to as informational privacy. Confidentiality and privacy are related to providers' attitudes and behaviours. In a recent literature review of the health and health care needs of lesbian, gay, and bisexual (LGB) adolescents, Coker *et al.* (2010) surmised that LGB youth wanted health care professionals to provide private and confidential services. Among 12-17 year old students in Australia, Booth *et al.* (2004) reported that the most important barrier for utilizing health services for a range of health concerns, including sexuality issues, was that confidentiality would not be kept, both in terms of service providers keeping disclosures confidential and being seen attending a service.

Berhane *et al.* (2005) found that 41% of adolescents in their Ethiopian study believed providers were confidential, 21% of adolescents did not believe providers were confidential, while 36% reported not knowing whether providers were confidential. These are important findings because any uncertainty regarding providers' ability to maintain confidentiality could prevent utilization for sensitive matters such as sexuality issues. However, the large proportion of adolescents with positive views of provider confidentiality is very promising.

Nonetheless, some health facilities and providers are deemed more confidential than others. Adolescents in Uganda were reportedly of the view that health centres lacked confidentiality, and as a result preferred to use traditional healers and drug shops. Furthermore, Langhaug *et al.* (2003) noted that confidentiality could be breached if a private space for consultation with

adolescents is lacking. Also, male adolescents in Langhaug *et al.*' (2003) study reported that confidentiality is breached because "sometimes you are taken into a private room. But the moment you say out your problem the nurses may invite other nurses to 'come and see what I have here' (p.152). In contrast, some adolescents use both Western and traditional providers because they considered both to be confidential (Biddlecom *et al.,* 2007; Kumi-Kyereme *et al.,* 2007). However, most adolescents in Biddlecom *et al.* (2007) study did not go to health facilities, despite positive expectations regarding government facilities.

2.5   Gaps in the literature

This literature review drew upon studies from various cultural contexts, using quantitative and qualitative research methods to investigate adolescents' health- and help-seeking behaviours for a range of SRH concerns. Taken together, the literature review shows that for concerns related to ASRH, high proportions of adolescents do not or prefer not to seek help. However, when adolescents chose to seek help, or at least identify preferred help sources, varied and multiple sources are often identified. Furthermore, adolescents may utilize multiple sources concurrently, and may even utilize sources for which they do not have a preference.

This review indicates that several contextual factors affect ASRH help-seeking behaviour. Although each factor has been discussed individually, the factors interact within and between contexts, which is reported as part of the difficulty in researching the influence of context. While some contextual factors, such as gender norms may affect female and male adolescents differently, they ultimately make adolescents as a group vulnerable to negative SRH outcomes. However, noticeably absent from the SRH help-seeking literature are other factors that may influence adolescent SRH help-seeking behaviour, such as religious affiliation and ideology, and the media (Couch *et al.*, 2006) – factors that may be salient in the Grenada context. However, the lack of literature on the SRH help-seeking behaviour of adolescents in the Caribbean reduced transferability of findings of the existing body of research to the Grenada context. Thus, further highlighting the gap for help-seeking research with a contextual gaze in the Caribbean region where the current study is located.

Some of the gaps from the above studies that this current study addresses are: (1) the lack of SRH-related help- and health seeking research in the Caribbean region – my review did not uncover any studies specifically pertaining to help-seeking, although one study in Jamaica

included questions on the topic. (2) Few studies have investigated help-seeking for SRH concerns identified by participants (Pearson and Makadzange, 2008; Van der Reit and Knoetze, 2004) compared to predefined SRH concerns, such as contraceptive information and access or STI diagnosis and treatment. Additionally, when adolescents were asked to identify their SRH concern and/or examine the influence of context, most studies utilized quantitative methods. However, considering that little is known about ASRH in Grenada, apart from a few school-based quantitative studies (section 1.3), an appropriate study design that allows identification of Grenadian ASRH concerns and salient contextual factors that influence how they manage those concerns is necessary. (3) Finally, the finding that most adolescents do not seek help for SRH concerns, and that those who do use a range of informal and formal sources are important issues to explore in the Grenada context. The assumption prior to undertaking this research is that adolescents in Grenada seek help primarily from informal sources for SRH concerns unless the issue is severe, because of the taboo nature of adolescent sexuality in Grenada and the potential lack of specialized ASRH programs and services.

2.6 Theoretical Perspectives Informing the Study

In this section, the focus is on help-seeking and contextual theories to better understand how they inform the current study based on the study's aim. In the discipline of Public Health, where the current research is based, few authors have used the concept of help-seeking (Pearson and Makadzange, 2008; Smith, Braunack-Mayer and Wittert, 2006; Ashley and Foshee, 2005; Barker *et al.,* 2005; Barker, 2007). However, in psychological or social-psychological sciences where help-seeking appears to be more commonly used, Rickwood *et al.* (2005 p.8) point out "the lack of a unifying theory to help-seeking behaviour" as a limitation of help-seeking research. Nonetheless, some of the dominant theories used in help-seeking research which will be discussed below include: (a) cognitive-behavioural models and theories such as the health belief model and theory of reasoned action and theory of planned behaviour; (b) decision-making or pathway models, such as Andersen's socio-behavioural model (SBM) and other pathway models; and (c) ecological theories and perspectives.

2.6.1 Cognitive-behavioural models

Cognitive-behavioural models theorize that cognition, or what people know and think affects how they act (Glanz and Rimer, 2005). Three such models and theories used in help-seeking research are *The Health Belief Model (HBM), Theory of Reasoned Action (TRA)*, and

Theory of Planned Behaviour (TPB). This section provides a critique of the models/theories, what they tell us about help-seeking and their practicality in the current research.

The HBM is a value expectancy theory, which attempts to predict and explain individual's health and health behaviour (Rosenstock *et al.,* 1994). The model addresses "individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy)" (Glanz and Rimer, 2005 p.12). In contrast, the TRA and TPB explore the relationship between behaviour and beliefs, attitudes, intentions (Ajzen, 1988; 1991; Glanz and Rimer, 2005), and perceived behavioural control (TPB only, which is remarkably similar to Bandura's (1977) construct of self-efficacy). They are concerned with individual motivational factors that are determinants of the likelihood of performing a specific behaviour, such as seeking help (Glanz and Rimer, 2005). The TRA/TPB assume that behavioural intention is the most important determinant of behaviour (Conner and Sparks, 2005; Glanz and Rimer, 2005). However, intention does not readily translate into desired behavioural outcome (Collins, 2010).

According to Mackian *et al.* (2004), the above cognitive-behavioural models/theories provide useful predictive and explanatory information in understanding how individuals seek care and about reasons for delay or timeliness of help-seeking. However, they have been criticized for being rational or deliberative processing models (Sheeran and Abraham, 1996; Hausmann-Muela, Ribera and Nyamongo, 2003; Wills and Gibbons, 2009), which imply that adolescents' help-seeking attitudes are formed after careful consideration of available information (Bibeau, 1997; Conner and Sparks, 2005; Brodwin, 1996). Furthermore, the HBM and TRA/TPB assume that all other factors, including demographics, culture, the environment (Glanz and Rimer, 2005) and past behaviour (Ajzen, 1991), operate through the models' constructs and do not independently contribute to explaining the likelihood of a person performing a behaviour. However, quantitative and qualitative research on adolescent sexual health has indicated a direct effect of the environment and demographic factors (Boldero and Fallon, 1995; MacPhail and Campbell, 2001; Voisin *et al.*, 2006). Additionally, while *cues to action* include external or contextual factors in addition to internal responses to threat, Weinstein (1988) argue that the construct does not easily fit with the rational expectancy-value structure of other HBM constructs.

Simply stated, these models/theories do not sufficiently account for wider environmental factors, including social factors that influence help-seeking decision-making processes.

2.6.2   Pathway models

Pathway models are discussed as a means of bridging the gap between outcomes (i.e. whether help is sought and the source(s) of help utilized) and process (i.e. sequence and influence on the outcome). Pathway models centre on the path that people follow, beginning with recognition of symptoms until they use different health services, such as home treatment, traditional healer or health facility (Hausmann-Muela, Ribera and Nyamongo, 2003). They attempt to identify a sequence of logical steps, and look at social and cultural factors which affect this sequence (GPA/WHO, 1995). Pathway models, as described by Hausmann-Muela *et al.* (2003) and GPA/WHO (1995), are a type of descriptive decision model rather than a normative model (Garro, 1998). Normative models, according to Abelson and Levi (1985 p.232 cited in Garro, 1998) are oriented toward "how people *should* choose", and descriptive models are oriented toward "how they *do* choose." The current study is interested in the latter, primarily because little is known about adolescents SRH help-seeking behaviour in Grenada.

Several help-seeking pathway models exist. In reference to mental health research, Logan (2001) points out that only recently have adult-based models begun to be adapted to apply to children and adolescents. Some models that include adolescents are: Shonert-Reichl and Muller, 1996; Pearson and Makadzange, 2008; Barker *et al.,* 2005, but only one has been found that emphasizes ASRH (Barker *et al.,* 2005; Barker 2007). However, three pathway models (Andersen, 1995; Pearson and Makadzange, 2008; Barker *et al.,* 2005) will be discussed below. Although not used with adolescents, Ronald Andersen's social behavioural model of health service use is discussed because it is a prominent framework for researching help-seeking behaviour. Pearson and Makadzange's (2008) and Barker *et al.*' (2005) model will be discussed because they focus on SRH and/adolescents.

Andersen's socio-behavioural model

In the 1960s Andersen (1968) developed the socio-behavioural model (SBM) of health care utilization to predict and explain the factors that can influence people's use of acute health care services. However, the model has since been modified (Andersen, 1995) for use with other services, such as oral hygiene (Andersen and Davidson, 1997) and mental health care (Parslow and Jorm, 2000; 2001). Andersen posited that people utilize health services

based upon their predisposition (i.e. predisposing factors) to use services, factors which enable or impeded service use (i.e. enabling factors), and their need for care (i.e. need factors) (Andersen, 1968; 1995). See Andersen's revised SBM model in Figure 2-2 below.
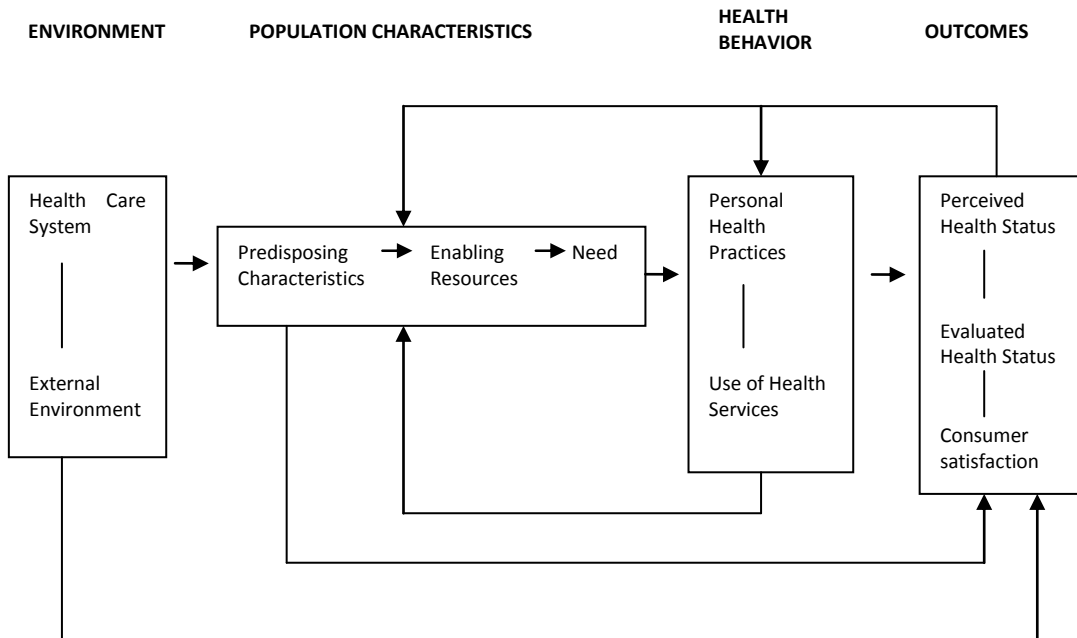
Figure 2-2 An emerging (SBM) Model - Phase 4 (Source: Andersen, 1995)

The model's constructs are hypothesized to have differential ability to explain health service utilization, depending on what type of service was examined (Andersen, 1968; 1995). This means that SBM will explain services related to contraceptive use differently than it would services for STI/HIV testing and/or treatment. However, most previous research using Andersen's model as a framework have used quantitative or mixed-methods, which can be viewed as a gap around the model. A major criticism of the model, as discussed by Penchansky (1976), is that the SBM's outcome measures are broad. However, Andersen (1995) asserts that the constructs are useful to inform national health policy rather than more specific measures relating to a particular condition, type of service or practitioner, or an episode of illness. Furthermore, Andersen uses the concept of mutability (i.e. the extent to which a factor within the model is changeable), and points out that mutable factors better highlight policy changes that can affect behaviour change (Andersen, 1995). The SBM's goal of policy development can be useful to inform ASRH policy in Grenada, since an ASRH policy does not currently exist.

Relevant for the current research is Pescosolido's (1992) criticism that Andersen's SBM does not give sufficient credence to social factors. However, Andersen tries to account for this more explicitly in his revised model (Andersen, 1995) as part of the predisposing factors. Considering the unit of analysis in the SBM is the individual's utilization of formal health services (Andersen and Newman, 1973), how individuals engage with friends, family, beliefs and information are viewed only in terms of the goal of utilizing health care (Verouden *et al.,* 2010). This further illustrate that the SBM does not fully capture the individual's embeddedness in the social context. Mackian *et al.* (2004) point out that the focus on health care utilization as the end-point likens help-seeking behaviour to a process of seeking treatment. Instead, Mackian *et al.* suggest that help-seeking behaviour should be approached as "a complex and ongoing process that cannot adequately be conceptualized by measuring dislocated actions aimed at a specific end point" (p. 141). Therefore, the SBM is viewed as inadequate to examine help-seeking as a process that may involve end-point helpers who are not health providers, or that may be used in addition to health providers.

Other Help-seeking Pathway models

Other pathway models, such as Pearson and Makadzange (2008) and Barker *et al.* (2005) try to re-dress the imbalance of models that focus too closely on the interaction between individuals and health services. Pearson and Makadzange (2008 p.361) conducted a qualitative study to identify Zimbabwean men's help-seeking pathway for sexual health concerns. Although adolescents were included in their study, the authors did not view adolescents as a separate subgroup. Nonetheless, the three-stage help-seeking model that Pearson and Makadzange (2008) have identified (Figure 2-3) has relevance for adolescents. Some of their findings resonate with the literature review in the previous section. Pearson and Makadzange's (2008) three stage model include:

1. Identifying symptoms and the condition;
2. Seeking information and advice; and
3. Seeking and accessing treatment.
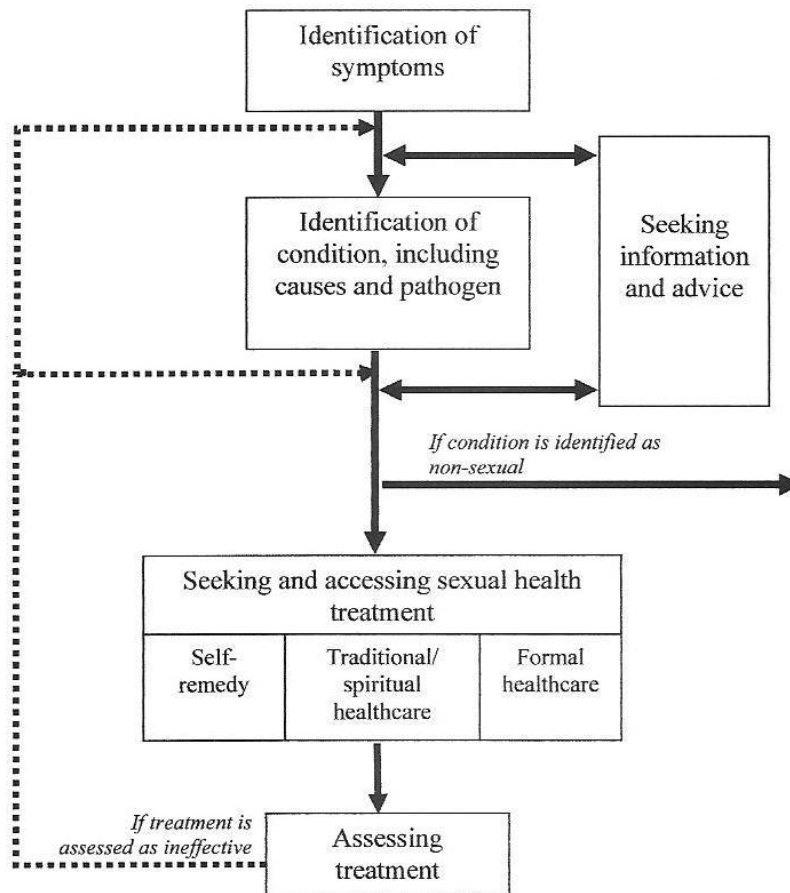
Figure 2-3 Help-seeking pathways for sexual health concerns
(Source: Pearson and Makadzange, 2008 p.365)

Pearson and Makadzange (2008) explain that help-seeking is located in the complex and dynamic socio-cultural contexts around men's sexualities, masculinities and reproductive health (Pearson and Makadzange, 2008). In the model, symptom identification was based on natural (i.e. disease and psychological) and supernatural (i.e. mystical and human-induced) factors; while information was sought from mainly formal or informal 'human sources' rather than media sources. However, the source of help sought was based on whether the symptom was perceived to be caused by natural or supernatural factors. Similarly to the literature discussed in section 2.3.3 relating to the programmatic context, seeking and accessing treatment was based on a number of factors related to the health system (availability, accessibility, quality and responsiveness of services and cost). Although, not explicit in the illustration of the model, Pearson and Makadzange (2008) point out that referrals between sectors and the serial or concurrent use of sources of help are important to achieve successful treatment, which is not accounted for in the SBM.

Barker *et al.'* (2005) model presented in Figure 2-4 is based on a literature review of the factors influencing young people' help-seeking behaviour for various types of concerns (e.g. HIV/AIDS, SRH, mental health, substance use). The authors propose the following seven stages of help-seeking:

1. Perception (i.e. problem or need or help);
2. Type of help need (normative developmental, personal stress or problem, health-related problem);
3. Motivation (motivated to seek help);
4. Behaviour (help-seeking);
5. Sources of help or social support;
6. Perspective of help-seeking attempt; and
7. Cycle recommences.

Barker *et al.* (2005) refer to help-seeking concerns as *needs*, which they categorised into three types: normative needs, specific health needs, and stress or problems. This is important for adolescents, because of the unique needs associated with their stage of development. Equally important, this allows for closer examination of help-seeking behaviour by the category of SRH concern rather than a single category of SRH. Help in the model is explained as social support of which there are four types: informational, instrumental, emotional and affiliative support; and help/support from both informal (i.e. social network) and formal (i.e. health care) sources of help are accounted for. This is particularly important for ASRH as conceptualized in the current study, because adolescents may require and utilize different types and sources of help, especially social networks if they are foregoing formal help sources (section 2.2). Other authors (e.g. Good, 1987; Janzen, 1978) have pointed out that the strength of the pathways model is the importance of significant others (e.g. relative and friends) in the decision-making process for negotiation and management of illness. Therefore, the pathways model will be apposite to understand adolescents' help-seeking behaviour. Baker *et al.* (2005) use motivation to describe the influences on adolescents' need to seek help, which resonates with cognitive models, suggesting there might be a need for a more explicit ecological construct.

Similar to criticisms of cognitive models, Good (1986 cited in Garro, 1998) notes that there is a risk that decision [pathway] models research might reproduce our understandings of individuals as rational actors. MacKian (2003) and DiClemente *et al.* (2007) support the idea of research that accounts for behaviour in broader non-biomedical terms (Evans and Lambert,

1997), which will affect the channels people engage and how we look at the influences on behaviour in particular contexts. To do this MacKian (2003 p.10) suggests addressing the "neglected *collective, social* element of health seeking behaviour, and the *interaction of individuals and societies with health systems*" (emphasis in original). Therefore, I draw on ecological theories to complement pathway theories of help-seeking behaviours as a more contemporary help-seeking research practice.

2.6.3   Ecological perspectives

According to Sallis *et al.* (2008 p.466), "Ecological models, as they have evolved in behavioural sciences and public health, focus on the nature of people's transactions with their physical and sociocultural surroundings." Although ecological models draw jointly on the person and the environment (Hawley, 1986) the emphasis is placed on the environment rather than the individual. Ecological models used with children and adolescents (e.g. Bronfrenbrenner, 1979; 1986; DiClemente *et al.,* 2007; Voisin *et al.,* 2006) acknowledge that children and adolescents are rarely solely responsible for seeking their own health and SRH care, which may make ecological theories more salient for adolescent populations. In relation to adolescents' mental health, Logan and King (2001) argue that adolescents are part of larger family, school, and community systems which play important roles in facilitating or impeding help-seeking and access to services. Influenced by Bronfenbrenner's ecological framework, DiClemente *et al.* (2007) developed an ecological model (Figure 2-4) and showed that "the individual [adolescent] is embedded within the proximal context of an environment defined by peers, community, and sexual and dating relationships" (p.892). Furthermore, the figure also shows that the "proximal influences are embedded within the distal influences of society, culture, values, economics, traditions, laws, mores"(DiClemente *et al.,* 2007 p.892). According to the authors the distal and proximal factors mutually influence each other and the adolescent, making "the adolescent the victim or the benefactor of these larger influences" (p.892). However, Grzywacz and Fuqua (2000) assert that the emphasis on the environment does not suggest that individuals are not actively involved in their own health in modifications to their circumstances.
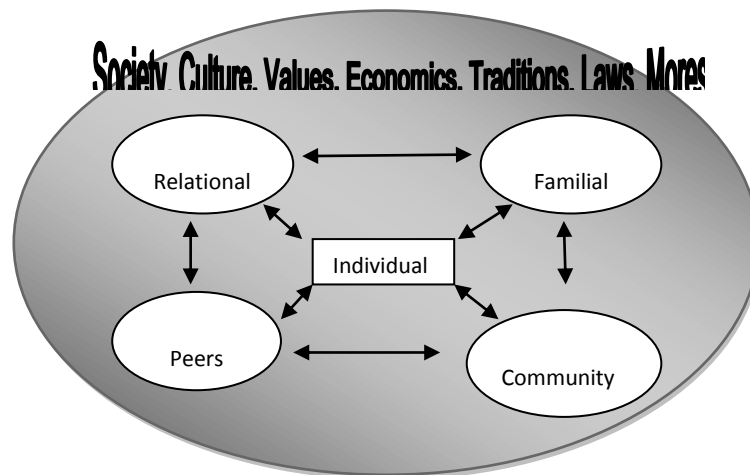
Figure 2-4 Multiple influences underlying adolescent sexual behaviour
(Source: DiClemente, Salazar and Crosby, 2007 p.892)

Bronfenbrenner's ecological model which he has revised several times and has been discussed extensively elsewhere (Bronfenbrenner, 1979; 1986) will not be detailed here, as the specific contexts he outlines will not be used in this study. However, what is of relevance to this study is Bronfenbrenner's concept of how levels of contexts are nested and influence each other and the individual. This is also illustrated in the following principles that distinguish contemporary ecological models from other health behaviour models:

a) Multiple influences on specific health behaviours, such as intrapersonal, interpersonal, organizational, community, physical environments, and public policy (Grzywacz J.G. and Fuqua J., 2000; McLeroy *et al.*, 1988; Sallis, 1997; Stokols, 1992; Sallis, Owen and Fisher, 2008);

b) Interactions of influences across different levels – the model should not merely predict that the categories of determinants interact, the model should also state how they interact (Sallis, Owen and Fisher, 2008; Stokols, 1992);

c) Multiple levels of environmental influences that directly affect behaviour (Glanz and Rimer, 2005; Sallis, Owen and Fisher, 2008); and

d) Development of behaviour-specific ecological models (Sallis, 1997), identifying the most relevant influences at each level (Grzywacz J.G. and Fuqua J., 2000; Sallis, Owen and Fisher, 2008).

In a study on detained female adolescents sexual risk behaviours in the USA, Voisin *et al.* (2006) used an ecological approach and found that together the ecological variables in their contextual analysis accounted for 51% of the variance in the index of sexual behaviour. The

authors argue that the importance of these wider environmental influences (i.e. parental monitoring, familial support, risky peer norms, school/teacher connectedness, and gender roles/dominance) in explaining detained adolescents' sexual risk behaviour would have been missed if only a micro-system paradigm was used. A qualitative study of the help-seeking patterns of 139 secondary school students ages 14-22 in various geographic locations in two South African Provinces found that contextual factors were significant mediators of help-seeking behaviour (Van der Reit and Knoetze, 2004). However, authors argue that conducting analyses at the environmental level is complex.

Studies applying an ecological perspective (Stephenson *et al.*, 2007; Stephenson, 2009; L'Engle, Brown and Kenneavy, 2006) usually incorporate concepts from different theoretical constructs, such as self-efficacy (Bandura, 1977) or behavioural intention (Ajzen, 1991). However, for the current study, constructs used are based on the stages from the pathways models in section 2.6.2 above and the literature review.

Additionally, Grzywacz and Fuqua (2000) point out that ecologists are reproached for including many factors in a health model without assigning priorities to factors in an intervention, especially in settings with limited resources. In their own work, the authors identify factors referred to as leverage points, which they argue are the most salient individual and environmental factors (Socioeconomic status (SES), family, employment and school) to address this limitation, which is similar to Andersen's concept of mutability. DiClemente *et al.* (2007) use leverage points based at each environmental level to demonstrate a more efficacious strategy of long-term, sustainable STI/HIV behaviour change among adolescents. In this study, the concept of leverage points was used to focus recommendations at the different levels of contexts.

2.7   Conceptual Framework

The Ecological help-seeking conceptual framework that guided the current study is presented in Figure 2-5 below, followed by an explanation of the framework.

Figure 2-5 Ecological help-seeking framework informing thesis (Source: Author, 2009)

Socio-Cultural Context

Legal and Policy

Programmatic Context

Adolescent Help-seeking

Categories of SRH Help-Seeking concerns

- Specific health need
- Normative need
- Problem or stress related need

Types of Help

- Instrumental support
- Informational support
- Emotional support
- Affiliative

Identification of help-seeking concern

Choice of Help Source

Health care Providers | Social networks

Evaluation of help received and restarting the cycle

Health service

Health education

Acceptability of ASRH services

Accessibility of services

Cultural norms

Gender norms

Media

Stigma

Religion

Criminal justice

Social services

43

Although many theories have been successfully utilized to investigate help-seeking behaviour, the current research was best served by applying multiple perspectives. Therefore, the literature review, in addition to the help-seeking and ecological theories and models discussed above, informed the development of the conceptual framework that guided the current study (i.e. research questions, data collection and analysis). Based on the broad definition of help-seeking used in this research (section 2.2), the help-seeking framework developed by Barker *et al.* (2007) provides a good foundation from which to examine help-seeking behaviour. This framework was chosen because in addition to being developed from the literature on AH, each stage is considered in its constituent parts rather than a whole. Furthermore, Barker *et al.*'s model, which interprets help as various forms of social support, is consistent with the various types and sources of help adolescents may choose to utilize to cope with SRH concerns. Taken together, these provided a framework adequate to guide data collection and analysis.

Pearson and Makadzange's (2008) influence on the current framework is in highlighting that the stages of help-seeking are messy and non-linear, as a result they may overlap and cycle over each other. This is represented by the directional arrows in the help-seeking behaviour pathways located at the individual level of the framework. This research takes from Bronfenbrenner's ecological theory the idea that "the ecological environment is seen as a set of nested structure, each inside the other like a set of Russian dolls. Moving from the innermost to the outside..." (Bronfenbrenner, 1994 p.39). However, rather than use Bronfenbrenner's ecological levels, the levels used are consistent with other levels of context within the literature (Couch *et al.,* 2006; Chalmers *et al.,* 2006). It was also assumed that labels such as programmatic, socio-cultural, and legislation and policy contexts would be more clearly recognized and understood by stakeholders with responsibility for ASRH. Each of the constructs used are defined below (Box 2-1). The contextual levels are delineated in the framework by nested oval structures – the blue highlights indicate the contexts that are the primary focus of the study. Although the red highlighted context is important, its relevance to the study is secondary and based on its interaction with the primary context being explored.

Box 2-1 Definition of constructs used in the study's conceptual framework
(Adapted from Barker *et al.,* 2005; Barker, 2007; Chalmers *et al.,* 2006; Couch *et al.,* 2006)

Categories of ASRH concerns

Normative needs: understanding changes associated with puberty, sexual identity, relationship formation and concerns

Specific health needs: health services in the formal or informal sector and pharmacist, as well as seeking SRH-related information

Stress or problems: as in the case of sexual violence and financial needs

Types of help/support sought

Informational support: general SRH-related information or for specific SRH concerns, referrals for help

Instrumental support: direct support to adolescents, including financial assistance related to SRH help-seeking, contraception, health services

Emotional support: close friends or family members, or professionals who provide help for emotional or personal crises related to SRH

Affiliative support: being with other individuals who have mutual interests

Contextual Levels

Legal and policy context: the enacting of legislation, the development and implementation of policy, relevance to the health and education of young people.

Socio-cultural context: beliefs, norms and practices, gender and sexuality, community, mass media, and religious influences on young people, and in which response to young people's SRH needs take place.

Programmatic context: in which responses to young people's sexual health needs take place, such as schools, private and public health facilities, non-governmental organizations, faith-based organizations, and media campaigns.

Other contributions of the ecological perspective for this research are the principles that posit interactions of influence across different levels, and that multiple levels of the environment directly affect behaviour. This is illustrated by the broken lines separating each level of context in this study's conceptual framework. Additionally, the specific factors (e.g. gender norms, accessibility) at each level of context affecting help-seeking behaviour were identified from the literature review. However, this was done with the awareness that the relevance of factors for the adolescents in Grenada may vary due to the differences in the contexts of the studies

reviewed and the methods used. These differences are accounted for in the revised conceptual framework in section 8-4, which is based on the analysis of the data.

2.8 Chapter Summary

This chapter discussed the literature from developed and developing countries related to ASRH and the influence of contextual factors. Gaps were identified on which to focus the scope of the study, and help-seeking theories were critically analyzed based on the scope of the study. Finally, an ecological help-seeking conceptual framework was created to guide the study data gathering and analysis. The next chapter discusses the scope of the research by providing an in-depth discussion of research methodology, methods and process undertaken related to the study design and data analysis.

Chapter 3 **– Research Methodology**

3.1   Introduction

This chapter begins by discussing the study type and approach in section 3.2. The research methods used for data gathering and their rationale are discussed in section 3.3. The study design is discussed in section 3.4. The data analysis procedures are discussed in section 3.5. A reflexive discussion of the methodological issues pertaining to quality and rigour to ensure validity are discussed in section 3.6. The ethical procedures addressed throughout the research process are discussed in section 3.7. The limitations and strengths of the study are discussed in section 3.8. A summary of the chapter is provided in section 3.9.

3.2   Study type and Approach

3.2.1   Constructionist Perspective

An exploratory qualitative study was conducted to examine the context of adolescents' SRH help-seeking behaviour in Grenada. Exploratory qualitative research, according to Patton (2002 p.193), is a reasonable starting point for research, "in new fields of study where little work has been done, few definitive hypotheses exist and little is known about the nature of the phenomenon." The dearth of research in the Grenada context regarding ASRH and help-seeking behaviour (section 1.3) lends itself to exploratory research utilizing qualitative methods, because my goal is to understand "questions about the 'what', 'how' and 'why'" (Green and Thorogood, 2009) of ASRH help-seeking in Grenada. As a result, quantitative research with its focus on "measurement and analysis of the causal relationships between variables" (Denzin and Yvonna, 2000 p.8) is not appropriate to achieve the aim of this study.

Qualitative research has been used successfully to explore SRH topics with adolescents (section 4.2.1) across various settings globally (e.g. Hyde *et al.,* 2005; Gibson, 2007; Morrissey and Higgs, 2006; Barker and Rich, 1992; MacPhail and Campbell, 2001; Kempadoo and Dunn, 2001). Several perspectives are used to guide qualitative research design (see Box 3-1). Patton (2002) refers to these perspectives as "theoretical perspectives" and criticizes their use as being "arguable and somewhat arbitrary" (p.80). Nonetheless, Patton uses 'foundational questions' to distinguish between the different perspectives. However to avoid confusion with

the use of theoretical perspectives discussed in section 2.6, methodological perspectives will be used in this thesis, and Patton's foundational questions in Box 3-1 were used to help choose the most appropriate perspective for this research.

Box 3-1 Theoretical perspectives and their distinguishing foundational questions

Ethnography
What is the culture of the group of people?

Social construction and constructivism
How have the people in this setting constructed reality? What are their reported perceptions, "truths," explanations, beliefs, and worldview? What are the consequences of their constructions for their behaviours and for those with whom they interact?

Phenomenology
What are the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?

Heuristic Inquiry
What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?

Source: (Patton, 2002)

While this research can be undertaken using a number of the different perspectives, these would be inappropriate. To conduct an ethnographic study using observational methods would be difficult, as it would not be possible to prospectively observe SRH help-seeking behaviour as a process, given the duration of the study. However, an ethnographic study would be feasible if the main interest was in observing end-point utilization of sources of help. Phenomenology, which allows for examining the meaning of help-seeking for adolescents provided a good perspective, however, meaning making alone is insufficient to achieve the goals of the study. Grounded theory was also considered (Charmaz, 2006; Glaser and Strauss, 1967); however, there are help-seeking theories that provide a good starting point to guide ASRH help-seeking behaviour research in Grenada (section 2.6). Furthermore, my primary interest was not theory development. Based on the assumption that SRH behaviours of adolescents in Grenada are influenced by social and cultural values, a social constructionist perspective was the most relevant approach to guide the research design. A social constructionist perspective recognizes the importance of social and cultural values in social systems in which behaviour occur (Gama, 2009).

In this thesis social constructionism is used, although some authors use the term interchangeably (Bryman, 2008; Green and Thorogood, 2009). Patton (2002) and Michael Crotty (1979 cited in Patton 2002) are among the few authors who attempt to distinguish the subtleties. Social constructivism/constructionism include the tenet that perception is "made up" and shaped by sociocultural, linguistic, historical, and political processes (Patton, 2002; Green and Thorogood, 2009; Schwandt, 2000). Furthermore, Patton's foundational questions specific to the constructionist/constructivist are relevant to this study, and are reflected in the research questions. Grenadian adolescents and stakeholders perceptions/constructions related to ASRH help-seeking are accessed by interrogating contexts (Figure 2-5) to understand how as groups and individuals, sense is made of the phenomena of help-seeking for SRH and what if any consequences result from these constructions.

Although social constructionists tend to present an unbiased view of the multiple constructions of different groups, they are usually presumed to serve the interests of the powerful (Patton, 2002). As such, this research takes a critical approach in an attempt to give voice to adolescents' perspectives and situation, as they are the less dominant and powerless group (Patton, 2002) compared to adult key informants, who are generally considered the more powerful group. The nature of the study with its focus on adolescents required special consideration as sensitive research, which is discussed in section 3.2.2 below.

3.2.2   Sensitive Research

The current research is considered sensitive, because according to Wellings *et al.* (2000 p.256), "it requires disclosure of behaviours or attitudes which would normally be kept private and personal, which might result in offence or lead to social censure or disapproval, and/or which might cause the respondent discomfort to express." Adolescent sexuality, described as taboo and leading to social disapproval, often results in discomfort to express in diverse contexts (MacPhail and Campbell, 2001; Kempadoo and Dunn, 2001). While this study did not interrogate adolescents' sexual behaviour, help-seeking behaviour was related to the sexual behaviour of adolescent participants or others they may know, which had implications for their social identity. Furthermore, the small geographic size of Grenada, in addition to the small numbers of ASRH-related organization and programs could result in potential negative impact of the study for organizations and groups of adolescents. As a result, conducting this sensitive research had implications for the choice of methods used for data gathering.

3.3   Research Methods and Rationale

In this study, different qualitative methods were used because of their suitability to best address the research questions. The multiple methods utilized included: document review, focus groups, and semi-structured interviews. Taken together, they addressed the aim of the research and provided a comprehensive picture of the context of ASRH help-seeking in Grenada. Table 3-2 shows how each data gathering method relates to the research objectives and questions. Furthermore, a scripted story, word game, card sort and mapping were used as strategies to stimulate interaction in focus groups and interviews with adolescents (Appendices C and D). Green and Thorogood (2009) assert that the use of multiple qualitative research methods within the same project is "common-sense good practice if the study addresses a number of distinct research questions, for which different methodological approaches are implicated" (p.239). Each method discussed in this section, therefore, contributes to the robustness of this qualitative study. Besides, using multiple methods makes it possible for triangulation to occur (section 3.6.4), albeit, the idea of triangulation as a means of increasing qualitative research validity is contentious (Green and Thorogood; Pope *et al*., 2000).

Table 3-1 Alignment of research objectives, questions and methods

Research Objective	Research Question	Research Methods & Data Analysis
1. To describe the ASRH promotion framework in Grenada.	1a. What ASRH-related programs, policies, and legislation exist in Grenada? 1b. What are stakeholders' perceptions of the adequacy of the current framework to meet the SRH needs of adolescents?	1a.Key informant interviews with managerial level health professionals 1b. Document review
2. To explore Grenadian adolescents' perceptions of how the socio-cultural and programmatic contexts influence adolescents' help-seeking behaviour for their SRH concerns.	2a. What are Grenadian adolescents' help-seeking pathways for SRH concerns? 2b. How do the socio-cultural and programmatic contexts influence Grenadian adolescents' interpretation of their help-seeking behaviour for SRH concerns?	2a.Key informant focus groups with community members 2b.Focus group with each group of adolescents as the main research method 2c.In-depth interviews with selected FG participants 2d.In-depth interview with non-focus group participants
3. To recommend the most appropriate and potentially effective solutions to promote adolescents help-seeking for SRH concerns in Grenada.	3a. What are solutions emerging from the data and best practices that can be recommended to improve the current ASRH framework and address adolescents' help-seeking needs for SRH concerns in Grenada?	3a.During focus group and interview methods above 3b.Thematic data analysis using Framework facilitated by NVivo to analyse all focus group and interview data 3c.Content and context analysis for document review 3d.Card sort analysis

3.3.1 Document Review

Reviewing documentary sources as a form of data in qualitative research is advantageous. According to Miller and Alvarado (2005 p.349) "documents exist before the researcher seeks to use them as data." This means that documents are a good source for gaining background information on a topic, and can help to focus data gathering using other sources, as was done in this study. Document review informed some of the questions key informants were asked related to the legal and policy context. Other authors (Mason, 2002; Abbott *et al.*, 2004) point out that the information available in documents may not be available from other sources, or can be used to supplement other methods, such as focus groups and interviews to verify or contextualize personal reflections. For these reasons, it made sense to review documentary sources to supplement interviews and focus groups regarding services, legislation and policies related to ASRH and help-seeking. Miller and Alvarado (2005) point out that some documentary sources are text-based, while others such as, photographs and films are not.

3.3.2 Focus Group Discussion

A focus group according to Green and Thorogood (2009 p.127) "is a small (usually 6-12 people) group brought together to discuss a particular issue...under the direction of a facilitator, who has a list of topics to discuss." Barbour considers focus groups as "invaluable in teasing out the influences on individuals' views and stages in the reasoning process," by allowing "access to interactional context", which is not obtained from individual interviews (Borkan, 1993 cited in Barbour, 1995 p.329). Similarly, Finch and Lewis posit that focus groups "reflect the social construction – normative, influences, collective as well as individual self-identity, shared meaning that are an important part of the way in which we perceive, experience and understand the world around us" (Finch and Lewis, 2003 p.172). This makes it possible to understand how an issue affects a community. According to Kitzinger (1995, p.299), focus groups allow participants to "explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities." It can therefore be argued that using focus group method is consistent with the social constructionist/constructivist approach (MacPhail and Campbell, 2001), which is the methodological perspective informing this study.

Focus groups were used in this research to explore the various contexts in which ASRH help-seeking concerns and behaviour are negotiated and constructed. Bloor *et al.* (2001) have discussed the use of focus groups as appropriate in exploratory studies; and according to Gibson (2007), the use of focus groups among adolescents has grown over the years. However, other authors (Bloor *et al.*, 2001; Farquhar and Das, 1999; Kitzinger, 2005; Hennink, 2007) have offered opposing views about the utility of focus groups in researching sensitive topics. Nevertheless, Barbour (2008) suggests that because all focus group participants do not have to answer every question, and the environment is supportive (Barbour, 1995), focus groups can be appropriate for researching sensitive topics. As discussed in section 3.2.2, researchers spanning Australia to the Caribbean have reported successfully using focus groups in ASRH research. Therefore, this study will add to this body of knowledge by determining the utility of focus groups among adolescents in the Grenada context where focus groups can be considered a novel method among adolescents.

3.3.3 Semi-Structured Interview

According to Green and Thorogood (2009 p.93), "the interview is the most widely used method of producing data in qualitative health research," and involves a "somewhat rarified, in-depth exchange between researcher and researched (Barbour, 2008 p.113). Unlike focus groups, interviews provide access to the perspectives and experiences of a single individual (Mack *et al.*, 2005) rather than group norms. Patton (2002) describes three basic interview approaches: unstructured/informal conversational interview, semi-structured/general interview guide approach, and the standard open-ended interview. However, the approach used in this study to complement focus group discussion is an amalgam of the semi-structured interviews and the standard open-ended interview, discussed below (see Appendix D for interview guide sample). Nonetheless it is still referred to here as semi-structured interviews.

The semi-structured interview provides a middle ground in comparison to the unstructured and standard open-ended interviews. The semi-structured interview is a flexible approach that allows the interviewer freedom to pursue certain issues in greater depth, by probing and asking further questions to illuminate the topic under investigation (Patton, 2002). Interview guides also consisted of a set of carefully arranged questions, which is typical of the standard open-ended interview (Patton, 2002). This made multiple interviews more systematic and

comprehensive by delimiting[3] in advance the issues to be explored for each organizational-level key informant and adolescent. The interview guide used, was particularly important for semi-structured interviews with adolescents because two interviewers were involved in gathering the data, whereas I was the only interviewer of key informants. The interview guide allowed the emergence of individual perspectives and experiences (Patton, 2002).

The standard open-ended interview approach would not have been appropriate because it does not permit the interviewer to pursue topics or issues that were not anticipated when the interview guide was written, and reduces the extent to which individual differences and circumstance can be understood (Patton, 2002). Also, the unstructured interview would not have allowed for sufficient systematic data gathering between interviews and would have required experienced interviewers.

The above three methods (document review, focus groups, and semi-structured interviews) are used for different purposes and have different strengths. Together they complement each other to achieve the aims and objectives of this study. The next section discusses how the study was designed to utilize these methods.

3.4   Study Design

The study design was informed by the literature review, conceptual framework, and my knowledge of Grenadian culture and society. Figure 3-1 highlights from top to bottom, five different procedural stages in the design of the study. Different colour boxes are used to indicate each stage, while the arrows represent the flow of activities between stages. While the figure illustrates an almost linear process, phases sometimes overlapped. Also, with the exception of document review, data gathering occurred sequentially from informants to adolescents. The two shades of orange illustrates that while data gathering and analysis are part of the same stage, the data analysis was primarily conducted after data gathering were completed. Data were gathered for a nine-month period between December 2009 and September 2010 in Grenada. This section discusses the procedures for participant recruitment and data gathering.

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[3] Delimiting refers to parameters used by the research study to addresses the boundaries of the study or how the study will be narrowed.

Stakeholder meeting upon entering the Field
(1 month)

-Identify community contacts to facilitate access to communities

- To gain national and local support

-Invite participation of 2 institutional sites for adolescent participant recruitment

-Invite participation of community sites for adolescent participation recruitment

Training research assistants & Piloting

(1) Document Review *(sporadic Dec '09 – Apr '11)*

Adolescent recruitment *(1month)*

(1) Rural & Urban out-of-school boys in NEWLO

(2) Rural & Urban pregnant or adolescent mothers

(3) Male and female adolescents in a rural community

(4) Male and female adolescents in an urban community

Data gathering *(6 months)*

(2) Organizational-level key informant interviews *(Apr '10)*

(3) Community-level key informant interviews *(Apr '10)*

(4) Focus group with adolescents *(Jun – Jul '10)*

(5) Semi-structured interviews with focus group and non-focus group adolescents *(Aug-Sept '10)*

Transcribing

Data analysis & reporting *(1.5 years)*

-Document analysis
-Framework analysis
-Card sort analysis

Legend

→ Flow of activities

Dissemination of findings

Figure 3-1 Overview of Study Design

3.4.1 Research Participants

Apart from document, the following participant groups were identified for inclusion into the study:

A. Organizational-level key informants

B. Community-level key informants

C. Community-based adolescents

    a. Male and female urban adolescents

    b. Male and female rural adolescents

D. Institution-based adolescents

    a. Pregnant or adolescent mothers attending the *Program for Adolescent Mothers (PAM)*

    b. Out-of-school boys attending the *New Life Organization (NEWLO)*

As discussed in section 1.3, in Grenada a range of adolescents had not been engaged by researchers to voice their views and experiences of SRH help-seeking. Furthermore, while data on Grenada is rarely disaggregated beyond sex, the data in Table 1-2 and Table 1-3, in addition to international evidence (Flisher and Gerein, 2006) suggests that rural adolescents, girls, poor and out-of-school adolescents might be more vulnerable to SRH problem than others. Therefore, there was a need to involve a range of adolescents, which would add to the robustness of the study and provide a more complete picture of the context of ASRH help-seeking in Grenada.

Table 3-2 lists the criteria for inclusion of documentary sources, key informant interviews and focus groups, and adolescent focus groups and interviews. For community-based adolescents, the criteria included that adolescents were enrolled in school and self-report that they are not pregnant, or an adolescent mother or father. Both of these criteria were included because some out-of-school boys and pregnant or adolescent mothers would be reached at the institutional settings. Furthermore, from cultural knowledge, I believed that including in-school adolescents with adolescents who are out-of-school may have hindered recruitment and/or comfortable discussions. Students rarely maintain close social ties with out-of-school or pregnant/adolescent mothers, especially girls. Therefore, the criteria are deemed appropriate to achieve the aim of the research. A sampling strategy was then developed to ensure that the criteria in Table 3-2 resulted in sampling the right mix of participants.

Table 3-2 Study Inclusion and Exclusion Criteria by Type of Participant

Participants	Inclusion Criteria	Exclusion criteria
Documents	1. Must pertain to ASRH-related laws; 2. Must pertain to ASRH-related policies; 3. Must pertain to ASRH-related programs or services; and 4. Will be legislative documents, organizational and donor reports, services delivery protocols, unpublished research reports and findings; informational and educational brochures, and organizational websites.	1. Emerging laws, policies and service that were being developed at the time of data gathering.
Organizational-Level Key Informants	1. Managerial level personnel; 2. Representing a key organisation or program related to ASRH; and 3. The most knowledgeable person about the organization's ASRH program and policies, and/or policies and legislation in Grenada.	1. Newly recruited or junior staff with limited institutional knowledge.
Community-Level Key Informants	1. Resident of the rural community X and urban community Y; 2. Knowledgeable about their community; and 3. Knowledgeable about ASRH issues in their community.	1. Non-residents of rural community X and urban community Y
Community-Based Adolescents	1. Male and female adolescents ages 16-19 2. Resident of rural community X and urban community Y 3. Enrolled in school 4. Self-report that he/she is not pregnant, expecting or an adolescent mother or father	1. Non-residents of rural community X or urban community Y 2. Residents of communities X and Y, but are not enrolled in school, self-report to be pregnant, expecting, or is already an adolescent mother or father 3. Adolescents who are related to or have a close relationship with the facilitators/interviewers
Institution-Based Adolescents	1. Male and female adolescent ages 16-19 2. Male will be attending the New Life Organisation (NEWLO) 3. Female will be attending the program for Adolescent Mothers (PAM) 4. Resident of any rural or urban parish 5. Males may or may not be adolescent father	1. Adolescents who are related to or have a close relationship with the facilitators/interviewers

3.4.2   Sampling

According to Patton (2002) purposeful sampling is an appropriate qualitative research strategy from which a great deal can be discovered. However, different purposive sampling strategies were utilized to select participants "by virtue of characteristics thought by the researcher to be likely to have some bearing on their perceptions and experiences" (Barbour, 2008 p.52). An overview of the sampling strategies is presented in Table 3-3.

Table 3-3 Purposeful sampling strategy used in the study

	Purposeful Sampling Strategy
Documents	Criterion sampling
Organizational-level key informants	Stakeholder sampling Snowball
Community-level key informants	Criterion sampling
Adolescent focus groups	Maximum variation Snowball
Adolescent semi-structured interviews	Maximum variation Theoretical sampling

3.4.2.1   Sampling Documentary Sources

Textual documents were used in this research and include legislative, policy, organization and donor reports, and research reports pertaining to the legal and policy context and the programmatic context in Grenada. Documents were obtained directly from a wide range of stakeholders related to ASRH contacted during fieldwork and from Internet searches using the keyword Grenada and specific SRH issues or conventions (e.g. Grenada and abortion, Grenada and Convention on the Rights of the Child). A total of 24 documents were gathered for review. However, a cursory reading of available documents and verbal summary provided by stakeholders of other documents indicated that 21 documentary sources were relevant to the study based on criterion sampling (Patton, 2002) which was set out prior to data gathering (Table 3-2). However, only 19 documentary sources were available for full review. See Appendix B for a list of the documentary sources. Some documents were excluded from

review because copies were unavailable, while others were literature review articles on ASRH in general.

3.4.2.2 Sampling Key Informants

Table 3-3 shows that stakeholder sampling was used among organizational-level key informants and criterion sampling was used among community-level key informants to primarily address research questions 1a and 1b (Table 3-1).

Organizational-Level Key Informants

Six organizational-level key informants were identified using stakeholder sampling. According to Given (2008 p.697), stakeholder sampling involves "identifying the major stakeholders who are involved in designing, giving, receiving, or administering the program or service being evaluated, and who might otherwise be affected by it." A list of the major stakeholders was created based on my knowledge of the Grenada health system (section 3.6.5). Other stakeholders were identified by attending workshops and fora related to the research topic, introductory meetings with stakeholders and during interviews with other key informants (i.e. snowball sampling). However, two of the originally identified programs related to HIV/AIDS were no longer in existence during the fieldwork, as were some identified by key informants; this, I attributed to the fluid nature of programs in Grenada. Nonetheless, the flexible nature of qualitative research made it possible to adjust the sample based on the realities of the field to best answer the research questions.

Community-Level key Informants

In the rural and urban communities a total of 13 community-level key informants represented diverse occupational backgrounds participated in two mixed-sex focus groups. Participants were identified using criterion sampling, which Patton (2002) describes as selecting cases that meet some predetermined criterion of importance (Table 3-2). It is noteworthy that initially, interviews were planned with two community-key informants in each of the participating communities. Instead, focus groups were utilized after obtaining ethical clearance for the change from interviews to focus groups. This was a better method to obtain a range of perspectives in a short amount of time (Hennink, 2007), because of the inclusion of a larger number of community participants.

In Table 3-2 above, although the inclusion criteria refer to the *most knowledgeable* person, in only one organization was there more than one person who dealt with ASRH. In this case, the person-in-charge made the decision as to who was interviewed.

3.4.2.3 Samplings Adolescents

Although researchers have conducted focus groups with children and adolescents (Heary and Hennessy, 2002; Charlesworth and Rodwell, 1997; Darbyshire *et al.,* 2005) it can be argued that older adolescents have a better sense of self and are more capable of understanding and articulating their current and past experiences compared to younger adolescents. Therefore, the purposive sampling strategies described below were used to target vulnerable subgroups of older adolescents representing rural and urban communities in Grenada. There was scope for older adolescents to reflect on their experiences and views of early adolescence. However, it is possible that information was lost due to memory recall and limited interaction with younger adolescents.

Adolescent Focus Group Participants

Thirty-three adolescents participated in 11 single-sexed and geographically-bounded focus groups to include: rural/urban male, rural/urban female, out-of-school boys, and pregnant or adolescent mothers. With the exception of female adolescents in the urban community where one focus group was conducted, two focus groups were conducted with each subgroup of adolescents. To recruit information-rich cases of adolescents, maximum variation and snowball sampling were used. Maximum variation allowed for the identification and inclusion of adolescents who have different experiences or perspectives in relation to the topic (Patton, 2002; Given, 2008). According to Patton, the patterns that emerge due to the differences in individual cases as a result of maximum variation highlight "the core experiences and central, shared dimensions of a setting or phenomenon" (Patton, 2002 p.235). Maximum variation was therefore utilized as a means of thoroughly describing and understanding the variations of experiences and perspectives in the group, while examining common themes (Patton, 2002).

Additionally, snowball sampling (Patton, 2002) was used to identify adolescents who were friends of participants. This method was particularly useful during the recruitment of males in the rural community, a group that were difficult to recruit using maximum variation. Hennink (2007) posits that for conducting focus groups on sensitive topics in international settings, it is

practical to recruit at least two persons per group who are acquaintances or members of existing networks. Therefore, considering the research topic and that in communities the majority of residents are at least acquainted, snowball sampling helped to ensure that at least two people in the community focus groups were friends. The purposeful sampling strategies utilized helped to obtain some balance of homogeneity and heterogeneity (Patton, 2002; Kitzinger, 1994) in the study.

Adolescent Interview Participants

Semi-structured interviews with adolescents addressed research questions 2a, 2b and 3a (Table 3-1). Adolescent interview participants consisted of: (1) adolescents who did not participate in focus groups identified using maximum variation sampling; and (2) adolescents who had participated in focus groups identified using a form of theoretical sampling. A total of 15 semi-structured interviews were conducted among adolescents.

Maximum variation was used to ensure that interviews were conducted with adolescents who had a range of experiences (Patton, 2002). Using the demographic information collected in the recruitment checklist, for example, some participants were selected who reported being sexually active and not seeking help, or reported not being sexually active and seeking help. In contrast, theoretical sampling was used to identify participants who represented particular incidents highlighting concepts in the conceptual framework or new concepts. For example, seeking instrumental or informational support, or seeking help from a counsellor. Barbour (2008) argues that she does not find differentiating between purposive and theoretical sampling particularly useful. However, differentiating between the terms in this research was useful because theoretical sampling referred to sampling that occurred after the research was underway. Nonetheless, theoretical sampling used in this study is not as rigorous as that used in grounded theory to encourage saturation (Glaser and Strauss, 1967). To identify focus group participants to potentially participate in the semi-structured interviews, preliminary analysis of emergent and important themes were identified by listening to the focus group audio-recordings, reviewing focus group notes and debriefing meetings with co-moderators.
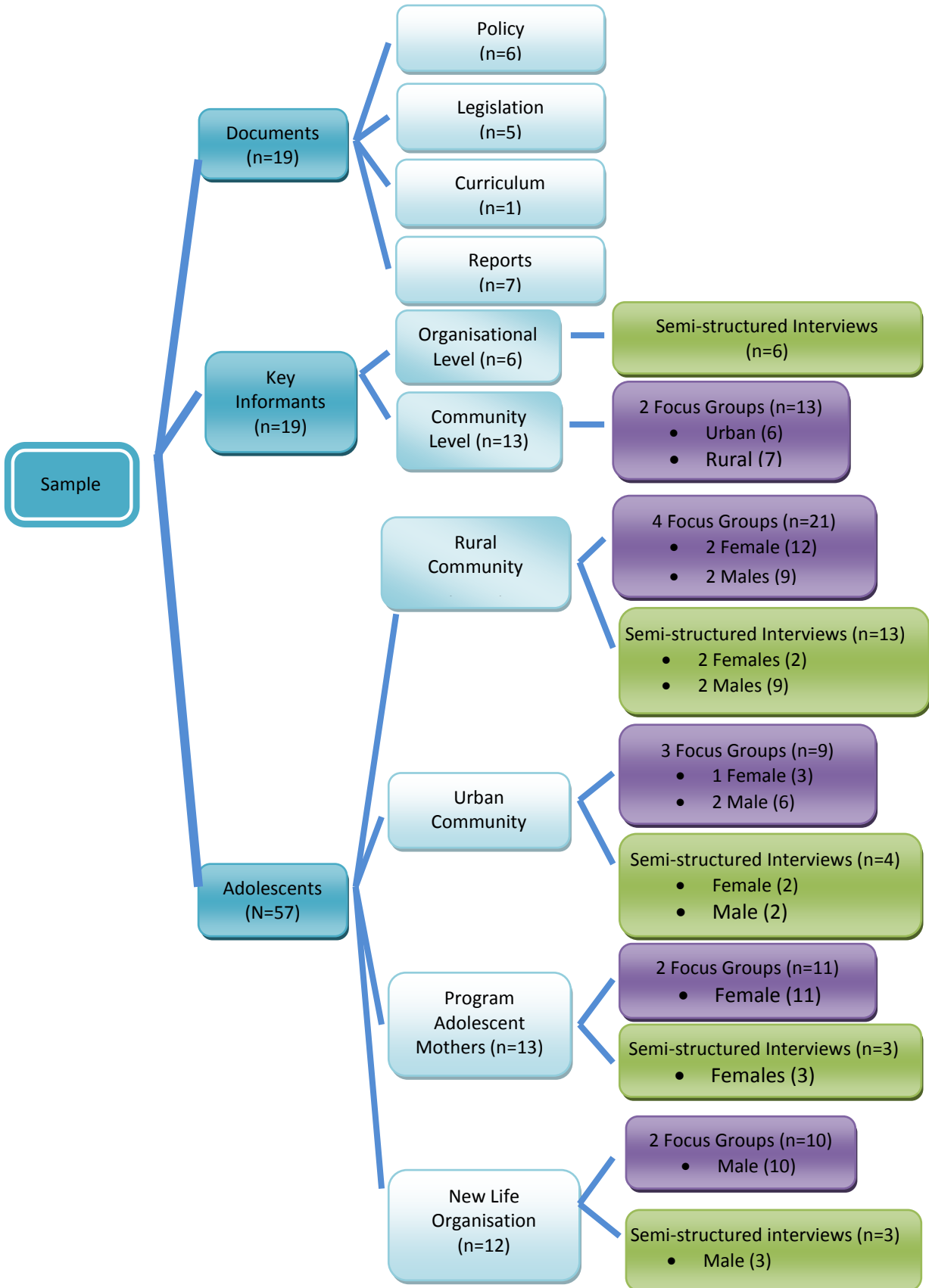
Figure 3-2 Breakdown of Sampling

3.4.3 Participant Recruitment

The inclusion criteria in Table 3-2 helped to ensure that a purposeful sample of document, key informants and adolescents were recruited to adequately explore the context of Grenadian adolescent help-seeking behaviour. The following section describes the recruitment strategies employed in this study. Table 3-4 provides a breakdown of adolescent demographic information.

Table 3-4 Breakdown of adolescent demographics

Participants	Focus Group			Interview		
	Total (n=51)	Male (n=25)	Female (n=26)	Total (n=15)	Male (n=8)	Female (n=7)
Age						
• 15*	3	-	3	-	-	-
• 16	15	8	7	6	3	3
• 17	12	5	7	4	-	4
• 18	10	5	5	2	2	-
• 19	10	7	3	3	3	-
• 20*	1	-	1	-	-	-
Type of Group						
• Rural community	21	9	12	5	3	2
• Urban community	9	6	3	4	2	2
• Adolescent mothers	11	-	11	3	-	3
• Out-of-school boys	10	10	-	3	3	-
Residence						
• Rural	29	13	16	7	3	4
• Urban		12	10	8	5	3
Ever had sex						
• **Yes**	26	15	11	10	6	4
• **No**	20	8	12	5	2	3
• **Missing**	5	2	3	-	-	-
Interview participants from focus group				8	5	3
Interview only participants				7	3	4

(Source: Recruitment Checklist)

*Adolescents ages 15 and 20 were recruited into the study considering that they would be within the age range during data gathering or was within the age range during recruitment.

The settings chosen were based on the best place to reach these particular groups. It was believed that the number of school dropouts and adolescent pregnancy would be insufficient in the communities of interest and thus too small for an adequate sample size, particularly for focus groups. Hence, the decision was made to reach these groups at programs that targeted

them. This was done knowing there was a chance that these adolescents may be different from adolescents not attending these programs.

3.4.3.1 Key Informant Recruitment

Organizational-Level Key Informants

Key informants were initially contacted via telephone or in-person to provide them with information about the research, invite participation, and obtain verbal consent to conduct the interview. Prior to the interviews, an information/invitation letter discussing the research, formally requesting the interview and relevant documents was hand-delivered or e-mailed to key informants. With the exception of one stakeholder who was reluctant to be interviewed because the program was experiencing a leadership transition and reported not working with adolescent at the time, recruitment of key informants was generally unproblematic. However interviewing this stakeholder could have yielded important information about why their organization was not targeting adolescents.

Community-Level Key Informants

Each community contact was made aware of the recruitment criteria and provided with copies of the invitation/information letter to provide to prospective focus group participants. After discussion with each community contact (GRENCODA in the rural community and a community member in the urban community), being knowledgeable, was translated into community members who were actively involved in community life, and had an awareness of the issues facing the community.

3.4.3.2 Adolescent Recruitment

To facilitate the two sampling strategies (i.e. Maximum variation and snowball), on the recruitment checklist prospective participants were asked about their preference for participating in a focus group, interview or both. Therefore, apart from meeting the study's eligibility criteria, prospective interview participants would have selected a preference for participating in the interview only, or both interview and focus group on the recruitment checklist. This was done to help participants choose a method that was most comfortable for them or best suited their personality. Prospective interview participants, including those who had participated in focus groups, were invited via telephone, informed or reminded of the

procedure outlined in the information sheet, and participants who consented verbally on the telephone were scheduled for an interview.

Community-Based Adolescents

Recruitment activities started more than a month in advance of data gathering in the rural community, and approximately two weeks preceding data gathering in the urban community. A description for rural community X and urban community Y is provided in Box 3-2 and Box 3-3 below. In both communities, adolescents were approached at strategic social spaces, such as their homes, 'on-the-block' – a popular hangout venue especially utilized by young men – and major road intersections which allowed identification of groups of students as they socialized on their way home from school. Upon being approached adolescents were provided a brief overview of the study to discern their interest, at which time more details were provided using the information sheet (Appendix F).

Prospective participants were provided with a copy of the information sheet and the recruitment checklist which was later used to collect demographic/background information. Prospective participants were encouraged to speak with parents/guardians about their participation, and were contacted via telephone one week later about whether they were willing to participate. The recruitment checklist was then completed and collected during a subsequent visit to the community (a few were completed during the initial contact with some adolescents) and another round of follow-up telephone calls were made to inform participants of their eligibility, based on the information in the recruitment checklist. Additionally, potential dates to schedule the focus groups were inquired about. Ineligibility was mainly due to adolescents being out-of-school, pregnant or already an adolescent mother/father, or being outside the age range. However, some recruited adolescents did not attend the group on the day, despite the promise of attendance.

Box 3-2 Description of rural community X

Rural Community X

The rural community is a farming community in the north of Grenada. It is considered among the most impoverished areas of Grenada, with issues pertaining to teenage pregnancy, drug use, school drop-out and violence (Personal communication, 2009). However, based on a windshield survey of the community, the following community assets are identified: a playing field, three churches (Catholic, Seventh Day Adventist, and Baptist), a pre-primary school run by the Catholic Church, and several shops/bars, and a sports club for football and cricket. There is a good road network, portable water, electricity and other utilities, and access to public transportation. However, there are no health facilities within the community, but in two neighbouring communities there are two public health facilities, and a few private health care providers.

Box 3-3 Description of urban community Y

Urban Community Y

The urban community is located in the south of the Grenada. Most adult community members earn a living working in the service and industry sectors (e.g. the breweries and tourism). This urban community can be described as low-middle income, with residents being include squatters (usually from rural communities working in the capital). Violence, drug use and school-drop, and unemployment are some of the challenges facing the community (Personal communication, 2009). Based on a windshield survey, the following community assets were identified: two churches (i.e. Baptist and Church of God) and shops/bars, and good access to portable water, electricity and other utilities, public transportation, and a recently formed young men's group. However, there is no playing field, school, or sports club. The terrain is very hilly making it difficult to access a significant number of homes, especially during rainy conditions. Apart from the main road, the majority of roads within the community are not paved, and are poorly networked. Similar to the rural community, there are no health facilities within the urban community, but there are a few public and private health facilities, in addition to the public and private hospital in nearby communities.

Institution-Based Adolescent

Out-of-school boys were recruited from the New Life Organization (NEWLO) and pregnant and adolescent mothers were recruited from the Program for Adolescent Mothers (PAM). Description for each institution is provided in Boxes 3-4 and 3-5 below. To recruit trainees at NEWLO and enrolees in PAM, an information session was conducted at each institution with young people on the day of the program. Like adolescents at the community level, interested adolescents completed a recruitment checklist, however, eligible participants and confirmation of participation was done through the institutions. NEWLO's contact person was provided with the list of names of prospective participants, and in the case of PAM, date of birth and year in the program was provided since permission was not granted to obtain a record of enrolees' names. Ineligibility was primarily due to trainees and enrolees being over age 19. Limitations of this approached will be discussed in section 3.8. Similar to community-based recruitment, it was clear that gatekeepers, such as parents, and teachers play an important role in accessing and recruiting adolescent participants.

Through the use of a recruitment checklist, it was possible to compose groups that had some diversity in terms of religion, ethnicity, and self-reported SRH help-seeking behaviour. Data on head of household income was unreliable and not used as a criteria for group composition, because many adolescents reported not being aware of this information. Nonetheless, most adolescents who reported on household income chose the lowest income brackets between EC $1000-$2000, which is approximately GBP 238.00 – 476.00, which is consistent with the adolescents being described coming from low-income communities.

Box 3-4 Description of Institutions – the New Life Organization (NEWLO) Mothers

New Life Organization (NEWLO)

NEWLO is a life and vocational skills training program for disadvantaged youth (i.e. low or no income, abusive and substance abuse families) across Grenada. However, the majority of trainees comprise of school drop-outs (NEWLO, nd). NEWLO offers a range of vocational/technical skills and basic academics for young people ages 16-25. The training at NEWLO commences with enrolment in the 14-week Adolescent Development Program (ADP) aimed at developing literacy and numeracy skills. It is from trainees in the ADP that participants were recruited to comprise the group referred to as out-of-school boys. NEWLO operates under an Executive Director who answers to a Board of Directors and an Executive Working Committee.

Box 3-5 Description of the Program for Adolescent Mothers

Program for Adolescent Mothers (PAM)

PAM is a two-year academic and skills training program for adolescent mothers and pregnant adolescents age 18 and younger to continue their education. PAM's main campus – the site of recruitment – is located in a peri-urban community in the parish of St. George. Additionally, PAM has two outreach satellites located in Carriacou, (one of the smaller islands of Grenada), while the other is located on the western coast of Grenada, in the parish of St. John (PAM, nd p.4). However, most pregnant adolescent and adolescent mothers enrolled in PAM attend the main campus, as it is the only full-time program. It is noteworthy that PAM offers fewer academic subjects than the traditional secondary schools, but unlike secondary schools, adolescent are taught parenting skills. Enrolees can attend the program during pregnancy and after giving birth. PAM also offers day-care services for the children of the adolescent mothers in the program. During the period of recruitment and data collection in July 2010, there were 28 enrolees in PAM, which is a small percentage of the adolescent mothers in Grenada during 2009-2010 based on the adolescent fertility rate (38.2%). PAM operates under a Manager who answers to a Board of Directors.

3.4.4 Data Gathering Procedures

3.4.4.1 Key Informant Procedures

Organizational-Level

All six key informant interviews were conducted at the key informant's place of work, usually in their offices. I conducted all key informant interviews, which lasted one hour to two and a half hours. Interview guides were adapted for each key informant based on the type of organization.

Community-Level

Focus groups with community members were conducted with a moderator and a note-taker. To begin, participants were seated in a circle and provided with background information on the research. Verbal informed consent was then obtained and recorded, and ground rules were discussed. Focus groups lasted for up to two hours.

3.4.4.2 Adolescent Procedures

Focus Groups

Focus groups were conducted mainly by co-moderators in mixed or same-sex pairs (Balch and Merten, 1999 among deaf and hard to hear participants; Itracks, nd for online focus group for custom market research), in contrast to the suggested moderator and note taker (Morgan, 1993; Krueger and Casey, 2000). This was done as a means to address the effects of potential power dynamics (Krueger and Casey, 2000; Kitzinger, 1994; Marshall and Rossman, 2006), because I am female researcher conducting research with both male and female adolescents. Although Green and Thorogood (2009) caution that matching alone is not always sufficient to deal with differences between researchers and researched, co-moderators provided support for each other because of their inexperience with the method (section 3.6.2), in addition to facilitate comfort and group dynamics.

Participants were seated in a circle, and the co-moderator doing the first activity reviewed the information sheet and obtained written and verbal consent from participants. The focus group format and guidelines were discussed and agreed upon. To help with anonymity and confidentiality participants were asked to choose a nickname for use in the focus group rather than their real names. The co-moderator acted as a note taker when he/she was not the main moderator. Seating charts of everyone in the room were drawn by the note taker for the first activity in each focus group, and was used to keep track of the discussion. Generally, the note taker indicated turn-taking to aid with participant identification during transcription, as well as document emotions and behaviour that cannot be captured via audio-recording (Kitzinger, 1995). Note-taking was not always an easy task as participants often became very animated and often talked simultaneously despite the ground rules stating otherwise. This affected transcription and analysis (section 3.5). Co-moderators took turns moderating the different activities which were created to focus the discussion around a specific set of issues (Appendix C), but in general the co-moderated process was very organic, allowing a co-moderator and/or the main research to probe further, as deemed necessary.

For groups with male adolescents in which I was not acting as a moderator, I mainly observed and asked probing questions to clarify or follow-up on important points that co-moderators may have overlooked (see Figure 3-3 for an overview of the moderated focus group schedule).

For example, asking male participants about their awareness of the sexual consent law, or challenging them on their views about relationship violence.
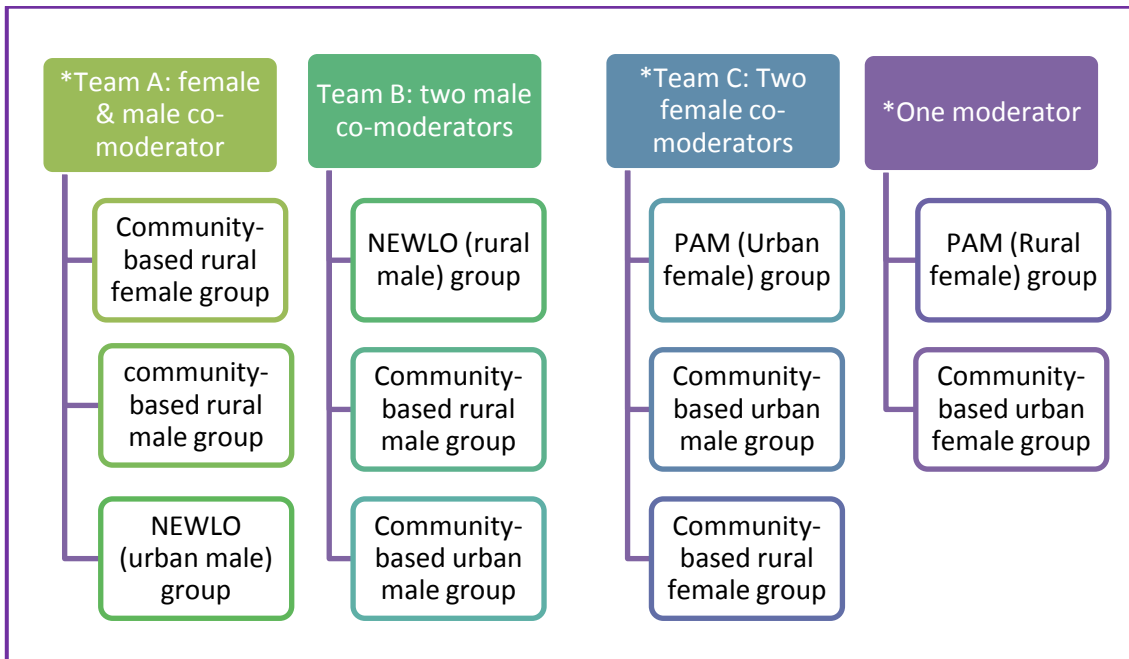
Figure 3-3 Overview of co-moderated focus groups

*Focus groups in which I participated as a co-moderator or the only moderator.

Before the session ended, there was a final opportunity for the research team and adolescents to ask any final questions or any final follow-up questions based on the discussion. Refreshments were available for participants to part-take in at the end of the focus group (section 3.7.5). Additionally, each participant was provided with a *Help-Seeking Resource Guide* (Appendix G) of websites and contact information for local sources of help, which was prepared for this research based on information gathered from key informants and documents.

Stimulating Focus Discussion

In addition to using probes (Hennink, 2007) and co-moderators, focus group discussions were stimulated for interactive discussions through the use of scripted stories (Colucci, 2007) and a word game, which are discussed below.

Using Scripted Stories

Colucci describes the use of storytelling where focus group participants are "invited to create a story… around the topic of interest" to make participants think "about a solution to a

problem, to see how they react to a situation, and to uncover their attitudes toward the topic under study" (Colucci, 2007 p.1426-1427). While the stories in this research are unlike those described by Colucci, they serve the same purpose. However, rather than participants creating their own stories, I scripted the two stories. In this sense the stories might be more similar to vignettes (Jenkins *et al.*, 2010; Rosenthal *et al.*, 1996).

The stories were titled *Girl Talk* and *Boys on the Block*[4], for girls and boys respectively (Appendix C for scripts). The stories were created in parallel, dealing with similar issues for both male and female groups. The main plot of the story dealt with the main character seeking help for the potential pregnancy between two school-going teenagers in Grenada. The issue of teenage pregnancy provided a good entry point to other issues such as sexual activity, contraceptive use, STIs, menstruation, and so on. These other SRH issues were interwoven into the storyline in addition to social mores to elicit discussions about contextual factors, which is an important aspect of the research. The story was on the conceptual issues discussed in the literature review, and my knowledge and experience of Grenadian culture. All adolescent groups were provided with the scripted story and participants either volunteered or were assigned to read the lines for one of the four characters.

After reading the script, participants were asked "what do you think about the story"? One of the probes was "do you think that these are real issues that girls your age deal with? Tell me more about that." Both male and female adolescents discussed finding resonance with the story, which can be used as a form of validation of the relevance of the story.

Using a Word Game

An activity titled W*ords-in-a-bag* was used to allow participants to talk about their perceptions and interpretations of specific sexual and reproductive health issues. Words or phrases relating to a specific issue were written on card cut-outs and placed in a bag, each word was removed from the bag and participants were asked "what comes to mind when you see or hear _____ (e.g. having period, girlfriend/boyfriend, forced sex, and so on)"? To reduce inhibitions in talking about the issues on the cards, participants were to say the first

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[4] The concept of boys-on-the-block refers to a designated place in the community (e.g. bridge, large stone, underneath a tree, or near community bars) usually near a main road where young men get together and talk about girls/women, sports, politics, and a host of other local, regional and international current events.

thing that came to mind upon seeing the card without judgement or repercussions. After participants were finished exclaiming what came to mind, they were asked to discuss the words or phrases. The word game helped to ensure that adolescents' perspectives on certain issues were captured in the event they were not raised in earlier discussions.

Interviews

Interviews with key informants occurred prior to any data gathering with adolescents, and interviews with adolescents were the final step of data gathering. The following is a discussion of the procedure and process of conducting interviews with stakeholders and adolescents. Similar to focus groups, researchers attempted to make the interviewee comfortable before proceeding with and throughout the interview to facilitate "a relatively informal style" (Mason, 2002 p.62). However, rapport with some adolescents was easier than others.

Interviews with adolescents were conducted by a male research assistant and/or me. The male research assistant was involved in interviewing some of the male adolescents, and I was minimally involved, except to take notes and ask probing questions mainly at the end of the interview. This strategy was deemed acceptable to help reduce the effects of gender on the interview process, while also providing support for novice researchers to help ensure good quality data. Interviews lasted between one to one and a half hours.

The information sheet was reviewed, and written and verbal consent were obtained. Each interview with adolescents was informed by previous interviews which meant that the initial interview guide, particularly the probes, was continually being adapted in the field. The majority of interviews occurred in the afternoon at a suitable date and time for the interviewee and/ institution. In each community, most of the interviews were conducted at the same venue as focus groups with adolescents. However, three interviews were conducted in safe, but less private venues (i.e. church steps, near the beach, and an empty restaurant). While these locations are unconventional and may raise ethical concerns, participants were reminded of the withdrawal policy and provided with the alternative of choosing another nearby location for the interview (see further discussion in section 3.8).

Similar to focus groups, at the end of the interview, participants had the opportunity to ask any 'burning questions' of the interviewer(s). Participants were given ten EC $10.00, which is approximately £2.30 (section 3.7), in addition to the *Help-Seeking Resource Guide*.

Stimulating Interviews

Similar to focus groups, strategies were developed to stimulate 'participant talk' during the interview. Apart from using probes in interviews, a card sort (Neufeld *et al.*, 2004) and a help-seeking mapping activity was used to facilitate the process – each is discussed below, although the mapping activity was deemed unsuccessful.

Using the Card Sort

The card sort (Appendix D), sometimes referred to as a pile sort, is a qualitative data gathering technique that allows research participants to appraise their social experience along specified conceptual dimensions (Neufeld *et al.*, 2004). According to Neufeld *et al.* (2004), the card sort has been used in a number of ways, such as addressing issues of conceptual similarity, categorical organization of concepts, developing decision models, determining participants' priority goals, and so on. In this study, 35 card sorts were created after focus groups with adolescents were completed. The card sort allowed participants to appraise their situation and level of concern with the concepts on the cards related to SRH. Other researchers (Lugina *et al.,* 2004; Neufeld *et al.,* 2004) have reported using as much as 50 and 63 cards with adult women.

The issues or concepts on the cards were based on the literature review, the conceptual framework, preliminary analysis of focus groups, and the main researcher's insider knowledge of Grenadian culture. However, the concepts were kept simple and local phases were used to help with clarity (e.g., "becoming a teenage mother/father," "will the nurse or doctor keep my information private"), so that participants did not feel overwhelmed. Participants were asked to sort the cards into one of three piles: (1) *Most Important*, (2) *Somewhat Important,* and (3) *Not Important*. Cards were discussed separately to understand why adolescents chose to place a specific card in a particular pile and whether participants had had a personal experience with the issue on the card. Although explanations for cards yielded important information about the types of SRH concerns adolescent perceived or experienced (Chapter 5, 6 and 7), it can be argued that fewer card sorts would have resulted in more depth interviewing. This is because it was time consuming discussing each card.

Help-Seeking Map

A help-seeking mapping activity was created to help participants illustrate their process of help-seeking for their SRH concern. Darbyshire *et al.* (2005 p.426) used mapping with children in focus groups and found that it "uniquely conveyed children's diverse contextual and spatial sense of their play and physical activity environment." However, few participants chose to do the mapping activity, instead most preferred to only discuss the processes related to their SRH help-seeking. For participants who drew maps, if was felt that the maps did not contribute any additional perspective to what was discussed, as such, it was not used in the analysis. While some participants may not have clearly understood the instructions, it may also mean that mapping may not be a good fit for this target group and topic (section 3.8). Nonetheless, another researcher might have found the maps useful.

3.5   Data Analysis

Documents were analysed using document analysis, while thematic framework approach was used to analyse focus group and interview data. Frequencies were run on the card sorting categories, and will also be discussed. Each approach is discussed in detail below.

3.5.1   Data Preparation and Management

In preparing for data analysis, a data management system was developed and followed systematically. This included a coding system to maintain participant and organization anonymity on written documents, including transcripts. Also, a data management checklist and log helped to ensure that all the required information (i.e. copies of signed informed consent forms, recruitment checklist, interview/focus group notes, and transcripts) pertaining to key informants and adolescents were collected and accounted for at all times.

Although transcription is not always necessary for data analysis (Green and Thorogood, 2009; Patton, 2002), Bailey (2008, p128) note that transcription is "an important first step in data analysis." However, transcription was the second step in data analysis, which began by making preliminary notes while listening to the audio-recording prior to transcript. Nonetheless, full verbatim transcripts were produced for focus group and interview data using Express Scribe software, which allowed the transcriptionist to control the speed of the recording to reduce errors. As reported by other authors (Green and Thorogood, 2009; McLellan *et al.*, 2003), during transcribing there were issues related to incomplete sentences, overlapping speech, a

lack of clear-cut endings in speech, background noises, when and where punctuation is required, and spelling. These issues have implications for the accuracy of the data (section 3.6) as posited by Gibbs (2007). Nonetheless, transcripts provided an accessible means of sharing data with supervisors and peers to contribute to a rigorous research process (Poland, 1995), and for organizing and managing the data in NVivo 8 (Bazeley, 2007). For the two instances when the audio-recording failed due to human error, interview and focus group notes were expanded and used in lieu of verbatim transcripts.

All audio-recorded interviews and focus groups, and transcripts were stored in a password protected folder on a password protected computer, and hard copies were stored in a locked filing cabinet during and after fieldwork. However, participants' personal information and identifiable information were stored separately from transcripts both in the locked filing cabinet and on the computer. All key informants' transcripts were stored together, while adolescent participants' transcripts were stored by method of data collection and type of subgroup. Where applicable, all participants' names and affiliation were omitted from transcripts and notes. Documentary sources were stored in a locked file cabinet.

3.5.1.1 Document Analysis

Preliminary document analysis begun in the field after the first document for review was received. Document analysis included both content and context analysis to judge the source and information conveyed (Miller and Alvarado, 2005). According to Miller and Alvarado (2005 p.351), content analysis focuses on documents as "independently adequate resources for understanding some aspect of social practice and meaning", while context analysis focuses on documents as "actors in a social field" referring to how documents generate social reality through interaction with actors. Therefore for this study, content analysis allowed for extraction of relevant textual information, and context analysis allowed for interpretation of the text based on factors, such as who were involved in creating the document, the purpose of the document, and whether the document was in draft form or finalized and disseminated. Using Microsoft Excel, a chart was created to store relevant documentary information pertaining to the research aim, objectives, questions, conceptual framework, and the context of the document.

3.5.1.2 Framework Analysis

While there are several qualitative data analysis approaches such as phenomenology, narrative and discourse analysis (Patton, 2002; Bryman, 2008), framework analysis as described by Ritchie and Spencer (1994) was selected for this research. According to Lacey and Luff (2007) framework approach provides a systematic and verifiable process of data analysis. While framework approach is inductive, it allows for *a priori* coding using concepts from the conceptual help-seeking framework (section 2.6) as well as coding using emergent concepts from the data collected (Lacey and Luff, 2007). This is in contrast to grounded theory which is based exclusively on the inductive approach (Glaser and Strauss, 1967). Being able to combine inductive and deductive approaches was particularly relevant for this study, because although useful concepts and contexts were highlighted in chapter 2, the novelty of this research in the Grenada context necessitated an inductive approach.

Five stages of framework analysis are identified in the literature (Ritchie and Spencer, 1994; Lacey and Luff, 2007). The five stages were utilized in this study; however, because the analysis was facilitated via NVivo 8, the corresponding names used in NVivo are included in parentheses to show compatibility of using NVivo to aid framework analysis. The five stages include:

Familiarization

Familiarization is the process of immersion into the data to become familiar with the diversity of the data. In this study familiarization begun during fieldwork through repeated listening of the audio-recording and making notes of recurrent or emergent concepts. Transcribing and editing transcripts for errors, as well as reading the completed transcripts also contributed greatly to the process of familiarization. My familiarity with the data made it relatively easy to recognize bits of missing data from some code during subsequent steps in the analysis process.

Thematic Framework (Node Tree)

Identifying a thematic framework is based on both the *a priori* issues and emergent issues identified during familiarization. The thematic framework was developed through an iterative process of reading and re-reading the transcripts and constantly comparing sections of text within and between transcripts, making judgements about the meaning. Initially, the thematic framework was developed as a manual process of writing the codes for bits of text in

the margin of the transcripts. This initial process was done primarily using terms that were used in the data and coloured pens to link related concepts (Barbour, 2008). Subsequent iteration of developing the thematic framework was conducted using the *Free Node* and *Tree Node* facility in NVivo. Nodes are where the textual data related to each code is stored in NVivo (Bazeley, 2007). Each node was defined in mutually exclusive terms to ensure that there was no overlap between concepts.

Indexing (Coding)

Indexing or coding is the process of applying the thematic framework to the data. Simply stated, coding "is a way of classifying and then 'tagging' text with codes or of indexing it, in order to facilitate retrieval" (Bazeley, 2007 p.66). Using NVivo, the coded texts were stored in the appropriate nodes and were later viewed in various ways, such as by participant type (e.g. adolescents, stakeholders, male, female), or method of data gathering (Bazeley, 2007), which helped to reconceptualise and reframe the data to higher levels of theorizing. An advantage of using NVivo is that it allowed for simultaneously creating the thematic framework/node tree and coding. Coding the data also resulted in revising the thematic framework/node tree, as some earlier definitions for nodes did not fit sections of the data. This resulted in the removal, addition, or merging of nodes, which was made easy with NVivo.

During coding, memos were also created in NVivo and linked nodes to help with thinking and linking the data. For example, a memo titled *interaction of context* was created, in which I recorded my thoughts about sections of the data that showed how the interaction of different levels of context were implicated in a participants' experience. Memos were directly or indirectly related to help-seeking. While management of the data was made easy with NVivo, the difficult part was deciding which codes best suited sections of the data. Based on the nature of the study and the way the node tree was developed, there were sections of data that were coded at multiple nodes because of how participants discussed some of the issues. This had implications for the next stage in the analysis, which is charting.

Charting

Charting is comprised of creating charts of the data so that similar content can be located together. Thematic charts were used in this study and developed in Microsoft Excel; each theme was listed across the top row and each participant and focus group was listed along the left column (see Appendix E for a sample chart). However, NVivo facilitated the charting process, because it was a matter of asking questions of the data and running queries

in NVivo then printing the queries' output, which was then summarized into sub-themes in the chart. Some queries did not yield any data references while others yielded tens or hundreds of references. NVivo allows searching of the data using six types of queries; however, the following three were used:

1. Text search query: this was used to find whole words or phrases in some or all of the data as specified in the query and provided a preview of the results and the sources where it can be found (Bazeley, 2007). For example, text search was used to find the context of *trust* in the data.

2. Coding query: coding queries are run using Boolean terms AND/OR to find the same/similar text that was coded at multiple nodes in the thematic framework/node tree, based on the search parameters. This query function made it possible to code the same text at multiple nodes in the previous stage. Coding queries were run for *Teacher* AND *Trust*, *identifying need for help* AND *pregnancy,* and so on.

3. Matrix coding query: this query "produces a kind of 'qualitative cross-tabulation' in which coding items define the rows of the resulting table, and the values of the attribute[5] define the columns" (Bazeley, 2007 p.143). Each cell references text that results from the combination in the search. Matrix coding queries allowed me to compare different groups' experiences. For example, to view *whether boys and girls had similar or different experiences regarding confidentiality*. It was also used to generate descriptive data from adolescents' demographic information.

For some codes I printed the relevant tree node and summarized the data into the relevant chart. During charting a few new codes were added, as each code was viewed more closely in light of the specific question asked of the data.

Mapping and Interpretation:

Mapping and interpretation are used to pull together key characteristics of the data and search for patterns, associations, concepts, and explanations in the data, aided by visual displays and plots to address the research aim, objectives, questions, and conceptual framework. However, in this research the data was explored and interpreted using the chart

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[5] Attributes are the record of data known about the case that is recorded separately from the text generated by the case. That is where participants' ID and demographic information are stored to link the participant to the relevant unit of data.

produced by reading across the rows per participant or focus group, and down the columns per theme or sub-theme.

3.5.1.3 Card Sort Analysis

To analyze the card sort data, the three piles for sorting the cards were each given a code *(Most Important = 2; Somewhat Important = 1; Not important = 0).* The cards representing each pile were given the corresponding code and entered into an excel spread sheet per participant. A frequency of the number of participants creating each of the three piles was calculated per card. Considering that the data is not meant to be viewed in quantitative terms, the data was interpreted in light of participants' discussion of the issues represented on the cards and their rationale for sorting the cards into the respective piles. Participants' discussions were captured via the transcripts and analysed using the framework analysis process outlined above.

3.6 Ensuring Quality and Rigour

Matters of quality and rigour were kept at the fore from conceptualisation, design and fieldwork planning, data gathering, analysis and reporting to ensure the validity of the study. While there is agreement that quality and rigour is important for ensuring validity in qualitative research, there is much debate as to what this entails in practice (Whittmore *et al.,* 2001; Lincoln and Guba, 1985). Several authors provide guidelines and checklists (Patton, 2002; Whittmore *et al.,* 2001; Lincoln and Guba, 1985; Bryman, 2008). The strategies used to ensure quality and rigour in this study cut across all aspects of the study, and is transparently discussed throughout this chapter. Furthermore, transparency is partly the reason for using excerpts of participants' discussions in presenting the study's findings in subsequent chapters (Corden and Sainsbury, 2006). This level of transparency will allow other researchers to make decisions about the relevance of various aspects of this study for their specific context, related to similar topics and populations. Therefore, to avoid repetition this section will focus specifically on issues related to stakeholder meetings, the research team, piloting, triangulation, and reflexivity.

3.6.1 Stakeholder Meeting

The fieldwork began with stakeholder meetings which were held individually with several stakeholders in Grenada (See Figure 3-1 and Table 3-5)) to achieve support for the study at

various levels. Fruitful discussions occurred with each organization, including discussion regarding the specific rural and urban communities that should take part in the research. Once communities were selected, community meetings were held to inform community members, including parents and engage them in discussions about the study and to address any questions or concerns they may have.

Table 3-5 Stakeholder organizations

Ministry of Health
Ministry of Education
Grenada Community Development Agency (GRENCODA)
New Life Organization (NEWLO)
Program for Adolescent Mothers (PAM)
Legal Aid and Counselling Centre (LACC)
Grenada Red Cross Society (GRCS)
Caribbean Youth Volunteer Services (CYVS)

GRENCODA in particular, an NGO working with rural communities played an important role in the success of the fieldwork.

3.6.2 Training the research support team

Research support included, research assistants (moderators/interviewers), transcriptionists, and recruiters. Morgan (2002) recommends that for focus group research with adolescents, moderators should be experienced in the method. However, because it was not possible to recruit experienced focus group moderators, I trained the three research assistants (2 male; 1 female) identified by GRENCODA in the relevant aspects of the research related to their roles. The training also helped to build the capacity of GRENCODA. A three hour training session was conducted with the three research assistants, and was supplemented by individual training in-person or via the telephone. The pros and cons of this approach are discussed in chapter 8. Recruitment volunteers were provided with tips on how to approach and discuss key information about the study; volunteers comprised of GRENCODA community officers and youth from the Caribbean Youth Volunteer Service (CYVS) – "a humanitarian organization led by youth volunteer and connect people of the world…" (CYVS, 2009 p.4). Additionally, two transcriptionists were identified from among GRENCODA's staff,

and trained in the transcription convention as outlined by Family Health International (Mack *et al.*, 2005).

3.6.3 Piloting

Two pilot focus groups were conducted. One focus group was composed of rural male adolescents in their community setting who were participants in one of GRENCODA's community programs, while the other composed of rural and urban females attending the T.A. Marryshow community college and was organized via the Grenada Red Cross Society. However, participants were not residents of the communities in which the study was being undertaken. The pilot was conducted to test how well the focus group guide and stimulus materials worked, in addition to co-moderators' ability to facilitate the groups to obtain the required interaction and data, and finally to identify areas for improvement. Participants discussed these issues at the end of the focus groups and their feedback was incorporated to improve data gathering materials and process. The pilot focus group was also part of the research assistants training requirements. The first pilot focus group was observed by an anthropologist working at St. George's University, and she provided feedback to co-moderators at the end of the session.

3.6.4 Triangulation

Triangulation was used because multiple methods were employed to gather data across subgroups of adolescents, community- and organizational-level key informants. However, triangulation was used to provide a more comprehensive set of findings, rather than as a genuine test of truthfulness (Mays and Pope, 2006). In practice, triangulation was used to look for patterns of convergence and divergence to develop an overall interpretation of the data, both of which is highlighted in reporting of the findings (Patton, 2002). The findings were compared from multiple methods and sources of data collection. For example, documentary sources were compared to organizational-level key informant interviews, and data was triangulated between subgroups of adolescents, as were adolescent focus groups and interviews, with that of key informants and the conceptual framework to develop interpretations (Denzin, 1978 cited in Patton, 2002). Supervisors also contributed to the process of triangulation by providing feedback on my description and interpretation of the data.

At the end of each excerpt used to illustrate the findings, the type of participant, recruitment site, method used for data gathering and the participant Identification number are included in parentheses *(e.g. Adolescent Female, Rural Community, FG2)* to help with ease of reading and transparency. For excerpts pertaining to adolescents, UCFG = Urban Focus Group; UI = Urban Interview; RCFG =Rural Focus Group; RI = Rural Interview. For organizational-level key informants, IE = Information and Education sectors, and HCCS = Health Care and Counselling Sectors. For Community-based key informants, UCKI = Urban Community Key Informant, and; RCKI = Rural Community Key Informant.

3.6.5   Researcher Reflexivity

Underwood *et al.* (2010, p.1586) cites Schwandt (2007, p. 260) as "defining reflexivity as consisting of two elements: (1) the process of critical self-reflection on one's own biases, theoretical predispositions, and preferences; and (2), an acknowledgement of the inquirer's place in the setting, context, and social phenomenon he or she seeks to understand, and a means for critical examination of the entire research process." In this research, reflexivity translated into me being self-aware of how my class, gender, religion, role as a student researcher and Grenadian national influenced the research process (Mays and Pope, 2006). Furthermore, reflexivity was engaged as a means of improving the quality of the research process to ensure participants' perspectives are emphasized (Underwood *et al.,* 2010; Patton, 2002).

I was aware that I held several biases about conducting the research in Grenada, which was due to growing up in rural Grenada, but also because my views of ASRH were cultivated as a public health student in the United States of America and the United Kingdom. Furthermore, my main exposure to public health in Grenada was as part of the public health faculty at St. George's University. Despite my religious affiliation being Roman Catholic, I openly disapprove of some of the Church's teaching on sexuality, particularly pertaining to condom use, which I believe creates an environment of vulnerability for negative SRH outcomes. I was also aware that my theoretical leaning for this research was driven by my public health training and belief about the role of the environment in creating vulnerability, and my assumption that Grenada lacked a supportive environment related to ASRH and adolescent sexuality. Therefore, during data collection I had to ensure that I did not say anything that would influence participants' responses. Additionally, during my previous experience as a health educator with adolescents at high risk for HIV and other STIs, I developed an appreciation for the effectiveness of using

participatory strategies with adolescents. As a result I was careful to ensure that the activities created and strategies would contribute to the process of adolescents' voices being heard.

Additionally, as a Grenadian I had to be clear about my role as a 'native researcher', because I have previously established relationships with the stakeholders and key informants, although not with the communities in the research. As a result, I chose to position myself as an outsider in the role of student researcher above all else with the organizations. For example, in the past I have worked with GRENCODA to facilitate their personal development session for 6-17 year olds on sexuality and SRH issues, and worked with the MoH on various projects and committees. Furthermore, one key informant was an experienced researcher and it was a bit intimidating to conduct that particular interview, and during that interview there were times when I felt that I had lost control of the interview to the interviewee, which may have affected the type of data gathered. In contrast, I chose to position myself as an insider – someone who grew up in small low-income community who understands what it is like being an adolescent in Grenada. However, during accessing the community and speaking with parents, my role as student researcher was more useful in garnering support for the study. Nonetheless, I am aware that I was never fully an insider in Grenada, because differentness is apparent in my speech and mannerisms, and in many ways my experience growing up is different from the adolescents in the study. However, my passion for the research on this topic is influenced by my personal and horrifying experience of dealing with menarche, and seeing one of my best friends fall pregnant while we were in secondary school, dropping out and later having 3 more children. And, while I blamed her, I blamed society more for failing her. Therefore, I had to allow the research process to be open to get to adolescents' concerns rather than my concerns for them or what other researchers were saying adolescent were concerned about.

Furthermore, I believe that all adolescent have a right to a healthy sexuality and that society with all its resources should facilitate that by being more open and providing the necessary information, advice and service systems rather than trying to inhibit what is only a natural development process.

3.7 Ethical Considerations

Ethical considerations are important to ensure that the benefits for and risks to participants and researchers are objectively assessed (Macklin, 1996) to promote good research practice. Ethical approval was granted by: (1) the Leeds Institute of Health Sciences

and Leeds Institute of Genetics, Health and Therapeutics (LIHS/LIGHT) joint ethics committee at the University of Leeds (ref no.HSLT09011) and (2) the Internal Review Board (IRB) at St. George's University in Grenada (ref no. 10001). Additionally, a letter of support was obtained from the Acting Permanent Secretary in the Ministry of Health in Grenada. However, permission was also obtained from the principals of NEWLO and PAM to involve their institutions in the research and to conduct the focus groups on-site, as good ethical practice.

Ethical practice varies in time and place, therefore it was imperative that ethical issues as conceptualized or experienced by others were considered in light of expectations in the Grenada context. And, although strict ethical procedures should be established and followed (Green and Thorogood, 2009) before entering the field, some procedures had to be negotiated while in the field prior to ethical approval and during the study. This was mainly due to the novelty of the type of research approach being used with adolescents and the fact that aspects of it were community-based. Nonetheless, ethical procedures were guided by Hennink's (2007) seminal work on conducting focus groups in international settings, and the WHO's ethical guidelines for research on reproductive health involving adolescents (WHO, 2009). Accounting for Grenadian culture, age of adolescents, and sensitivity of the research, the ethical strategies addressed: gaining access to the community, informed consent, confidentiality, anonymity, protection from harm, and reciprocity. Please note that there are areas of overlap between strategies.

3.7.1   Gaining Access to Communities

Hennink (2007) discusses the issues of gaining access to communities in developing country context with regards to focus group research, but it is applicable to qualitative research in general. It was important to be respectful of communities and gain their acceptance of the research by letting them know what was planned to occur in the community and to encourage community support. A lack of support could have potentially hindered recruitment and participation. Access to the communities was facilitated through a source familiar to community members. Both contacts were provided with background information about the research, they in-turn provided background information about the community and assisted with mobilizing the community members for a meeting. This was an important first step because of the taboo nature of ASRH issues.

Door-to-door invitations were made for the community meeting; however, in the rural community there were a small number of persons who attended the meeting, while no one attended the meeting in the urban community. A second attempt to schedule a meeting was not made because of the almost 100% door-to-door visits/information dissemination that was conducted. However, many community members were able to recall the door-to-door visit and key words in the study during recruitment of adolescents, which indicated that there was some level of success in sensitizing the communities.

3.7.2 Informed Consent

Voluntary informed consent (verbal and/or written) was obtained for all participants according to the procedures outlined in the information sheet in appendix F. A main issue was the uncertainty regarding whether parental consent was required for adolescents' participation. Although the ethics committees in Grenada and Leeds recommends that for persons age 16 and above, parental consent was not required, some local stakeholders believed that parental consent was required for persons under age 18. The arguments were based on issues pertaining to laws regarding the age of majority and age of sexual consent. There appeared to be no local precedent regarding research with adolescents in the community setting. However, during in-person discussions with the Ministries of Health and Legal Affairs, and telephone discussions with the local ethics committee at SGU in Grenada, the competence of adolescents at age 16 and their ability to understand the information and make an informed decision to participate was discussed, in addition to the age of sexual consent law in Grenada (age 16) and the fact that that was an acceptable standard in other context, including Leeds. It was then agreed that adolescents' signature would be adequate.

Nonetheless, prospective participants were encouraged to speak with a parent/guardian to decide on participation, and the process of gaining entry into the communities and recruitment provided multiple opportunities for parents to learn about the study. However, some adolescents approached outside the home explicitly requested researchers/recruiters speak with their parent/guardian before they decide about participation. This was taken as an indication of the Grenadian culture denoting that children/adolescents require adult involvement in decision-making. Conversations with parents/guardians impressed the importance of voluntary consent. In practice, there were no concerns raised by parents/guardians about not explicitly requesting their permission. Among recruited participants, three withdrew participation prior to the start of data collection.

3.7.3   Confidentiality and Anonymity

Confidentiality: Steps to maintain confidentiality were discussed in the information sheet and in person with all participants prior to start of the focus groups and interviews. The difficulties of maintaining confidentiality in focus groups are well documented (Bloor *et al.*, 2001), and as such participants were encouraged that if they were to talk to anyone about the focus group discussion they should refrain from naming the persons 'who said what'.

In addition to measures for adolescents, steps were also put in place for researchers, such as ensuring that researchers were not residents of the communities of inquiry and that there were not close relationships between participants and researchers. However, since male research assistants resided in neighbouring communities, they were at least acquainted with several of the participants and the main research assistant had taught a few of them in primary school several years earlier. Nonetheless, the level of familiarity that existed between researchers and participants was not sufficient to have a negative impact on the study in terms of recruitment, group dynamics, and level of openness. This is because participants are always negotiating which story to tell and how to tell it, according to Barbour (2008). However, it is questionable whether adolescents would have indicated their discomfort with a specific researcher or fellow participants.

It is noteworthy that no issues arose during the fieldwork that needed to be reported to or discussed with sources outside the research team (e.g. child welfare authority or the police). When such issues arose in interviews, probing indicated that they had previously been reported to the proper channels.

Anonymity: The identity of participants was not completely protected from person not involved in the study, because community members saw who went to the designated locations to be interviewed and staff at the two institutions knew the identity of those participating in the research. However, personal information provided for the study was coded and stored securely. Furthermore, adolescent participants' use of pseudonyms during the focus groups ensured that participants' true identities were not on the audio-recording device. The few instances when either the researcher or participants used the participants' true identity, those were erased from the transcripts and replaced with the pseudonym. However, in this thesis and any other publication or discussion of the research, a new pseudonym will be assigned, as

it was later realized that some participants used the pseudonym they are usually identified with by friends and family.

While some of the findings have the potential to show positive images of the communities and their adolescent residents, it is possible that anything reported that may be considered less than positive might serve to 'further' stigmatize those involved. Similarly, only stakeholder service/program category will be identified when presenting the findings, in an effort to protect the identity of key informants to minimize any harm, such as discord among ASRH-related stakeholders.

3.7.4   Protection from Harm

Several measures were in place to protect all those involved in the research from harm. During recruitment and data gathering, research assistants and recruiters knew the whereabouts of each other and maintained contact via mobile telephones. In a few instances, the main researcher ventured into the communities alone, but generally communities were visited by at least two persons. However, there was never cause for concern while in the communities. Due to participants showing up late, especially for focus groups, a few focus groups with adolescents ended between 7-7:30pm, however, community members had then gathered around the venue, especially in the rural community, and participants did not live far from the venue which made it safer to walk home.

Researchers and recruiters' previous experience working with young people and the training provided, including how to deal with adolescents who became distressed illustrate that the study made attempts to protect adolescents from counter-productive and harmful practices. When one female participant became distressed during the semi-structured interview and decided to withdraw from the interview, she was probed about the source of her distress and provided with the appropriate referral for support in addition to the *Help-Seeking Resource Guide.* It is possible that research participants did not become upset because the research team used good judgement and knew when to probe deeper into a topic or specific experience to prevent discomfort and distress. However, a great deal of the focus group discussion and interviews were emotionally difficult for the research team, and the debriefing session after the focus groups and interviews provided the team with an opportunity to deal with the feelings brought on during data gathering.

Regarding data that was gathered in somewhat unconventional and not-so private spaces (section 3.8), efforts were made to ensure that participants felt and were safe. Participants had to approve of the alternative venue, which was in their community or nearby, and inform a parent/guardian of the change. However, they were made aware that with either decision they would receive the incentive and that the decision was completely theirs to make. While the venues were not ideal, both researcher and participants adapted to the situation in the field without sacrificing safety and other ethical considerations.

3.7.5 Reciprocity

While reciprocity can be defined as a form of quid pro quo, it is not the form that influences or violates voluntary participation. Two issues were considered regarding reciprocity: (1) participant incentives and (2) dissemination of the study's findings.

Incentives: The issue of providing incentives for participants is one that is widely debated. However, during the planning stage stakeholders supported giving a small token of appreciation to adolescent participants. Refreshments were provided during focus groups and as discussed previously, a small monetary incentive was given to adolescent interview participants, in addition to transportation reimbursement for some adolescents from PAM and NEWLO. Adolescents and community member alike enjoyed the refreshments at the end of the focus groups, particularly in the rural community where it became a form of socializing. Some participants were happy to receive money at end of the interview, but on one occasion two male participants refused the money or any incentive. This suggests that incentives may not always be necessary for all adolescents, but it may be welcomed by some

Dissemination of findings: Based on the methodological paradigm in which this research is based, the findings of the research will be fed back to the stakeholders, decision makers and communities of inquiry, including adolescents. Already a progress report has been submitted to all research assistants and stakeholder groups, with the exception of the adolescents themselves. Although this is an identified weakness, all participants did not provide a working email address. A report of the findings will be submitted to all stakeholder groups after completion of the PhD. Additionally, two regional stakeholders (UNFPA and PAHO) have been engaged about funding a dissemination workshop in Grenada. The findings regarding informed consent will also be shared with the local ethics committee and other stakeholders to inform

future community-based research with adolescents. These steps are deemed important if the research is to have a practical impact in Grenada rather than theoretical impact to the field.

The next section discusses the limitation and strengths related to the practicalities of the research process.

3.8   Study Limitations and Strengths

During the research process, not only does one discover interesting data, but also insights based on how well the design and plans work for the research setting. Discussion of the strengths and limitations will help others to determine the validity of the study, as well as the transferability of the findings presented, and should be noted for future work with similar subgroups in Grenada. These are categorised and discussed below as: researcher bias and choice of methods and design.

Researcher bias can affect the research process and interpretation of findings. Potential researcher biases include the researcher's position as an insider-outsider (section 3.6.5), and assumptions about adolescent SRH promotion in Grenada. While I view my position as one of the strengths of this research, in this chapter I have been explicit about the research processes allowing the reader to understand the basis for the findings and interpretations.

Design and method choice: This thesis shows that qualitative research is a useful method for research with adolescents in Grenada. Both focus group discussions and semi-structured interviews were adapted to be interactive and effective methods for gathering data and researching the sensitive topic of the context of ASRH help-seeking in Grenada. With the exception of the mapping activity, the methods and strategies were successful in providing the necessary data to achieve the research aims, objectives and questions. The support that focus group participants showed to participants with reading difficulties during the role-playing of the scripted stories is evidence that the focus group environment was supportive. However, it also shows that similar stimulus activities and other reading material should consider participants ability to read.

Although documentary sources provided useful information for this study, it proved challenging to obtain contextual information for some documentary sources from the documents and key informants. This was because several of the documents were obtained

after key informant interviews, although the research design specified collection and review of documentary sources prior to key informant interviews, partly as a strategy to combat this problem. This problem could have been handled in the field by interviewing the relevant key informant(s) about the context of the document once the document was mentioned, even if the document was not yet available for review. Additionally, if time permits, it would be useful to contact key informants after reviewing the said document to obtain the necessary contextual information. Gathering and understanding the context of documentary sources is important to help us understand the drivers and political environment of ASRH in Grenada, and in relation to the regional and international context of ASRH – these have implications for interventions. Therefore it would be important for future documents to provide more explicit details on the circumstances around its development.

Prior to this qualitative study, quantitative research methods have been used with adolescents, primarily in school settings (GOG, 1998; 2008; 2010). While both community and alternative educational institutional settings were used in this study, participant recruitment was easier and attrition was lower in the institutional settings. Some of the challenges with recruitment in community settings were due to the stricter eligibility criteria, in an attempt to recruit a diverse sample. However, the communities were small, and the extent of the impact that a few adolescents who were pregnant, and not enrolled in school was underestimated, and negatively impacted the number of adolescents eligible to participate, based on the information provided in the recruitment checklist.

Additionally, the decision to include only older adolescents (age 16-19) may have also contributed to the smaller than anticipated sample size at the community level, especially in the urban community, as several of the adolescents matching the remaining criteria were under age 16. Although qualitative sexual research has been conducted with younger adolescents in other contexts (Selikow *et al.,* 2009; Kumi-Kyereme, 2007), this has not be the case in Grenada. Therefore obtaining ethical approval would have been particularly difficult and an unwarranted challenge at this stage. However, the lessons learned could serve as an entry-point into research with younger adolescents. For example, community members and parents were open to younger adolescents participating in the research, as they repeatedly asked why the younger ones were excluded. In the end, sufficient adolescents were recruited to achieve the aims of the study without compromising the quality of the study and data collected.

Although the research did not utilize a comparative design, the inclusion of subgroups of vulnerable adolescents has contributed greatly to the dimensions of findings and our understanding of Grenadian adolescent help-seeking behaviour (chapters 5, 6, 7, 8). Additionally, adolescents, including those who were less talkative during focus groups voiced their gratitude for the opportunity to share their views and experiences. This attests to the success of the study and suggests that more opportunities should be provided for adolescents to engage in discussions about ASRH issues, including in policy-making and service decisions.

A limitation of this study is that 'theoretical sampling' was used only to identify interview participants from focus group participants to help develop the help-seeking pathway. However, Brennan (2009) points out that theoretical sampling can be used to identify previous sources to be revisited to gain new information or expand developing categories, or identifying new participants. This suggests that, while revisiting focus group participants to explore further issues in-depth based on theoretical sampling is acceptable, continuing this approach for the adolescents who had not participated in the focus groups would have been a more rigorous process. Nonetheless, this was not a grounded theory study and therefore the limited use of theoretical sampling does not diminish the validity of the findings.

This study used both hypothetical scenarios and actual help-seeking experiences to determine adolescents' help-seeking pathways, which can be viewed as both a limitation and strength. The hypothetical scenarios were used in the focus groups based on the scripted story and for interview participants who reported not having any SRH concerns. While using both complicates the analysis and reporting, it helps to highlight some of the differences and similarities in help-seeking based on actual and hypothetical help-seeking (see chapter 5, 6, 7, 8).

3.9   Chapter Summary

In this chapter, I discussed in-depth the processes utilized to address the research aim, objectives, and questions. This study took a critical constructivist/constructionist approach, utilizing multiple methods (i.e. document review, focus groups, and interviews) and participatory strategies (i.e. activities, role-playing scripted stories, word game, card sort and mapping, and co-moderators) with subgroups of vulnerable adolescents, and community- and organizational-level key informants. To generate the findings in the subsequent chapters, data

analysis was undertaken in the form of documentary analysis, framework analysis and card sort analysis. The chapter concluded with a discussion of good research practices, by discussing the strategies to ensure quality and rigour, ethical application, and by highlighting the limitations and strengths of the study. The next chapter addresses the first research question and objective to highlight existing ASRH legislation, policies, and services/programs in Grenada.

Chapter 4 – **ASRH-Related Legislation, Policy and Services**

4.1   Introduction

The aim of this chapter is to describe legislation, policies, and organizations/program and the services available, related to ASRH. As noted in sections 1.3 and 2.4.3, various sectors and not just health contribute to ASRH, therefore *ASRH-related* is used because the activities in other sectors may directly or indirectly address ASRH. The findings in this chapter are based on the analysis of 19 documents (Appendix B) and six key informant interviews in response to objective and research question one (Table 3-1). The findings in this chapter provide a more comprehensive picture of the existing health system, and the legislative and policy context of ASRH in Grenada.

This chapter begins by critically reviewing relevant legislation and policies in section 4.2. Next, key organization and/or programs that provide ASRH education and services are critically reviewed in section 4.3. Key informants perceptions about adequacy of the legislative, policy and services environment are discussed in section 4.4. The chapter concludes with a summary of the findings in section 4.5 to show its relevance to ASRH help-seeking behaviours in Grenada.

4.2   ASRH-Related Legislation and Policies

In this study, ASRH-related legislation refers to the range of rules and sanctions in Grenada that shape the behaviour of health workers, adolescents and their caregivers, and society in general related to ASRH. In contrast, policy in this study refers to the national and institutional principles, values and strategies that shape institutional behaviour related to ASRH. These definitions are based on that provided by Pillay and Flisher (2009).

Table 4-1 provides a list of 15 ASRH-related legislation and policies categorized by the sector through which they are developed. With the exception of three documents (highlighted by *) listed below, all other documents were available for review.

Table 4-1 Overview of legislation and policy by sector

Sector	Title	Year	Document Type
Ministry of Social Development	Child Protection Act (Updated)	2010	Legislation
	National Child Abuse Protocol	2004	Policy
	* National Gender Policy (New)	2009	Policy
Ministry of Education	Education Act	2002	Legislation
	Education Policy on Pregnant Students	2008	Policy
	National Policy on Health and Family Life Education	1998	Policy
	Health and Family Life Education Curriculum	2006	Curriculum
	*HIV in the Education Sector Policy		Policy
Criminal Justice System	Criminal Code of Grenada section 179: Unlawful Carnal Knowledge		Legislation
	Criminal Code of Grenada sections 234, 247 & 250: Abortion		Legislation
	Criminal Code of Grenada section 431: Unnatural Connexion (same-sex intimacy/Sodomy/Buggery/homosexuality)		Legislation
Ministry of Health	National Strategic Plan for Health, 2008-2012	2008	Policy
	National HIV and AIDS Strategic Plan, 2009-2015	2009	Policy
	*Health Practitioners' Act (New)	2010	Legislation
NGO	Grenada Planned Parenthood's Position Statement on Abortion, 2008	2008	Policy

Table 4-1 above indicate that there are a wide range of legislation and polices in Grenada related to ASRH. However, it also shows that there is no specific Adolescent Health or ASRH policy – a point that was confirmed by all key informants. With the exception of most legislation for which the dates are unknown, some policies were recently developed or updated, as suggested in the Table.

The following discussion focuses of the type of legislation and/or policies, and includes the following three categories where they cluster: (1) health care services, (2) education, and (3) criminal acts. However, these categories intersect and affect each other as will be highlighted below. It is noteworthy that some documents, particularly legislative documents, did not provide background information to discern the context in which they were developed. As a

result this document review primarily focuses on the content, and where possible the context of the documents reviewed.

4.2.1 Services-related policies

Health services related to ASRH are provided for through the following two policies: *National Strategic Plan for Health (NSPH) 2008-2012* (GoG, 2008a) and the *National HIV and AIDS Strategic Plan 2009-2015* (GoG, 2009). However, only the former was available for review and is discussed below. The legislation laid out in the *Criminal Code* sections on also pertains to ASRH health services, but will be discussed in section 4.2.3.

National Strategic Plan for Health (NSPH) 2008-2012

The NSPH titled *Health for Economic Growth and Development* is the most recent national plan updated quinquennially, aiming "to outline a policy framework and set a strategic direction to address priority public health and health systems issues in Grenada" (GoG, 2008a p.19). The document states that the NSPH was developed within international and regional frameworks for primary care, purports to be the result of an analysis of the public health situation and health system, and a consultative process with a wide range of stakeholders. However, in the available list of stakeholders involved in the consultation, the Ministries of Education and Legal Affairs were not included as participants. Also, it was unclear which groups represented youth, although key NGOs with a reputation for advocacy on issues affecting adolescents were listed.

The NSPH group key health issues into five thematic areas. ASRH are primarily accounted for in *Reproductive and Child Health* issues; however it is a cross-cutting theme (Table 4-2).

Table 4-2 NSPH 2008-2012 Strategic Priorities related to ASRH

Thematic Areas	Priority Health Problems related to ASRH
Health Issues	• Non Communicable Diseases (Mental Health) • Communicable Diseases • Reproductive and Child Health
Health Services	• Quality of Care • Community Health Services • Hospital Services • Specialist Services
Management and Health Systems	• Health Systems Structure • Legislative Framework

	• Health Planning
Resources for Health	• Health Financing
	• Human Resources Management and Development
Wider Determinants of Health	

The development of the NSPH was facilitated by the Nuffield Centre for International Health and Development at the University of Leeds in the United Kingdom. Based on my review, the NSPH can be credited for its comprehensiveness and inclusion of ASRH issues, as it covers a range of noteworthy ASRH-related strategies, including: providing consistent health education program via schools and Primary Health Care (PHC), collaborate with other ministries and NGOs to develop and implement accessible preventive and curative services.

However, at the time of data gathering in 2010 the NSPH was still in draft form some two years after being developed. Although the NSPH is available on the Internet as identified by a web search, two key informants confirmed that the NSPH had not been disseminated to stakeholder, ratified by Cabinet, and operationalized and/or utilized for health system or health sector planning and/or service delivery.

4.2.2   Education-related legislation and policies

ASRH-related legislation and policies pertaining to education include the *Education Act of 2002* (Friday, 2008) regarding access to education in its general sense; *Education Policy on Pregnant Students* (PAM, 2008); and the *National Policy on Health and Family Life Education* of 1998 (GoG, 1998b). There is also a Policy on *HIV in the Education Sector pertaining to HIV Education* (nd), which was the interviewee was unable to find and provide for review. The three documents reviewed are discussed below.

The Education Act (2002)

The *Education Act of 2002* makes provision so that all persons in Grenada have the right to receive an education appropriate to his or her needs, and mandates the Chief Education Officer to provide an education program for every person of compulsory school age, which is defined as ages five to 16 (Friday, 2008). The Act does not explicitly deprive adolescents an education due to pregnancy, especially those age 16 and under.

Education Policy on Pregnant Students (2008)

The Ministry of Education's policy regarding pregnant students states that "...it is the right of every Grenadian of school age [age 5-16] to receive an education" and makes explicit that "this right is in no way negated by pregnancy" (PAM, 2008, Statements 1 & 2, p.9). According to the document, the need for this policy was based on local drivers when the issue of a pregnant student remaining in school became the centre of national attention in 2007. This student was in her final year of secondary school (i.e. Form 5) and there were objections from several quarters, primarily from the Parents-Teachers Association (PTA) about her attending classes. Therefore a range of stakeholders were engaged to develop a specific policy regarding students' right to education in the event of a pregnancy (PAM, 2008).

In contrast to statements one and two above, it is noteworthy that the policy also states:

> "It is neither appropriate nor proper for the student to continue in the regular school system once the pregnancy is visible and confirmed by a medical practitioner."

(PAM, 2008, Statement 3)

In light of the three above statements, the Policy does not include a statement requiring the mandatory transition of students with visible pregnancy into alternative educational programs/institutions, such as the PAM or NEWLO. Such a statement is necessary to ensure that students' rights to an education are upheld.

The policy also states that the Chief Education Officer has the authority to suspend a female student until the results of a pregnancy test can be obtained from a medical practitioner, if the pregnancy is visible, but not acknowledge by the parents or guardian, or if the student is over age 18. However, suspension prior to proof of pregnancy leaves much room for damage to the adolescent's reputation. Similarly, so does the statement giving pregnant students the option to continue in the regular school system out of uniform (Statement 7). This may also be an indication of the influence of moral arguments of stakeholders such as the Council of Churches and the PTA. It is possible that the policy may intentionally or unintentionally be worded in a manner that allows pregnant student an education while trying to discourage pregnancy from occurring. This Policy has implications for delaying help-seeking due to the potential impact on adolescents' future aspirations.

Gender inequality is also implicated in the policy as it can be viewed as generally putting the burden on pregnant female students, and especially if the boy identified as responsible for causing the pregnancy is also a student. For example, the policy states that:

> ...there must be a program of mandatory counselling for the student, parents or guardian and also the father of the child, if he has acknowledged this to be so and is a student.
>
> (PAM, 2008, Statement 12)

This statement suggests that potential adolescent fathers may negate responsibilities and consequences related to a pregnancy by their word alone, without undergoing any biological testing as proof of paternity. However, this may be suggestive of the role of fathers in Grenadian society indicated by the high percentage of households headed by single mothers.

The Policy also includes a statement connecting it to the larger agenda for child protection via the criminal justice system. The policy states "that for every pregnancy which occurs within the school system, the Ministry must be made aware of it, and once the student impregnated is under the age of 16, the law relating to statutory rape must be enforced" (PAM, 2008, statement 10, p.9). However, it is unclear whether it is the Ministry of Education or the Ministry of Social Development that must be made aware. It is also uncertain how the protocol will be implemented if the 'perpetrator' is also an adolescent who may be in- or out-of-school, but in an existing consensual relationship with the impregnated female student.

National Policy on Health and Family Life Education (HFLE) (1998)

Within the education sector, sexuality and sexual health education are addressed through the 1998 National Policy on Health and Family Life Education (HFLE). Since 1987 the National Population Policy (NPP) in Grenada had as one of its goals, "to reverse the upward trend of teenage pregnancy and to reduce the number of teenage pregnancy," with strategies including "the incorporation of Family Life Education in schools and Teachers' College"; "delivery of Family Life Education to adolescents; and providing Family Life Education for the nation as a whole" (GoG, 1998b p.5). The HFLE policy was developed in response to Regional level recommendations, specifically for the Caribbean Community (CARICOM)[6] to strengthen HFLE in- and out-of-school (GoG, 1998). In 1994, the CARICOM Standing Committee of

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[6] CARICOM is an organization of 15 Caribbean nations and dependencies. Its main purpose is promoting economic integration and cooperation among its members, to ensure that the benefits of integration are equitably shared and to coordinate foreign policy (CARICOM, 2011)

Ministers of Education passed a resolution to support the development of a comprehensive approach to HFLE by CARICOM, the University of the West Indies (UWI), and UN and other partner agencies working in the Region (UNICEF, 2009). In 1996, CARICOM Ministers of Education and Health endorsed the document, "A Strategy for Strengthening Health and Family Life Education (HFLE) in CARICOM Member States" (UNICEF/CARICOM, 1995), and in 1998 the Grenada HFLE Policy was developed (UNICEF, 2009).

According to the vision statement, the policy was to be valid until 2002, but to date a new national policy has not been developed, although a new "CARICOM HFLE Regional Curriculum Framework" was developed in 2005 (CARICOM/UNICEF/EDC, 2008). This illustrates the pace at which regional-level mandates sometimes trickle down to the country-level. However, it was found that the policy still guides sex-education in schools supplemented by the Regional Framework. Technical assistance for implementation of the Policy is provided by UNICEF, as a coordinating agency of HFLE in the Caribbean Region (GoG, 1998). Despite having clear strategies focusing on adolescents in general and the nation, the MoE has remained focused on implementation related to students, neglecting out-of-school adolescents.

4.2.3   Criminal Acts

This section describes legislation and policy pertaining to a range of SRH-related issues that are considered criminal acts and carry sanctions by law. With the exception of the *Child Abuse Protocol (2004),* these are addressed in the *Criminal Code of Grenada* and include: 'carnal knowledge" or age of sexual consent; abortion; consensual or forced same-sex intercourse; and the Child Protection and Adoption Act (2010). Each is described below; however, there was no information available pertaining to their development.

Age of sexual consent/statutory rape

Sexual consent of adolescents as addressed in the Criminal Code states that it is an offence for anyone to have sexual intercourse with a female less than sixteen years of age, with or without her consent (Ramdhani, 2005); this is commonly referred to as the "statutory rape" or "age of consent" law. However, this law unfortunately only applies to girls and not boys (Ramdhani, 2005; Sealy-Burke, 2006) – an area of gender inequality. But even among girls, the law differentiates between girls who are less than age 13 and those who are age 13 but not yet age 16. In the latter category, the penalty carries only five years on conviction, and prosecution for this offence may be avoided altogether if not instituted within three months of

the date of the offence. Furthermore, the male offender has a defence if it could be shown that he believed the girl was at least 16 years at the time of the act. The former category carries 15 years and there is no limitation on the prosecution of this offence (Ramdhani, 2005). This has implication for whether girls and/or their families will voluntarily or under duress delay or forgo reporting of some incidences of sexual abuse according to the definition and penalties in the law.

Abortion

The issue of abortion is provided for in *the Criminal Code*. Abortion in Grenada is restricted, as the law states that it is an offence to intentionally and unlawfully cause an abortion or miscarriage. The offender is liable to imprisonment for ten years. According to the document, the offence can be committed either by the woman or any other person; furthermore, a person can be guilty of using *means* with intent to commit the offence, although the woman is not in fact pregnant (emphasis added). While the law does not specify means, I have interpreted it to refer to medical or homemade devices/treatment to induce an abortion, which has implications for help-seeking related to adolescent pregnancy. However, the law makes provision for an abortion for the purpose of medical or surgical treatment, whereby it is presumed that the intention is not to cause death. According to the law, abortion is only permitted on the following basis:

- To save the life of the woman;
- To preserve physical health; and
- To preserve mental health.

However, abortion is not available upon request, as a result of rape or incest, or economic, social and other reasons, and may have implications for coping with pregnancy among adolescents. Considering that pregnancy puts the health and life of adolescents at enormous risks due to their still developing bodies, it can be argued that the permissive conditions for an abortion in Grenada can be viewed as a loophole and can be applied to adolescents. Nonetheless, it was not clear whether there are specific policies or protocols within the health sector to guide health providers' decision-making and reporting of legal abortions.

Consensual or forced same-sex intercourse

Consensual or forced same-sex intercourse, referred to as sodomy, is criminalized through the offence of "unnatural crime" which is committed by way of anal sexual

intercourse. The offence can be committed by a male person with/to another male person and/or a male person with/to a female person, and is punishable by imprisonment for ten years. Based on the wording of the text, the offence cannot be committed by two female persons, and or by a female person with/to a male. However, locally, this law is interpreted to mean that homosexuality among male and female is illegal. This criminalization of same-sex sexuality, similar to the criminalization of abortion, highlights the prominence of religious and moral values in Grenadian society, and has implications for adolescents who may identify as being a homosexual or bisexual. This may also hinder help-seeking, especially related to HIV if adolescents believe that HIV/AIDS is associated with homosexuality.

Child Protection and Adoption Act

Sexual abuse is also provided for in the updated Child Protection and Adoption Act (2010) and in the Criminal Code. The Child Protection Act protects adolescents considered to be at risk, among other things, where they have been sexually molested or exploited where the parents know or should know and fails to protect the child. This Act makes provision for the establishment of an Authority with the capacity to apply to a court for an order of protection with respect to a child in need of protection (Friday, 2008). According to the information on the Royal Grenada Police Force web page, the Criminal Code carries strong penalties on sexual offences against children (www.rgpf.gd). However, the penalties are not detailed on the website.

To support the implementation of the earlier Child Protection Act (1998), and other child abuse related legislation, a National Child Abuse Protocol was developed in 2004 to give direction to the agencies and professionals involved in child abuse cases. The protocol includes guidelines and procedures for reporting suspected child sexual abuse; conducting investigations; case management, inclusive of placement, treatment and follow up services; involvement of schools; information sharing; interviewing the child; medical Interventions and; establishing roles and responsibilities of agencies (GoG, 2004). The next section describes the key organizations and services/programs available related to ASRH.

4.3   ASRH-Related Services/Programs

In Grenada programs and services related to ASRH are available in the government and non-government sectors. In the government or public sector, programs and services are provided via the MoH and MoE, and in civil society, several non-governmental organizations

(NGOs), community-based organizations (CBOs) and faith-based organizations (FBOs) provide aspects of ASRH-related programming.

The following organizations related to ASRH promotion discussed below are considered mainstream organizations/programs. They are categorized according to the type of ASRH-related services they provide and include: (1) information and education, (2) health services 3) legal aid and counselling. However, services/programs may be made available at the community, school and national level. The following section provides a brief background, describing each organization/program by the type of services offered in response to ASRH.

4.3.1 Information and Education

The organizations/programs in this category provide primarily sexuality and SRH education and information for adolescents at school and community levels, and to a lesser extent via the media.

Health and Family Life Education (HFLE)

HFLE is a program regionally mandated by CARICOM and is administered through the Ministry of Education (MoE) in the public school system. HFLE is a life skills-based curriculum guided by the 1998 HFLE policy. HFLE is described as:

> ...guided learning experiences [where children] develop attitudes, knowledge, skills and values which would empower them to develop healthy lifestyles and make choices and decisions which would impact positively on them, their homes and communities.
>
> (GoG, 1998 p.8)

According to the policy, HFLE is implemented as part of schools core curriculum from Kindergarden to Form 3 in the secondary schools, omitting students in their final two years of secondary school. However, it was reported that HFLE program materials are made available to private schools and PAM, although the MoE is only responsible for monitoring public schools. Nonetheless, based on the school enrolment rate for this group (63%) it can be argued that HFLE reaches the largest amount of adolescents to provide sexuality and sexual health education, which is one of four modules within the HFLE curriculum. Based on the policy and review of the curriculum, each module is based on age appropriate lessons (Table 4-3 for topical examples of a sexual health module). The policy describes that teachers are to

be specially trained to deliver the curriculum. HFLE has implications for sex education both in- and out-of-school contexts, and also for help-seeking from teachers (chapter 7).

Table 4-3 Sample HFLE Curriculum: Sexuality & Sexual Health (Age 13-14)
Source: (GoG, 2008)

Module 1: The concept of Human Sexuality
Unit 1 – Factors that Influence the Expression of Human Sexuality
Unit 2 – Exploring Gender Issues
Module 2: Optimising Reproductive Health
Unit 1 – Factors and Risks Affecting Reproductive Health
Unit 2 – Pregnancy and Child Rearing
Module 3: Cervical Cancer, STDs, and HIV/AIDS: Empowerment to Protect
Unit 1 – Cervical Cancer, STDs, and HIV/AIDS Can Be Prevented and Controlled
Unit 2 – The Human Side of HIV and AIDS
Module 4: Accessing Accurate Age-Appropriate Health Resources
Unit 1 – Health Resources Related to Sexuality and Sexual Health

HIV Education Program

The MoE also has an HIV Education program, separate from that provided through HFLE and is available to schools upon request by teachers or principals.

GRENCODA

GRENCODA was established in 1985 "to provide guidance and support to rural individuals, families and communities to improve their quality of life" (GRENCODA, 2008). GRENCODA's programs are primarily located in the West and Northwest rural parishes of Grenada, but there are also national level activities. GRENCODA's initiatives fall under the five areas of:

- Community development, mobilization and services;
- Education and training;
- Institutional strengthening;
- Small business and entrepreneurial development; and
- Advocacy and Research.

As reported in GRENCODA's annual report for 2008, the organization's strategic priorities for 2006-2010 included but were not limited to: (1) facilitating skills training and the acquisition of life skills for personal development to alleviate poverty and; (2) advocacy on policy issues that are impacting on the situation of marginalize persons/groups. ASRH can be seen to be addressed in both priority areas; however, the latter is achieved through a separate program – the Legal Aid and Counselling Centre (section 4.3.3). The annual report indicate that during the school holiday period GRENCODA conducts a *Youth Development Program* during July and August for ages 5 to 17 in rural communities. In the context of personal and life skills development, program participants gain, through the use of interactive methodologies, information on sexuality and sexual health topics such as STIs, including HIV/AIDS, abstinence, relationships, and so on (GRENCODA, 2008). Facilitators for the program include persons from Ministries of Education and Social Development including civil society. The rural community which participated in this study is also a recipient of the *Youth Development Program*. GRENCODA's role in the community has implications for engaging communities related to ASRH help-seeking.

The Agency for Rural Transformation (ART)

Like GRENCODA, ART is a non-profit, rural development NGO and has been in existence since 1981. ART's mission is "to guide, focus and provide support to rural communities to accept responsibility and take action that will improve the quality of life in the communities on a continuing and independent basis" (ART, 2010). ART conducts rural youth development programs targeting children between the ages of 6-16, focusing on literacy enhancement, creative expressions, sport and basic life skills (ART, 2010).

According to the information on the agency's website, ART conducts an annual holiday youth program - *Rural Youth Empowerment Program* targeting children between the ages of 5-16 and engaging them in supervised activities during July and August. The website also states that the program commenced in 2002 and includes health education sessions on HIV/AIDS for participants, which is facilitated by resource persons drawn from the Health Promotion Department of the MoH and the Grenada Red Cross Society (GRCS). ART utilizes community theatre to promote HIV prevention, and in 2007 took its production titled *A Sip of Red Wine* to four (4) secondary schools and held panel discussions following each show. Although the website states that *A Sip of Red Wine* is broadcasted on local television networks as part of the networks local programming for public education (ART, 2010), it was unconfirmed whether

this is still happening. In contrast to GRENCODA, ART serves primarily rural communities in the Southeast and Eastern parishes (i.e. St. David and St. Andrew). ART's role suggests that the organization may be useful in engaging communities and the media.

Grenada Red Cross Society (GRCS)

The GRCS was started in 1955 as a Branch of the British Red Cross following the devastation of the island by Hurricane Janet. The GRCS became an independent National Society in 1987 headquartered in St. George's, Grenada's capital city. The mission of the GRCS is to "serve humanity through the promotion of health and safety, disaster preparedness and response, social welfare and youth programs" (GRC, 2012). Through its social welfare and youth program, the GRCS offers its own HIV/AIDS education activities, but also functions as an HIV/AIDS education resource for schools, churches, and other NGOs across Grenada. Whereas other organizations are staffed by paid employees, based on my knowledge of GRCS, its activities are conducted through volunteerism of its membership. The GRCS has implications for HIV/AIDS information seeking particularly in urban communities, including the urban community in which this research was based. Furthermore, the concept of volunteerism may be useful in regards to the provision of ASRH services.

National Parenting Program (NPP)

The NPP is based in the Ministry of Social Development (MoSD). It was fully implemented in 2010 collaboratively between Government and NGOs through a Planning Committee to review and plan activities in relation to the NPP Strategic Plan (Glasgow, 2010). The need for the NPP emerged as a recommendation from national consultations on the CARICOM Charter for Civil Society held in October 2001 and January 2002. It is reported that the consultation included a cross-section of participants representing professional bodies, political parties, NGOs and other activist organizations. Through discussions regarding social development in Grenada, participants suggested that there was a need for civil society to focus more on the family, and that a NPP would be appropriate (CARICOM, nd). Between 2006 and 2007, several local factors converged (i.e. high rates of teenage pregnancy and female-headed households, increase in crimes involving young people, especially boys) resulting in the development of the NPP (GoG, 2008b).

As stated in the strategic plan, the goal of the NPP is to provide overall direction to men, women, boys and girls for parenting. The Mission Statement of the NPP is:

> To develop and implement non-formal, community-based parenting programmes geared toward building mature individuals, stronger families and integrated communities throughout the state of Grenada.
>
> (GoG, 2008b)

According to the program's 2010 annual report, during 2010 the NPP provided parenting education sessions to adolescent boys and girls, as well as adults in several communities, workplaces, schools and churches across Grenada. In addition, parenting sessions were also conducted by social partners including NGOs, CBOs, and FBOs. The NPP curriculum is also taught as part of the core curriculum for adolescent mothers attending PAM. Particularly interesting is that the NPP targets potential parents, which includes adolescents between ages 13 and 19 who may or may not be pregnant or expecting a baby, in the case of adolescent boys. Parenting information was disseminated via the Government Information Service (GIS) and other media stations, and a drama series titled *Pelican Point* was also aired on 3 television and 2 radio stations on the island as part of parenting education (Glasgow, 2010). Based on the NPP's mission, there is scope to address parent-adolescent communication in various setting, including the workplace around sexuality and sexual and reproductive health, which has implications for SRH help-seeking. Furthermore, their use of the media for education is noteworthy.

4.3.2 Health services

Health services related to ASRH are provided through public health care, private health care and the Grenada Planned Parenthood Association (GPPA). Adolescents' perceptions regarding these findings are discussed throughout Chapter 7.

Public Health Care

According to a source in the MoH, adolescent health at the level of the MoH is under the purview of the *Family Health Committee*, which is responsible for child and maternal health. The role of the Committee, according the source is to:

> Look at the maternal and child health services that are offered; look at any gap in the services and would make recommendations towards improving the service delivery, plan programs, and implement programs a lot of the times with assistance from PAHO and other agencies.

However, it was pointed out that ASRH programming has not been a priority of the Committee. Rather the Committee's activities have been in large part to achieve MDGs four

and five pertaining to reducing child mortality and improving maternal health, respectively. Nonetheless, the source reported that SRH services such as, contraceptives, pregnancy testing, STIs/HIV counselling and testing, and maternal health care which are targeted to adults and are available at a network of health facilities (Figure 1-6) are sometimes used by adolescents seeking these services.

Additionally, the Health Promotion Department within the MoH have pamphlets available in the event students stop by seeking information or if schools request resource persons. However, a more proactive role is not taken by the Health Promotion Department regarding ASRH. Television and radio advertisements were observed promoting condom use to protect against HIV infection, which were sponsored by the National HIV/AIDS Program. Unfortunately, the Program was not fully operational during the fieldwork due to lack of funding. The MoH's current role in ASRH has implications for the availability and access of SRH services for adolescents' (section 7.3.1) and may also impact how other organizations and sectors approach ASRH.

Grenada Planned Parenthood Association (GPPA)

The Grenada Planned Parenthood Association (GPPA) was founded in 1964 to provide family planning services to poor women working on plantations, and who were unable to pay for medical services. The mission of the GPPA is "to improve the quality of life of Grenadians by providing sexual and reproductive health information and services" (GPPA, 2008). The GPPA's mission is primarily achieved through its two clinics – one located in the capital city, St. George's and the other in the largest city centre Grenville in St. Andrew where the Association reportedly provides the widest range of contraceptive options on the island, and other SRH services and counselling, such as pap smears and pregnancy tests (GPPA, 2008), which are targeted to men and women.

The GPPA, which is in part funded by the International Planned Parenthood Federation (IPPF), is guided by the International Planned Parenthood Strategic Plan 2005-2015 which includes strategic priority related to ASRH services. However, it was pointed out that there is no written local interpretation of the Plan, but that the organization encourages its clinicians to provide SRH counselling and services for adolescents. Previous attempts by the GPPA to target sex education were short-lived. GPPA's unique position as the only NGO provider of health services has implications for ASRH programming and policy development.

4.3.3 Legal Aid and Counselling

Legal Aid and Counselling Centre (LACC)

The LACC is a program of GRENCODA, through which GRENCODA's strategy pertaining to advocacy on policy affecting marginalized groups is addressed. However, the LACC deals primarily with the provision of legal advice and representation and psychosocial counselling, primarily for women (Personal communication, LACC staff, 2010). The LACC encounters and deals with children and adolescents around issues of sexual abuse, child maintenance, and provide counselling and education services for young men who have been sent to them by the court in lieu of going to prison (Personal communication, LACC staff, 2010). Unlike GRENCODA, the LACC's office is located in the capital city of St. George's. Overall, the LACC deals with ASRH issues from the perspective of adolescents who are experiencing particularly difficult situations. Based on my knowledge, the LACC has a growing profile in Grenada and the Caribbean Region for its role in research and advocacy pertaining to child sexual abuse legal reform, domestic violence and child protection. As such, the LACC has implications for adolescents, primarily those residing in urban areas and may require counselling and legal services related to SRH, but also for addressing legislation and policy issues pertaining to ASRH help-seeking.

The next section describes the factors that affect the development and implementation of ASRH-related programs and services in Grenada to effectively promote ASRH. The primary source of data for this section is organizational-level key informants.

4.4 Adequacy of the Existing ASRH-Promotion Environment

This section focuses on perceptions about the adequacy of the existing environment of ASRH promotion in Grenada, with a focus on the strengths and weaknesses. When key informants were asked about the adequacy of the existing environment to meet the SRH help-seeking needs of adolescents in Grenada, there was consensus that the existing environment was inadequate. However, there were some positives identified. Analysis of the key informants discussion and documents indicates that there are several reasons for key informants' perceptions. The discussion below is organized according to the three categories (Figure 4-1) that are perceived to affect the development and implementation of adequate SRH programs/services and policies for ASRH in Grenada. The circles are connected in the

figure below to indicate that the factors are interrelated, and together affect the existing environment. Findings from each category are presented below.

Figure 4-1 Factors influencing ASRH services and programs

4.4.1 Organizational Capacity

Organizational capacity is used to capture discussions pertaining to organizational mandates and resource availability that permits or limits organizations' activities regarding ASRH.

Organizational mandates

Organizational mandates pertain to whether ASRH is outlined in organizations/programs mission, vision, or strategy documents. When key informants were asked how ASRH fit within their organization's priorities, half of the key informants reported that ASRH are among their main priorities while the other half discussed that it was not a priority. This was consistent based on policy statements, strategic plans, and annual reports reviewed. However, only half of the key informants provided plans and reports for review.

Some key informants discussed that their organizations/program's response was based on perceived unmet need for ASRH programs, based on their observations or statistics. Three organizations indicated that they were also influenced by international or regional conventions/strategies, and provided copies of the relevant documents. However, some organizations that have written mandates may be hindered from achieving such because the policy may be outdated or remain in draft form which affects effective planning (section 4.2). For example, in the draft NSPH 2007-2012 ASRH was prioritized, but only in recent times has adolescent health become a priority for the MoH. This was evidenced by their partnership with PAHO and discussions with country-level stakeholders regarding the development of a National Adolescent Health Policy, which I participated in during fieldwork. Key informants were optimistic that the policy will include tenets pertaining to SRH to propel the health system's response to ASRH, and other key informants were hopeful that it would increase their scope to address ASRH.

> …It means that institutions like ours will be able to be more proactive, write bigger projects….young people can now make their demands knowing their rights and privileges, so they would now be able to legally and forcefully request services, and if we start advocating for youth services, we cannot be overrun by other persons because we have the support and the legislations, plus we will have the support from the young people.

> *(Key Informant 1, HCCS)*

According to the above key informant, a policy on ASRH would make organizations feel more comfortable in addressing ASRH and would also give adolescents a stronger position to request/demand services.

However, when key informants were asked who had responsibility for facilitating policy and/or legislative changes regarding abortion, all but one key informant discussed that it was the MoH's role. The same key informant also pointed out that it was the MoH's role to develop policies in keeping with the law and had no intentions of making abortion legal. But one key informant in the NGO sector explained why the MoH may be reluctant to assume this policy, advocacy and development role, which is perceived to be within their purview:

> You see the abortion debate is so politically charged that it does fall squarely within the mandate of the Ministry of Health, it is a health issue. But it's not going to be spearheaded by the Ministry of Health until it's debated in the

> political arena, right. So a State Ministry is not going to put their Ministry behind something that the politicians have not brought out into the open as yet.
>
> *(Key Informant 4, HCCS)*

This key informant highlights the role of politics in advancing the agenda for SRH, and as such there may be a role for NGOs and other advocacy groups to instigate the political debate on SRH topics.

Resource Availability

Resource availability was also discussed as a reason for the inadequacy of the existing environment. Resource availability pertains to human, material and financial capacity of the organizations/programs. Some key informants reported that their organizations/programs are inhibited by insufficient resources to implement programs and services. This often results in staff being over-tasked. For example, key informant 5 describes the staffing for his program as such:

> Well I don't have staff. Umm, and I don't have, what you see around (Yeah) is, is what the resources are. I have a computer, I have a desk, you know, and *I* try my best. *I* sometimes get the [secretarial] assistance of our persons upstairs…[where] this desk falls under.
>
> *(Key Informant 5, IE)*

The above key informant is responsible for a national program for which the informant is the only staff and the above are the material resources available to achieve the goals of the program. Findings from the report on Grenada by the Committee on the Rights of the Child also identified human resource shortage as a limitation to implementation of the CRC:

> Given the multiple roles played by staff of the Ministry of Social Development due to a severe shortage of human resources, the Committee is concerned that there is no entity to specifically focus on coordination between the different ministries and between the national, provincial and local levels, as well as on the harmonization of national policies and plans of action related to child rights.
>
> *(CRC, 2010 p.2)*

Based on the above excerpt, the CRC agenda is not effectively progressing in Grenada. This suggests that the lack of human resources dedicated to ensuring implementation of the CRC may also negatively impact policy actions, and service availability impeding ASRH rights. Related to the issues of staff shortage is high health promotion staff turnover, which was

reported by one key informant as making it difficult to sustain health education programs in the clinical and community setting. This has implications for SRH health education; however, in sub-section 4.3.1, GRCS is described as using volunteers to implement their programs.

The main reason identified for lack of staffing and material resources pertained to the availability of funding. While NGOs and public sector organizations reported receiving government subventions to fund their activities related to ASRH, key informants reported that the amount was small leaving managers to rely heavily on external funding sources. The following key informant offering information and education indicated how the program's reliance on external resources has been both a positive and negative experience:

> this year 2010 September to 2011 we have a $20,000 US budget to work with from UNICEF…so with that we are able to cope better, for example I've been given permission this year to purchase a lap top and a projector, so when I have training I won't have to go searching all over the [organization] for the one ping-a-ling projector that they have. In terms of implementation, you know in terms of production of resources…we have a lot of breakdown of machinery, or sometime ink not available, for example, we had some printers I think many institutions and Ministries in Grenada got them from Korea as a gift, but somehow we're not getting the ink since the first batch of ink was finished. So it's almost going on three years now and that is there like a white elephant, so that handbugs [hinders] in terms of production of resource materials.
>
> *(Key Informant 2, IE)*

The above key informant indicates that while organizations are appreciative of the subventions, monetary and material donations, such as printers from donors, it is made clear that this is method is not sustainable. This is because organizations may be unable to maintain the equipment after the donor has left. Key informant 5 above also discussed that the lack of funding hinders the implementation of media programs related to ASRH:

> Finances is one, cause just to put some information on the media about HIV/AIDS, or about attitudinal changes, or about something related to sexuality cost a lot of money. And, it cannot be easily sustained you know.
>
> *(Key Informant 5, IE)*

The above key informant identifies media as a means of addressing attitudes in society; however, the cost to use media sources appears to be out of reach for some programs. This may also affect the sustainability of the media programs discussed on ART's website and in the National Parenting Program's annual report (section 4.3.1).

Training of a range of program staff including medical practitioners and teachers was also discussed as being hindered due to the lack of financial resources. Although key informants reported a range of ways in which staff training occurs, such as through regional organizations and networks, educational qualifications, in-house training, and participation in training opportunities through other local organisations, most key informants indicated that training was often based on the availability of international funding. Additionally, with the exception of one key informant, all key informants perceived that HFLE was not effective in reaching students due in large part to the lack and/or quality of training teachers receive. The following is a typical view regarding teachers' capacity to implement the HFLE:

> lack of information that is of really meaningful value are sex education in schools through the HFLE program….The teachers are not trained to deliver it and they are uncomfortable delivering it and they do a half-baked inferior job in my assessment as much as I can speak to it.

(Key Informant 4, HCCS)

However, another Key informant who provides information and education pointed out that while teachers are uncomfortable teaching HFLE, it is due to personal experiences rather than a lack of training. This is illustrated in the following excerpt:

> A teacher said "is not that I am comfortable so much, you know, is just that I was sexually abused as a child," so I realized that even our teacher who once were very young boys and girls at home could have been sexually abused. And you know these things and the psychological effect it can have on a person. Sometimes you think it's over and often times it's not over.
>
> *(Key informant 2, IE)*

The above key informant also suggests the importance of coping with childhood sexual health concerns, because they can negatively affect the person's future, but also the students who need to be taught about these issues.

In summary, the issues regarding organizational capacity pertain to the lack of organization/programs that have a mandate and/or leadership to address ASRH, lack of funding, which affects staffing, training, material production, which affect organization's ability to develop and implement ASRH programs and services that are effective and sustainable.

4.4.2   Implementation and Enforcement

Implementation and enforcement pertains to the manner in which sex education and healthcare services are delivered in regards to legislation and policies. For example, key informants were concerned that despite a policy on the implementation of the HFLE program, schools made decisions about what aspects of the sexuality and sexual health module to implement, and that denominational school in particular choose to focus more heavily on abstinence and not (adequately) teaching about pregnancy prevention.

> And so even though it [contraceptives] is in the curriculum of HFLE, it is not taught for example at Convent. Convent specifically goes for abstinence…they teach abstinence and chastity….they [public schools] would tell you about condoms in terms of lessening your risk to HIV and AIDS and other STIs as well as pregnancy, the other schools like the public schools will teach that…
>
> *(Key Informant 2, IE)*

However, the key informant further discussed that lack of implementation of certain aspects of the module in part attributed to some principals placing less priority on HFLE because it is not an examinable subject.

In contrast, some key informants perceived that unclear policies and/or legislation pertaining to the issues of parental consent for SRH services hindered the implementation of SRH services, such as the provision of contraceptives for adolescents. This results in inconsistent/unreliable provision of SRH services for adolescents, as discussed by a key informant in the HCCS sector:

> …there are no specific guidelines for dealing with the adolescents… but how do you deal with an adolescent…So you would find that the care delivered to adolescents would vary from care provider to care provider. Those who feel comfortable giving the adolescent contraceptive would give it, others who don't feel comfortable they will not give it.
>
> *(Key informant 3, HCCS)*

The above excerpt is typical of stories discussed by key informants on this issue. In fact, the same key informant reported that it is against the law to provide health services to persons under age 18 without parental consent. However, other key informants reported being unaware of such a law, neither was such a law found during the document review. This is consistent with a report by Sealey-Burke (2006) who found that there is no law requiring parental consent for health services or SRH services. However, according to key informants,

the confusion seem to stem from the law regarding the age of sexual consent, which is 16 years and the age of majority, which is 18 years. This lack of clarity has implications for the consistent provision of SRH care for adolescents, and could negatively influence adolescents SRH help-seeking (section 7.3.4).

Furthermore, a key informant in the NGO sector perceived that the lack of consistent implementation contributes to the status of sex education in Grenada, and states that:

> Sex is still a subject to be learned by the way. Contraception is a taboo subject and they believe contraception should be only for (pause) married people or people living in house (pause) family. So the education system does not put contraception in its right perspective as an element regarding sexual activity.
>
> *(Key informant 1, HCCS)*

However, respondents also recognized that there were other opportunities to provide safe sex information to students, apart from schools as discussed by this key informant in the IE sector.

> You do what is required of you, having respect for the particular religion and the particular school… but you also tell the student that if you know you need further information, you know I can be contacted... A lot of students wanted to find out more about condom use and so on… so I told them invite me outside of the school and actually some of them have; they have done that through their community groups and so
>
> *(Key Informant 5, IE)*

The ability to reach adolescents through community groups indicate that these groups may be avenues through which HFLE can target communities as outlined in their mission statement (section 4.3.1). Furthermore, community groups may be a potential source of information and advice for adolescents with SRH concerns, and could potentially facilitate health services utilization. Overall, respondents believed that the hard-line position of some schools regarding sex education was not adequately preparing students for the inevitability of sexual activity now or in later life.

Additionally, some key informants discussed that not all SRH-related laws were supportive of ASRH (e.g. abortion), and viewed law enforcement as problematic. For example, regarding the sexual abuse laws they believed that health workers were unaware of reporting procedures which limited the ability of the law to provide adequate protection for adolescent who might access health care services. For example, one key informant discussed that:

But in terms of sexual issues or because of the nature of it you would not find any standard protocol or so at the community level. Even in terms of suspected cases of where the child may be abused, no clear guidelines, for example, the doctor or the nurse see that child at the causality department, no clear guidelines to follow. They may choose to call the police, or may call domestic violence you know but there's nothing in place as it relates to that.

(Key informant 3, HCCS)

Although the Child Abuse Protocol (section 4.2.3) addresses reporting of sexual abuse by different sectors, according to key informant 3, the lack of operationalization of national policies across sectors is a barrier to effectively meeting the SRH help-seeking needs of adolescents. Problems with coordination are also implied, and are discussed in the next theme.

4.4.3   Coordination and Collaboration between organizations/programs

While collaboration could have also been discussed under organizational capacity, there are elements of it that are related to the other themes; as such it is best discussed separately. Collaboration captures key informants discussions about how organizations and programs work together to provide ASRH education, advice and services. Most organizations/programs discussed working together through formal or informal collaborations regarding ASRH programming. However, informal collaborations did not involve any written agreement or contract, and were more often discussed. In contrast, formal collaborations were binding via contractual agreements.

Resource Sharing

Informal collaborations often took the form of resource sharing. For example, most key informants discussed that they facilitated training or health promotion activities planned by other organizations, implemented programs or research for other organizations, shared health promotion paraphernalia, and even referred clients to other organizations for more appropriate services for their concern. The following key informant in the NGO sector discusses how other sectors are involved:

Training programs with young people include HIV/AIDS issues, and volunteers from across the sectors facilitate these trainings to deal with sexuality and HIV. For example, Ministry of Education is involved.

(Key informant 6, IE)

When asked about how the organization works with other organizations, this key informant in the HCCS sector described an informal referral service:

> There is a very informal arrangement. For example there are women who need services because of violence against women, you know, abuse and so on. We do referrals with Legal Aid and Counseling Clinic [LACC], so we have that kind of loose arrangement.
>
> *(Key Informant 1, HCCS)*

Although 'women' is used in the above excerpt, the key informant later clarified that adolescents are also referred in this manner. Nonetheless, referral is an important aspect of integrated services, and may have implications for the Grenada context considering that there are no specialized ASRH services. However, the fact that referrals are done informally rather than through a formal process has implication for continuity of care during help-seeking.

Only one formalized collaborative activity was discussed. However, based on the key informant's discussion, the collaboration may have been formalized because it involved the regional arm of an international agency for a program targeting adolescents and young people. In general, it appeared that collaborations provided organizations and programs an opportunity to reach subgroups of adolescents that they would not have otherwise accessed.

Committee Representation

Committee representation was discussed as one of the main ways in which organizations work together. This is evidenced in the range of documents reviewed that listed the involvement of several organizations in the development of the strategic plan or policy (section 4.2). Most key informants reported that their organization is represented on the committees of several other organizations to form multi-sector committees, including related to ASRH. However, with the exception of two committees, the role of other multi-sector committees was not probed, but the roles of these committees included aspects of policy and program planning and implementation. This suggests that there is a good foundation for participatory decision-making for policies and programs, which should augur well for efforts to scale-up ASRH promotion.

Nonetheless, despite the many ways in which key informants discussed working together, collaborations were not without challenges. Some key informants discussed that information sharing was one of the weakest areas of collaboration among organizations. For example, a

key informant in the IE sector discussed that having to request data, rather than routine data sharing to inform program decisions was a weakness.

> So let's say [Ministry of] Health is the custodian of information….in terms of statistics and so I have to request it… And still I am not too happy with the statistics that I am getting because I want to be sort of able to break it down…really look at some of the issues, look at some of the areas and so forth…. I want something more specific…look into a parish and look at the villages and see exactly what is happening there and so forth…but they don't have that sort of statistics.
>
> *(Key Informant 5, IE)*

Keeping organizations abreast of programs being planned and following up with updates on committees' initiatives were also discussed as a weakness. For example, one organization reported having to abandon a major program for adolescent mothers after all the ground work had been done, because they found out that another organization was planning a similar program. This highlights the issue of overlap and duplication of efforts considering the lack of financial resource (section 4.4.1), in addition to the lack of an effective communication system to relay information between stakeholder organizations during and outside of committee meetings.

Another challenge is related to the timeliness of organizations honouring agreements or whether agreements are honoured at all, as discussed by the following key informant in the NGO sector:

> …we could not do [the HIV Rapid Test] because CAREC and the MoH special regulations we were not able to meet that requirement….It's about 200 [tests] - THAT WAS NOT VERY FEASIBLE, plus training had to be done by the MoH. They made many offers but nothing materialised.
>
> *(Key Informant 1, HCCS)*

Although the key informant was not probed as to whether there was a formal or informal agreement for the MoH to provide training for the HIV Rapid Test, the tone of the informant and the use of *offers* suggest that it was informal. It is possible that by adding the administrative step of formalizing the training agreements may have helped to accelerate the process or at least inspire confidence that the agreement will be upheld.

4.5   Chapter Summary

While several legislative and policy documents have been indentified that relates to ASRH issues, evidence suggests that some legislation and policies are unclear. The findings suggests that parental consent for SRH services policies may be based on health worker practice over time, rather than a written policy since no legislation or policy document was found. Furthermore, the main policy and planning document that gives guidance on SRH is reportedly not being used (i.e. NSPH). And, the contents of several sections of legislative and policy documents suggest issues of: gender inequality; discrimination based on age and sexual orientation, and; whether the penalties attached to laws may be hurting or helping ASRH seeking. However, a few recently updated policies and laws may augur well for ASRH.

Regarding ASRH services, HFLE can be considered the only adolescent-friendly program provided, however, no adolescent-friendly health services were identified. Nonetheless, public health facilities which target adult SRH and the school system have the ability to reach the most adolescents, since they are dispersed across the island. Apart from these two government programs, other notable organizations are in the NGO sector and include: GRENCODA and ART in rural communities that reach both in- and out-of-school adolescents, GPPA and LACC in the Capital, and the GRCS and the NPP that have some reach across the island.

Finally, key informants were unanimous in that they perceived that the existing environment around ASRH promotion is not adequate to meet the SRH needs of adolescents. Their reasons for this are categorized as: Organization capacity, implementation and enforcement, and coordination and collaboration.

Having examined the existing environment around legislation, policies and services in Grenada, chapter 5 discusses the SRH concerns adolescent participants discussed and the pathways they describe for coping with some of those concerns.

Chapter 5 – **ASRH Help-Seeking Pathways**

5.1   Introduction

The goal of Chapter 5 is two-fold. In section 5.2, the first goal is to provide a description of the main SRH concerns that adolescent participants have identified. A description of the specific issues that adolescents are concerned about provides the reader a better perspective to understand the SRH concerns for which adolescents seek help. Hence, the goal of section 5.3 is to explain the help-seeking pathways adolescent participants' utilize to cope with some of their SRH concerns identified in section 5.2. The information in this chapter is derived from the four subgroups of adolescents who participated in the focus groups and interviews. Section 5.3 is structured according to the four stages of the help-seeking pathways.

5.2   ASRH Concerns

The SRH concerns described in this section are categorized into: (1) vulnerability concerns, and (2) outcome concerns. Each will be discussed in-turn below.

5.2.1   Vulnerability Concerns

Vulnerability concerns pertains to the situations in which adolescents find themselves relating to SRH behaviours, and can be related to factors of their environment and/or individual factors. Adolescents were concerned about their vulnerability to a range of sexual and reproductive matters. Most adolescents discussed concerns pertaining to early pregnancy (i.e. becoming pregnant or causing a pregnancy during adolescence), including adolescents who reported not being sexually active. Based on discussion using the card sort all interview participants were *most concerned* about becoming a teenage mother/father. During the interviews and focus groups, adolescents discussed girls' vulnerability to early pregnancy based on their knowledge that some boys trick girls into believing they are having safe sex. In the following excerpt, 17-year old adolescent female, Jenna discuss that sometimes partners wilfully damage condoms:

Jenna: Yeah when you using the condom you have to make sure it's not burst....So when you get into it then you might not come out at the end pregnant and stuff like that, because you know some boys they like to burst it at certain point in time.

(Female Adolescent, RCI1)

Jenna's response illustrates that condoms are subject to failure based on factors attributed to the adolescent user, which concurs with the views of some male adolescent participants. Nineteen-year old Cal in the rural community focus group, discussed that some boys might 'burst' condoms due to a girl's initial rejection to a boy's sexual advances, or as a means of controlling girls. Cal's view is interpreted to mean that issues of power and control are at play during adolescent sexual activity. However, male adolescent participants attending NEWLO discussed that sometimes boys apply oil-based products to condoms prior to using it during sexual activity. Considering that only some participants in the group were aware that petroleum jelly causes condoms to weaken and break suggest a lack of knowledge about safe sex practices, which may partly be linked to sex education that prioritizes sexual abstinence in lieu of comprehensive sexuality education, which includes safe sex practices (Section 4.3.1). Adolescents may also lack the skills to correctly engage in safe sex practices, as only one male participant reported being taught condom use through the use of a dildo, while most male participants discussed learning on their own, following the instructions on the condom box, or reading a book in- or out-of-school. Therefore, some adolescents may feel intimidated or lack the self-confidence to put on a condom, which may affect adolescents' help-seeking to procure condoms (section 5.3) and increase their vulnerability to pregnancy and STIs/HIV.

In contrast to vulnerability due to user factors, other participants discussed that condoms also break because of design factors. This is discussed by the female focus group participants in the urban community:

Andrea: No matter what you do, sperm could pass through a condom.

Kara: And the one that is the skin type condom they say that's not good to use because they say it have holes.

Andrea: It has more pores in the (pause)

Kara: Yeah.

Andrea: than the rubber.

(Female Adolescents, UCFG10)

Other adolescent participants discussed unwillingness of themselves and/or partner to use a form of contraceptive, mainly condoms, but a few participants discussed the contraceptive pill. Notwithstanding, both male and female adolescent participants accused each other of not wanting to use condoms. However, the following excerpt of adolescent mothers is selected because it illustrates that both boys and girls may discourage condom use at times.

> Co-Moderator 1: But why do you think girls don't use protection when they have sex?
>
> Linda: Because of/ the boy, the boy.
>
> Jennifer: Boys, the influence of/ the boys.
>
> Co-Moderator 1: Influence of the boys?
>
> Linda: Yeah.
>
> Jennifer: Yeah the boys say all kinda thing/ he wouldn't feel it.
>
> [....]
>
> Rachel: Yeah is not always because of the boys because when I meet my boyfriend (pause) that was like the first time I ever had sex (Uhuh) *we use condom*, I was scared. And then I say "let we try it without the condom one of these days nuh" and we just (pause) try it without the condom and we continue doing it without the condom and (pause) it happen.
>
> *(PAM, UFG4)*

According to the above excerpt, condom may be discouraged and/or not used because sex without a condom is viewed as more pleasurable, or experimental. However, even when condom use is intended it may not be used. Nineteen-year old Jerry discusses that this may be due to being in 'the heat of the moment'.

> Jerry: ...most likely sometimes you might okay, you have intention and you going and have sex with this certain girl ... you understand. You gonna walk with you protection and still never use it (pause) 'cause certain times you so up to it, you so want this girl (pause) you know sometime you forget you have the condom in your pocket.
>
> *(Male Adolescents, RCFG7)*

However, one female adolescent, 17-year old Donna discussed condom use decision as a combination of pleasure and protection:

Donna: ... when you use condom (pause) is like nothing, but when you don't use you feel certain things and you experience it.

Interviewer 1: Okay. But how about your peace of mind, for example, you're worried about becoming a teenage mother. Do you worry more or less when you use condoms?

Donna: Uhh, when I use condoms I worry more because (pause) actually there's a saying, "as long as you're doing and it burst and the man cums [ejaculates] then you could get pregnant," so I does worry about that. But then when you don't use sometimes, for instance when me and my boyfriend don't use, is when he cum he does pull out.

(Adolescent Female, RCI2)

In the above excerpt Donna's views may be because she had previously gotten pregnant and had had an abortion. However, Donna was not probed about her contraceptive behaviour at the time of her pregnancy. Additionally, two female adolescent participants in the urban community discussed that they had a general fear of injections and 'taking tablets' which was compounded by the fact that one of the two females did not like the feel of condoms and had no desire to use it, but was willing to use the withdrawal method when she marries. This suggests that their contraceptive options may be limited when they do decide to have sex in the future (see chapter 8).

In addition to vulnerability to pregnancy, there was also some discussion about condom use in relation to fears about STI/HIV vulnerability, especially HIV. However, this was in large part due to concurrent and multiple sexual partnerships that was reported as commonplace among adolescents, especially males. This is illustrated in the following excerpt by the male focus participants.

Cameron: Miss 'cause he, why he using condom with outside woman because he know he woman, personal woman mightn't have no disease or anything so he go have sex with other woman outside with condom to prevent getting any disease.

Co-moderator 1: Ok, what about you Will, what do you think?

Will: Same thing I think.

(Adolescent Males, UCFG11)

This was also discussed among female participants. However, the above excerpt suggests that there is trust between 'main' or steady partners, that might hinder condom use as a means of STI/HIV prevention, while the same level of trust does not exist with the 'outside woman'. This is consistent with discussions among male participants that suggest that the primary concern with a 'main' girlfriend is pregnancy prevention rather than STI/HIV. This might also help to explain pressure from partners to have unprotected sex as discussed above. However, HIV vulnerability was a concern in large part because it was incurable, as many participants discussed. A few participants, especially male adolescent participants lacked accurate knowledge about HIV treatment, symptoms/signs, and prevalence. For example, in the excerpt below, male focus group participants discussed using pesticide and alcoholic drink mixtures as treatment/cure for HIV and Crabs:

> Fox: A shot a gramoxone woudda cure you [from AIDS]./
>
> RU: /Chaser Flanka [mixture of rum and coke or rum and red bull]
>
> Fox: Chaser Coke
>
> Milo: All you cure (pause), all you cure (inaudible)
>
> Co-Moderator 1: All you talking about serious thing there you know.
>
> Milo: That is death (inaudible) more fast. /
>
> RU: /That good for cure. Tha' the cure for AIDS.
>
> Milo: Who give you that cure?
>
> Co-Moderator 1: But somebody said it doesn't have a cure for AIDS.
>
> [...]
>
> Fox: Miss no it wash out everything. Is like a warm out, it like washing it outta the blood? (participants laughing)
>
> *(NEWLO, UFG1)*

In the above excerpt, male participants did not correct themselves about the ways to "cure" HIV after being challenged by one of the moderators and a group member. The participants' laughter is interpreted as a means of light-heartedly discussing a topic that the male adolescents are very concerned. As such, lack of knowledge might contribute to adolescents' sense of vulnerability regarding SRH matters, and have implications for prevention efforts, including help-seeking. However, some participants discussed that they use condoms all the time, and so did not feel vulnerable or concerned about early pregnancy or STIs/HIV.

Vulnerability to engaging in their first sexual intercourse was also a concern discussed by some participants, especially male participants. Peer and partner pressure to have sex was a recurring theme in relations to sexual activity, however, peer pressure was more often discussed among male participants while partner pressure was more commonly discussed among females. This is discussed by 18-year old Shaka as he talks about why becoming involved in a sexual relationship was not important to him, currently, during the card sort:

> Shaka: Yeah before it kinda came as an issue, you know, friends maybe might have um (pause) shared their experience and you, you wouldn't have any experience to share so maybe at the time you know you were just so like a listener and like when you have nothing to say you might be like, okay you know everybody will give you the eye and then you hear (laughter) you get couple laughs you know like
>
> Interviewer 2: So did you ever feel pressured by your friends, probably?
>
> Shaka: Ah little bit sometimes (Okay) according to the amount of (pause) laughs you get
>
> *(Male Adolescent, UCI9)*

Shaka reported feeling pressured to have sex based on how much his friends laughed at him. Nonetheless, not all participants reported experiencing pressure to have sex, including one female adolescent who discussed having a boyfriend and being abstinent. While some participants sought help to cope with pressures to have sex (section 5.3.3), others participants, such as 16-year old adolescent mother Carmen discussed succumbing to the pressure from her boyfriend to have sex.

Despite the range of SRH that were discussed, participants were mainly concerned about vulnerability related to early pregnancy, contracting STIs/HIV, and sexual activity. Although one male participant discussed physically hitting his girlfriend, and one female adolescent discussed being sexually abused, these participants and others did not report vulnerability to these SRH issues.

5.2.2 Outcome Concerns

Outcome concerns pertain to the consequences or end product of experiencing or engaging in certain sexual and reproductive practices. Adolescent participants were concerned

about a range of outcomes related to menstruation, sexual activity, pregnancy, contraceptives, and STI/HIV.

Regarding menstruation, the main outcome that female participants were concerned about pertained to discomfort of wearing sanitary napkins, cramping and headaches which resulted in missed school days and social activities. As a result of this, most female participants reporting that they disliked 'having periods'. The following two excerpts illustrate female participants' views:

> Mary: Well first of all I hate seeing my period (Uhuh) because every month I don't like to feel pad, *I hate to use it.*
>
> *(PAM, UI14)*

> Jenna: One thing I'm most concerned about is my period because it always changes dates and it gives me headache and cramps….The good thing…is I don't do any work at all, just lie down and sleep for the whole day and drink Supligen and Welsh's wine [energy drinks].
>
> *(Female Adolescent, RI1)*

Jenna, unlike other female participants talks about being pampered during her menstrual period due to the discomfort she experienced. Moreover, adolescents' dislike toward their menstrual cycle may be a result of the timing and manner in which they learn about menstruation. According to female adolescent participants, they learned about menstruation during menarche from a female family member, or in primary and/or secondary school which sometimes occurred after menarche. In the following focus group excerpt, participants Kara and Andrea discuss their experience learning about menstruation:

> Kara: But when I never used to see my period... [my] mother never used to (pause) talk about period and stuff.
>
> Andrea: Yeah and now like when we going out she's like, "don't/ go out and have sex because you could get pregnant."...
>
> Kara: She used to tell me that./ Or…she doesn't like come out plain and tell me, she does just tell me, "be careful"....
>
> *(Female Adolescents, UCFG10)*

In the above excerpt, 17-year old Kara discusses that her mother never told her about menstruation before she experienced it, and both Kara and 15-year old Andrea note that

unlike prior to menarche, now they are cautioned to practice sexual abstinence because of the risk of pregnancy. Therefore, it is possible that some parents view menstruation in their adolescent daughters as an unwelcomed developmental marker because it signals the potential for pregnancy. Parents' view of menstruation may also explain female participants' high levels of vulnerability to pregnancy discussed in section 5.2.1. The above excerpt also suggests that parents may experience discomfort talking about menstruation and sexual activity, as Kara states that her mother 'doesn't like come out plain and tell me', which is consistent to other female participants' response (section 6.2).

Additionally, there were outcome concerns about menstruation that were related to pregnancy. This pertained to irregular menstruation (i.e. 'missed period' and 'spotting') as an indication that conception had occurred. However, not all participants viewed irregular menstruation as a cause for concern. In the excerpt below, 18-year old Brian discussed two reasons why irregular menstruation might occur.

> Brian: ...if the girl don't see she period for the last month, well to me like she breed....I hear when girl like- she accustom having sex [and] you go and have sex with somebody else, the period does change.
>
> *(NEWLO, UFG1)*

Although some adolescent mothers discussed that their experiences of spotting or light flow was indeed a sign of conception, Brian also point out that irregular menstruation could indicate the body balancing itself because of change as is done via homeostasis, or conceptualized via astrology. Seventeen-year old Sara from the rural community more clearly discusses an astrological perspective which would not cause concerns about pregnancy:

> Sara: Well, no I don't find she should worry about that, because (pause) according to what me mother said, according to how the moon cut your period does miss sometimes.
>
> *(Female Adolescent, RCFG5)*

Nonetheless, pregnancy as an outcome of sexual activity was a concern shared across subgroups of adolescent participants, as is clearly illustrated in the card sort activity. One reason for this is because pregnancy was viewed as a big responsibility for the adolescent parent(s) and/or his or her family. For example, during the word game, when adolescent participants were asked "what comes to mind when you think, hear or see the words *teenage pregnancy, adolescent mother, adolescent father*" most times responsibility was the first and

most recurring adjective used. Responsibility was discussed as being able to provide the basic needs for the baby and mother during and after pregnancy, and participants discussed that this was no easy feat. In the following excerpt, male focus group adolescent boys discuss their feeling about becoming teenage fathers based on the scripted story:

> Shaka: Yes, scared of the whole issue of becoming a father.
>
> Jay: Like if I, me and my girlfriend get pregnant I go kinda fall down, yeah I go get scared because I still in school, I have to go and work and mind me child and mind she too. I go feel kinda frustrated.
>
> *(NEWLO, UFG9)*

As illustrated in the above excerpt, participants see teenage fatherhood as scary and resulting in taking on adult responsibility. However, most male participants agreed that most boys their age wanted to be fathers, which may be one of the reasons why girls are concerned about their vulnerability to early pregnancy (section 5.2.1). Furthermore, with early pregnancy, most participants were concerned that the burden of responsibility lies with the adolescent mother. According to participants, whether or not some men/boys admit to causing the pregnancy they may not accept/undertake their responsibility as fathers, and policies such as the *Education Policy on Pregnant Students* (section 4.2.2) do not appear to emphasize the responsibility of the young father. Additionally, some male participants discussed that pregnancy was used as a survival strategy for some adolescent girls, as is illustrated in the following male focus group excerpt:

> Justin: Or according to what family you come out in too, they go do anything to get child from you because they know (sucks teeth) the family go stand up.
>
> James: Yeah you rich.
>
> Justin: So they go like, "the money man, make a child for him."
>
> *(Adolescent Males, RCFG8)*

In the above excerpt, the male participants suggest that a girl may choose a boy to conceive with based on his family's socioeconomic status as a means of securing her livelihood during difficult economic situations. This has implications for whether girls decide to proceed with a pregnancy, and help-seeking.

Another outcome concern pertains to adolescents being hindered from achieving their educational and career aspirations as a result of unwanted outcomes, such as pregnancy and HIV. The majority of participants discussed that especially for early pregnancy, they risked being 'thrown out of school'. This happens in spite of legislation and policy mandating education for all between ages 5 and 16 (section 4.2.2). Adolescent participants discussed that girls are more likely to be 'thrown out of school' or leave of their own volition (section 6.4). Thus adolescents were concerned about early pregnancy occurring as a means of interrupting their education and future careers. However, adolescent mothers in the study discussed that pregnant girls can attend PAM successfully and go on to have their dream careers, as is also documented in PAM's Handbook (PAM, 2008).

Related to pregnancy and STI/HIV are outcome concerns pertaining to the side effects of some contraceptive methods. However, this was only discussed among female participants. For example, some female adolescents were concerned about the carcinogenic outcome of some contraceptives. This is illustrated in the following focus group excerpt:

> Coco: The pill and the condoms can also give you cancer (pause) anyway. These two can also give you cancer so it doesn't make no sense using those things, you just have to wait (pause) and wait. (giggle)
>
> Sherma: The spermicide and pills good for when people married already and thing
>
> Coco: And abstinence until you ready (Okay) well not when you ready, but (pause) when you settle./
>
> *(Female Adolescents, RCFG2)*

The above excerpt also suggests that contraceptive may be for married adults and that abstinence is the preferred method for adolescents until they are older and have finished college and/or married, as this group of adolescents defined as the right time for adolescents to have sexual intercourse. Additionally, one participant, 16-year old Carmen indicates a balancing act between two outcome concerns – concerns about the carcinogenic outcomes of the pill similar to the females in rural focus group above, but also the about the outcome of being expelled from PAM even if she does not want to use the pill:

> Carmen: And then most people who on the contraceptives die from cancer.
>
> Interviewer 1: Okay. So you think it's safer *not* to be on contraceptives?

Carmen: Yeah. But because of the school ah go have to get it though, huh
(laughs) I want the card, just the card I want to show that I join in the thing.

(PAM, RI15)

Some adolescents are concerned about experiencing certain SRH outcomes, because of the consequences attached to them, however other adolescents discussed that SRH outcomes may be desirable, especially for boys. The findings suggest that outcome concerns are caused by behaviours of the adolescents or paraphernalia, such as issues contraceptives, designed to prevent these concerns. Notwithstanding, some adolescent participants discussed first-hand experience, mainly via semi-structured interviews, with some of the above concerns and how they coped with them. Adolescents' help-seeking behaviour as a form of coping with their SRH concerns is discussed in section 5.3 below.

5.3   ASRH Help-Seeking Pathways

Adolescents' help-seeking pathways are described as the stages and processes through which adolescents seek help to manage their SRH concerns. This section focuses primarily on the SRH concerns adolescent participants reported experiencing – referred to in this thesis as experiential concern. Nonetheless, adolescents' perceptions on the hypothetical scenarios are also incorporated where possible to provide a more comprehensive picture of Grenadian adolescents' help-seeking behaviour. Table 5-1 provides a list of experiential concerns by type of concern

Table 5-1 Overview of experiential help-seeking concerns by type of concern

Type of Concern	Experiential SRH Concern	Participant	Sex	Subgroup
Normative & Stress-related	Peer pressure to have sex	Shaka	M	Urban community
	general relationship concerns			
Specific health related	HIV-related (unspecified)	Ryan	M	Urban community
Specific health-related	HIV-testing	John	M	NEWLO (Urban)
Stress-related & Specific health-related	Uncontrolled erection caused by sexual fantasies			
Normative & stress-related	Peer pressure to have sex	Mike	M	NEWLO (Rural)
Normative	Fantasizing about sex	Ray	M	Rural community
	pressure to have sex			
Problem/Stress-	Sexually abused by stepfather			

		Linda	F	PAM (Urban)
related				
Specific health-related	Determining if pregnant			
Normative	Missed period prior to sexual debut			
Specific health-related	Determining if pregnant	Carmen	F	PAM (Rural)
Stress-related	Feeling alone with no-one to talk to after confirming conception			
Specific health related	Determining if pregnant	Mary	F	PAM (Urban)
Specific health-related	Determining if pregnant	Donna	F	Rural community
Normative & Stress-related	Determining what was happening during menarche			
Normative & Stress-related	Determining what was happening during menarche	Jenna	F	Rural community

In Table 5-1 adolescents reported experiencing one or more SRH concerns. Among adolescents reporting multiple SRH concerns, with the exception of Carmen who reported on multiple dimensions of the same concern and Ray who reported experiencing similar SRH concerns, other adolescents reported experiencing multiple SRH concerns that were unrelated. Regarding help-seeking concerns related to pregnancy, the pathways focus primarily on confirming that conception has occurred. However, some participants also discussed their experiences during antenatal care, and one adolescent discussed her experience with obtaining an induced abortion. Additionally, several of the experiential concerns could be categorized as multiple types of SRH concerns based on the classification in the conceptual framework (Figure 2-5Figure 2-3) – normative, specific health-related, and Stress/problem-related. This may suggest that ASRH concerns can be multidimensional and complex, which will affect the help-seeking pathway.

Based on the concerns in Table 5-1 above, the four stages of ASRH help-seeking behaviour include:

- Stage one: Identification of the SRH concern(s)
- Stage two: Identification of the need to seek help
- Stage three: Seeking help and the choice of help source
- Stage four: Assessment of the help-source and re-starting the cycle

Although the stages are presented separately, they do not always occur discretely, as will be demonstrated in the discussion below of the stages.

5.3.1   Stage 1: Identification of the SRH Concern(s)

Stage one is defined as *Identification of the SRH concern(s)*, and describes adolescent participants' interpretation of the signs they experience as an indicator that something may be amiss, leading to the immediate or eventual identification of a SRH concern. The concept of signs is used because some indicators of a concern were not related to disease or illness (e.g. pressure to engage in sexual activity), and some were visible by someone other than the adolescent, while others were not. Based on participants' narratives, signs are categorized as being: (1) physical, (2) psychological, and (3) superstition. Each is discussed below. It is noteworthy that adolescents may experience more than one type of sign leading to identification of their SRH concern.

5.3.1.1   Physical signs

Physical signs refer to adolescents' experiences of visible signs that may be observed by others. Physical signs as a determinant of participants' identification of a SRH concern were observed only among female adolescent participants. Based on participants' narratives, physical signs included:

- Constant eating and cravings, nausea and vomiting (i.e. morning sickness)
- First menstrual bleeding (i.e. menarche)
- Irregular menstruation (related and unrelated to pregnancy)

For example, 16-year old pregnant adolescent, Mary, discusses constantly eating and her menstrual period skipping as a sign that she could potentially be pregnant:

> One Saturday I just get up [awoke] that day and I just start to eat, eat, eat, eat. Everything pass I eating and when me period supposed to come it didn't come
>
> *(PAM, RI14)*

Despite these initial signs Mary identified about her potential pregnancy, Mary remained uncertain and decided to observe whether the signs persisted and did not identify a need to seek help at that time. This suggests that uncertainty about the nature of the sign can delay progression through the stages of help-seeking. Although other adolescents attending PAM also discussed experiencing similar signs, 16-year old Carmen was the only other female adolescent participant who discussed believing her signs were related to a potential

pregnancy. However, unlike Mary, Carmen did not identify her signs as a cause for concern, as she explains in the following excerpt:

> Carmen: Yeah, but the whole time since ah had sex [unprotected] ah just find something was SO wrong. Ah dey in class now ah find ah dosing off, ah tired ah trying to walking up the hill, ah drifting backwards. When ah going up ah going backwards.
>
> Interviewer 1: Uhuh
>
> Carmen: Ah was like no. Then, but then the thing is, ah saw me period but it wasn't as it supposed to be for five days. Three days and the blood came so lightly well ah say well it still come. So ah wasn't bothering about it.
>
> Interviewer 1: Okay
>
> Carmen: And afterwards now mommy find no. She say, "no." We agree something wrong, face getting fairer, "well you picking up size" and I'm not a fat person.
>
> *(PAM, RI15)*

Above, Carmen discusses that her signs were identified as a concern by her mother, after she ignored them as a SRH concern, although she had engaged in unprotected sex. Additionally, Carmen's narrative suggests that family members play an important role in adolescents' identification of their need for help. This is consistent with other adolescents who experienced pregnancy which was initially identified by a female family member, particularly mothers. One such example was found in the interview with 17-year old adolescent mother, Linda:

> You know sometimes ah used to be vomiting and stuff. Buh I never used to, like ah din [wasn't] checking on like pregnancy and stuff. Buh is like my mom maybe realize ah used to vomit, like ah vomiting a lot (Uhuh) and ah morning she tell me [she'll] go bring me by the doctor.
>
> *(PAM, UI13)*

In the above excerpt, Linda perceives that her mom believed that she might be pregnant because she was vomiting after meals. However, unlike Carmen and Mary above, Linda did not consider the possibility of pregnancy, which suggest a lack of vulnerability on Linda's part (section 5.2.1). Linda's excerpt above also highlights the earlier point about the simultaneous way in which concerns and need for help are identified (section 5.3.2).

For a few adolescent mothers, other signs related to pregnancy were downplayed if the menstrual period occurred after sexual activity, suggesting the absence of the menstrual period may be one of the most important signs of conception for adolescents. Related to this is the following example of 17-year old Linda who identifies the absence of her menstrual period prior to sexual activity as a concern.

> Ah went and stay by my father for two months and like my period skip
> months but ah never used to have sex.
>
> *(PAM, UI13)*

The above excerpt suggests that Linda links her "period skip[ing] months" with sex and pregnancy, indicating a lack of knowledge about normative maturational/pubertal issues. It is possible that Linda may have experienced irregular menstrual period due to any number of stressors, including her temporary living arrangements, as she discussed usually living with her mother and described their relationship as "not too bad". Other female adolescents discussed identifying their SRH concerns because they lacked the knowledge about the physical signs they experienced. For example, two rural female adolescents discussed identifying the sign of blood during menarche as a cause for concern. The following is 17-year old Donna's experience as she discussed it:

> First thing was my period. I didn't know nothing what going on, it just that
> when, I just feel this thing coming out on me, when I went into the
> bathroom, I was like,"A! What this blood is about"?
>
> *(Adolescent Female, RCI2)*

However, while Donna reported not knowing what was happening to her, 17-year old Jenna from the same community discussed that she identified her sign of blood as a concern although her mother had previously spoken to her about it, albeit in a harsh way. This suggests that communication style may be a factor in adolescents' identification of SRH concerns (section 6.2).

5.3.1.2 Psychological signs

Psychological signs pertain to experiences of a mental or emotional nature, and may be less visible for others to observe. Psychological signs were primarily stress-related and included feeling afraid, confused and lonely. Based on the concerns in Table 5-1, psychological

signs were reported mainly among male participants as the reason for identifying their SRH concerns. In contrast, most female participants reported psychological signs as an outcome of identifying a (potential) SRH concern, but not the reason for identifying their SRH concern. Psychological signs were triggered by the occurrence of specific behaviours or events. For example, 19-year old John discussed being unable to control his penile erections in response to watching girls and having sexual fantasies. The following is John's experience as he described:

> Well before normal thing you just watching a girl and just thinking 'bout it might just cause something to happen or I might just get hard [erection]....Well that continue as I getting older, well that stay with me...is the thoughts
>
> *(NEWLO, UI7)*

Based on John's narrative, when he was younger he did not interpret this same signs as a concern, however, considering that he is age 19, and on the margins of adulthood John may be interpreting his situation as a sexual dysfunction and was causing him anxiety. This suggests that the meaning of SRH behaviour at different stages of adolescents may be a factor in adolescents' interpretation of what constitute a SRH concern. This is consistent with the experiences of 16-year old Ray from the rural community and 18-year old Mike who attends NEWLO but also resides in a rural community. Both male adolescents discussed worrying about "keeping up with not wanting to have sex", in the words of Mike, as they were both committed to remaining sexually abstinent. In discussing his help-seeking map, Ray describes being pressured to have sexual intercourse:

> Ray: He telling me lets go have sex with some girl ah tell him no ah have to go home and study… That's just the easy how to get outta that, so like ah walking away so ah don't really have to go through all that problems.
>
> Interviewer 1: So walking away takes care of it, but what happens the next time when/
>
> Ray: nah/ sometime ah does feel like going but majority time, once I ever go behind them but then we didn't get through (pause) so ah find that kinda good in ah way.
>
> *(Male Adolescent, RCI4)*

According to Ray, although most times he walks away from pressure to have sex, the one occasion he succumbed to the peer pressure, he managed to remain abstinent because "we didn't get through", suggesting that something happened to foil their plans. Giving in to peer

pressure, Ray experienced stress that he might be unable to remain abstinent. Ray and Mike's experience suggests that adolescent's ability to cope alone in the face of expectations of others may be a factor in identifying SRH concerns (see chapter 6).

In contrast to Ray and Mike who were open about the specific catalyst that resulted in the identifying of their SRH concern, 19-year old Ryan was not open. When Ryan was asked in the semi-structured interview to talk about his help-seeking from a counsellor that he mentioned during his focus group participation, the following was his response:

> Interviewer 1: Okay alright, did something in particular happen that made you go to her at that point to ask her about HIV?
>
> Ryan: No I guess. A little thing happen, something happen but I can't say what happen.
>
> Interviewer 1: You can't say what happen?
>
> Ryan: Something happen, I get a little 'fraid.
>
> *(Adolescent Male, UCI10)*

Ryan being unwilling to open up about the cause of his fears suggests that he may have been embarrassed about having his concern (section 6.4), and uncomfortable talking about it in the interview. Carmen, the only female adolescent reporting psychological signs, discussed feeling alone with no one to talk about her earlier concern – early pregnant. This concern emerged during the *card sort* when discussing "who can I speak to" – one of the issues Carmen sorted as *Most Concerned*. Carmen reported feeling that way because, "Everybody saying I'm a beast because I en cry" after finding out I was pregnant. "A beast", suggesting that she was not emotional and regretful as a girl her age should be about falling pregnant, therefore, she was feeling misunderstood and alone.

In contrast to the adolescents above, one adolescent, 19-year old John discussed that his concern was not triggered by any specific risk behaviour or event. Rather it was merely prevention and is interpreted as 'wanting peace-of-mind', as his reason for being concerned about his HIV status. This concern was unrelated to John's earlier concern about his potential sexual dysfunction. It is possible that the event may have occurred earlier and John did not remember, or did not want to disclose to the interviewer. However, throughout the interview and focus group, John appeared to be knowledgeable, responsible and interested in a healthy lifestyle.

5.3.1.3   Superstitious signs

Superstitious signs refer to the identification of the need to seek help based on the superstitious interpretation of encountering snakes. This was only reported in the focus group of pregnant or adolescent mothers at PAM who reside in urban communities, but not among any other participants. According to this group of adolescent mothers, adolescents or persons close to them having dreams about or encountering snakes, is interpreted as someone close to you being pregnant. The following focus group excerpt from 17-year old Sherry and 18-year old Jennifer illustrates this phenomenon:

> Sherry: Well when I was in school…"yes I dream I see um, some serpent on the tree outside there" …. I say, "all of us was on the cherry tree" us got pregnant. So when ah reach home me mother call me…she tell me she dream something, then me boyfriend mother tell me she dream something and she hearing people saying I pregnant so she say, "you better go and tested."

> Jennifer: So I telling… my daughter godmother, I say, "something wrong with me, my period coming and it stick," whole time I telling her and we making joke….So ah didn't worry, the night I go to sleep I look out the window I see a snake. I say, "no but that is wrong," I saying, "all you, somebody in the room pregnant" and I warning everybody…. I say "but how I dreaming about snake and I always bouncing up snake" I say, "no no, no, something wrong."
>
> *(PAM, UFG4)*

In the above focus group excerpt, both participants in addition to the other group members reported experiencing this phenomenon. The snake may be interpreted as a phallic symbol because of its shape, therefore, the link to pregnancy. However, adolescent participants also reported experiencing physical signs of pregnancy, and Jennifer who did not understand why she was having irregular periods was more perceptive to her dreams than to 'missing' her period. This suggests that for some adolescents superstition may be an important influence on their help-seeking behaviour. Considering others may see superstitious signs also mean that they may identify or facilitate adolescents' identification of their SRH concerns, as discussed by Sherry above.

In stage one, participants identified their concerns based on physical, psychological and superstitious signs. However, only girls identified physical concerns, although John's uncontrolled erections can be viewed as a physical sign. In contrast, mainly boys reported

experiencing psychological signs, and only adolescent mothers identified superstitious signs. Nonetheless, some adolescents may experience multiple signs between and within categories. Additionally, SRH concerns are sometimes identified by a female family member rather than by the adolescent. Regardless of who identifies the SRH concern, adolescents in this study discussed identifying a need to seek help for their SRH concern. This is discussed as stage two of the help-seeking pathway in section 5.3.2 below.

5.3.2 Stage 2: Identification of the Need for Help

Stage two is defined as *Identification of the need for help,* and describes how adolescents identify their need for help based on the perception that seeking will help shed light on and help them cope with their situation. Some participants identify a need for help after they have either ignored the concern in the hopes that it will resolve itself, or have unsuccessfully tried to cope with the concern on their own. For example, Mike and Ray both valued being abstinent and the recognition that they could no longer cope alone helped them to identify the need for advice. As a result, stage two followed immediately after the identification of the concern in stage one. In contrast, John identified his need for advice for his uncontrolled penile erections several years later, because he had previously viewed it as a normal part of adolescence. However, approaching adulthood, John viewed his situation as a serious concern that required help. This may be due to the importance of sexual activity and sexual performance in relations to manhood in Grenada (section 6.3).

Additionally, some adolescents believe that they would be able to obtain information or advice about their signs to help them understand the nature of their concern. For example, Donna in the rural community perceived that seeking help would help her determine what the blood she was seeing coming from her vagina meant. Furthermore, considering that the vagina is deemed private, it is not surprising that someone like Donna without prior knowledge of menstruation would view blood from the vagina as serious. However, Jenna who had reported previous knowledge about menstruation discussed that it was "a new experience" she was scared and identified her need for help. This suggest that even for adolescents like Jenna who are knowledgeable about menstruation may be scared and identify a need for help because of how and what they are taught about menstruation (section 5.2.1).

However, for most adolescents, identification of the need for help was based on the type of SRH concern with which they were confronted. For example, in sections 5.2.1 and 5.2.2, early

pregnancy was discussed as a major concern for adolescents and pregnancy-related concerns were explained as warranting help-seeking in experiential pathway and hypothetical scenarios. Similarly, in section 5.2.2, contracting HIV was discussed as a major concern for most adolescent participants, and as such when Ryan and John were confronted with personal concerns about their HIV status, they identified a need for HIV-related information and advice. Ryan and John perceived that seeking help would contribute to them resolving their concern. However, in contrast to Donna above, Ryan and John's identification of the need for help may have resulted because they were knowledgeable about HIV prevention and transmission. Alternatively, it may be for the fact that conception and HIV cannot occur without exposure nor confirmed without a test obtained from a health provider.

In contrast, Linda who was confronted with being sexually abused by her stepfather also perceived that she needed to get advice to deal with her emotional state. Although Linda along with other adolescents reported lack of vulnerability to sexual violence, including sexual abuse (section 5.2.1), Linda's identification of the need for help suggests that adolescents do consider seeking help if they become a victim. Being mindful that Linda's situation represents a single occurrence, it indicates that SRH concerns are variable and therefore has implications for help-seeking and help-giving. The evidence suggests that when identification of the need for help was based on the type of SRH concern, help-seeking may be the norm for coping. However, for 18-year old male adolescent, Shaka, and 16-yer old female, Carmen, in their experiential pathway described help-seeking as their coping style for problems. According to Shaka, "I usually just talk things out" with his brothers and cousins of similar age. Similarly, 15-year old Andrea from the urban community discussed this style of coping in the hypothetical scenarios.

Among the female adolescents experiencing concerns about a potential pregnancy, only one (i.e. Mary) identified her need for help while the others discussed that their need for a pregnancy test (i.e. service) was identified by a close female adult family member. In contrast other adolescents reported self-identifying their need for help when the SRH concern was not about confirming early pregnancy. This suggests that other adults, especially adults are important in female adolescents' identification of the need for help to confirm a potential pregnancy. Additionally, identification of the need for help occurred almost simultaneously with *stage one: identification of the SRH concern* (section 5.3.1) when the concern was identified by a family member rather than the adolescent.

In stage two, some male adolescent participants identified their need for help after they ignored the concern or were unsuccessful coping alone. However, some females lacked the knowledge about what was happening, and others identified their need for help based on the type of concern or their individual style of coping with concerns. However, for some adolescent mothers, the need for help was identified by adult family members who identified the concern immediately after identifying the potential SRH concern. All participants in this study who discussed identifying a need for help discussed seeking help for the SRH concern. Seeking and accessing help is discussed as stage three of the help-seeking pathway in section 5.3.3 below.

5.3.3   Stage 3: Seeking and Accessing Help

Stage three is defined as *Seeking and Accessing Help,* as adolescent participants sought out sources to access the desired information, advice or services after their need for help was identified. However, some adolescent participants reported seeking help during the same day or within days of identifying the concern and/or identifying the need for help (i.e. immediate help-seeking), while others reported seeking help weeks, months and several years later (i.e. delayed help-seeking).

5.3.3.1   Source of Help Accessed

Source of Help Accessed refers to the range of sources adolescents utilize for help-seeking in their experiential pathways, and sources they prefer to use or would refer a friend to use based on discussions of hypothetical scenarios. Table 5-2 provides the ranking of the sources of help adolescents discussed during help-seeking; rank was determined by counting each time a different participant discussed a source as used for help-seeking in the experiential pathways and hypothetical scenarios. Yellow and green represents the two top ranked sources of help adolescents reported using or prefer to utilize.

Table 5-2 Ranking source of help

Source of Help	Experiential Pathways		Hypothetical Scenarios	
	Male	Female	Male	Female
Mother	2nd	2nd	3rd	1st
Father		4th		
Sibling		3rd		3rd
Other Family member	2nd	3rd		3rd
Friends	1st	3rd	2nd	2nd
Teacher		5th		
Community Member	2nd	5th	5th	4th
Church/Pastor			4th	
Media		5th		
Public Health Providers		3rd	1st	1st
Private Health Providers		1st	3rd	2nd
Pharmacy		3rd		
Counsellor		5th		
Stranger		5th		
Boiling Spring			6th	

Social Network Sources

Formal help sources

Other Sources

In Table 5-2 the types of help sources are categorised into social networks (e.g. family, friends, and community members) and formal help sources (e.g. public and private doctors, hospital, and pharmacy, counsellor), comprising the 'help-system' and which is consistent with the conceptual framework. Although differences were observed based on gender and experiential help-seeking versus hypothetical scenarios, the table shows that parents, especially mothers, friends and health care providers are among the main sources of help adolescents reported. This suggests that both social network and health care sources are important for adolescents' help-seeking. Although adolescents in this study discussed friends as *a* main source of help, organizational key informants perceived that peers were *the* main source of help for adolescents, and health providers and parents were rarely utilized. The following excerpt is the views shared by a key informant:

> We are not seeing a heavy influx of young people asking for that [SRH] information [….] We are of the opinion that some people are using the internet…so in this case I say the first thing, their concerns are shared among their friends, but the real impact, they are not looking in the right direction for professional, and they're not talking to their parents, most of them are not talking, as I've said some parents take the initiative.
>
> *(Key Informant 1, HCCS)*

The above key informant suggests that professionals and parents are better sources than others from which adolescents should seek help, but that most adolescents are not utilizing those sources. However, adolescent participants indicate that they are using both sources. Nonetheless the majority of health providers use reported pertained to confirming conception, and not for information, advice or services to prevent negative SRH outcomes. Furthermore, the key informant indicates that the communication about SRH topics is a shared responsibility between parents and their adolescent son/daughter (this is further addressed in section 6.2).

During focus groups, some male adolescent participants reported using media sources, such as books and the information on the condom box to learn how to put on condoms. One female adolescent, 16-year old Carmen discussed utilizing music to deal with her loneliness and being misunderstood:

> Music is my source of umm, comfort. (Laugh) Anytime I'm feeling bad I just listen to music.
>
> *(PAM, RI15)*

However, Carmen viewed this as a means of coping alone rather than seeking help, suggesting that adolescents who seek help from non-human sources, such as books and television may not view this as a source of help-seeking.

Table 5-2 also shows a wider range of sources were identified by adolescent in both the experiential pathways and using the hypothetical scenarios, but especially among female adolescents' experiential pathways and male adolescents' using the hypothetical scenarios. Interestingly, bathing in the boiling spring (i.e. sulphur spring) because of its purported healing properties, and drinking homemade remedies to induce an abortion were only discussed in the hypothetical scenarios. Therefore, suggesting a need to account for a range of sources when planning help-seeking interventions, including traditional sources of healing. Analysis shows

that while participants may experience the same SRH help-seeking stages variations exist in individual pathways. These variations are categorized into: (a) direct pathways, and (2) indirect pathways, and are discussed below.

Direct Help-Seeking Pathways

Direct pathways refer to adolescents' utilization of a single source of help to cope with their SRH concern. Most adolescents, including all males discussed using single sources of help to cope with their concern. However, the source of help in a direct pathway can be a social network source or health provider sources. Although only three participants reported utilizing a formal help sources in a direct pathway, two of them were part of the adolescent's social network (see later in this section). Nineteen-year old Ryan was the only adolescent who reported seeking help from a guidance counsellor at his school to deal with his HIV concern. When asked why he chose to go to a counsellor at school whereas others his age might not, Ryan responded:

> Yes/ because that is not the first time I'm going to her, that is the first time I'm going to her and tell that situation [HIV concerns], but that's not the first time I'm going to her and talk.
>
> *(Adolescent Male, UCI10)*

During the interview Ryan had discussed previously speaking with the counsellor about problems at home, therefore, Ryan decided to seek help from the counsellor on the basis of his previous experience. However, girls in the rural focus group had discussed that school counsellors are not trained to help students with SRH matters, suggesting that few students with SRH concerns will utilize school counsellors as helpers. Other adolescents in this category also discussed seeking help from family and friends whom they had previously sought SRH information and advice. Additionally, they discussed that the sources used were among their preferred sources for information and advice. When asked about the sources from which he might have sought help for SRH concerns, 18-year old Shaka had the following to say:

> Actually my counsellors was my family...
>
> *(Adolescent Male, UCI9)*

Shaka describes his family in this way because he reported feeling that he can talk to them about anything. In contrast, some female adolescents discussed that they had not previously

sought SRH help from their chosen source, which was also not their preferred source. Both Jenna and Donna discussed that they accessed information and advice from their mothers regarding menarche because they were present when menarche occurred, as is implied in the following excerpt from 17 year old Donna

> And then I bathe, and when I went inside I was so scared to go and tell me mother [about menarche]. I just, actually just go in front her and ask her…
>
> *(Adolescent Female, RCI2)*

This suggests that some adolescents utilize helpers because they are available and convenient at the time help is needed, rather than based on preference of helper – I refer to this as *opportunistic utilization*. This is consistent with 16-year old Ray who was seeking advice about dealing with pressures to have sex despite his desire to remain abstinent. In the following excerpt Ray discussed one of the reasons he chose his best friend as his source of advice for his concern:

> Ah don't know is according to who, like right before the situation happen if ah bounce [meet] up my friend first ah go tell him if ah bounce up my father first ah go tell him.
>
> *(Adolescent Male, RCI4)*

In the above excerpt, Ray indicates that his father and his friend are usually the sources he utilizes for his SRH concerns, but his choice of source is based on who he encounters first. However, Ray had also discussed that they have been friends since childhood and this friend is quiet unlike his other friends. Ray's situation also highlight that some adolescent may feel they have multiple sources from which they can seek SRH help, while others may feel they have few or no source for help-seeking. The reasons for this are discussed in further details throughout chapters Chapter 6 and Chapter 7. The two other adolescent participants who discussed seeking help from health provider sources reported doing so based on opportunistic utilization, as is illustrated in the excerpts below of 19-year olds, John and Linda:

> My period skip ah month and ah went ah take out ah tooth and ah was talking to the lady in the clinic and ah was-, because she and me father is good friends (Uhuh) and ah was telling her
>
> *(PAM, UI13)*

John: Tha' ah speak to ah nurse.

Interviewer 1: Okay so you spoke to ah nurse, so that means you went to a clinic or a/

John: Nah she staying in the community.

(NEWLO, UI7)

Additionally, Linda discussed that she sought help from her school because:

The teacher used to tell us about it [sexual abuse] and they say if anything, you could come in the office and just [tell someone], like a day ah just go in the office and ah told them. And ah told them not to tell me mother and thing…

(PAM, UI13)

Based on the above excerpt, although Linda's secondary school teacher talked to students about informing teachers about occurrences of sexual abuse, Linda was expecting that her concern would be addressed at the school level, without involving her mother. However, what Linda expected to be a direct help-seeking pathway evolved into an indirect pathway as other helpers would have become involved. Apart from the involvement of the court system, Linda was uncertain of other organizations or agencies that may have been involved in addressing her SRH concern. However, based on the *Child Abuse Protocol* (section 4.2.3), it is likely that the MOE and Ministry of Social Development would have been involved considering the court system's involvement. This suggests the influence of systems outside Linda's control that affect how the situation is handled.

Some adolescents also discussed directly accessing and utilizing different helpers for different dimensions of the same concern, which I refer to as *Successive utilization*. For example, 17-year old Jenna discussed talking to her friends in addition to her mother about menstruation.

I was wondering what all this blood was all about (Uhuh) and then ah went to my mom, first I was scared….And ah talk to my friends about it they were all like, yeah they started seeing they period but is like they din wanted to see it at all (Okay) because it's very painful.

(Adolescent Female, RCI1)

Jenna sought informational help about "what is all this blood is about", but subsequently spoke with her friends for affiliative help (i.e. wanting to know if they were having similar

experiences). The above excerpt also shows that in addition to receiving information, Jenna also received instrumental help (i.e. sanitary napkins) from her mother. This suggests that adolescents may seek one type of help and may actually have a need for other types of help as well, which is consistent with the narratives of other female adolescents, such as 17-year old Donna below:

> My stepdad bring me by the doctor and that's how I came to find out that I was pregnant. When I get to find out that, I went back home and I was like, no, something have to be done… my mom bring me by some kinda doctor and I got rid of it…even like before I get rid of it, I was like thinking in two ways, I had two minds, if [to] keep it or get rid of it.
>
> *(Adolescent Female, RCI2)*

Donna reported going to a doctor to determine whether she was pregnant and upon confirming her pregnancy going to a private doctor to obtain an abortion. In contrast, adolescent mothers talked about seeking antenatal health services because they decided to keep the baby. Other adolescents who reported identifying different dimensions of the same concern sought help via indirect pathways, as is discussed in the next section.

Indirect Help-Seeking Pathways

Indirect help-seeking pathways refer to adolescent's use of multiple sources of help to cope with one dimension of the same SRH concern. Only female adolescents reporting pregnancy-related concerns (i.e. confirming conception and obtaining an abortion), and seeking help from health providers discussed experiencing indirect help-seeking pathways. Indirect pathways can involve the combined utilization of social network sources and health provider sources, and can sometimes result in long and complex help-seeking chains, as that reported by Mary. Mary sought help from three social network sources (a neighbour, her sister, and her sister's boyfriend), and a stranger in her attempt to purchase pregnancy tests from the pharmacy and conduct a successful test. Some sources, which I refer to as *Intermediaries*, are used to facilitate adolescents' access to their desired or appropriate source of help (i.e. target helper) that will provide the necessary information, advice, or service related to the SRH concern. Based on participants' discussion, intermediaries included friends, parents, neighbours, and strangers, and were discussed in interviews and focus groups. The following is an example of *intermediary utilization* as described by focus group participant, 16-year old Jessica.

> Well me, I went [to the doctor] with my mother. (Pause) [....] I answer the
> question like normal; I just pretend she's not there. [....] I was brave enough
> to answer the questions and them in front her.
>
> *(PAM, UFG5)*

In the above excerpt, Jessica discusses that her mother went with her to the doctor to obtain her pregnancy test, which was needed to confirm whether she was pregnant. Jessica's narrative suggests that other girls may not have the same self-efficacy as she does, and might have been hindered from answering the doctor's questions because of their mother's presence (section 7.3.4) Additionally, in some instances participants discussed intermediary utilization after failed attempts to resolve the concern via help-seeking from the health providers by themselves.

In stage three, adolescents discussed utilizing and/or preferring to use a range of social network sources and formal helpers to cope with their SRH concerns. However, a wider range of sources were identified using the hypothetical scenarios. Gender differences were also observed in the number of help sources reported, rank of sources of help and pathways used, as boys tended to utilize direct pathways compared to girls mainly utilized indirect pathways for pregnancy-related concerns. Furthermore, adolescents or helpers may identify other SRH concerns as a result of help-seeking, which contributed to creating more complex help-seeking pathways. Finally, some adolescents may seek help within the same day or days of identifying their SRH concern and need for help, whereas others may seek help in a more delayed manner, up to several years later.

5.3.4   Stage 4: Assessment of Help-Seeking

Stage four is defined as *assessment of help-seeking,* and refers to adolescents' satisfaction with their help-seeking experience. Adolescents discussed mixed views about their help-seeking experience. The main themes through which adolescents assessed satisfaction of their help-seeking experience are categorized in order of most importance and include: resolution of the SRH concern, quality of the interaction between adolescents and helper(s), and the process of accessing the helper.

Resolution of SRH concerns pertains to adolescents' receiving the help sought to cope with their concern. All adolescent participants who sought help discussed receiving help to cope

with their SRH concern, regardless if help was sought via direct or indirect pathways. As such, adolescent participants were satisfied that they were able to obtain the information, advice or service which enable the resolution of their SRH concern. In the following excerpt, 18-year old Shaka talks about how his family has helped to successfully resolve his SRH concerns:

> It was very interesting like we exchanged (pause) um like encounters and (pause) laughed and eh you know had fun…. It was all about advice and different times…. We resolve ah couple matters.
>
> *(Adolescent Male, UCI9)*

According to Shaka, not only was his family able to help him resolve his SRH concern, but it was done in a fun way. This suggests that the quality of the interaction also contributed to adolescents' satisfaction of their help-seeking process, which is also consistent with 19-year old Ryan describing the counsellor as "She was just gentle," and 16-year old adolescent mother Carmen reported feeling comforted after talking to her sister about feeling alone. Additionally, even the two female adolescents in the rural community, Jenna and Donna, who had reported being afraid to talk to their mothers about their first menstrual bleeding reported that talking to their mothers "turned out to be good" in the words of Jenna.

However, not all adolescents reported receiving such 'good' quality interactions during help-seeking. For example, in the following excerpt, 16-year old Ray discussed that his father sometimes emasculates him when he talks to him about the issue.

> Interviewer 1: Okay how is it normally when you go to your friend or your father?
>
> Ray: I'm more comfortable speaking to my friend than my father. Yes sometime he tell me I macco or certain things like that. My friend might just tell me something better.
>
> *(Male Adolescent, RCI4)*

In the above excerpt, the term 'macco' is a derogative term that is used in Grenada and other Caribbean Islands and has several meanings. However, it is used in this instance to suggest that Ray is being less than a man by wanting to remain abstinent. Ray indicates that his best friend provides him with better advice than his father. According to Ray his friend's advice reassured him that he was making the right decision by refusing pressure to have sex.

Furthermore, some adolescent mothers reported being dissatisfied with their interaction with some public health providers. They perceived that the providers treated them with less respect when attending doctors' visits alone than when accompanied by an adult (i.e. intermediary). This is illustrated in Jessica's explanation below:

> Jessica: Well when I went to see Dr Jeffery well everybody say Dr Jeffery is a pig. Well I go to experience Dr. Jeffery. Well first time I went for meself. He embarrass me, he tell me well I too young, what ah going and have sex now for, I young to go and have child, and all kinda thing he say. Well ah walk outta the office crying. Next time I go with me mother and like he 'fraid me mother, he didn't tell me nothing, he just talk to me like normal and then since after that every time I had was to go to ah doctor was he I always use to go back by.

(PAM, UFG4)

In the above excerpt, Jessica suggests that the doctor was being unprofessional when she visited alone, but that he was different when her mother was present. Although other adolescent mothers discussed similar experiences, 17-year old Linda discussed that her mother was helpful in answering questions that she could not – this was despite her discomfort with being asked 'personal questions' in the presence of her mother. Nineteen-year old adolescent mother, Cindy, discussed the doctor asking her *intermediary helper* to leave the consultation room to make the interaction between doctor and adolescent more comfortable; however, Cindy was dissatisfied that she was unable to attend the doctor's visit alone. The above findings suggest that, in general, adolescent mothers were not satisfied with having to use an *intermediary helper* to access health services. However, the evidence shows that there are some benefits for involving parents/guardians in the doctor-adolescent interaction and that some doctors are sensitive to the needs of the adolescent. These issues will be discussed in-depth in section 7.3.4.

Additionally, one adolescent mother, 16-year old Carmen, talked about her displeasure with the invasive procedure the doctor used to determine whether she was pregnant. Carmen was referring to a pelvic examination conducted by the doctor, which could be uncomfortable especially for adolescents who have not previously had a pelvic exam. Adolescent may be unfamiliar with the equipment used (i.e. speculum) and the pressing of the stomach can be make adolescents nervous and viewed as unfriendly for adolescents. However, this study did not investigate whether the type of pregnancy testing affected adolescents' source of help for

pregnancy testing (e.g. over-the-counter pregnancy testing vs. visiting a medical doctor), or the timing of help-seeking.

The process of accessing the help source was also another dimension on which adolescents' discussed their satisfaction with help-seeking. And, 16-year old Mary talked about having to go early to avoid long lines in the following excerpt:

> When I went up in the hospital, I was the first person, because me mother leave very early. I had to go for 1 'O Clock, but she leave early, early the morning because it does have a lot of people. Well when I went by Dr. Thomas the first time, it had people before me but we had to wait and thing.
>
> *(PAM,UI 14)*

This issue of long wait times as described by Mary and several of the other factors discussed related to satisfaction have implications for future help-seeking and are related to social attitudes and factors of the help system (Chapter 6 and Chapter 7). Based on their satisfaction with help-seeking for their SRH concerns, some adolescents discussed their willingness to utilize the same sources in the future, while others were unwilling to do so. However, those who were unwilling did not necessarily have a bad experience. This is illustrated by 19-year old Ryan who reflected on seeking advice from his school counsellor for his HIV-related concern.

> Interviewer 1: You said she gave you good advice, what she said to do worked, you fixed the problem, you talked to her in the past about violence and other things and you've gotten good results right?
>
> Ryan: Uhuh
>
> Interviewer 1: So are those things not good enough for you to keep going back to her?
>
> Ryan: Yes it good enough, I would still go back to her but I want to try a new one…I wouldn't tell her all my business, but I would tell her some.
>
> *(Male Adolescent, UCI10)*

According to Ryan's interview, he wanted to try other sources of help in the future because he feared being too well known to the counsellor. For Ryan it was important that the counsellor did not know "all my business", which was why he did not disclose his HIV situation in its entirety to the counsellor. It is possible that Ryan is worried about issues of familiarity and confidentiality, or feelings of being judged by helpers.

In stage four, adolescents discussed their satisfaction of their SRH help-seeking based on resolution of the concern, quality of interaction with the helper and the process of accessing their target helper. While all adolescents reported satisfaction that their concerns were addressed, some adolescents were pleasantly surprised that their help-seeking experience "turned out to be good." However, there were mixed findings pertaining to the interaction and process of accessing the helper, and adolescents preferred not having to use an intermediary helper to access health providers for pregnancy testing. For some adolescents, satisfaction with the source of help was not sufficient to facilitate help-seeking from the same source for further help-seeking.

Based on Grenadian adolescents' help-seeking pathways for SRH concerns discussed in section 5.3, the following diagram in Figure 5-1 provides a summary of the stages, determinants and concepts discussed.
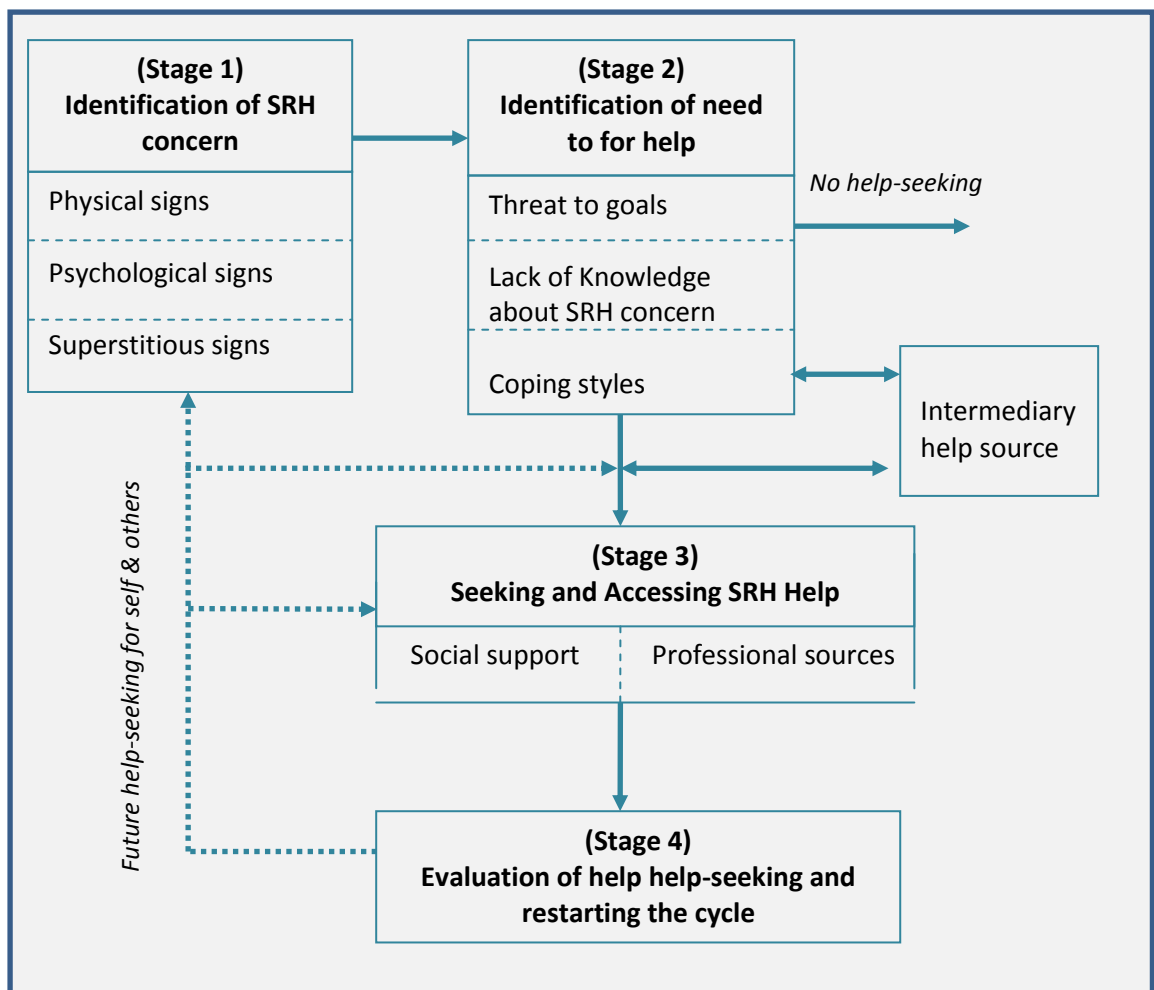
Figure 5-1 Grenadian adolescents help-seeking pathways

5.4   Chapter Summary

In Chapter 5, Grenadian adolescents are discussed as being concerned about a range of SRH concerns, which are categorized as vulnerability concerns and outcome concerns. The concerns in both categories include SRH matters pertaining to menstruation, sexual activity, early pregnancy, STIs and HIV, but exclude sexual violence and same-sex relationships. Adolescents discussed experiencing and seeking help for one or more SRH concern, some of which are multidimensional in nature and are categorized into multiple types of SRH concerns (i.e. normative, health specific, and problem/stress-related). The findings show that adolescents who seek help to cope with their SRH concern do so by navigating a four-stage help-seeking pathway.

In *stage one,* adolescents *identify the SRH concern,* by recognizing physical, psychological and superstitious signs; interestingly while girls mainly discussed experiencing physical signs or a combination of signs, boys mainly discussed experiencing psychological signs, adolescent mothers discussed superstitious signs of pregnancy. In *stage two,* adolescents *identified their need for help* after ignoring the SRH concern, unsuccessfully coping alone, lacked knowledge about the signs being experienced, the type of concern or their style of coping, or an adult identified the need for help. In *stage 3, adolescent sought help from social support or profession sources*. Although there was a preference for social support sources, adolescents used both types of sources in their experiential pathways and hypothetical scenarios. Help-seeking occurred via direct and indirect pathways, but mainly female adolescents reported utilizing indirect pathways via an intermediary helper whereas boys reported utilizing direct pathways. In *stage 4*, adolescents *assessed satisfaction with their help-seeking* based on the whether the SRH concern was resolved, the quality of their interaction with source(s) of help used, and the process of accessing the source of help. Overall adolescents were satisfied with being able to resolve their concerns, but there were mixed findings about the latter two categories. Other adults, particularly parents and female family member were also highlighted at each stage of the pathway. The findings indicate that there are several factors outside the adolescent that influence their help-seeking behaviour.

The next two findings chapters focus on the contextual factors that influence ASRH help-seeking behaviour, specifically as related to the stages of the help-seeking pathways discussed in Chapter 5. Chapter 6 focuses on the socio-cultural factors that promote and/or hinder adolescents' help-seeking behaviour.

Chapter 6 – **Socio-Cultural Contextual Influence on ASRH Help-Seeking**

6.1 Introduction

Given participants' accounts of their help-seeking behaviour described in Chapter 5, there is clearly a need to identify the barriers and facilitators in the help-seeking pathway, if help-seeking behaviour is to be improved through interventions. Considering that most help-seeking research in section 2.4 focuses on barriers to help-seeking, identifying both facilitators and barriers to help-seeking will contribute toward the knowledge gap. Therefore, this chapter builds on the findings in Chapter 5 and takes a contextual approach to explain the socio-cultural influences on Grenadian adolescents' help-seeking behaviour, as set out in the second research objective.

The information in this chapter is drawn from focus groups and interviews with adolescents and key informants[7], highlighting convergence and divergence where possible. However, findings from adolescents were used as the starting point for the analysis and given more prominence, which is consistent with the critical social constructivist paradigm. The chapter reflects some *a priori* themes based on the literature review and the contextual influences represented within concentric circles in the ecological help-seeking framework (Figure 2-5) informing this thesis, and emergent themes representing the diversity of participants' perceptions and experiences. Alternative explanations are provided in each thematic area, and headings reflect the overlapping factors participants identified. Where applicable, reference will be made to the influence of the theme or subtheme on the specific stage(s) of adolescents' help-seeking pathway (

Figure 5-1); otherwise, general reference will be made to Grenadian adolescents' help-seeking behaviour. The considerable interaction between factors identified as influencing adolescents' help-seeking behaviour meant that factors could have potentially been discussed under multiple themes. However, themes and subthemes were organized based on best fit with the data, and cross-referencing is used to help show links with themes and subthemes between and within contexts.

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[7] Reference to key informants indicates both community- and organizational-level key informants, unless otherwise specified; reference to participants indicates key informants and adolescents. In participants' excerpts, RU indicates that the speaker is unidentified.

The socio-cultural context is defined as the operating syntax or *scripts* that guide most of social life (Simon and Gagnon, 1984). In chapter two the socio-cultural context is comprised of family, peers, community members/neighbourhood, religious affiliation/beliefs, school, and the media through which individual adolescents manage their SRH concerns. However this chapter will focus primarily on the main determinant and apply them to sources of help as applicable. The factors in the socio-cultural context that participants perceive to facilitate and/or hinder adolescents' help-seeking behaviour are categorized into the following themes: a) Sexuality communication; b) Community social support; c) Social Stigma; and d) Gender power relations. Figure 6-1 below highlights the interconnectedness between the themes in the socio-cultural context. Similar text boxes represent themes at the same level; the main themes are represented by the innermost boxes.
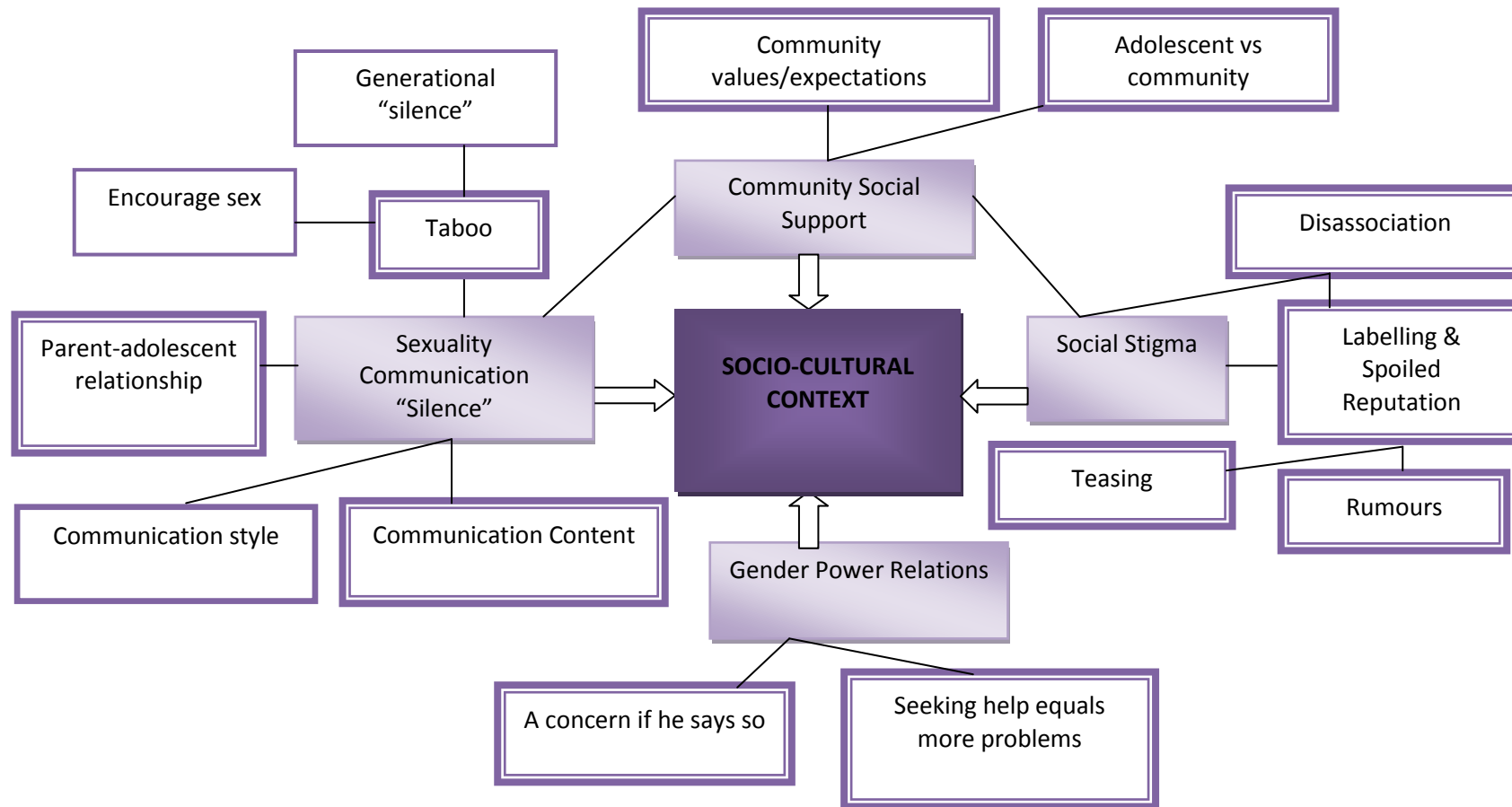
Figure 6-1 Overview of socio-cultural determinants of ASRH help-seeking

6.2   Sexuality Communication

Based on participants' discussions, sexuality communication is used in this thesis to refer to the manner in which sexuality communication occurs or does not occur between adolescents and social network sources. Sexuality communication between mothers and adolescents is the primarily focus of this section, as this was the main type of sexuality communication involving social network sources discussed by adolescents. Both adolescents and key informants explained that the general lack of communication or "silence"[8] about sexuality issues is attributed to adolescent sexuality being taboo and difficult to talk about in Grenada, as is highlighted in the following excerpts:

Some people could only talk [about sex] when night fall, take off the lights
and close the door. But to talk about sex in daylight some people, even
adults, to talk about sex in daylight is the most difficult thing.

(Key Informant 1, HCCS)

John: Some parents grow up old time-ish. And what, we know now, they
parents never used to tell them before, back in the day so they ain't go really
want to say it because they 'fraid well because they talk 'bout sex tha' mean
we go go and try it or something so.

(NEWLO, UFG1)

The key informant above illustrates that talking about sex is both private and embarrassing, relegated to nightfall, even among adults. Also, some parents and adolescents were viewed as uncomfortable talking about sex. According to 19-year old John, generations of parents did not talk to their children about sex for fear that it would encourage sexual activity. This suggests that parents focus on current sexual behaviour rather than on future sexual behaviour (e.g. during adulthood) and remained silent on the matter. However adolescents have a need for information and advice during adolescence. A similar concern was raised in section 4.4.2 regarding denominational schools omission of safe sex lesions as part of the HFLE. Situations as described in the above excerpts make it difficult for both adolescents and parents to talk about sexuality and SRH concerns. However, as one community key informant explained,

---

[8] Silence was the term used by Namisi and colleagues (2009) among adolescents in South Africa and Tanzania to describe parents and adolescents who hardly ever or never talk about sexuality topics.

adolescents learn about sexuality topics in school, while some parents believe that they are unaware:

> 'cause one of my son, he when um they was showing a program on TV once and I went and turned it off, and he turn and he say to me, that time he was going to, he was in Form Five in GBSS, and he said to me "Mom, you turning off the TV, what you think I don't know, I learn it in school."
>
> *(Female participant, key informant, UCFG)*

As described in section 5.2.1, adolescents learned from several social sources, including peers about SRH matters. Consistent with the above community member excerpt, most adolescents discussed that their parents never talked to them about sexuality and SRH topics; therefore, it was difficult for some adolescents to initiate conversations with their parents about their SRH concerns. As a result, some adolescents did not talk to their parents about SRH concerns, while others devised strategies through which to seek advice and financial help from parents. Adolescents appeared to be more comfortable talking to friends about their SRH concerns. However, some peers were described as giving "weak advice", as 19-year old Ryan did in his explanation of why he sought help from a counsellor compared to a social network source (section 5.3.4). Ryan's point-of-view is supported by knowledge deficits about SRH topics that some adolescents demonstrated (section 5.2). The above suggests that the credibility of the help received was important in choosing the source of help used.

Although parents were often described as more credible than peers, for example, several adolescents discussed being hindered from seeking help from their parents, especially mothers, because they perceived doing so would cause disappointment, and may have consequences. When interview participants were asked "how would my mother or father react?" regarding early pregnancy in the card sort activity, the adolescents responded in the following ways:

> Kara: Well they go be disappointed in me so I go really, I want to know what they go do, what they go say or if they go throw me out?
>
> *(Adolescent Female, UCI11)*

> Ray: Eh me mother might [be] disappointed because she tell me married before ah have any children.
>
> *(Adolescent Male, RCI4)*

As a result, some parents were described as being "rough", "loud", "accusatory", and even "threatening" when told about SRH concerns, although this style of communication was also discussed as the manner in which some parents communicated about sexuality and SRH topics. According to 17-year old Jenna, during communications about menstruation which her mother had initiated prior to menarche, her mother was rough, as a result, during menarche Jenna was hesitant to seek help from her (section 5.3.3). Therefore, this style of communication can be viewed as a major barrier to adolescents' identification of their SRH concerns and help-seeking help from parents. However, the evidence indicates that parents did not always react negatively, as adolescents had expected. Participants suggested that if adolescents get information in a good environment, such as when parents were not always quarrelling, adolescents would be more comfortable to seek from them.

In addition to style, the content of sexuality communication may influence ASRH help-seeking behaviour. For example, male adolescents who reported receiving sexuality communication discussed receiving information about the consequences of sexual activity which they described as *"the after blow"*, as well as encouragement to use condoms. In contrast, most female adolescents discussed only receiving information about *"the after blow".* This is interpreted as a means of discouraging sex among girls, while being more open to male sexuality (section 6.3). Therefore, it is likely girls will not want to talk to parents who had cautioned them about negative SRH outcomes. Carmen, one of the few female adolescent participants who reported receiving communication about safe sex did not seek help during sexual debut. However, this was partly attributed to issues of gender power (section 6.5).

In contrast, some parents' general inability to talk to their adolescent son/daughter was perceived to also hinder communication about SRH concerns. For example, one organizational-level key informant six discussed that in the rural community:

> There is a lack of expressed love based on the heroic efforts of parents to see their children improve. There isn't enough hugging and kissing and birthday remembrance and so on.
>
> *(Key Informant 6, IE)*

However, according to the key informant, the lack of expressed love may not be deliberate. This is in contrast to the views of some adolescents who believe some parents do not care

about their adolescent son/daughter. When focus group participants were asked if there are sufficient sources available for adolescents to deal with their SRH concerns, the following explanation was provided by female adolescents in the urban community:

> Andrea: No. You see, really and truly emm adult kinda put a feedback on the younger people because they don't spend enough time with their children. They kinda give their children lack of communication, lack of everything else. Yeah material stuff is not everything but at least lack, they lacking a lot of stuff in the communities because they don't pay attention to their kids.
>
> Kara: yeah
>
> *(Adolescent Female, UCFG10)*

The above excerpt is interpreted to mean that parents provide material needs for their adolescents but neglect other needs, such as spending time, which implies parental neglect and lack of supervision. Andrea's narrative suggests it is unlikely that adolescents will identify a need to seek help for a SRH concern that does not require instrumental support. The evidence suggests that this can contribute to the development of relationships where parents and adolescent are not close. Nonetheless, the data indicates that while most adolescents discussed having a "good" or "close" relationship with their parents, especially mothers and siblings, 'silence' was often reported. "Good" or "close" parent-adolescent relationship was described as being able to talk to parents about non-sexuality related problems, and involve trust, respect and support, but do not always facilitate ASRH help-seeking. This suggests that a "good" or "close" parent-adolescent relationship was not a necessary criterion for sexuality communications, and vice versa. Few references to relationships and communication with fathers are unsurprising because most adolescents reported living with their mothers or as part of an extended family.

The findings show that sexuality silence prior to experiences of SRH concerns hinders ASRH help-seeking, while open communication, style and content sometimes facilitated help-seeking. The culture of sexuality silence was based on fear of encouraging sexual activity, discomfort in talking about sexuality and SRH topics, and lack of communication skills among parents and adolescents. Nonetheless adolescents reported utilizing several strategies to get information, advice and money for services from parents (Figure 6-2).. Furthermore, the culture of sexuality silence may be changing as adolescent mothers who were themselves birthed to adolescent mothers discussed already initiating sexuality communications to their

toddlers. However, it is not clear whether this effort at early sexuality communication will be a consistent effort into adolescence, which may affect future generations of adolescents' help-seeking behaviour.
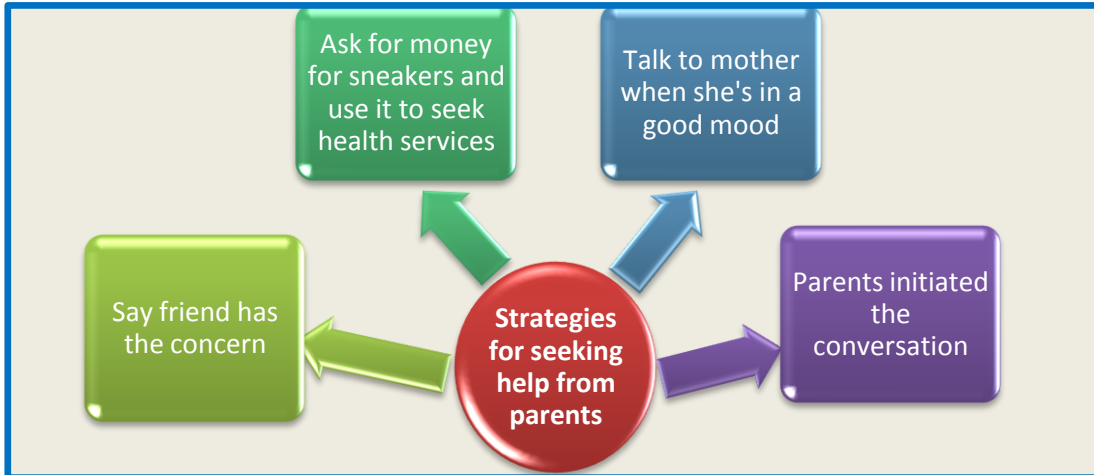
Figure 6-2 Strategies to facilitate sexuality communication

6.3 Community Social Support

"There aren't enough supportive adults for adolescents to get help from. Adults aren't less supportive than before they just were never very supportive regarding sexuality"

(Key Informant 4, IE)

Based on participants' narratives, community social support refers to community members understanding and supporting adolescent sexuality, and SRH help-seeking. Data analysis indicates that community support for adolescent sexuality and SRH help-seeking is based on the values within society in general and the specific community. There is evidence that in general adolescent sexuality is taboo in society. However, it is less taboo in relations to male adolescents. Nonetheless, there were a few male adolescents who discussed that their friends and other community members, such as religious leaders and adults were not supportive of them engaging in a range of sexuality behaviours, and a few adolescent mothers reported peers supporting their sexual activity. In addition to parents, the perceived expectations of other social sources affected adolescents' views of acceptable sexuality, which influenced what adolescents identified as SRH concerns and their willingness to seek help. The contradictory expectations resulted in tension about acceptable behaviour and facilitated

identification of SRH concerns and the need for help. For example, both male and female adolescents who were expected to wait until marriage to engage in sexual activity discussed being concerned about their desire to have sex. However, only male adolescents (section 5.3.1) discussed identifying a need for help and seeking help. In contrast, although 16-year old Sandy in the urban community was concerned about her desire to have sex with her boyfriend of a few months, she did not identify a need for help.

While these behaviours appear to be counterintuitive, it is interpreted that these adolescents valued the sources (e.g. mother and religion) that supported sex after marriage more than peers and partners who valued the alternative. However, boys may have sought help because peer pressure to have sex might be viewed as a normal part of boys growing up. In contrast, Sandy might not have identified a need for help or seek help because she and girls in general, are not expected to be in situations where they will be pressured to have sex. However, girls in the rural community discussed that community members expect certain girls in their community to be sexually active, as is illustrated in the following focus group excerpt when asked about community member's expectations of girls in the community:

> Coco: But according to some of like people not everybody that go expect for like everybody to be doing it [having sex], you know. They go have certain people in mind according to the way some dress or something they might say that they are doing it, but they might not, but sometimes it's just an accident, you know.
>
> Co-Facilitator 1: Okay just an accident. (Participants giggling)
>
> RU: Accident?! (laughter)
>
> Co-Facilitator 1: Is just an accident that the person is dressed the way they're dress or it's just an accident that they're doing it? (Participants laughing)
>
> Coco: Okay it's an accident and they have to take- well for both. Because according to the clothes you have on that don't mean you really having sex or anything. It's just because you wanna be in style (laughter)
>
> Co-Facilitator 1: Ok so based on the way that you dress people might think certain things about you.
>
> Coco: Uhuh.
>
> Janice: Or you attitude./
>
> Co-Facilitator 1: Or your attitude, what type of attitude?

Janice: Negative.

Judy: Negative.

Coco: Some might say she dressing sexy so she maybe have a little man outside dey. (lowers voice)

Tasha: And the attitude that you portray, if you portray this negative attitude or this attitude that you're big and stuff like that, they would think "you see how she behaving like a big woman, she probably doing it already and like that."

(Adolescent Female, RCFG2)

According to the above excerpt, girls with a bad attitude or who dress in a particular way are perceived to be sexually active. The implication is that such girls may not view their desire to have sex as a concern, and may be less inhibited to seek help as 18-year old Justin from the rural community discussed that "some girls don't care. They just go and do what they have to do", referring to those labelled with a *bad girl* reputation.

Additionally, participants discussed that some community members were willing to help some adolescents based on whether they held a 'positive' view of the adolescent and/or their family. Adolescents were viewed as positive or good if they were perceived as helpful and respectful, especially to elders in the community. Although a few adolescents discussed that they did not know how community members viewed them, most adolescents perceived community members viewed them positively. However, one adolescent, 19-year old Kenny discussed that young people were generally viewed negatively, although he believes that he was seen as "a positive thinking and good person." In contrast, 19-year old Ryan believed he was viewed negatively because community members see him as one of the 'boys-on-the-block'. Also, one female adolescent, 16-year old Mary discussed that because she stands up for herself, she is viewed as liking confusion and fighting. The evidence suggests that female adolescents who describe themselves as 'standing up from themselves' were not viewed in a particularly good way. In Grenada, girls are still viewed in the traditional manner that dictates that 'girls should be seen and not heard' – be timid and passive. As such, 'positive' or 'good' adolescents were perceived to be more likely to receive advice and instrumental help for SRH concerns (including pregnancy) than adolescents who were perceived to have a 'bad attitude'. This is illustrated in the following community key informant excerpts.

Debra: Not all girls get help

Ann: Because of their situation

Phillip: Because some are disrespectful

Bob: And have bad attitude

Ann & Phillip: Yes

Theresa: Usually girl ends up getting help because she might be bad to one person but good to another

(Key Informant, UCFG)

RU: Initially community blames the girl for getting pregnant, but by the birth of the baby everyone supports her.

(Key Informant, RCFG)

However, according to the excerpt from urban community members, a girl with a bad attitude may receive help from a community member who views her as a "good" person. Besides, community members' support is not static, as reported by the above informant from the rural community. This is consistent with adolescents' narratives. For example, 16-year old adolescent mother Carmen discussed her fear of losing the support of elders in her community when she tells them she is pregnant. Other adolescent mothers also talked about their babies being "well loved" and "getting more attention" than they do from parents and community members. Nonetheless, not all adolescents perceived as "good" identified community sources as helpers, as illustrated by 16-year old adolescent mother, Jessica:

Well people in my community, it have this lady, I used to do everything for her (pause) and then when I get pregnant, my grandmother tell me how the lady say if I had come and told her I was pregnant, when I got pregnant before I told everybody else, I would have finished St. Mary's secondary school. She would have made me throw the child…

(PAM, UFG4)

Despite the legal restrictions on abortion (section 4.2.3) and social stigma (section 6.4), Jessica discussed that "the lady" was willing to help her obtain an abortion because she was helpful to her when she had no one else. However, Jessica found out about her offer to help after it was already too late for an abortion. Both Carmen and Jessica highlights that an anticipated lack of support does not necessarily translate into lack of support in reality. Nonetheless, the anticipated lack of support may be due to societal values against adolescent pregnancy and abortion.

Additionally, adolescents may perceive that community members are unwilling to help them and may be hesitant or refuse to seek help from them because they generally view their fellow community members as lacking unity, being inquisitive into the lives of others, unsupportive of each other, and spreading gossip. For example, when adolescents were asked "what do you not like about living in" their specific communities the following were typical description:

> Marlon: Well like I said the violence, people that always want to mind other people business, it have a lot ah them in here.
>
> Co-Facilitator 3: What about you Shaka?
>
> Shaka: Violence and crimes and the confusions and you know, that kinda vibes.
>
> *(Adolescent Male, UCFG9)*

> Roxy: Sir, like umm, like when people doh know nothing about you they like to talk and say like how they (inaudible)
>
> Jenna: There are a lot of enemies up here, and I hate that. And when you passing people always have to talk about you, no matter what you do,/ and about the way you dress they always have to complain. If you go out, they always have to say about you go out by some kind of a people, and wrong thing they saying and it won't stop. I hate that.
>
> Sara: Confusion/
>
> *(Adolescent Female, RCFG5)*

Based on the above excerpts, some adolescents, especially females discussed not being involved in their communities. It is possible that adolescents lack of involvement in community life, which was compounded due to a lack of community-based activities, such as youth groups, sports clubs, and recreational facilities negatively affected social ties. Therefore, reducing the number of trusted social network sources available as helpers. Some adolescents preferred to utilize sources outside their communities, or only trusted sources within their community. Trusted sources included parents and siblings, other family members, friends, friends' parents, and community leaders. For example, when male focus group participants were asked how they would advise *Joe*, the main character in the scripted story (Appendix D) used with male adolescents, the following response was given by 16-year old Marlon:

> Well he could go to somebody he know he could talk to and they go give
> him a good advice so he could go and they'll tell him what to do. Somebody
> he has a little confidence to go and they go give him advice.
>
> *(Male Adolescents, UCFG9)*

The data also suggest that society may not be supportive of adolescent boys seeking help. For example, in male focus groups, especially among adolescents attending NEWLO, it was important for boys to "bear" their SRH concern rather than seek help. The exception appears to be obtaining condoms, which should not be confused with condom use. In contrast, in the in-depth interviews, most adolescents did not view seeking help as a sign of weakness. This apparent contradiction may be due to focus groups tapping into cultural norms. Therefore, it is interpreted as a lack of cultural support for adolescent boys help-seeking, which may hinder boys' identification of the need for help and help-seeking. As a result, boys may identify the need for help only if the situation does not resolve itself or deteriorates, as occurred with all the male participants who discussed seeking help (section 5.3.2).

Based on the findings, community social support was an important facilitator and barrier in ASRH help-seeking. In addition there may be differences between societal and community expectations that might affect ASRH help-seeking behaviour. However, taboos may serve to hinder male adolescents' identification of SRH concerns and need to seek help, while facilitating adolescent girls' identification of SRH concern but not need for help. Communities appear to support adolescents based on whether they are perceived as "positive" or "good"; however, female adolescents reporting "good" attitude may not seek help from community members. An interesting finding was that anticipated and actual help-giving may differ in favour of adolescents. Some adolescents had negative perceptions of their communities and were not involved in community. As a result they were unwilling to seek help from community members. It is noteworthy, that with the exception of accessing condoms, culturally, boys' help-seeking may not be supported, although individually boys did not perceive help-seeking as a weakness.

6.4   Social Stigma

Stigma is defined as an attribute, behaviour, or reputation which is socially discrediting and undesirable, resulting in the devaluation of a person (Goffman 1963). In this thesis, social stigma refers to negative labels and ways in which adolescents are treated due to suspected involvement in SRH behaviour, having SRH concerns and seeking help. Participants discussed

social stigma as a major consequence of engaging in behaviours contrary to the social norms and expectations associated with adolescent sexuality (section 6.3), especially for girls, and was a major hindrance to adolescents' help-seeking behaviour for SRH concerns. Ultimately, a stigmatized adolescent is labelled as a 'bad girl', which affects her reputation. However, the label 'bad boy' is rarely used in a negative way. Also the stigmatized adolescent is treated differently from other non-stigmatized adolescents. There is evidence that such labels could potentially lower some adolescents belief that their SRH concern is worthy of external help. Participants discussed that stigma is manifested and/or spread through teasing, spreading rumours, and disassociation.

Teasing Adolescents

Teasing is a common means through which stigma is expressed. Teasing refers to unpleasant ways in which adolescents are referenced, and is one of the more overt ways in which stigma is expressed. According to adolescents, teasing can range from occasional or frequent name calling to extreme instances where songs are sung about the stigmatized individual. For example, male participants in one of the focus groups in the rural community discussed songs being sung about someone believed to have had an abortion and boys being called "crab man" if believed to be infected with the STI, Crabs. It is possible that as the intensity of teasing increases, help-seeking behaviour diminishes. In the following excerpt 17-year old Kara explained that even a girl who is raped risk being teased and potentially having rumours spread about her:

> Kara: …It have some people who does talk about it [sexual abuse] yeah, anywhere you pass you hear people talking 'bout it or you hear your name calling. Yeah and some people does spread rumours and sometimes is not right thing and like they going and say something else.
>
> *(Female Adolescent, UCI11)*

Kara's narrative is interpreted to mean that community members may embellish the story of the incident of sexual abuse through rumours. The social stigma linked to sexual abuse for the victim may help to explain why Linda delayed seeking help after identifying her need to talk to someone after being sexually abused by her stepfather (section 5.3.3.1).Therefore, based on the above findings, adolescent girls may not want to seek help for sexual abuse, and help-seeking may be delayed if help is sought at all. Adolescents also talked about girls choosing to

drop out of school because of teasing from other students about STIs, abortion, and especially pregnancy.

Spreading Rumours about Adolescents

Rumours are among the most common ways that stigma was discussed. The issue of spreading rumours is also highlighted in the above excerpt. Female participants in the rural community discussed that people would assume the worse about a girl seen in the health centre without knowing the reason for her visit. Additionally, some adolescents, especially females discussed some adolescents receiving disapproving or "funny" looks when purchasing condoms from community shops or supermarkets and from other patients in the health centre. The following excerpt by 16-year old Samuel is used to highlight the seriousness of stigma related to females purchasing condoms:

> I working they [in the supermarket], once it have a lady come and buy [condoms] and when she buy she used to put it under the counter and put it in a plastic bag (Okay) she didn't want nobody to see what she have.

> (NEWLO, RI8)

According to Samuel, even female adults do not want to be seen purchasing condoms, suggesting that stigma related to purchasing condoms may be more a gender issue than an age issue. Considering the lack of trust male adolescent have towards girls who are not their main sexual partner (section 5.2.1), a female purchasing a condom may be viewed as promiscuous and hence concerned about catching or spreading STIs/HIV.

Expecting to be stared at disapprovingly, some adolescent mothers reported trying to minimize their chances of being seen in public or wearing clothes that would hide their pregnancy. Linda, a 17-year old adolescent mother reported discontinuing church attendance because she did not want church-goers to stare at her. While discontinuing Church could have eliminated Church as a source of support for Linda (section 6.3) and resulted in social exclusion, Linda discussed that members of the Church invited her back. This invitation demonstrates community support for Linda in her time of need, despite the Seventh Day Adventist (SDA) position against premarital sex.

However, disapproving looks and the resulting rumour was not discussed as a deterrent for all adolescents wanting to obtain condoms, especially for male adolescents. For example, 19-year

old Tony, a male adolescent attending NEWLO from a rural community, explained that he would not be deterred by receiving "funny looks" from clients in the health centre, and expected to be looked at in this manner because of his age. It is likely that primarily, women and the elderly will be in attendance at the health centre, hence, the disapproving looks. Most female adolescents discussed that they would ask someone else, such as a partner to purchase the condom or access it from another source, such as friend or sibling. A key informant also shared the view that male partners obtained condoms rather than female adolescents. The above may have implications for girls' help-seeking behaviour and safe sex practices.

Additionally, most participants, including adolescent mothers, discussed that "people always have the worse to say about adolescent mothers." This is because adolescent pregnancy is not desirable in Grenadian society, especially among female adolescents. As discussed in section 5.2.2, among peers and some male adolescents, fatherhood is viewed as desirable. However, being able to conceive and give birth to a baby was viewed by adolescent mothers as a better alternative than not being able to reproduce or having an abortion – both are stigmatizing behaviours. Participants explained that the expectations of rumours sometimes facilitate identification of the need to seek help for adolescents who believe they may be pregnant. For example, some adolescents across groups agreed that some girls have an abortion as a means of preventing being labelled a "bad girl" and to secure their future aspirations. In the following excerpt, adolescent mothers talk about abortion as an option for pregnant girls:

> Co-Facilitator1: So (pause) is getting rid of a pregnancy an option, a real option for girls?
>
> Most participants: No (in unison)
>
> Jessica: They does do it because they feel people go talk about them/
>
> Rachel: No.
>
> Linda: No some of them parents
>
> Karen & Jennifer: Is parents
>
> Jennifer: And they feel the child go hold them down from doing what they want to do, and some parents does encourage they children to get rid of it.
>
> *(PAM, UFG4)*

The majority of adolescent mothers discussed that they were encouraged to have an abortion by various social network sources, but refused on religious and moral grounds, in addition to

fears of not being able to conceive in the future (section 6.5). For those who viewed abortion as an option, perceived that stigma may facilitate timely identification of the need to seek help, because it would be imperative to obtain an abortion prior to visible signs of pregnancy. However, this would depend on early identification of pregnancy, which is not always possible. This suggests that abortion may be conducted through channels that may be unsafe and risky, considering the restrictions regarding legal abortion in Grenada (section 4.2.3).

Through rumours, stigma has the potential to follow adolescents beyond their communities resulting in a bad reputation island-wide. This is explained by 18-year old Coco in one of the rural focus groups with female adolescents:

> The other communities might know that girl and communities go to other communities and just like the whole island will be looking at that girl as an H [whore]!
>
> *(Adolescent Female, RCFG2)*

Being viewed as a whore, girls are not taken seriously, however, unless a girl with a spoiled reputation is interested in repairing such, according to rural adolescent boys, she can more easily access condoms because she does not care about what others think about her. The ability for rumours to spread beyond one's community is a real issue considering the small size of Grenada and easy access to telecommunications, and increasingly Internet. One of the main reasons participants attributed to rumours is the meddling, inquisitive or *"fass"* nature of Grenadians (section 6.3). It is believed that the small size of Grenadian communities helps to perpetuate rumours, which helps to create a less trusting and supportive environment, conducive to ASRH help-seeking. Therefore, stigma can impact adolescents' identification of their SRH concern, need to seek help and source of help.

Dissociating with stigmatized adolescents

Adolescents discussed that friends and community members were weary of associating with adolescents (suspected of) engaging in unacceptable SRH behaviours or having negative SRH outcomes, such as pregnancy and STI/HIV infection. However, this was discussed as more commonplace in regards to STIs/HIV compared to pregnancy. In the following excerpt, male participants in the rural focus group talk about close friends maintaining physical distance from boys perceived to have an STI:

Justin: And some of them fellas like if you have it they won't really want to thing with you/

James: They don't want you around them./

Justin: and they don't wanna talk to he because according to what they parents say, they own parents say like, "you see, you see what he have you and him was friend you go get it too, you go get it too." So that kinda vibes now, that influencing you, you don't really wanna be (pause)

Jude: be around that person.

Justin: If you talking (pause), you go be like here and he go be quite down so when you talking to him and he go be like, "not so we used to be, we used to be like real tight and stuff."

(Male adolescents, RCFG8)

The above excerpt is interpreted to mean that the physical distance result from the belief that one risk becoming infected or perceived by others to be infected if he/she gets too close, which implies a lack of knowledge. The statement "we used to tight" suggests emotional distance from a close friend, indicating reduced social support sources. Also evident through Justin above is that some parents discourage existing friendships between their children and the stigmatized adolescent. This is consistent with discussions among female adolescents in focus group regarding early pregnancy. The above views are based on the belief that the non-stigmatized adolescent risk the same negative SRH outcome and/or may acquire a similarly bad reputation merely by association. However, in reference to the community member who wanted to help 16-year old Jessica obtain an abortion (section 6.3), Jessica explains that the non-stigmatized adolescent may also be engaging in similarly stigmatizing behaviour:

She see she daughter as better than everybody but she daughter doing the same thing like wha' all of us doing. The only thing she daughter don't have ah child….But like, you talking to her good in she face, and behind my back she saying the worse about me. She does say all kinda wrong things "I living ah bad life and she doh want she child follow me."

(PAM, UFG4)

As a result of stigma, some male adolescents discussed the risk of being passed over for future sexual relationships if they become infected with an STI/HIV. This suggests that male adolescents' identification of their SRH concern may be further delayed considering the lack of symptoms among boys for several STIs. Additionally, adolescent boys may choose not to seek help from others or to seek help from a trusted and confidential source, to minimize risk of

jeopardizing subsequent romantic or sexual relationships. The following excerpt captures some of the typical responses from participants regarding social stigma.

> Randy: Well, one, you won't have much friends because they go want to scorn him [Joe], they go say "tha boy, [have] HIV and STIs and thing", dem girl don't really wanna be around him. They won't want to have sex with them and all kinda thing….It go be bad for him….Who don't know would, you know, move with him, but who know, will go and tell he other partner and dem, "woye you partner have thing and thing, and go keep on spread[ing] all around the place."

> Co-facilitator 2: Ok. Shaka what do you think?

> Shaka: Well, I think if Joe becomes a father at a young age (clears throat), I think he will be forced to drop out of school and umm enter the world off work and um well he have to mind his offspring (little laugher) and his, and his future wife maybe. And in the STI case yea people will scorn him, you know because they might think it's transmittable by contact or something so they might try to stay far. People might maybe stop talk to him or whatever, try to keep they distance as much as you, as possible so yeah. It's going to bad for him if he umm contracts an STI.

> Co-facilitator 2: Okay

> Shaka: But on a father role maybe a whole different level of maturity and thinking and, life-wise.

> *(Adolescent Male, UCFG9)*

The findings show that social stigma primarily affects girls, resulting in being labelled a "bad girl". Stigma is spread and manifested through teasing, rumours and disassociation. In Grenada, the news of one's bad reputation can be spread quickly because of the small communities and the small island setting, and hinders all stages of the help-seeking pathways but can also be an outcome of help-seeking. Adolescent mothers, those perceived to be pregnant or have an STI/HIV are among the most stigmatized. Although both pregnancy and abortions are stigmatized behaviours, abortions are quietly sought and encouraged by a range of social sources. Stigma also serves to reduce the number of social network sources that adolescents have access to as helpers, because some sources choose to or are forced (e.g. peers) to disassociate themselves from the stigmatized adolescent.

6.5   Gender-Power Relations

According to Taylor (1995) gender-power inequalities (i.e. male dominance and female subordination) in sexual relationships manifest themselves in a number of ways. In this thesis, gender-power refers to power imbalances in adolescent dating and romantic relationships based on views on masculinity and femininity that may hinder or facilitate adolescents' help-seeking.

The data revealed that power relations resulting from gender norms affect male and females through different mechanisms, which primarily hinders help seeking behaviour. For example, some girls may not identify a SRH matter as a concern if their male partner does not view the matter as a concern. Through use of the stimulus materials, adolescents explained that unprotected sexual intercourse and physical abuse was sometimes not viewed as a SRH concern among girls, because it was not a concern for their male partner. However, not all adolescents perceived it as a form of power and control; it was sometimes perceived as a sign of love in the dating or romantic relationship (section 5.2.1). According to adolescent participants, when some boys were unable to control girls' identification of SRH concerns or help-seeking, such as the need to use condoms during sexual intercourse, they found other ways to exert their power, such as providing defective condoms (section 5.2.1). This is consistent with the following key informant's perception that when girls challenge their male partners there may be consequences:

> She doesn't do the right thing she should get a few thumps….But that is highly perpetrated because girls do some cheating too and the only way the boys could respond to deal he have to give her a few slap, and some of the girls accept it too. So that kind of perpetuates it a little...so it's a degree of acceptance....Because it happens, it happens still.
>
> *(Key Informant 1, HCCS)*

According to the above excerpt, physical abuse "a few thumps" is one of the ways that boys know to control girls. Participants explained that because adolescents are exposed to physical abuse at home and among others within their communities, including peers it is difficult to identify it as a concern warranting help. This is highlighted by the following key informant:

> Young people don't see that okay, if I'm in a relationship with this guy, and whatever happens and he slaps me they don't see it as a sign of bad things

> to come or more to come. What they see it as a one-time incident, so the
> person apologizes and they just accept that.
>
> *(Key Informant 2, IE)*

In chapter 5, most female adolescents' discussed that they would not seek help for physical abuse, because they could deal with it on their own, either by fighting back or running away However, some girls were able to identify sources for advice and counselling (section7.3.2). Girls were concerned about their reputation (section 6.4) and therefore, did not want to seek help. By fighting back girls may view themselves as empowered, rather than powerless in the relationship. In contrast, one male adolescent, 18-year old Shaka discussed that he would not seek help because being male helpers would not take his situation seriously:

> I don't think the court will take it serious if ah female hits ah male, but if is
> the other way around you in for some serious troubles. It all comes under
> domestic violence, but they take it more serious if ah male hits the females.
>
> *(Adolescent Male, UCI9)*

The above excerpt suggests that although physical abuse is also perpetrated by males, help is perceived as targeted toward females only, which Shaka believes would discourage he and other boys from seeking help for physical abuse. This has implications for the *Child Protection and Adoption Act* and the *Child Abuse Protocol* (section 4.2.3) to ensure that provisions are made for the protection of boys. Additionally, some adolescents may identify a SRH concern but not a need to seek help, or may delay help-seeking because of unequal gender-power relations. For example, 16-year old adolescent mother Carmen, who became pregnant during her sexual debut, identified unprotected sex as a concern, but did not seek help because her boyfriend who was older convinced her that they did not need to use one. Also, part of the reason Linda delayed seeking help after she was sexually abused by her stepfather is because at the time, she was residing in his house together with her mother and brother. Therefore, she was worried that by seeking help, she would be the reason for additional conflict in the home, or that her family would be left homeless. This is consistent with key informants' reports suggesting that identifying concerns, need for help and help-seeking for sexual abuse was hindered when the perpetrator is a boyfriend, someone the adolescent is dating or a family member, and is facilitated when the perpetrator is outside this group. This is highlighted in the following key informant excerpt:

> You may find a bit or two of incidence of probably date rape I would say, not regular, but we have had incidence of children reporting that. But what is sad about it is that they do not see it as rape, because I went with him and he is my boyfriend, I just was not ready for that….So I've had a bit of sessions with young people, college level, and when I told them of date rape and it can happen, it's when one or two of them began to think probably it happened to me. But because they knew the person and they went to the person… they saw yes, the person forced it on them but they felt they were to blame sort of, because that's their friend and that's the person they went to movies with it's just that they didn't cater for movies and something else.
>
> *(Key Informant 2, IE)*

Based on the findings, gender-power relations hinder identification of the SRH concern, need for help and help-seeking. In some cases, girls may not feel empowered to identify their SRH concern unless it is first identified by their male partner. In other cases, some girls may identify their SRH concern but not feel empowered to seek help. However, girls may perceive that coping alone is tantamount to being empowered or autonomous, or they may be embarrassed to seek help. However, girls' blaming themselves for causing the concern was also found to hinder help-seeking behaviour. Regarding dating violence, boys' perception that helpers would not take their situation as serious if help is sought was a barrier to help-seeking.

6.6   Chapter Summary

In this chapter, the socio-cultural contextual factors influencing ASRH help-seeking behaviour was explained as a complex interaction of: sexuality communication; community social support; social stigma; and gender-power relations, which affects all stages of the help-seeking pathways. Table 6-1, provides an overview of the relationship between the socio-cultural contextual determinants and the help-seeking pathway. The former two determinants included both barriers and facilitators of help-seeking, and the latter two comprised of primarily barriers to ASRH help-seeking. Additionally, some factors were more influential among males than females and vice versa. A bi-direction relationship was discussed between stigma and help-seeking, in which stigma hindered help-seeking and help-seeking resulted in stigma. The chapter also alluded to interrelationships between the socio-cultural context and the programmatic context. The programmatic contextual factors influencing ASRH help-seeking behaviour are discussed in-depth in Chapter 7.

Table 6-1 Relationship between socio-cultural determinants and help-seeking pathways

Stages of the help-seeking pathway	Socio-cultural determinants
Stage 1: Identification of SRH concern	Sexuality communication; Community social support; Social stigma; Gender-power relations
Stage 2: Identification of the need for help	Sexuality communication; Community social support; Social stigma; Gender-power relations
Stage 3: Help-seeking and Source of help	Sexuality communication; Community social support; Social stigma; Gender-power relations
Stage 4: Assessment of help-seeking	Sexuality communication; Community social support; Social stigma; Gender-power relations

Chapter 7 – **Programmatic Contextual Influence on ASRH Help-Seeking**

7.1   Introduction

> She couldn't maybe go on the pill if she wanted to go on the pill because she couldn't get to a clinic, a doctor wouldn't give it to her because she needed her mother's permission and she couldn't get her boyfriend to use a condom so what she reverted to was the rhythm method or whatever method she felt was the best, the next best that she could do and it didn't work, right?
>
> *(Key informant 4, HCCS)*

The above key informant excerpt captures some of the main arguments pertaining to the programmatic context discussed by adolescents and in the literature review (section 2.4.3). In this section, the programmatic context refers to how the systemic response to ASRH concerns facilitates and hinders ASRH help-seeking behaviour. The findings in this chapter are drawn from adolescents and organizational-level key informants. The programmatic context focuses on factors in the healthcare, education and social services sectors that affect ASRH help-seeking behaviour, and are categorized into acceptability and accessibility based on the conceptual framework in Figure 2-5. However, the prominent subthemes and interpretations for each categories are based on the the analysis of participants' discussions. Links will be made to the specific stages of the help-seeking pathways (Figure 5-1) as are applicable. Strategies used and recommendations made by adolescents for coping with barriers in the programmatic contexts will also be discssused. The chapter concludes with a summary of the main findings discussed in the chapter.

Figure 7-1 below highlights the interconnectedness between the themes in the programmatic context. Similar text boxes represent themes at the same level; the main themes are represented by the innermost boxes.

Figure 7-1 Interconnectedness of programmatic determinants of ASRH help-seeking
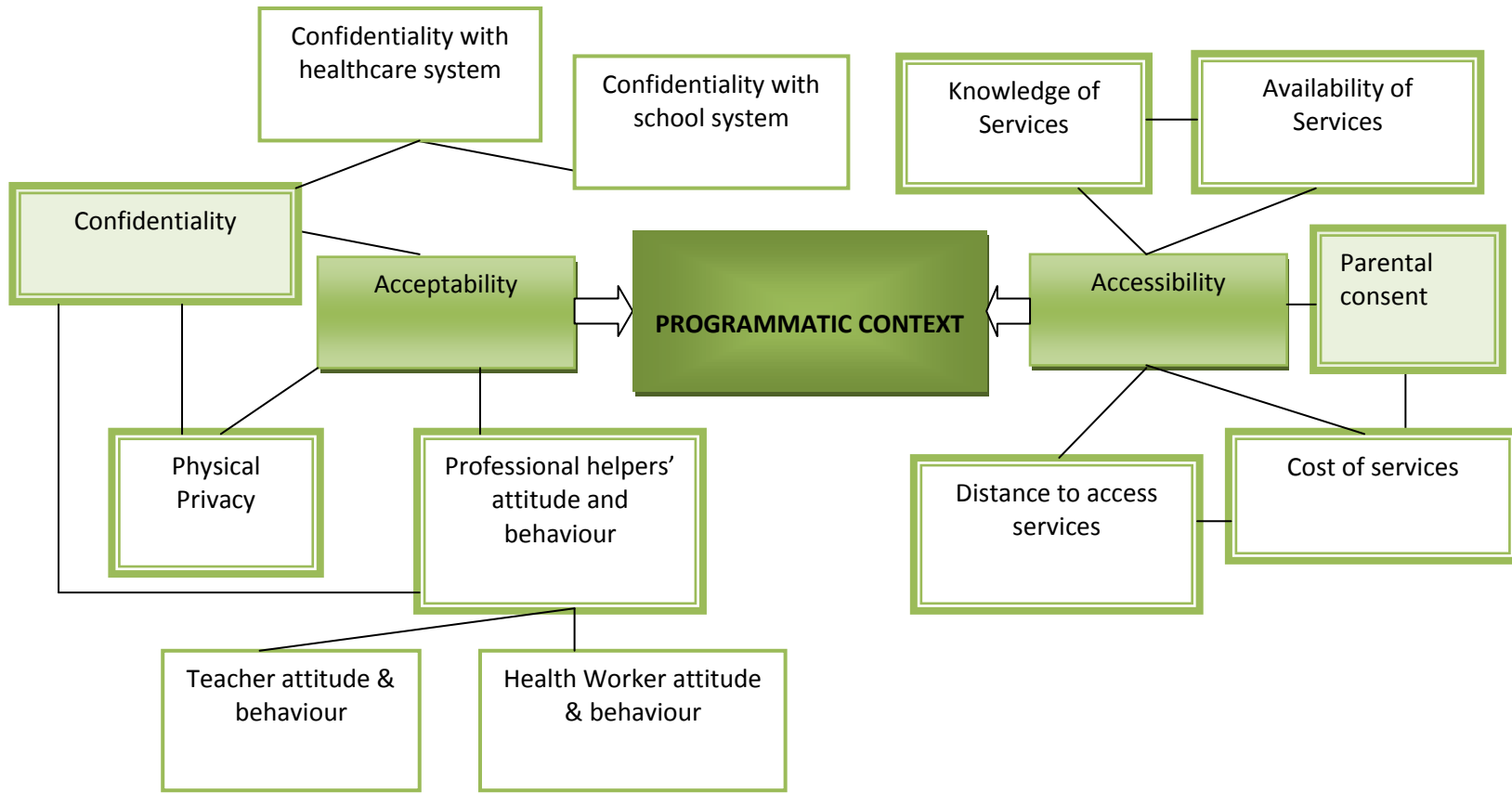
7.2   Acceptability of SRH Services

In the literature review, acceptability of services is described as "how humanely and considerately the treatment/service is delivered" (Maxwell, 1992 p.171). In participants' narratives, acceptability is categorized into confidentiality, privacy and provider attitude; each of which will be discussed below.

7.2.1   Confidentiality of ASRH Help-Seeking

Confidentiality here refers to how the health and school systems, manage adolescents' sensitive/personal information, including help-seeking. However, confidentiality was discussed mainly with regards to health providers, and less about teachers and guidance counsellors. Not all adolescents were worried about confidentiality as they explained that it is part of the health workers' job to maintain confidentiality; as a result, they expected such. While, some adolescents explained that health workers may need to discuss with each other the best way to help adolescents during seeking help, adolescents did not approve of health workers casually talking among themselves or with non-health workers, such as community members and friends, and parents about their SRH concern and help-seeking. Nonetheless, some adolescents explained that the importance of confidentiality may vary depending on the SRH concern. For example, an adolescent mother explained that eventually the pregnancy becomes visible and cannot be hidden from the family and community members, while an adolescent male explained that an adolescent father will be seen "taking his baby for a walk" and people will know that he is a father. Regarding STIs one participant responded that confidentiality would only be a concern if the STI is not curable.

7.2.1.1   Confidentiality within the healthcare system

Despite the above, most adolescents and some key informants did not believe that health providers would maintain confidentiality regarding ASRH help-seeking. Participants used the phrase "talk too much" to describe the perceived lack of confidentiality among health workers, especially nurses. Most participants, including those who believed that confidentiality will be maintained perceived that the lack of confidentiality within the healthcare system hindered some adolescents from utilizing health care sources when they have SRH concerns. This is highlighted in the following excerpts by urban and rural female participants:

Kara: Yeah cause sometimes they does go and tell like they friends and them yeah, about it....I won't want to go back they again

[...]

Interviewer 1: Would you encourage your friends to go there?

Kara: No.

(Adolescent Female, UCI11)

Tasha: If they know they have a STD and they would be afraid that the nurses might tell people/ you know and ah lot of people in the end get to know that they have an STD

Respondent unknown: Uhuh/

(Adolescent Female, RCFG2)

In the above excerpts it is clear that adolescents may be hindered from utilizing health services and even refuse to refer these services to their peers. Consistent with Tasha's views above, other adolescents and organizational-level key informants also discussed that some nurses call or visit adolescents' parents, guardians or relatives to tell them about adolescents' clinic visit and test result for STIs, contraception, and pregnancy testing. This is illustrated in the following key informant explanation:

This young girl 15 years [and] pregnant went to clinic, and from the time she come from there a nurse picked up the phone and called her friend. And the friend learning that this child is pregnant and is cousin to the child father, call the father. You understand what I'm saying? What if the child did not tell daddy that she was pregnant before?

(Key Informant 2, IE)

When probed, the above key informant clarified that the girl's father was aware of her clinic visit and the prospect that she may be pregnant. This finding draws attention to the potential consequences for adolescents when health workers do not practice confidentiality, and introduces the issue of parental consent for health services (section 7.3.4). However, some adolescents may choose not to disclose help-seeking to their parents because they desire autonomy, may not want to disappoint parents, or risk punishment, as 17-year old Donna discussed receiving a beating from her mother after learning that she was pregnant. The same key informant also discussed that pharmacists sometimes tell relatives about adolescents

purchasing condoms, resulting in adolescents' preference to have sex without condoms rather than risk relatives being aware that they are sexually active. This is consistent with some female adolescents' narratives, and partly explains 16-year old Mary's use of a stranger to purchase a pregnancy test from a pharmacy:

> Mary: I go in the pharmacy and ah buy one [pregnancy test]. Well I had on me school clothes, but I let a lady buy it for me. I tell her is for my friend, and I let her buy it for me.
>
> *(PAM, UI14)*

Based on the above except, it is possible that Mary's believed that her behaviour may have been reported to her school, rather than family considering she was wearing her school uniform. Therefore, risking the reputation of self (section 6.4) and school, hence the need to ask for help from a stranger, rather than someone she knows or purchasing the pregnancy test herself.

Regarding confidentiality using the health centre for HIV testing, one male adolescent discussed that "other people [non-health workers] will know your HIV results before you", which he perceived hindered help-seeking. In contrast, 19-year old Ryan, another male adolescent from the urban community discussed being okay with nurses first telling his mother if he had a positive HIV test result. This was because he perceived it being done to protect his mental health as he would not be able to cope with the test results alone. However, this study was unable to discern whether there is a protocol for informing adolescents and/or parent or guardian about their HIV test, which is a gap in the current study.

A few participants also discussed confidentiality being breached when health workers and adolescents reside in the same community, as is explained by 16-year old adolescent mother, Jessica.

> Jessica: I not safe going there at all because up way ah use to stay, it have this lady that staying right next to us (pause) and she working inside there
>
> Co-Moderator 1: Uhuh
>
> Jessica: before she see you walking in you house, she on she phone and when she come home...if you and she fall out, the first thing she telling you, when she walking outta she work place you walking in. So if you don't want people to know you going there everybody will know, she go tell everybody.
>
> *(PAM, UFG4)*

In the above excerpt, Jessica discusses feeling unsafe utilizing the family planning clinic because a staff member immediately tells friends about who utilizes the clinic, and uses that knowledge to embarrass adolescents during verbal altercations. This issue was only discussed by a few urban adolescent participants, including 16-year old Sandy based on her cousin's experience. Related to this, some male adolescents discussed that they would be put off if health workers from their community were working in the community regarding SRH promotion. The male participants discussed that if services were to become available in their communities (section 7.3.1), it should be delivered by outsiders. However, 17-year old adolescent mother, Sherry, highlights that there may be structures in place to deal with breaches of confidentiality. According to Sherry, she no longer wanted to use the health facility in her community after she perceived the cleaning lady told community members she was pregnant. However, she reported the incident to a family member who is a social worker, who then reported it to the correct authority resulting in the cleaning lady being transferred and Sherry discussed that she was no longer worried about her confidentiality being breached at that facility when she used it. While, it is unclear whether any actions would have been taken against the health worker if Sherry's cousin was not within the system, taking disciplinary action suggests that there exists either a written or unwritten policy regarding confidently of health services. However, no confidentiality policy was observed or discussed during investigation of the existing policy context (section 4.2), which suggest that the policy may not be specific to ASRH or SRH in general.

In contrast to Sherry above, some adolescents reported taking more drastic steps in their attempt to maintain confidentiality and anonymity, as is explained in the following focus group excerpt:

> Jennifer: Well they not suppose to be telling!/ These things suppose to be confidential.
>
> Cindy: Yeah well, that's what they does do.
>
> Karen: That is like ah clinic by us, when ah use to live in Constance. It have clinic in [a nearby community], my cousin does work there and it have some nurses they fass [inquisitive], they real fass. Anytime you go there, they want to know wha' you come for and then they going and sit down and talk about it afterwards.
>
> Co-Moderator 1: Uhuh.

Karen: Yeah they talking about it and who going with it and telling other people and thing. So that is why really ah come and stay in Midford, so even though ah have to go clinic and thing ah go go in Sendall [designated clinic for Midford residents].

Sherry: Doh trust Sendall people please.

Karen: No well I ent know nobody in Sendall, nobody doh know me so.

(PAM, UFG4)

Similar to Jessica above, 16-year old adolescent mother Karen is put off by health workers gossiping about adolescents who seek help for pregnancy. Karen discusses that she relocated to another community to use the health facility there, which implies that some health workers are confidential. However, her response to 17-year old Sherry's warning implies that Karen's decision may have been driven by her need to be anonymous due to embarrassment and stigma related to her pregnancy (section 6.4), rather than expecting that confidentiality would be maintained. Karen's narrative also suggests that lack of confidentiality may be less important if you do not know or have a close relationship with your community members (section 6.3).

Figure 7-2 summarizes several reasons discussed by male and female adolescents for the perceived lack of confidentiality of health providers. The overlap in the middle represents common reasons among both groups.
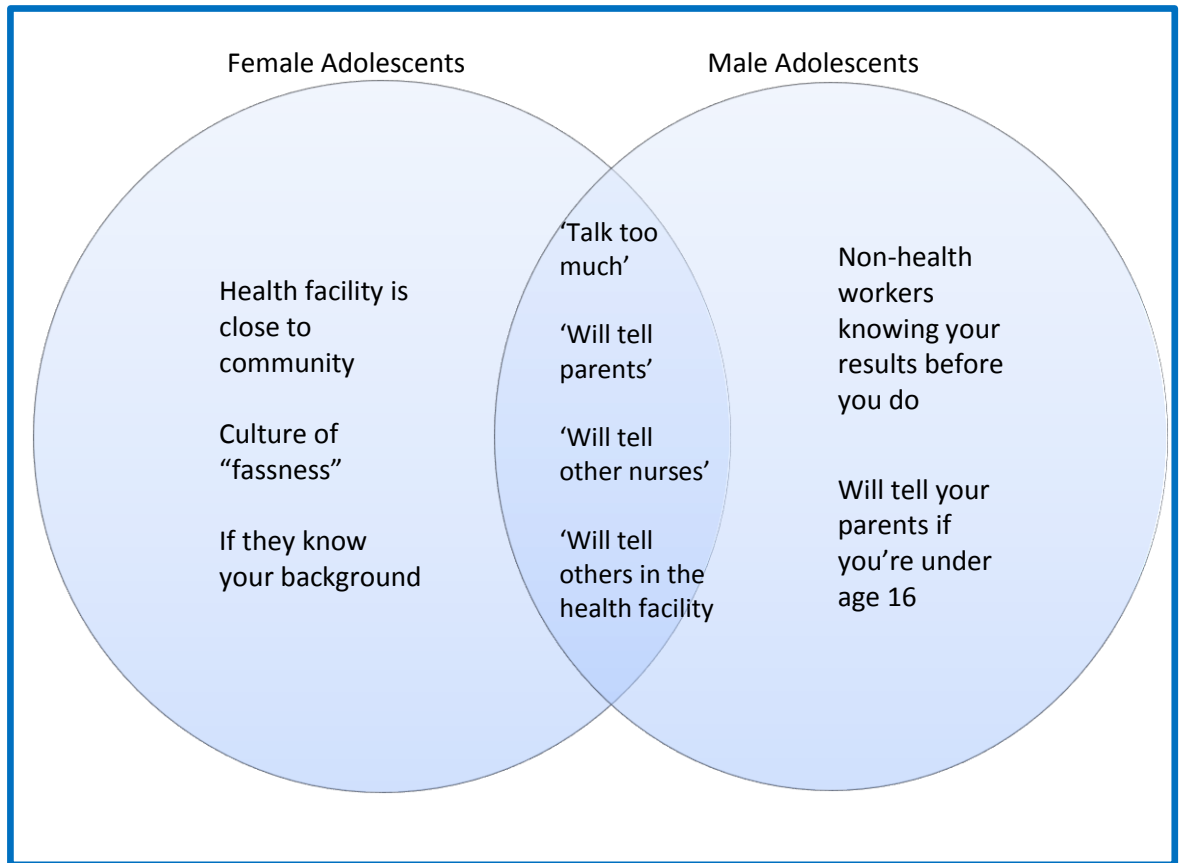
Figure 7-2 Factors affecting confidentiality in health providers

7.2.1.2 Confidentiality within the school system

Similar to confidentiality of health workers, lack of confidentiality among teachers and counsellors hindered their use as helpers for SRH concerns among some adolescents. For example, most participants discussed that teachers and guidance counsellors would talk to other teachers about the SRH concern for which adolescents sought information or advice. In the following focus group excerpt, two adolescent mothers discussed confidentiality among some teachers:

Co-Moderator 1: Okay. Um anyone else, would you talk to your teachers? (Pause) Counsellors?

Rhonda: Miss/ some teachers not [all]

Rose: Yeah ah talk to them but/ not nothing personal.

Co-Moderator 1: Okay

Rhonda: Miss some teachers are not confidential. The younger teachers are not confidential. Miss you talk to them now and they go in the staff room.

(PAM, RFG6)

Above, Rose states that though she seeks help from teachers, she will not do so for 'personal issues', which is how sexuality and SRH was described by some adolescents. Rhonda points out younger teachers in particular are not confidential, which is interpreted as younger teachers drawing on their socio-cultural selves rather than their professional training. However, like health workers, teachers may also be obtaining support from other teachers about the best help to provide adolescents, rather than gossiping. Nonetheless, students may perceive that teachers have biases against them because of the content of what was disclosed by the teacher in whom they confided. Therefore, as the following key informant explained:

> While they [teachers] might feel that it's ok to discuss it with another teacher umm, that poses a problem and sometimes it creates some sort of distrust among students.
>
> *(Key Informant 5, IE)*

In contrast to the above discussion about confidentiality, Linda's reporting of sexual abuse to her school (section 5.3.3) is interpreted as the only evidence where lack of confidentiality was based on a policy – the *Child Abuse Protocol* (section 4.2.3). According to Linda, she was informed by the school that the protocol for dealing with reports of sexual abuse among students dictated that her mother is informed. Although Linda was not probed to verify whether her teacher had informed the class of the protocol for dealing with sexual abuse, the data suggests that this information was available to Linda after she disclosed her SRH concern to school officials. It is uncertain whether Linda would have sought help from the school if she knew her mother would be informed.

Based on the above, not all participants viewed professionals as lacking confidentiality, but lack of confidentiality appeared to be more problematic among health workers than teachers and counsellors. This may be because teachers and counsellors are not often used or viewed as sources of help for SRH concerns. However, most participants viewed confidentiality as lacking and a barrier to identifying need for help and choice of helper. Adolescents also discussed strategies to cope with helpers' perceived lack of confidentiality. These strategies have implications for help-seeking intervention programs.

7.2.2   Professionals Attitude and Behaviour

Professionals' attitude and behaviour refers to health workers, teachers, and counsellors' understanding adolescents, as well as being sensitive to their needs and realities during help-seeking.

7.2.2.1   Health Workers Attitude and Behaviour

Adolescents discussed mixed perceptions about the different types of attitude and behaviour they had experience or expected from providers, and the impact it had on adolescent help-seeking behaviour. Similar to parents in the socio-cultural context, some health providers were described as not being respectful towards adolescents, but instead were rough, cursed at, gave lectures, disapproving looks and embarrassed adolescent seeking SRH services. For example, some male adolescents talked about being afraid to ask for SRH services from a health provider if he/she is not the person they expected to consult. When asked how easy or difficult they thought it would be to get information, advice or condoms from a health centre, the following was the response provided by Tony 18-year old Tony in the focus groups of rural boys from NEWLO:

> Tony: Nah well sometimes it depend on if you em, if you afraid to ask. Becau' sometime you go, the person you expected to talk to is not the person you see.
>
> Co-Moderator 2: Right
>
> Tony: But you know you want the advice or you want the em the condom or whatever you still have to ask the person. So sooner or later you have to em try and get acquainted and then after you ask the person....(laughter) If the person don't know you, is obvious they go want to start questioning you and asking you what you want the condom for, wha' you want to know about sex and (pause) thing. They go start questioning you.
>
> Co-Moderator 2: Uhuh
>
> Tony: After they get to know you then, everything go just go along smooth. At least it should.
>
> *(NEWLO, RFG3)*

According to Tony, the realization that the encounter would take place with a different health provider introduces uncertainty about the success of the interaction. This suggests that there is the establishment of a comfortable or safe space between health provider and the

adolescents, prior to asking for specific SRH help. Based on the above excerpt, Tony's comfortable/safe space for successful help-seeking is familiarity with the health provider. This, however, is in contrast to adolescents' concerns about familiarity and confidentiality in section 7.2.1, which suggests that health providers need an array of skills and flexibility to effectively meet the SRH needs of adolescents.

Related to the above, other adolescents and key informants also shared the perception that the quality of the adolescent-health provider encounter is inconsistent and may be explained by the lack of untrained providers to deliver adolescent-friendly services. The lack of training in AFS may be partly a result of the lack of financial resources and regularized training opportunities as discussed by key informants in section 4.4.1.

Female adolescent participants frequently reported experiencing negative provider attitude when seeking SRH services. For example, female adolescents discussed being asked many questions and often being told that they are "too young" to be having sex and/or to be given contraceptives. This is illustrated in the following excerpt by 17-year old Rhonda when discussing that *Asha* (i.e. the main character in the scripted story for female adolescent participants) might need to seek STI testing because she had unprotected sex:

> Rhonda: And then when they young again like the nurse and them go curse them [girls]. Yeah they might curse them, "you at a young age why you doing that" you know, they might talk to them rough.
>
> Co-Facilitator 1: Ok. Anyone esle? So do think that the nurses have a right to or should curse them and tell them, you know, "you too young, what you doing"?
>
> Judy: Yes, they should.
>
> Coco: No I don't believe that they should, they should do that.
>
> Tasha: When the nurses do that I believe that they put added stress on the/, on the young women.
>
> Coco: Yeah
>
> Tasha: They make them feel more bad[ly] than how they're feeling.
>
> Co-Facilitator 1: Ok. So they shouldn't do that.
>
> Tasha: I think they should encourage them on how to go about taking care of the child right now or taking care of their self.

Judy: It have some people they does say they don't going back dey you know, because how the nurse and them does react.

(Female Adolescent, RCFG2)

In the above excerpt, most female adolescent participants agreed that health workers should not talk to girls rough or curse at them because of their age, when seeking help. However, 17-year old Judy's contrasting view was based on her belief that adolescent sexual activity was irresponsible behaviour. Besides, she acknowledged that negative health worker attitude and behaviour discourages further help-seeking among some adolescents. Help-seeking can be viewed as a stress-reduction strategy, therefore, if help-seeking form health workers is also seen as stressful, as discussed by 15-year old Tasha above, help-seeking may not be viewed as a useful coping strategy. Similar to Tasha's view that nurses should encourage girls to care for themselves and child, rural adolescent mothers agreed that health workers should provide condoms without questions. According to 18-year old Rose, instead nurse make girls feel like they are "committing a crime" when they ask for condoms.

Compared to female adolescents, most male adolescents did not discuss provider attitude and behaviour as a hindrance to help-seeking. The evidence suggests that nurses may be more welcoming to boys and offer services to boys even when they have not requested it. This is highlighted in the following excerpt:

Justin: Because for me for most, when ah go like passing up, and ah in school in TAMCC, when I pass up by the surgery, it have ah nurse who really know, so then every time ah pass out she say, "son you have you boots [condoms]"? So she does give me and those fellas and them condoms and thing.

Co-facilitator 1: Ok, ok. Alright, and I see James is nodding his head. (participant snickers) You agree with what he is saying?

James: Yeah ah agree.

(Adolescent Males, RCFG8)

Based on the above excerpt, nurses in adolescents' communities as well as outside are proactive about giving boys contraceptives. This is because most segments of society have liberal view regarding boys' sexual activity compared to girls (section 6.3), which may translate into health workers' being more comfortable giving condoms to boys than girls.

It was discussed that help-seeking for information, advice and counselling is also hindered due to some professionals asking adolescents for information that will not contribute to resolving the SRH concern. When asked how they were treated by the nurses and doctors during pregnancy-related help-seeking, 17-year old Linda described her experience as follows:

> Linda: Only one alone, when ah went up in the hospital, Dr. Thomas, she was asking me ah whole set ah questions, ah was jus dey, and me head hurting me (participant snickers) and questions like, "wha' ah come back for", asking me about secondary school children on bus, "why dey does choose em special bus" and dis and dat/ (group laughter), and "why the bus lock up" and...me belly hurting me, ah want to go. (laughter) And she asking all kinda question, but them nurse and them was real nice to me in them clinic.
>
> *(PAM, UFG4)*

Considering that doctors are held in high esteem in Grenada it would be considered extremely disrespectful for Linda to refuse to answer the questions, or to openly express frustration about the way she was being treated by the doctor. Therefore it may be fair to say that the interaction between Linda and Dr. Thomas is more indicative of the power imbalances in the doctor-adolescent relationship that can hinder future help-seeking by Linda. However, a key informant involved in health services delivery discussed that the nurse asks some of these seemingly irrelevant questions to get a better understanding of the adolescents' situation. According to one HCCS key informant, these questions help the health provider to offer the most appropriate service based on adolescents' "desire". This suggests that while adolescents may seek help for a specific service, interaction with the health provider may highlight other issues that need to be addressed, a more appropriate type of service that may be needed, or that the health provider is uncomfortable providing the requested services to the adolescent.

As a result of negative health provider attitude and behaviour, some adolescents discussed a preference for seeking services from other sources, as is illustrated in the following focus groups excerpt:

> Rose: Tha' is why most ah them don't go because them nurses and them (pause) they want to know everything, everything they want to know. Wha' you want if for? Or come, who send you? All kinda thing they asking you.
>
> Rhonda: Ah rather buy it in the shop oui.
>
> *(PAM, RFG6)*

In the above excerpt, Rose prefers to obtain condoms from the shop to avoid the many questions that some nurses tend to ask adolescents. While the issues of policies and laws were not explicitly discussed as a reason for the many questions helpers ask, the evidence suggests that there is some awareness among adolescents of laws and social codes regarding abortion, sex, and pregnancy. Therefore, helpers asking questions may indicate to adolescents that they have breached legal and social codes regarding those SRH matters (sections 4.2.3 and 6.3, respectively). Additionally, some adolescents discussed a preference to seek help from private health providers rather than public health providers. This is because public health providers are at times perceived as unforthcoming with information to adolescents about their SRH concern(s). According to 17-year old Thomas who attends NEWLO from a rural community, "You could go in the medical station but you not getting much information." Also, adolescents and key informants discussed that health providers provide SRH information and advice to adolescents in a manner that is described as "lecturing" or "preaching", which may hinder help-seeking behaviour. When asked about health providers' reaction if she were to ask for condoms, 16 year old adolescent mother, Carmen responded:

> Carmen: ...And then in my clinic, they would give you a whole lecture about not having sex and all these things.
>
> Interviewer 1: Okay. So you'd get a lecture in your clinic?
>
> Carmen: Uhuh. Even when ah was pregnant and ah go there ah did get one still, nuh.
>
> Interviewer 1: You got one?
>
> Carmen: Uhuh. I did get a lecture.
>
> Interviewer 1: Okay. Why do you think they gave you a lecture?
>
> Carmen: So you wouldn't go back and get pregnant. Or you would try to abstain. Or even though you want to have sex you would come and get the condoms, or buy the condoms, or go on contraceptives after you make the baby....While ah was there to get me pap smear the lady tell me come and get the umm, injection now. Hear me, nuh [not] yet, nuh yet. (laugh)
>
> *(PAM, RI15)*

This excerpt was chosen mainly because it highlights multiple elements of provider attitude and behaviour in the interaction between Carmen and the nurses that can hinder as well as encourage timely help-seeking in the future. Carmen explained that while she was displeased with being lectured by nurses in the health centre, she understood that they were disappointed she was pregnant and only trying to help her prevent future negative SRH

outcomes. What the excerpt does not show is that Carmen has a close relationship with the nurses in the health centre, which she also believed was a reason for the nurses' behaviour towards her. However, in chapter 5, Jessica also discussed being lectured although she did not have a close relationship with the health provider. Together, these findings further attest to the unpredictability of health providers' attitude and behaviour regarding ASRH help-seeking. Carmen pointed out that if another pregnancy were to occur in the short-term, she may choose not go back to the health centre in an attempt to prevent disappointing the nurses again. Therefore, lecturing can be interpreted as hindering future help-seeking. However, the fact that the nurses did not lecture Carmen in a "rough" manner could encourage future help-seeking for other SRH concerns, such as for pregnancy and STI prevention. An overly close relationship involving provider emotions and expectations may help to deter help-seeking, as well as ineffective health provider communication which is similar to negative parent-adolescent sexuality communication discussed in section 6.2.

Contrary to other adolescents, 18 year old adolescent mother, Jennifer, blamed adolescents for having too much pride, which she discussed as preventing adolescents from help-seeking rather than the attitude and behaviour of the service provider. Nonetheless, as a result of negative or undesirable health provider attitude and behaviour, the majority of adolescents discussed that adolescents were uncomfortable, afraid, nervous, and embarrassed to seek help from service providers, especially from those in government health facilities and pharmacies. Based on the above findings, desirable health workers attitudes and behaviours that could promote and improve adolescents' help-seeking experience are shown in Figure 7-3 below.
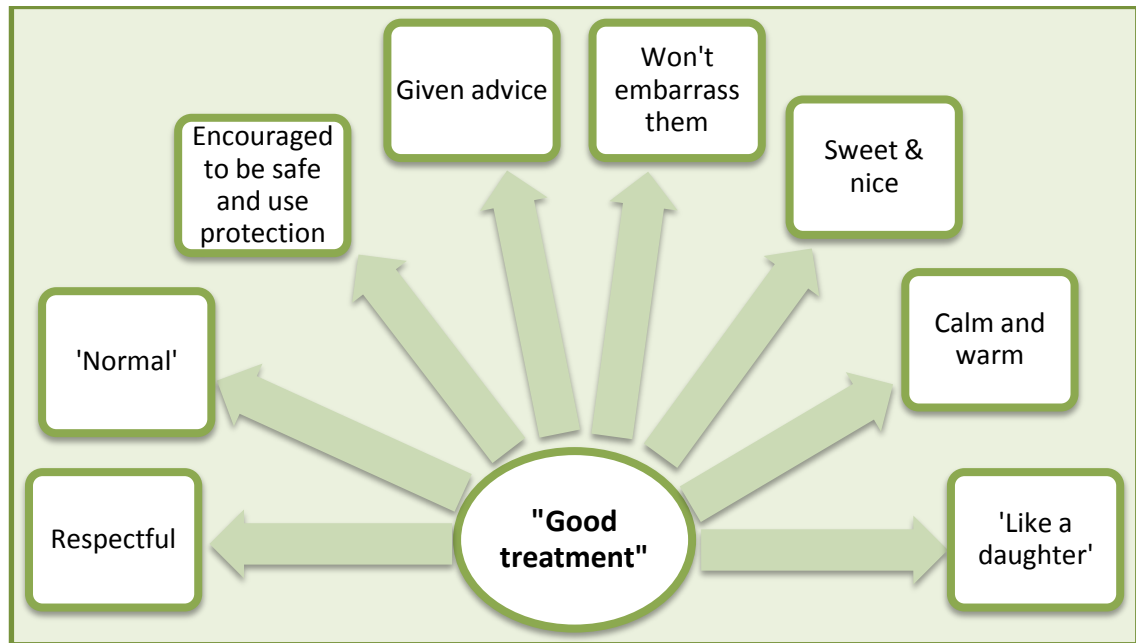
Figure 7-3 Characteristics of desirable provider attitude and behaviour

7.2.2.2 Teachers Attitude and Behaviour

Similar to the service providers' attitude, the way in which sexuality education is delivered in schools also may influence help-seeking. For example, a key informant discussed that a group of students at the Community College had commented that:

> HFLE is a good Programme, but what I don't like is the people they give us to teach the HFLE. They sound like my mother and I never saw that….So at home they hearing the preaching, at school they hearing the preaching, you understand what am saying?...They had issues with who was /delivering….And of course because they are parents, these teachers and they would sound like mothers and the old concern for boys and girls and not having sex.

(Key informant 2, IE)

The question that this key informant is raising here is, why seek help from teachers if they're sounding like my mother and have the same values as she does? While teachers are expected to implement the curriculum, doing so in the manner described above does not encourage help-seeking from teachers. However, some teachers were described by adolescents and key informants as being very good HFLE teachers, which may encourage help-seeking. Similar to health providers, some teachers were also described as not being forthcoming to provide adolescents with SRH information and advice. Two participants discussed that they may not

get the answer they are looking for if they seek help from teachers. Advice given does not have to match-up with expected advice. However, anticipating this discordance, some adolescents may be hindered from seeking help from sources who may give them advice contrary to or is unsupportive of the behaviour leading to the SRH concern. It is possible that adolescents' anticipation of teachers' attitude and behaviour may be based on social norms and expectations about the SRH concern or what may have been taught about the topic in school. This suggests that sexuality education has implications for SRH help-seeking from teachers.

While strict comparisons are not possible between groups of adolescents, enrolees in NEWLO and PAM agreed that teachers at their institutions had a good attitude regarding SRH; this is in contrast to discussions about secondary school teachers. Figure 7-4 highlights the differences in how teachers at the different institutions related to students SRH concerns.

Secondary school
- some teachers grumble and talk behind your back when they know certain things
- some are comfortable teaching HFLE
- younger teachers are not confidential

NEWLO
- teachers boost your self esteem
- less people to bring you down
- they portray themselves with standards so you feel free to open up
- they don't hide and talk about you, they unite and talk to you
- they teach you to be positive influence on others and discourage rumours and bad talking

PAM
- your spirit gives
- motivate you
- most are lovely and kind, they understand and try to help you understand

Figure 7-4 Characteristics of teachers across institutions influencing help-seeking

The differences in Figure 7.4 were reported to have influenced the help-seeking behaviours of some adolescents. One organizational-level key informant noted that some teachers are not always sensitive when probing adolescents for information during help-seeking, as is highlighted in the following excerpt:

> …Our communities are so small that a child would come and say "look, I, this gentleman I had sex with him because of money problem" or whatever and right away the teacher is so curious that she will want to find out exactly who this gentleman was or they might indicate and say I know, I know this particular individual.
>
> *(Key Informant 4, HCCS)*

According to the above key informant, this insensitivity was considered a hindrance to help-seeking because of the small size of Grenadian communities, and the fact that the teacher may know the parties involved in the adolescents' help-seeking concern. This has implications for disclosure during help-seeking, and confidentiality of the information after disclosure within the school system and community (section 7.2.1.2), which can also negatively affect the adolescent's reputation (section 6.4).

In summary, professional helpers' attitude and behaviour both facilitate and hinder ASRH help-seeking. However compared to female adolescents, male adolescents did not discuss helpers' attitude and behaviour as hindering their help-seeking behaviour. Although health workers were more welcoming to boys than they were to girls, it was not clear whether this influenced male adolescents help-seeking. In contrast, negative helper attitude and behaviour, such as cursing at and being rough, asking too many and irrelevant questions, not being forthcoming, and lecturing and preaching were found to hinder female adolescents utilization of these sources during help-seeking, while the absence of these behaviours were perceived to facilitate help-seeking. Although the manner in which the data was gathered does not allow for strict comparisons among subgroups of adolescents, an interesting finding was that teachers in the PAM and NEWLO may have a better attitude towards adolescents that facilitated help-seeking compared to secondary school teachers.

7.2.3 Privacy

Based on participants' narratives, *privacy* refers primarily to others overhearing the helper-adolescent interaction or seeing the adolescent at the health facility. This definition is

consistent with Britto *et al.*' (2010) definition of physical privacy, but is less broad. As was discussed in section 5.3.4, some adolescent participants who utilized health services for pregnancy concerns were satisfied that privacy had been maintained, specifically being overheard during consultations by others in the health facility. However, participants who had not utilized health services were worried about privacy. Nonetheless, most participants, including those who reported experiencing a private consultation discussed that privacy could be violated and hinder help-seeking behaviour. One of the reasons discussed is the configuration of the space. For example, some participants discussed that seeking condoms in the health centre, shops or pharmacies did not afford adolescents any privacy. Adolescents discussed that it would be more acceptable if they can access condoms in a manner that detracted attention, such as not having to request it from a person but just paying for it. This has implication for condom access, especially among girls considering adolescent girls' discomfort and the stigma implicit in accessing condoms from shops and health providers (section 6.4).

Private health providers afforded some participants greater privacy to seek help for their SRH concerns. According to a male and female adolescent, one of the reasons for this is that public facilities are often crowded. This is explained by 16-year old Donna:

> Interviewer 1: What was your reason for going to St. Peter (participant laughs) and maybe not somewhere closer?
>
> Donna: Ummm, because, the reason why I went St. Peter it's like less people go to St. Peter. The only how people does go to St. Peter because if they child really, really sick they would go to ah clinic.
>
> *(Adolescent Female, RCI2)*

Although Donna's mother chose the health provider to obtain Donna's abortion, physical privacy was important to them. The perception that fewer people utilize the facility implied that the chances are reduced that she would see someone whom she knows or who knows her; therefore, reducing the chances of being labelled with the stigma of a pregnancy and an abortion (section 6.4).

Related to the above, special clinics were also viewed as a hindrance to help-seeking. For example, one key informant and a few adolescent mothers were concerned about being seen going to the health centre, which means that it is relatively easy to know the purpose of an

adolescent's visit to the clinic. For example, adolescents discussed that antenatal clinics are offered on a particular day of the week at the health centre. Earlier in section 7.2.1.1, Sherry implied that the cleaning lady found out she was pregnant because of the day she attended the clinic. Therefore, if an adolescent wanted to keep the early stages of her pregnancy private her mere presence that the health centre on the day of the antenatal clinic would indicate to others present that she is pregnant. Additionally, the location of the HIV/AIDS treatment unit (i.e. National Infectious Disease Control Unit - NIDCU) was discussed by the following key informant as hindering help-seeking for HIV/AIDS:

> Ministry of Health has a department, you can get free HIV/AIDS testing, but you have to walk through the entire building to go to that particular door to ask that that test be done. Who wants to do that? Persons prefer to do their thing in secret, but walking towards the door, workers open in the hall sees you, walking from the door a week or two after that, workers will look at you.

(Key informant 2, IE)

The department the key informant in the above excerpt is referring to offers HIV treatment and not testing as stated in the excerpt. However, the key informant perceived the lack of privacy to access the NIDCU was unacceptable because it put adolescents at risk of being stigmatized. This specific issue was not discussed by adolescents, possibly because adolescents may be unaware of the actual location of the NIDCU. These findings suggest that 'special clinics', a key design of primary health care in Grenada can hinder help-seeking for other SRH concerns.

Based on the above findings, privacy was found to be maintained among adolescents who utilized health services. However, the perception of a lack of privacy among non-users was found to be a hindrance to SRH help-seeking. The reasons for this included: the design of the physical space, crowded facilities, and specialized clinics. The findings indicate that privacy was more likely to be maintained in private versus public facilities, and privacy was also an issue in pharmacies and shops for obtaining condoms and pregnancy test. Physical privacy is interrelated with stigma, confidentiality, and location of services which is discussed in *accessibility of SRH information and services* below.

7.3   Accessibility of SRH Information and Services

In chapter 2, accessibility of health care was described in terms of whether "people are able to get treatment/services when they need it" (Maxwell, 1992 p.171). Accessibility themes that resonated as major influences on ASRH help-seeking to participants in this study are: availability of SRH services; knowledge of services; distance to access SRH services; parental consent and; cost of services. Some issues pertaining to distance were discussed in 7.2.1.1 in relation to confidentiality, and will not be repeated here.

7.3.1   Availability of SRH services

In section 5.3.3.1, it was reported that there are several sources through which adolescents may seek SRH-related information, advice and services. However, among adolescents and key informants there was disagreement within and between groups as to whether there are sufficient organizations in Grenada and at the community-level to provide adolescents with information, advice and services to deal with SRH concerns. Some adolescents explained that it would be useful to have other organizations available to provide SRH services, especially in the communities. This is consistent with findings presented in section 4.3, which shows a lack of community-based ASRH-related programs and services. For example, female participants in the rural community discussed that the best counselling services were available in the capital city, St. George's, because school counsellors are trained mainly for academic issues and not SRH issues.

Additionally, while a few adolescents reported being unsure as to whether there are sufficient sources of help for adolescents to deal with SRH concerns, 18 year old Mike who attends NEWLO from a rural community perceived that a lot of adolescents with problems were not utilizing existing services. This view was supported by other adolescents and consistent with that of key informants. One key informant explained that:

> We are not getting a major influx of young people asking about birth control information
>
> *(Key informant 1, HCCS)*

However, this is the same key informant whose organization turned away the female adolescent requesting the contraceptive pill with her mother's consent. Based on discussions

of the ease of spreading rumours in Grenada, it can be inferred that rumours of adolescents being turned away from health services with parental consent may also spread. This can result in the service organization having a bad reputation among adolescents, as such hindering access to services for adolescents who meet the assumed criteria of parental consent. Despite this, most other key informants shared the following views:

> There is a lack of institutions and programs…if programs are available adolescents will use it.
>
> *(Key informant 6, IE)*

Based on the above, there is the perception that sufficient services may exist for adolescents at the country-level, but not at the community level. For example, services were not available within the communities in which adolescents in the study resides. Furthermore there is the issue of whether services will be used if they become available, since adolescents were hesitant about using services in the community because of the perceived lack of confidentiality (section 7.2.1.1).

7.3.2   Knowledge of SRH services

Knowledge of SRH services refers to adolescents' awareness of existing SRH-related services and programs. Despite the availability of ASRH-related services, there is evidence that adolescents' lack knowledge about available organizations and programs related to SRH, and this may hinder help-seeking. Apart from government or private health care, most adolescent participants were unaware of other organizations offering SRH information, advice and services. With the exception of adolescent mothers, not all other adolescents were aware of the Grenada Planned Parenthood Association (GPPA) or "family planning" as it was referred to by adolescents. However, this may be because it is mandatory for PAM enrolees to obtain one of two types of contraceptive from GPPA, which can be viewed as a form of forced help-seeking (Booth *et al.*, 2004).

Among male adolescents, those from the urban community were more unaware of GPPA, considering it is located in the urban community. Some adolescent participants were aware of the existence of some organizations, but was unaware that the organization provides SRH-related programs/ and or services. For example, some adolescents were aware of organizations like the GRCS and GRENCODA, but were unaware that these organizations

provide SRH related programs and services. Male rural adolescent participants discussed that because of their knowledge of GRENCODA's work in the community and manner of interaction with community members, they will seek help from GRENCODA's staff for SRH concerns. In contrast, female adolescent participants in the community were less certain about seeking help for their SRH concerns from GRENCODA's staff. In discussing the scripted story, there was some agreement among subgroups of male adolescent participants that not knowing where to go for SRH services could delay *Joe's* help-seeking, and could also prevent *Joe* from seeking help. This is highlighted in the following excerpt when adolescent males were asked what they thought *Joe* would do if he needed advice for HIV and did not know where to go:

> Tony: Aa no, he go continue to seek and see if he could find that.
>
> Terry: If he could find, yeah
>
> Jordan: Well (pause)
>
> Tony: And then sooner or later he might end up talking to somebody if possible.
>
> Jordan: If he thinking positive he will do that.
>
> Tony: And then they go em give him a little advice as to where he could get help cuz sometimes they can't help him but they know of a place or they know somebody that could help him out. They could give him directions, tell him where he could go, who he could go to or they might even give him the name of somebody to talk to.
>
> *(NEWLO, RFG3)*

Based on the above excerpt, some male adolescents discussed that eventually *Joe* will find someone who will know where he can find help and advise him of such. However, they also discussed that it may take some effort on *Joe's* part to eventually find an *intermediary* helper (section 5.3.3.1). This suggests that help-seeking will be delayed if the adolescent lacks the knowledge about sources of help. Also, that Joe may initially be using sources, such as peers who may not be very knowledgeable about sources of SRH help for boys, or boys may be selective about the *intermediary helpers* they use because some male adolescents discussed some community members being unsupportive of boys seeking help (section 6.3).

Related to the above, adolescents discussed the media as a source through which they could seek information about SRH concerns and learn about other sources where they can obtain SRH services. For example, some of the male adolescents discussed that they obtained

information from media sources, such as books and condom boxes because most male adolescents reported not learning to use condoms from other sources. In the urban community, two female community key informants recalled seeing programs on television that demonstrated how to put on the male condom on a banana and a mannequin, and discussed that it was a good way for adolescents to learn how about condom use. However, the group members acknowledged that other community members may view it as encouraging sexual activity. Additionally, adolescents were aware of several media campaigns promoting safe sex, abstinence and discouraging HIV/AIDS stigma and discrimination. However, the Population Services International (PSI) *"Got it? Get it!"* Caribbean condom use campaign was the only media campaign through which adolescents discussed learning about where to access SRH services (i.e. condoms). According to 18-year old Coco, a female adolescent from the rural community, "the sign" (Figure 7-5) meant that "nobody won't know your business, usually"; meaning that locations displaying the *"Got it? Get it!"* logo should provide private and confidential services, but that that is not always the case.

Figure 7-5 "Got it? Get it!" logo for PSI Caribbean condom use campaign
Source: www.psi.org (2007)

Regardless of whether adolescents perceived that the campaign was encouraging safe sex or sex in general, most adolescents were able to recall the campaign's messages and discussed that the yellow and black sticker indicated that condoms were available for purchase at the site where displayed. Overall, participants agreed that utilizing the media sources, such as television and billboards to advertise organizations and programs related to ASRH promotion, could help to facilitate SRH help-seeking. Although utilizing the media is reportedly expensive which hinders the use of this source for ASRH promotion (section 4.4.1), the following key informant, discussed that there are myriad of media sources that can be utilized, implying some may be more affordable than others:

Use billboards, issue handouts that are reader friendly in the rural community playing field where sporting activities are very well attended. Record messages to play during community activities or the need to talk about SRH concerns.

(Key Informant 6, IE)

According to the findings, while adolescents are aware of some of the SRH programs and services they were unaware of other organizations that provide related services. Nonetheless, some male adolescents discussed the belief that an *intermediary helper* could be used to provide adolescents with advice as to where to go for help. Also "Got it? Get it!" condom use media campaign was found to be useful in helping adolescents to identify adolescent-friendly locations to purchase condoms.

7.3.3   Distance to Access SRH Services

Distance to access SRH services refers to the location of where SRH-related programs and services in comparison to where adolescents reside. For most adolescents, the distance where SRH-related services are located was not considered a major hindrance to accessing services during the help-seeking process. Health centres are located at the community level, and most adolescents discussed that they can either walk or get a free ride from motorist if they are unable to pay for public transportation. While some participants viewed the closeness of health facilities to their community as encouraging help-seeking from those facilities, other adolescents discussed that this would discourage help-seeking. This is illustrated in the following excerpt among rural male focus group participants.

Co-moderator 1: Okay so em (pause) do you think that if there was one [a health centre] in the community that would make it easier?/

Jason: Yeah man.

Jamal: Yeah

RU: Ah still not going they.

Jerry: Nuh boy tha' make it harder man (laughter).

Co-moderator 1: Make it harder?

Jim: Yeah. [CROSS TALK] You see me ah doh

John: Yeah, yeah, you, you make it easy for me you know.

Jason: Yeah it easier ah find oui [yes], you walking go (pause) because/ you walking.

Based on the above excerpt, facilities located within the community facilitated getting there, but not necessarily utilization because of the fear of confidentiality (section 7.2.1.1). There is also the question about whether adolescents would choose private providers located within close proximity to their communities or providers who are located further away from their community. Although this was not an issue that was probed during data collection, as discussed earlier (section 7.2.3) 17-year old Donna from the rural community chose to go to a private doctor located far from her community although she might have been able to receive the required service from a private health provider located nearer to her community.

However, adolescents may face difficulty utilizing public health facilities outside their catchment area where they may not be familiar with the health staff and community members. This is explained by key informant 2 in the following excerpt:

> They're not going to the health centre at all (pause) because often time the health centre demands that you go in your area and that's why I say that's not adolescent friendly. So you go and you say my name, they want your name, they want where you from, they want a contact number. So if I come to St. George's and I say I'm from Grenville they ask me well "why you din go to Grand Bras"? So I become mute; I'm silent because I don't want them to tell them that I don't want them to know and things like that.
>
> *(Key informant 2, IE)*

According to the above key informant, health workers requesting information such as place of residence and reason for using a specific health facility can hinder help-seeking because adolescents want to keep their help-seeking confidential. However, the health care system is organized so that health centres and medical stations are used to provide for the needs of residents in a specific catchment area surrounding the facility. As a result, it may be more difficult for adolescents to access primary health care facilities that are outside their catchment area.

Therefore, distance was found to facilitate the ease of getting to the health facility, but not utilization per se. While adolescents discussed being able to access facilities outside the community, one key informant perceived that adolescents would be hindered by the questions

health workers ask rather than with difficulties commuting. Distance interacted with confidentiality and availability of SRH-related programs and services.

7.3.4   Parental Consent

Parental consent can be viewed as both an issue of acceptability and accessibility. However the decision was made to include parental consent as a matter of accessibility, because participants' discussions focused on adolescents' rights to independently access SRH care services. The lack of a written or consistent policy regarding parental consent for adolescents to access health or SRH services, according to one key informant, means that:

> Young people have no idea what's going to happen if they go to seek out a
> service. If they want HIV testing do their parents have to be notified or not,
> will they be turned away?
>
> *(Key informant 4, HCCS)*

The above excerpt illustrates the inconsistencies in accessing SRH services related to parental consent. While the key informant specifically references HIV testing, this is a general issue regarding ASRH services. Consistent with key informants, there were mixed views among adolescents about whether they are able to utilize SRH services without parental consent. Figure 7-6 highlights the four main factors related to parental consent that influenced ASRH help-seeking behaviour. The figure shows that there is overlap between the factors described, indicating that multiple factors operate concurrently.
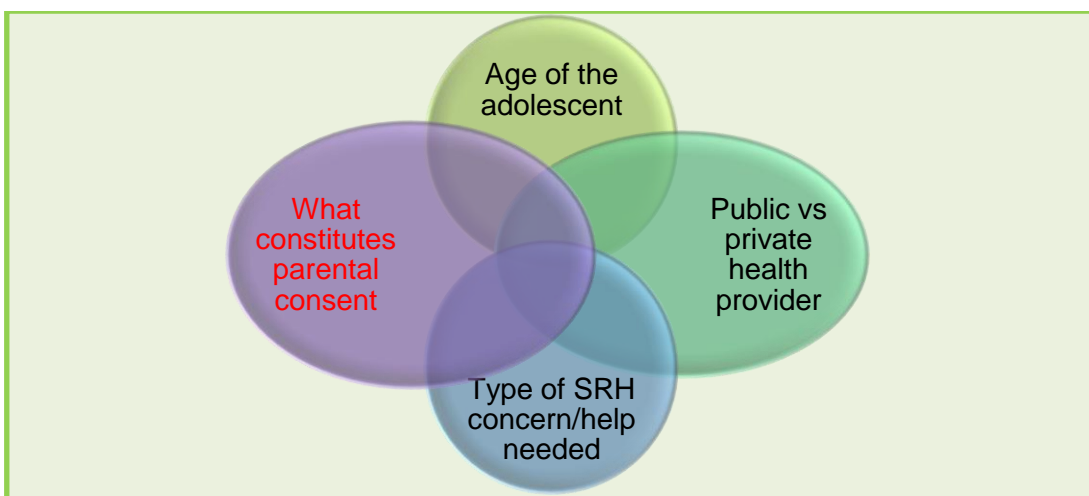
Figure 7-6 Parental consent considerations

Adolescents debated whether parental consent was needed to access SRH care services under age 16 or 18. Some adolescent mothers discussed successfully seeking pregnancy testing from health providers with and without parental consent under age 16, while others discussed being turned away (section 5.3.4). The following key informant excerpt draws attention to the issue that some adolescents who are turned away because of parental consent may not return for the service.

> …this young lady came and she really wanted to be tested [for HIV]. And she was, I think was either 14 or 15 years, and they had to turn her away. And they ask her to get her parents and she didn't come back. So I don't know maybe there are other cases like that, or maybe there are cases where the person doing the testing would have facilitated had facilitated the umm, the persons.
>
> *(Key informant 5, IE)*

The above key informant was uncertain about whether there were similar incidences of adolescents being turned away. Among adolescents who discussed being turned away during help-seeking, only adolescent mothers reported returning to the health facility with a parent or guardian for pregnancy testing. This, however, may be due to the nature of the concern, because one can only postpone pregnancy-related help-seeking for a limited time while HIV testing may be delayed for longer periods or help may never be sought.

However, discussions about age requirements occurred alongside discussions about the type of health facility/providers that might require parental consent. The following excerpt between urban female adolescent participants highlights some of the inconsistencies regarding when parental consent is required.

> RU: When ah went in the health centre they tell me ah have to get somebody in authority/ to come with me.
>
> Cindy: Me too.
>
> Jessica: To come with me./
>
> Karen: When I went in the health centre they didn't tell me anything I just/ went to the doctor.
>
> Linda: I went in the health centre to see the nurse when I was pregnant, for the first time, I went for myself and they didn't tell me nothing but when I went up in the hospital I had was to go with me mother because I was

> underage. Ah had was to see Dr. Thomas with me mother but to go in clinic
> ah went for meself and she didn't tell me nothing.
>
> Rachel: Well me, all when ah went and make me child me mother had was
> to sign.

(PAM, UFG4)

Based on the above excerpt, it is possible in health centres where health providers are familiar with community members, and walk-in visit are allowed, some providers might be more inclined to provide services to adolescents without parental consent. Furthermore, at health centres, health providers may forego parental consent at the time of service delivery because they could later notify the adolescent's parent, guardian or other relative to inform them of the SRH care visit. In contrast, the main hospital is centrally located, and requires a referral and an appointment, unless visiting the emergency room, which may help to explain why parental consent is required. For example, some adolescent mothers discussed that their mother or someone in authority had to sign paperwork when they went to deliver the baby. However, there was no mention of inquiries of the baby's father made by the hospital staff, which may have legal implications, as was discussed by a key informant in section 4.4.2. Private health providers who may be considered to be more profit driven were perceived to more strictly enforce parental consent policies. This was surprising considering that Grenada does not have a culture of suing health providers. However, some adolescents supported parents accompanying adolescents for SRH services, as they believed this would prevent subsequent fall-out between the parent and adolescent, since the parents will eventually find out about the SRH concern and/or help-seeking (section 7.2.1).

Nonetheless, some key informants were of the view that having parental consent do not always result in health service provision to adolescents, as an adolescent girl was refused contraceptive pills despite having consent from her mother to obtain such. However, it was not probed if parental consent was provided to the adolescent girl verbally or in writing. This suggests that the process and acceptable means of providing parental consent may be unclear for parents and adolescents, and even health providers considering that among health providers there are uncertainties about parental consent (section 4.4.2). There is evidence in section 5.3.4 that help-seeking may be perceived as unsatisfactory and hindered if parental consent requires parental presence during the help-seeking encounter. For example, some female adolescent participants talked about being scared of fully disclosing relevant

information to health providers when parents are present during their encounter with the doctor or nurse. However, as 18-year old Jennifer explained:

> It's according to who you trust and who go to the clinic with you, you'll give different reaction to the different questions asked to you.
>
> *(PAM, UFG4)*

Nonetheless, some adolescents were of the view that adolescents seeking information about puberty or safe sex may be helped without parental consent, while adolescents seeking contraceptives or a pregnancy test may be required to have parental consent. This is illustrated in the following focus group excerpt:

> Kara: Uhuh. Once it is that kinda/ situation [pregnancy].
>
> Andrea: situation, they would advise you [to bring a parent or guardian].
>
> Kara: But if you just come to get information, then they [doctors] would just give it to you, but if you are in the situation they would, they would advise you to go/
>
> Andrea: bring your parents.
>
> *(Adolescent Females, UCFG10)*

However, adolescents did not report seeking information from health providers for puberty related (e.g. menstruation and wet dreams) and safe sex issues in the experiential pathway, but from parents and friends. The exception was urban adolescents who reported seeking information from a doctor about contraceptive methods for a school project. Nonetheless, adolescents' decision to withhold relevant information from health providers may affect health providers' ability to provide adolescents with the correct or most appropriate information, advice or treatment.

The findings show that inconsistencies in SRH service delivery created uncertainties about if, when and possibly how parental consent is to be provided. Although parental consent was mainly an issue for girls, some girls supported parental consent as a means to preserve parent-adolescent relationship.

7.3.5   Cost of Services

Cost of services pertains to the financial cost of diagnosis and treatment which influences adolescents' access to SRH services. Some adolescents discussed cost as a barrier to help-seeking for SRH concerns. Despite being unable to afford to pay for private services, some adolescents discussed unwilling to access free public health facilities. In the following excerpt, Mary, a 16-year old adolescent mother discussed delays in seeking a pregnancy test because she did not have money to pay the doctor's fee.

> Interviewer 1: And, why did you wait that amount of time before you went to actually see a doctor?
>
> Mary: Well, ah didn't have the money at the time so ah had to wait. And then me boyfriend wasn't working at the same time. Because he who gave me the money to go.
>
> Interviewer 1: So how did he get the money, where did he get the money from?
>
> Mary: Well he started to work.
>
> *(PAM, UI14)*

According to Mary, she waited until she got money from her boyfriend to access the services of a private medical doctor after confirming her pregnancy via over-the-counter pregnancy testing. This was because she was unwilling to seek free services from a government health facility. Similarly, 19-year old Kenny from the rural community reported that he too would wait until he could afford a private doctor, rather than go to a public health facility. In contrast, some female adolescents discussed utilizing government health facilities only if private doctors were unaffordable. Notwithstanding, some adolescents discussed adolescents being able to access money for health services from trusted social network sources (e.g. parents, and other adults in their community). This highlights the importance of *intermediary helpers* in accessing health services (section 5.3.3). Another participant suggested that if private providers were to offer services for adolescents at a reduced fee or utilize payment plans she would prefer to utilize private providers rather than government providers. Together the above findings indicate a preference for private provides, and show that cost may be the main barrier to accessing private health care services. Nonetheless, access to free SRH services did not always facilitate SRH help-seeking; highlighting that multiple determinants are actively influencing help-seeking behaviour. For example, some rural female adolescents vehemently disagreed with one group member who suggested that public health facility was an option because it

was free. Their disagreement pertained to the perceived lack of confidentiality of health workers.

The evidence shows that financial cost for diagnosis and treatment affected some adolescents' ability to utilize private health services in a timely manner, but not public health services. However, considering adolescents preference for private health care providers, they may be able to access trusted social networks sources to help with health care cost, if it is a barrier to SRH services. It is noteworthy that free public health services only facilitated help-seeking for few adolescents, due to the interrelatedness of cost and other factors of accessibility and acceptability.

7.4   Chapter Summary

Acceptability and accessibility were described as the two broad themes in the programmatic context that influences Grenadian adolescents' help-seeking behaviour. Subthemes for acceptability included: confidentiality, professionals' attitude and behaviour, and privacy. Subthemes for accessibility included: availability of SRH services, knowledge of SRH services, distance, parental consent, and cost of services.

Table 7-1 provides an overview of the relationship between the programmatic determinants of ASRH help-seeking and the help-seeking pathways.

Table 7-1 Relationship between programmatic determinants and ASRH help-seeking pathways

Stages of the help-seeking pathway	Examples of programmatic determinants
Stage 1: Identification of SRH concern	Professionals helpers attitude and behaviour
Stage 2: Identification of the need for help	Confidentiality; Parental consent; Professional helpers attitude and behaviour
Stage 3: Help-seeking and Source of help	Confidentiality; Parental consent; Professional helpers attitude and behaviour Availability of services Knowledge of services Cost of services Distance to services
Stage 4: Assessment of help-seeking	Confidentiality; Parental consent; Professional helpers attitude and behaviour Availability of services Knowledge of services

	Cost of services
	Distance to services

There was interaction between the help-seeking facilitators and barriers in the programmatic and socio-cultural context, but many of the factors interacted with confidentiality and stigma to affect help-seeking. Gender differences were observed in the programmatic context, in that mainly females discussed parental consent as a hindrance to help-seeking. The findings indicate that health workers were more proactive and appeared to have better attitudes regarding the SRH concerns of boys. However, gender findings must be cautiously interpreted because few adolescent male participants reported actually seeking help from health providers. Participants discussed several strategies that adolescents use and made recommendations for strategies they believed could facilitate adolescent help-seeking. Some of these included: ensuring that health workers are not doing ASRH promotion within their community, training health workers and teachers to maintain confidentiality, using the media to increase and adolescent's knowledge about SRH issues and sources of help. The importance of intermediary helpers in ASRH help-seeking was also highlighted.

The next and final chapter provides a discussion of the main findings in the thesis and show how they are related to the wider help-seeking literature and the conceptual framework guiding this thesis, as well as the implications of the findings.

Chapter 8 – **Discussion, Recommendations & Conclusions**

8.1 Introduction

This chapter will begin by revisiting the aims and objectives of the thesis, discuss the key findings for each research question and their implications in relations to the Grenada context and the wider literature (sections 8.2 and 8.3). Next, the implications of the study on the conceptual framework which guided the thesis will be discussed and a revised conceptual framework will be presented (section 8.4). Following this, recommendations for policy, ASRH promotion practice, and research will be presented (section 8.5). Finally the chapter will end with some concluding thoughts on the thesis (section 8.6).

8.2 Revisiting the Aim, Objectives and Research Questions

The aim of the current study was to investigate how adolescents in Grenada perceive the socio-cultural and programmatic contexts as it relates to the promotion and prevention of their help-seeking behaviour for sexual and reproductive health concerns. The thesis was driven by five research questions:

1) What is the existing ASRH framework in Grenada?
2) What are the help-seeking pathways for Grenadian adolescents reporting SRH concerns?
3) What are the influences of the socio-cultural context on Grenadian adolescents' help-seeking behaviour for SRH concerns?
4) What are the influences of the programmatic context on Grenadian adolescents' help-seeking behaviour for SRH concerns?
5) What are potential solutions to addressing ASRH help-seeking?

During the course of the study the research questions were revised to some extent in response to challenges presented. The questions of investigating how the socio-cultural and programmatic contexts affect the identification and interpretation of adolescents' need to seek help were changed. These questions focused too heavily on one stage of the help-seeking pathway at the expense of other stages that could provide important insights into Grenadian adolescents' help-seeking behaviour. Furthermore, because of the exploratory nature of the study, looking at the influence of the entire help-seeking pathway was deemed a more

appropriate starting point for research. Therefore, this research question is not omitted, but is simply extended to include other stages of the help-seeking pathway.

The above changes have helped to improve the quality of the thesis, making it more focused and relevant to the exploratory nature of the research in the Grenadian context and gaps in the field.

8.3   Key Findings and implications

The study identified some key issues regarding the context of ASRH help-seeking behaviours in Grenada. The key issues for each research question are summarized and discussed in light of existing knowledge regarding help-seeking behaviour, to highlight fit and contribution to the literature, and relevance for ASRH help-seeking in Grenada.

8.3.1   The Existing ASRH Framework

The findings confirm that there is no specific ASRH policy in Grenada, but disparate policies related to ASRH. This is consistent with other Caribbean islands, based on discussion with an official in the MoH in Grenada and the lack of results of my web-based search for ASRH policies in the Caribbean. Although it is common to find disparate ASRH-related policies and legislations in developing countries context, countries such as Uganda, Zambia and Zimbabwe are reported to have separate policies (Makwate, 2002; AYA/Pathfinder, 2003). However, disparate policies and legislations that are unlinked and inconsistent to form a cohesive context are described as problematic (Pillay and Flisher, 2008). The current policy context in Grenada is interpreted as one where ASRH is not prioritised, because policy development processes are incomplete (e.g. NSPH), policies are expired (e.g. HFLE policy) and/or not used (National Strategic Plan for HIV). This suggests lack of planning and support for policy development and implementation. It is possible that a shortage of technocrats in policy and planning in the Government sector (GoG, 2008), but primarily in the health sector may affect policy and legislative agenda setting and process, in general.

According to a recent UNFPA report on SRH and HIV policies systems and services in Grenada, "political resistance to either the new or old Government administration" hinders implementation of new and old policy (UNFPA, 2011 p.41). In this study, key informants have questioned the political will of past and current Grenadian Governments to implement

supportive ASRH policies and legislation. This is because issues such as contraception, abortion and homosexuality are socially contested issues that have implications for political parties support base. Therefore, there is a need to mobilise political support for ASRH issues in Grenada which would facilitate related policy and legislation implementation, as is suggested in the 2011 UNFPA report. This is linked to the importance of identifying the policy window in the process of policy development (Pillay and Flisher, 2008).

Lack of enforcement of existing policies and legislations was discussed as a major hindrance to effectively promote ASRH in Grenada (section 4.4.2). This is important, bearing in mind that guidance for ASRH services emanate from legislations rather than health policy. Therefore, seeking help for several types of SRH concerns may put adolescents in direct contact with the criminal justice system (e.g. police, lawyers, and courts). However, this may not augur well with adolescents, as adolescents in this study reported discomfort and resistance to engage the criminal justice system to report SRH concerns, such as physical and sexual abuse, or pregnancy caused by an older 'consensual partner'. In addition to adolescents' resistance, a range of health workers participating in the 2010 launch of the *Protocol on Domestic Violence*[9], also discussed that health providers and families were also resistant to engaging the criminal justice system. Based on the 2008 Country Poverty Assessment conducted in Grenada, there is little evidence that the criminal justice system is engaged and/or that prosecutions occur for clear instances of statutory rape (GoG, 2008).

Policy or legislative language that is unclear may create difficulties for health and law enforcement professionals and users, and negatively affect implementation and enforcement. For example, if healthcare professionals are uncertain whether statutory rape has occurred in cases of consensual sex between heterosexual adolescent partners under age 16, then a resulting pregnancy may not be reported by the health worker who may view the adolescents as peers, compared to if the pregnancy was caused by an adult. Furthermore, health providers may be unwilling to provide services for adolescents as it may also call into question their professional ethics. While there is a need for improved enforcement of existing ASRH-related policies and legislation, it is important to ensure that policies and legislations are honouring ASRH rights and that professionals' rights are also considered. Also there is a need for the development and implementation of social policies so that the criminal justice system is not

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[9] This was one of the fora I attended during my fieldwork in Grenada.

viewed as the main or only form of intervention for certain types of ASRH concerns. Nonetheless, enforcement in the absence of mechanisms in place for monitoring and evaluation may mean that policies and legislation may not be promoting ASRH, and perpetuating a culture of inequality (e.g. gender, age and sexual identity), as discussed in section 4.2.

The finding that there is no law regarding parental consent for adolescents to access SRH care services, but rather, inconsistent unwritten policies is consistent with that of other studies in Grenada (e.g. Sealy-Burke, 2006; UNFPA, 2011). According to the UNFPA report, written policies in Grenada were not always implemented and unwritten policies were used in an *ad hoc* manner (UNFPA, 2011*).* This can be linked to what Lipsky (1980) describes as *street-level bureaucracy*. According to Lipsky (1980), health workers who should be seen as part of the "policy-making community" enforce rules and laws assigned to them to varying extents, often for their convenience rather than the service user. It is possible that in the absence of national policies, or policies that are translated into workable guidelines and procedures for practice, health professional conveniently make up policies as a means of implementing their duties in a manner consistent with their moral beliefs. However, this is not discernible from the current study, because health provider were not interviewed, suggesting a need to elicit the views of health providers regarding ASRH-related policy and services implementation. Hence, there may be a need for written policies to be created and disseminated to health workers to reduce inconsistencies in interpretation and implementation.

It is important that no organisation was found to provide specialised ASRH services, instead SRH services designed for adult were available through: 1) maternal and child health clinic in primary health care facilities, and 2) family planning clinics offered by the GPPA – the only NGO offering SRH services. However, specially designed sexuality and SRH education were available through schools and the NGO sector, but these were not ranked as main sources of help adolescents for adolescents (Table 5-2). Nonetheless, sexuality education is important for help-seeking; it can contribute to increasing knowledge about pregnancy and STI/HIV prevention strategies, including types and places of service availability in Grenada (section 7.3.2). This therefore can help to reduce delays in help-seeking linked to lack of knowledge about available services and how negative SRH outcomes may be prevented.

Apart from the media, HFLE in particular has the potential to reach and increase the largest numbers of adolescents' knowledge about SRH-related services adolescents. This is because secondary school enrolment rate in general and for those within the study's age range is about 73% and 63%, respectively (GoG, 2008). Health facilities were not found to be a main source of sexuality and SRH education for adolescents. Based on the lack of specialized ASRH services, and several organizations/programs offering ASRH information and education, it can be argued that the current service provision framework will benefit from a multi-sector and integrated approach to service delivery (Nichols *et al.,* 2012). According to the WHO (2009) despite the dearth of long-term evaluations, linking reproductive health and community needs-based livelihood interventions have potential and are more effective than didactic approaches. Therefore NGOs with a long history of development work in rural Grenadian communities (dating back to 1955 – section 4.3.1) may be able to work with the health and education sectors for ASRH promotion.

Considering the types of organizations related to ASRH, how they work together, and the lack of resources (i.e. financial, material and human), there is a need for improved collaboration through strong leadership. The findings show that the MoH has not taken a leadership role in ASRH promotion (i.e. information, education and services). This is important, because stakeholder organizations are looking to the MoH to assume leadership in spearheading and coordinating ASRH policy and services. Without strong leadership of the MoH, it is possible that ASRH promotion in Grenada will continue to be under-prioritized. However, there is hope for improvement, because in 2009 an adolescent health focal point was appointed in the MoH, a stakeholder consultation was conducted, followed by the submission of a proposal and budget to the Pan American Health Organization (PAHO) regarding the development of a *National Adolescent Health Policy* in 2010. It is possible that if ASRH is prioritized in the policy, it may prove to stakeholders that the sector is serious about ASRH and rights. Based on the current role of the MoH, there is scope for the MoH to re-orient primary health care to integrate AFS, and SRH information and education during adolescents' visit for other health concerns. However, it is possible that the NGO sector may be best suited for leadership of ASRH promotion.

8.3.2   ASRH Help-Seeking Pathways

Based on the findings in Chapter 5, a key finding pertains to the nature of SRH concerns. For example, the signs of some SRH concerns are similar to other non-SRH concerns,

and may not be linked with a SRH issue. This sometimes contributes to delaying help-seeking because the signs may not be viewed as serious. Therefore, there is a need for adolescents and helpers to be able to identify, provide and/or refer adolescents who seek help to sources that are able to help them adequately. As such, it is important for sexuality education in schools and communities to include discussions with adolescents, especially younger adolescents about the signs and symptoms of SRH matters. This is important because it can reduce delays in adolescents' identification of their SRH concerns and subsequently help-seeking caused by errors in identification of SRH concerns.

Additionally, some SRH concerns may have both a psychological as well as physical dimension. Health providers could be trained to respond to both psychological and physical dimensions of SRH concerns and refer adolescents if necessary. The findings are mixed regarding adolescents willingness to seek help based on the severity or seriousness of the concern. However some studies, such as Raviv *et al.*' (2000) quantitative study suggest that severity of a concern will influence adolescent help-seeking (Raviv *et al.,* 2000), while others, such as Tishby *et al.*' (2001) qualitative study suggest that level of distress experienced by adolescents is unrelated to their willingness to seek help. The difference may be due to different research methods and types of SRH concerns studied. However, in this study, a range of SRH concerns were discussed suggesting that the type of concern may influence help-seeking (Black *et al*. 2008). This is because adolescents were willing to seek help for pregnancy concerns and menstruation, but not for dating violence. In Jamaica and Mexico among adult populations, studies found that only around half of the victims of sexual violence told someone about the incident (Waszak *et al*., 2006; Ramos-Lira, *et al*., 2001). While 50% is fairly high, it can be argued that it may be lower among adolescents because in some cultures, help-seeking for SRH violence may not be the norm.

Another key finding regarding ASRH help-seeking pathways pertains to the importance of parents and adult relatives to adolescents' help-seeking behaviour, especially girls. In chapter 2 parents and other family members have been established as an important source of help (Namisi *et al.,* 2009; Berhane *et al.,* 2005). This study suggests that parents and other family members may be more important to ASRH help-seeking than initially assumed, because of their role as a *target and intermediary helper* for adolescent with SRH concerns. Parents as *intermediary helpers* are referred to by Logan and King (2001) as the parental pathway because of the critical role they give to parents in adolescents' mental health help-seeking.

According to Wintre and Crowley (1993 cited in Logan and King, 2001) parents or other adults are typically central in adolescents' initial identification of distress to navigating the service use, which is consistent with this study's findings. This indicates a need to understand parents' perspectives, but also to further investigate the various roles that parents play in ASRH help-seeking. Based on the above, offering parents guidance on effective ways to recognize early signs of SRH concerns (section 5.3.1) may be helpful in preventing negative outcomes.

Similar to studies in other contexts (Pearson and Makadzange, 2008; Bankole *et al*. 2007; Ackard and Neumark-Sztainer; 2001), Grenadian adolescents also utilize a mix of social network sources and professionals, but social supports networks were the most commonly used source of help among adolescents in this study. Furthermore, the diversity of helpers identified both in the experiential pathways and hypothetical scenarios indicate the importance of competent professional and social support network sources as helpers. Although, hypothetical help-seeking cannot be taken as evidence of actual help-seeking of adolescents with SRH concerns, it suggests that adolescents are at least aware of a range of potential helpers. Nonetheless, there is a need for research that explores the help-seeking behaviour of health service adolescent clients.

Gender differences were observed in the types of concerns adolescents experienced, sought help for, and the range of helpers used in the experiential pathways versus the hypothetical pathways. Although more female than male adolescents identified a need to seek help, it is uncertain whether this is indicative of true gender differences because of the inclusion of pregnant and adolescent mothers. Similar to findings by Cauce *et al.* (2002), but contrary to findings by Van der Reit and Knoetze (2004) gender did not play a significant role in patterns of mental health help-seeking and use of help-sources. Both studies found that female participants accessed professional sources while males did not report this as a preferred source of help. However, a US-based quantitative study (Ashley and Foshee, 2005), found that adolescent male perpetrators of dating violence were more likely to seek help than female perpetrators. Male victims and perpetrators in the study also used professional sources of help more frequently than female victims and perpetrators. This suggests an interaction between type of concern and gender, considering that most boys sought help for stress-related SRH concerns via identification of psychological signs, but reported seeking help from social network sources.

An interesting gender difference that was found pertains to the types of concerns male adolescent participants experienced. In contrast to female adolescent participants, male adolescent participants reported experiencing SRH concerns that were psychological in nature. This is important because it suggest that adolescent boys may be stressed out by the social expectation pertaining to sexual desire and activity. Boys' inability or unwillingness to meet those expectations may indicate a need for help. Char *et al.* (2012) have discussed this concern among adolescent boys in rural India, and Pearson and Makadzange (2008) have discussed psychological concerns regarding the SRH of men in Zimbabwe. This study suggests that psychological concerns should be viewed as an important dimension of SRH concerns, especially for boys. Therefore, stress related to ASRH should be considered when designing SRH services. Although one male adolescent reported utilizing a counsellor, adolescent boys may be unwilling to utilize professional counsellors, outside the school system considering their preference for social network sources. However, SRH services may not readily provide for the psychological dimension of ASRH care. Hughes and MacCauley (1998) argue that there is often a mismatch between ASRH needs and service provision. Therefore there is a need for SRH services to include psychological services, such as counselling in YFS. Considering that counselling is taboo in Grenada, health providers should be trained to provide basic counselling and referral service if needed.

In the current study, adolescent males generally tended to report using a single source of help regardless of the type of help they were seeking. In contrast, female adolescents reported using a single source only for some categories of SRH concerns, such as normative and problem/stress-related concerns. This suggests a need for education to change help-seeking behaviour to make it more effective, such as seeking help for serious concerns. Finding that some boys would seek out help sources until they found an appropriate helper suggest that help-seeking is important for some concerns for some boys. However, adolescent help-seeking behaviours were based on some key socio-cultural and programmatic contextual factors. These are discussed in section 8.3.3 below.

8.3.3   Factors Influencing ASRH Help-Seeking

Several contextual factors have been identified that hinder and/or facilitate ASRH help-seeking. According to Rickwood *et al.* (2005) at each stage of the help-seeking pathway, contextual factors intervene to prevent the progression of the help-seeking process. Based on the influence of contextual factors, the SRH concern may not be identified; if the SRH concern

is identified, the need for help may not be identified; if identified, the need for help may not be translated into help-seeking, or may be delayed. This section discusses the main socio-cultural and programmatic contextual factors that hinder Grenadian ASRH help-seeking.

8.3.3.1 Influence of the socio-cultural context on ASRH help-seeking

Community Social Support

The perceived lack of social support was viewed as a barrier to ASRH help-seeking. This was because of the perception that society did not approve of adolescent sexuality, especially that of girls. It was perceived that most social sectors, such as church, school, some families and adolescents viewed premarital sex as immoral based on religious and cultural values. However, adolescents described that some social sources view premarital sex as permissible, especially if the adolescent has completed secondary schooling, or is male (section 6.3). Studies have suggested that some adolescents misperceive the extent to which their parents disapprove of them engaging in sexual intercourse, underscoring the need for parents to communicate their expectations effectively (Jaccard *et al.,* 1998 cited in Jaccard *et al.,* 2002). Nonetheless, the concept of permissible premarital sex among adolescents in the Grenada context may be indicative of a cultural shift where parents are more accepting of sexuality. This may be because other important landmarks, such as educational attainment, via secondary school completion may be viewed as a marker of adulthood. While this is an important finding, it does not necessarily facilitate SRH help-seeking in the short term. Nonetheless, the dominant view of the immorality of premarital sex persists in Grenada.

Despite preference for social network sources, it was found that girls especially, felt that by using social network sources to cope with their SRH concerns, they risked losing the respect and trust of their network members and society, therefore, putting strain on social relationships. Taylor *et al.* (2004) found that in collectivist cultural contexts, individual goals may be seen as promoting relationships; therefore, pursuing the goal of the self may risk straining relationships if one calls on his or her social support networks (Markus *et al.,* 1997 cited in Taylor *et al.,* 2004). Although Grenada may best be described as transitioning from a collectivist to an individualist culture, it is still largely collectivist. As such, adolescents may feel that they have less to gain personally than they have to lose socially by seeking help from their social network. However, more social support for boys' sexuality and sexual activity due to gender norms does not necessarily facilitate help-seeking among boys. This is so interpreted

due to the contradictory sexuality expectation from sub-groups of social sources (section 6.3). Alternatively, both male and female adolescents reported the belief that they could deal with a range of SRH concerns on their own, which can be interpreted as adolescents demonstrating high self-efficacy[10], or a strategy for avoiding the judgement of society (i.e. stigma – section 6.4). Although male adolescent participants did not perceive that help-seeking was socially acceptable, some adolescent boys reported seeking advice from family members about sexual activity because they were aware that their family held more liberal views on sexual activity (section 6.2). Hence there was less risk of straining social relations.

Social support is described as one of the resources arising from social capital within a community that create family and social organization, and is developed in relationship to and with others (Swann and Morgan, 2002). Although adolescents' reported mixed feeling about whether they liked living in their community, family was the consistent positive. A consistent negative was the lack of trust because of gossiping and the negative perception some adults had about adolescents, and few opportunities for community participation because of the lack of community resources (section 6.3). Therefore, there is a need to develop social capital with communities by helping adult community members to develop a more positive outlook toward adolescents in the community and curbing the culture of gossiping. However, this may be unrealistic or at least too difficult to achieve in the short-term. Therefore, it might be necessary to develop community social resources by initiating community activities to allow more positive interactions between adults and adolescents in an effort to build social capital.

Sexuality and SRH Communication

Based on the findings in section 6.2, intergenerational communication about sexuality and SRH in Grenada is taboo. It is so entrenched into the social fibre that even when adolescents and parents enjoy good and close relationships with each other, it may still be difficult for one or both to talk about sexuality topics. Harris-Hastick and Modeste-Curwen (2002) also noted the culture of sexuality silence in Grenada, and also Trinidad. Similar to the current study, Langhaug *et al.* (2003) posited that parents and nurses in rural Zimbabwe believed that talking about sex will encourage sexual activity, which serves to reinforce sexuality silence. In the developed country context of Ireland, Hyde *et al.* (2010) found that although parents prided themselves on the culture of openness to sexuality, little sexuality communication actually occurred. However, the authors reported that the main barrier was

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[10] One's belief in their ability to achieve desired outcomes in the face of challenges and demands

adolescents' reticence to engage in sexuality communication with parents. Similarly, in a US-based study, Phular and Kurilof (2004) found that more daughters expressed discomfort related to sexuality communication than did mothers. Unlike the current study, Hyde *et al.* (2010) interviewed parents rather than adolescents, and Phular and Kurilof (2004) interviewed both adolescent girls and their mothers. Despite the limited transferability based on the context, together these studies show that both adolescents and parents are uncomfortable talking about sexuality concerns. Hence, there is a need to improve comfort with sexuality communication by teaching both parents and adolescents sexuality communication skills to improve sexuality information and advice-giving. There is also a need to elicit parents' views about sexuality communication and understand the dynamics to influence parent-adolescent communication interventions.

Mothers were found to communicate messages about condom use and the consequences of sexual activity ineffectively (i.e. a rough manner) during help-seeking or parent-initiated communication. This may be because parents lack the skills, or do not see the need to communicate with adolescents about SRH topics. Hyde *et al.* (2010) note that there is no consensus about whether parent-adolescent sexuality communication brings positive results in terms of sexual health. In the USA, Rosenthal and Feldman (1999) found that most high-schoolers in their cross-sectional survey were of the perception that parental communication was insufficient, as well as unimportant. However, according to Phular and Kurilof (2004), parent-adolescent communication at an early age, especially about sexuality helps with developing close parent-adolescent relationship and reduces the discomfort in sexuality communication. In regards to mental health help-seeking, Logan and King (2001) cites Seiffge-Krenke (1998) who suggests that positive communication between parents and adolescents may enhance parents ability to recognize their adolescents' problems. Schonert-Reichl and Muller (1996) suggests that poor parent-adolescent communication is less likely to result in the utilization of professional services in times of difficulty. Therefore, positive parent-adolescent communication may serve as a modelling function for adolescents, leading to adolescents' increased receptivity to communication with and accepting help from other adults, including professionals. Considering that mental health is a sensitive health issues for adolescents and an outcome of ASRH issues, one can hope that positive parent-adolescent communication may have similar results in ASRH help-seeking; however, this is an area for further research.

Blake *et al.* (2001) found that school sex-education homework assignments designed to be completed by both parents and adolescents enhanced parent-adolescent communication. However, Jaccard *et al.* (2002) point out that the intervention should help parents to become more effective communicators as opposed to simply encouraging parents to talk about sexual issues with their adolescent son/daughter. It may be feasible to incorporate this strategy into the NPP and HFLE in Grenada to reach a range of adolescents and parents.

Social Stigma

Stigma is discussed as a major barrier to and resulting from ASRH help-seeking, especially for condom, pregnancy, STI/HIV and abortion in Grenada (section 6.4), which is consistent with other studies (Meekers *et al.,* 2001; Atuyambe *et al.,* 2009). In this study, stigma related to SRH is gendered, and has been reported elsewhere (Wood and Aggleton, 2002). The evidence suggests that for female adolescents, stigma is greatest around help-seeking for SRH concerns that are considered to be highly taboo. Male and female adolescents reported feeling that they had to hide some types of SRH concerns (e.g. incurable STIs/HIV, pregnancy and physical abuse) because of stigma. According to Wood and Aggleton (2002), stigma results in secrecy and shame. In Grenada, secrecy was important because rumours were spread about adolescents. However, few adolescents discussed feeling ashamed about the concern.

In this study, experiences of stigma were most commonly reported among adolescent mothers. This is because a pregnant outcome is one of the easiest ways of knowing that an adolescent has engaged in sexual activity, which is against the social code for a '*good girl*' (section 6.3). In a US study involving low-income adolescents mothers (n=925), 39% of adolescent mothers identified as feeling stigmatized by their pregnancy. Adolescent mothers were surveyed within 48 hours of giving birth in a university hospital (Weimann *et al.,* 2005). Similar to this study, adolescent mothers reported experiencing stigma because others believed that they were too young and needed to focus on their educational attainment (Weimann *et al*. 2005). However, being enrolled in secondary school or PAM during pregnancy also carried stigma (section 6.4), suggesting that in Grenada, pregnant adolescents' right to education is not respected despite a policy on the matter. Nonetheless, for the pregnant and adolescent mothers in this study, education remained an important goal after pregnancy. Attending PAM provided pregnant and adolescent mothers with peer and institutional support, and an opportunity to achieve their goals in life. This is interpreted to mean that schooling during pregnancy is an important form of support for adolescents that have

experienced early pregnancy. Considering the loneliness caused by early pregnancy, help-seeking to access education during that period may be important.

Consistent with findings in this thesis, Langhuag *et al.* (2003, p.151) point out, "if ones goes about inquiring about a certain disease, like STI or reproductive health [sic] the nurses are quick to label you and suspect you have that disease or are pregnant." Therefore, it is possible that because of stigma, male adolescent participants sought information and advice from outside the health care system prior to determining if there is a need to seek health services (section 5.3.3.1). Additionally, using the hypothetical scenarios, some adolescent boys were unwilling to return to the health centre for their HIV test result; because "the thought of being HIV positive is sufficient to kill" them. This suggests a need for more education (e.g. via school and community outreach) about HIV testing and treatment targeted at male adolescents, and a need to reduce HIV related stigma. A rapid HIV-testing system may be needed so that HIV test results can be obtained during the same visit during which testing is conducted. The rapid HIV testing method received strong support among youth receiving HIV testing in an adolescent clinic in the US, based on the results of a quantitative survey (Tuysuzoglu *et al*. 2011). It is also feasible, cost-effective, and accurate in low-resources settings with high HIV-prevalence (Wilkinson *et al*. 1997). Although Grenada is considered a low HIV-prevalence setting (see section 1.3), there is a need to determine the usefulness of the rapid HIV test among adolescents in Grenada.

It was also found that adolescents may be stigmatized based on the community in which they live. However, there is insufficient evidence as to whether negative attitudes toward the community by outsiders, affected ASRH help-seeking, considering that rural participants reported that their community was viewed negatively and marginalized by others. This was because of the community's history of violence and low education status. Wood and Aggleton, (2002) reported a similar view. It can therefore be assumed that help-seeking for SRH concerns may serve to reinforce negative beliefs about the community. While there is evidence in this study suggesting that negative attitudes between adolescents and community members reduce social capital and help-seeking from community members, it is possible that community expectations of some groups of adolescents, including boys and some girls may facilitate their help-seeking. For example, compared to '*good girls*',' *bad girls*' may not be hindered from purchasing condoms because they already have a negative reputation in the community. However, '*bad girls*' who want to repair their reputation may choose not to access

condoms because it may confirm that the reputation is deserved. While this suggests a need for more discreet and accessible condom outlet, this is an area for further research.

Gender-Power

This thesis clearly highlights that the imbalance of power in heterosexual relationships involving adolescents inhibit girls' ability to identify their SRH concerns, need for help and help-seeking. This finding adds to the help-seeking literature in that previous studies have primarily reported on gender differences, and less about how power dynamics as a result of gender affect help-seeking behaviour. Studies have shown that gender socialization may influence a man to behave in controlling and aggressive ways, and a woman to think that she should be submissive and self-sacrificing (Ocampo *et al.,* 2007; Contreras, 2010). According to Connell (2005), the main axis of power in patriarchy is the overall subordination of women and dominance of men. Although there are multiple constructions of masculinities and femininities which are not static, hegemonic masculinity occupies the dominant position in a given pattern of gender relations (Connell and Messerschmidt, 2005). Throughout history and in contemporary society, hegemonic masculinity continues to be sustained and reproduced by using various mechanisms to police men/boys and exclude or discredit women/girls (Connell and Messerschmidt, 2005). In this thesis, this is exemplified in society's perception of boys as weak for seeking help and discrediting girls who 'stand up for themselves'.

In reference to adults Blanc (2001) posits that gender-based power is "linked to sexual and reproductive health in three main ways: (1) directly; (2) through its relationship with violence between partners; and (3) its influence on the use of health services" (p.190). These were observed in the findings in this thesis; however, the former two were more clearly explicated in the findings. According to Blanc (2001), gender-based power directly affects subordinated partners' acquisition of relevant SRH information, ability to make health related decisions and to take action to protect or improve their health. In this thesis where adolescents perceived that because of the power that some boys/men have in relationships with girls they were unable to take health promoting actions, such as, use condoms to prevent pregnancy even when they identified a need for such actions.

According to Blanc (2001 p.190), "power relations have a clear causal link with violence and the threat of violence within sexual relationships, and violence, in turn, influences health." Among adults, Ocampo *et al.* (2007) note that Hispanic women who experience intimate

partner violence may feel they have little recourse, because of gender socialization. Similar to findings in this study, among adolescents in South Africa, MacPhail and Campbell (2001) reported that male participants discussed lying about condom use, and punishing girls who had too many sexual partners by beating them to teach them a lesson, as expressions of male dominance. As such, imbalances in power can reduce female adolescents' voice for help-seeking for condoms and dating violence, in particular. Forced unprotected sex and forced reproduction have serious negative consequences for girls and women, including unwanted child bearing and STIs (Miller *et al.*, 2010). In Grenada, apart from seeking legal recourse, help-seeking for legal abortion is restricted (section 4.2.3); therefore, women and girls who become pregnant as a result of rape may have to carry their pregnancies to full term or seek unsafe abortions. There is a need to address gender-power relations in Grenada by teaching respect for partners and ensure that by enforcing SRH health-related laws, professionals are not perpetuating a culture of gender inequality (section 8.3.1).

A noteworthy finding is that help-seeking for sexual violence is delayed or hindered when the perpetrator is a family member or someone close to the adolescent. According to Contreras *et al.* (2010), child sexual abuse is typically perpetrated by an adult or someone older than the child who uses their position of power to coerce the child into sexual activity. However, most perpetrators are known to victims; they are frequently trusted caregivers (e.g. fathers, stepfathers, relatives, friends, neighbours) who take advantage of their dominant position (Jewkes *et al.*, 2002). This is important considering high levels of sexual coercion reported among Grenadian adolescents (Table 1-2) and Caribbean adolescents in general (Halcon *et al.* 2003). For example, the 2002 Jamaica Reproductive Health Survey found that 20% of women aged 15-19 reported having ever been forced to have sexual intercourse (Waszak *et al.* 2006). This suggests a need for children and adolescents in the Caribbean Region to be more knowledgeable about what constitutes sexual abuse and to be more aware of systems in place for reporting and dealing with the outcomes.

Although, the complex relationship between poverty, gender relations and help-seeking was not specifically explored in this study, its discussion in reference to adolescent sexual behaviour is noteworthy. While this is a possible area for future research, it can be inferred from findings such as 17-year old Linda's concerns about a place to stay if she reported being sexually abused by her stepfather. This finding suggests that in situations of such economic dependence, it may be difficult for adolescents to practice healthy sexuality, including

initiation of help-seeking when a need has been identified. Therefore, there is a need for support services to provide basic needs for adolescent victims and their families. Overall, there is a need for more research on gender-power relations on adolescent SRH help-seeking behaviour. According to Blanc (2001 p.190), "services can have an important mediating effect on outcomes depending on whether they address the influence of power", and points out that "services that ignore power relations or reinforce imbalances can contribute to worsening women's abilities to promote their health." In the Grenada context, the evidence from this study suggests that gender-power in policy and health services provision is primarily addressed in relation to sexual violence, neglecting issues pertaining to the development of healthy ASRH relationships.

It is likely that gender-power imbalances in adolescent sexual relationships mimic that of adult sexual relationships because these are all socially constructed, and sexuality and sexuality communication, including for adolescents, is viewed as the domain of men and boys. Although sexuality communication occurs inter-generationally and generationally among women/girls, the timing and content of such conversations (section 6.2) may not occur in a manner to counteract the effects of gender-power expressed through partner communication.

The evidence in this thesis also shows that some male and female adolescents in Grenada may be challenging negative constructions and portrayal of hegemonic masculinity. While hegemonic masculinity in Grenada has its roots in the Island and Region's history of colonialism (Lewis, 2003), challenges from segments of contemporary adolescents bode well for the future of gender relations. This may be because of the increasing levels of female education, and the growing importance of global forces like globalization and westernization, which may negatively affect other aspects of Grenadian culture.

This thesis is moving the debate regarding gender-power and sexuality forward by highlighting that similar gender-power dynamics may be involved in sexual relationships involving adolescent partners or an adolescent and adult partner. While this thesis did not differentiate between these two types of sexual relationships, it is possible that the gender-power dynamic may be similar, unless the relationship pair includes an adult female and adolescent male. This may be because men and boy are typically in a more powerful position. This thesis therefore helps to highlight perceptions about gender-power in adolescent sexual relationships and SRH, and points to the importance of ASRH services addressing issues of gender-power to improve

girls' ability to acquire information and act in ways that promote SRH. The perception that some female adolescents may be unable to identify their SRH concern if it has not been previously identified by their male partner is worrying and warrants further inquiry and intervention.

8.3.3.2 Influence of the programmatic context on ASRH help-seeking

Provider Attitude and Behaviour, Confidentiality, and Parental Consent

Professionals' attitude and behaviour, confidentiality, and parental consent affected providers' interaction with adolescents affecting their help-seeking behaviour. This is consistent with several studies regarding seeking health services discussed in section 2.4.3 (Langhuag *et al.,* 2003; Atuyambe *et al.,* 2009; Berhane *et al.,* 2005; Meekers *et al.,* 2001). Despite their designation as professionals, health providers and teachers in this study were perceived by participants to experience difficulty with interacting with adolescents regarding SRH concerns. In their qualitative study among South African adolescents and nurses, Wood and Jewkes (2006) discussed that seeking contraception was tantamount to a public admission of sexual activity, which was "a scandal for nurses to know" so they felt obligated to provide lectures even if doing so was a barrier to service access. In this study, negative provider attitude and behaviour can be viewed as organizational norms. Considering the absence of an AFS culture, propagated by the lack of an Adolescent Health policy or ASRH policy and requisite AFS training, the organizational culture is perceived to be one based on social norms. This also relates to the discussion in section 8.3.1 of Lipsky's (1980) concept of *street level bureaucracy.* However, the findings indicate a need to develop an AFS culture (WHO, 2002; Senderowitz, 1999). This can be done by developing training for service providers based on the desirable characteristics adolescents identified in Figure 7-3 (e.g. being respectful, advising adolescents to be safe, and being calm and warm), in addition to strategies offered by the WHO (2002) and Senderowitz (1999).

The issue of professionals' lack of confidentiality with regards to ASRH help-seeking is an important finding and may be particularly so because of the small size of Grenada. Several studies support the finding that confidentiality is of utmost importance in help-seeking (Wilson and Deane, 2001; Barker, 2007; Ginsberg *et al.,* 1995, Langhuag *et al.,* 2003, Agampodi *et al.,* 2010; Thrall *et al.,* 2000; Britto *et al.,* 2010). Despite the convention of the rights of the child, in

the Grenadian social context, children and adolescents are yet to be viewed as beings with rights, especially sexual and reproductive health rights. Therefore, the line between professional and social responsibility regarding adolescents may be blurred. In this study, the lack of confidentiality was not only related to parental notification regarding use of SRH services, but generally health providers disclosing adolescents help-seeking to their friends. This can be linked to the gossiping participants discussed in the social-cultural context.

Although both boys and girls in this thesis had concerns about confidentiality, the evidence suggests that girls were more concerned about confidentiality than boys. This may be due to stigma related to help-seeking that mainly affect girls, boys' limited use of professional helpers and health providers' willingness to offer SRH services to boys. Other studies reporting on confidentiality have not reported on gender difference (e.g. Langhuag *et al.,* 2003). Contrary to Ford *et al.* (1997), but consistent with Thrall *et al.* (2000) the findings in this thesis suggest that receiving explicit confidentiality assurance from health providers may not be sufficient to improve disclosure and help-seeking. This is because many adolescents hear rumours about the experience of other adolescents, but also because the communities are small. However, Britto *et al.* (2010) suggest that providers explaining and negotiating their rationale and method for disclosing sensitive information to parents may make adolescents feel less violated. The above suggests a need for informed consent policy and practices regarding service provision for adolescents. Considering adolescent mother Sherry's renewed trust in the confidentiality of facilities after the staff who reported breached her confidentiality was disciplined, suggest that confidentiality guideline with consequences for health professionals should be made known to adolescents if available.

Availability and Knowledge of SRH services

There were mixed findings about whether there are sufficient sources of help that adolescents could use for SRH concerns. This may be due to the inclusion of urban and rural adolescents and the range of SRH concerns discussed. However, Barker *et al.* (2005 p.323) note that "in developing countries, formal public health and other social services for young people may be lacking." This is consistent with the services available for ASRH-related concerns in Grenada (section 4.3). Schools were not viewed as a major source of help-seeking, and while the HFLE curriculum includes lessons on help-seeking it is unclear what sources of help are promoted. Based on key informant interviews and a review of the HFLE curriculum, it appears that HFLE teachers are responsible for populating the guide with help-sources.

However not all teachers may be aware or sufficiently motivated to inquire about relevant sources of help for their students. Therefore, suggesting a need for a more general *ASRH Help-Seeking Resource Guide* as the one used in this study (Appendix G), so that schools can refer adolescents for services regarding SRH concerns. Furthermore, including help-seeking resources in the HFLE module for younger adolescents may contribute to establishing help-seeking as acceptable.

In section 2.4.3, Char *et al.* (2011) were reported as stating that lack of knowledge about available services may be due to lack of marketing about available services. In Nigeria mass media campaigns which included educational messages led to a significant increase in the number of new adolescent clients accessing family planning clinics (Piotrow *et al*. 1990). However, utilizing the media on a large scale in Grenada may not be feasible, due to the high financial cost to utilizing the media (section 4.4.1). However, television and radio advertisements were observed targeting young people regarding getting tested for HIV and accessing condom (i.e. *"Got it? Get it?"* - see section 7.3.2). This suggests that there is a need to publicize help-seeking for other SRH concerns that adolescents may have, including for puberty issues (e.g. menstruation, dating and romantic relations, sexual desires and so on - section 5.2). According to the WHO (2009) adolescents' knowledge from a range of sources about the availability of SRH services is important to generate demand for services, and information should include details about the time and place of services, and information to allay adolescents' anxieties about service utilization. Although use of new media, such as social networking and mobile phone texting may be less expensive media sources, more research is needed about their effectiveness (WHO, 2009).

An important finding was adolescents' suggestions for the type of helpers needed at the community, which were youth groups, sports clubs, and health providers who were not residents of their community, rather than for more health services. The first two are linked to increasing social capital, while the latter address lack of confidentiality. One advantage of the building social capital is that it is a means of targeting both in- and out-of-school adolescents, and offers the opportunity for a potential collaboration between the Ministry of Health and the Ministry of Youth Empowerment and Sports. However, the WHO (2009) notes that although youth centres, sporting events, and the media reaches large numbers of people, the evidence that these encourage SRH service utilization is poor. Disadvantages have been reported, such as those using the youth centres tend to be older than the age of the target

group and often female; and the high cost to maintain youth centres not being justified compared to the costs of supporting outreach/peer promotion interventions (Erulkar and Mensch, 1997; FHI/YouthNet, 2002 cited in WHO, 2009). The feasibility of utilizing such an approach in Grenada should be further investigated.

Distance

The distance between where adolescents live and where health services are located did not prove to be a barrier to adolescents getting to the health facility. This is because health centres were located in nearby communities that were within walking distance or a short bus ride from the research communities. Although this finding is contrary to some studies (Miles *et al.,* 2001; Kiapi-Iwa and Hart, 2004; Atuyambe *et al.,* 2009), it is consistent with other studies (Kumi-Kyereme *et al.,* 2007; Biddlecom *et al.,* 2007) as discussed in section 2.4.3. The 2008 Country Poverty Assessment (CPA) conducted in Grenada, stated that the main reason for respondents' "first place visited for medical attention", which was mainly the health centre (37%), followed by private doctor/dentist (27%), is because of its "closeness to home" (14.1%) (GoG, 2008). Although the above suggests that distance to access health facilities is not a barrier for most communities, it may still be a barrier for some adolescents, especially those who reside in the rural mountainous interior of the island, and not included in this study. This suggests that alternative mode of health service delivery should be explored. For example, a mobile clinic or roving community health workers or peer educators, similar to the Roving caregivers Program that conducts informal early childhood education to children in several rural communities in Grenada may be feasible.

An impact evaluation of the effectiveness of *the Bashy Bus*[11] mobile clinic in Jamaica, indicated that within two years adolescents awareness and utilisation of professional helpers increased, in addition to higher ability to seek help from family members and friends (Tindigarukayo, 2012). In 2009, *the Bashy Bus* mobile clinic had reportedly reached 50, 402 individual (37,732 adolescents/children; 12, 670 adults) (Children First, 2012). A study in Kenya (Grabbe *et al.,* 2010) assessing the utilisation and cost-effectiveness of stand-alone and mobile clinics for HIV

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[11] *The Bashy Bus* is a mobile reproductive health clinic that has been providing HIV/AIDS/STI information, skill-based counselling and services to vulnerable adolescents in Jamaica since 2006. The bus travels to rural and inner-city communities, making stops at popular "hang-out" spots frequented by hard-to-reach adolescents. There is also a facility on the bus to provide confidential HIV testing and counseling by a trained health professional. In general services are provided by a team of doctors, counselors and peer educators trained in YFS.

counselling and testing found that more clients attended the mobile clinic (76%), and the cost was also cheaper for the mobile clinic compared to the stand-alone clinic (US $14.91 vs $26.75). The above suggests mobile clinics as a cost-effective method that may reach large numbers of adolescents and adults, especially rural young people and those at higher risk for negative SRH behaviours for SRH services.

Financial cost

Financial cost of care was reported as delaying and preventing help-seeking only for private health services; this is because public health care is free. Although there may be fees related to purchasing treatment and diagnostic tests from public health services, it was not mentioned by participants. This may be because fees are only necessary when medication cannot be procured from the public pharmacies and diagnostic tests have to be obtained directly from the hospital. However, the fact that some adolescents refuse to seek help from public health services despite it being free (section 7.3.5) is an important and worrying finding. This is because some adolescents are refusing to use services they are aware that is available and affordable, which is consistent to findings from Meuwissen *et al.* (2006) as discussed in section 2.4.3. This phenomenon may be explained by using the concept of help-negation, which has been used in mental health research to describe not utilizing available help when it is needed (Rickwood *et al*. 2005).

Evidence indicating that adolescents prefer to delay help-seeking from private services until they can afford the financial cost or forgo help-seeking altogether suggests that there is room to improve help-seeking from private providers if the cost is reduced. However, a voucher program, such as the one discussed by Meuwissen *et al.* (2006) may not be particularly useful for adolescents in Grenada considering adolescents' preference for private health services. In contrast linking public and private health services for adolescents via a referral-voucher program may help to increase public health service utilisation. What is noteworthy is the interrelatedness of components of service delivery to achieve AFS. The greater onus seems to be to reduce the barriers (e.g. confidentiality; see chapter 6) in the public health system that appears to be more important than the cost of the service. In section 2.4.3, some authors (Miles *et al.,* 2001; Atuyambe *et al*. 2006) discussed that adolescents use alternative sources of help that may be more expensive when cheaper help-sources lack confidentiality or may be judgemental or embarrassing. This resonates with the findings in this study, as discussed

above. However, adolescents may also use other sources that may not have a financial cost, such as drinking herbal remedies or bathing in the boiling spring as discussed in Table 5-2.

8.4   Revisiting the Conceptual Framework

The original conceptual framework presented in Figure 2-5 proved to be a useful tool to guide data collection. However, based on the findings of the thesis, it became clear that the conceptual framework could be amended, particularly the components pertaining to adolescents' help-seeking pathways. The original conceptual framework is defined as an ecological help-seeking model based on the adolescent help-seeking literature review of Barker *et al.* (2005), and the ecological theory and principles of Bronfenbrenner (1979) and Sallis and Owen (1997). The amendments reflect the findings of this thesis with adolescents in Grenada. The revised ecological help-seeking framework for ASRH is presented in Figure 8-1.

First, the help-seeking pathway is amended to better reflect the four stages in Grenadian ASRH help-seeking behaviour. The following is a discussion of the changes made to the pathway, in addition to how the theoretical models discussed in section 2.6 relate to the results and may be modified in light of the results.

a)   *Categories of SRH help-seeking concern* and *types of help* are omitted from the amended framework because they are not stages of help-seeking; rather they are concepts that help to understand the multidimensional nature of SRH concerns and the types of help needed. However, these concepts were useful to guide data gathering and analysis, and showed that the *categories of SRH help-seeking concern* are interrelated as concerns may be multidimensional. For example, menstruation which is categorized as a type of *normative* concern because it is a normal part of adolescence can also be categorized as be a type of *stress-related concern,* because adolescents experience fear, pain and discomfort during menarche and menstruation. The literature review by Barker *et al.* (2005) did not capture this important interrelationship between categories of concerns. Nonetheless, it is important to make this relationship explicit, because it can directly affect how the SRH needs of adolescents seeking help are assessed and addressed. More generally, it may influence the types of services categorised as ASRH services.

Figure 8-1 Revised ecological help-seeking framework

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Legal & Policy Context

Socio-Cultural Context

Health services

Health Education

Programmatic

Cultural norms

Criminal Justice

Social Services

Acceptability of ASRH services

Social support

Adolescent Help-Seeking

Identification of SRH concern	**Identification of need for help**
Physical signs	Threat to goals
Psychological signs	Lack of Knowledge about SRH concern
Superstitious signs	Coping styles

Confidentiality

Sexuality communication

Attitude& behaviour

Media

No help-seeking

Privacy

Social stigma

Accessibility of ASRH services

Gender-power relations

Intermediary help source

Religion

Availability

Knowledge of SRH services

Seeking and Accessing SRH Help

Social network sources	Professional sources

Distance to access SRH services

Parental consent

Cost of SRH

Evaluation of help help-seeking and restarting the cycle

Future help-seeking for self & others

b) *Identification of SRH concern:* In the revised help-seeking pathway, the determinants of adolescents' identification of their SRH concern reflects the finding that through the manifestation of *physical, psychological* and *superstitious signs*, adolescents or an adult may identify the adolescent's SRH concern. The use of signs in this thesis rather than symptoms, as used by Pearson and Makadzange (2008), is an attempt to move away from a biomedical discourse. The concept of signs helps us to view adolescents' SRH concerns as being more than about disease/illness conditions. In Pearson and Makadzange's (2008) model, the source of help was based on the perceived cause of symptoms (i.e. natural or supernatural); however, this was not observed among adolescents in Grenada. The broken lines represent that adolescents may experience different types of signs for their SRH concern. However, what is not shown in Figure 8-1 is the role that adults play in this early stage of the pathway. Future help-seeking research with adolescents should take this into account as it can affect the timeliness of help-seeking.

c) *Identification of the need for help:* In the original conceptual framework, identification of the need to seek help was not explicitly included. However, based on the findings adolescents clearly go through a stage of identifying their need for help after the SRH concern is identified. The need for help was sometimes identified by an adult and not always the adolescent, and is represented in the box labelled *Intermediary help source* in Figure 8-1. The key determinants to identification of the need for help for SRH concern included: *threat to goals, lack of knowledge, and the adolescents' coping style,* which are individual factors*.* In section 2.6, it was suggested that there may be a need for more ecological concepts to account for adolescents' identification of their need for help, rather than conceptualization that reflect cognitive theories and models, as used by Barker *et al.* (2005). However, the findings of this thesis reinforce the view shared by Grzywacz and Fuqua (2000) that emphasis on the environment should not negate the role that individual play in their health (i.e. agency). Adolescents in this thesis were found to make decisions about their need for help based on whether they were successful in dealing with their problem alone or the likely impact they perceived the problem may have on their lives. However, like the rest of the help-seeking pathway, the individual-level determinants in stage two of adolescents' help-seeking pathway are affected by the socio-cultural and programmatic contexts. For example, it

is assumed that the socio-cultural and programmatic context will affect help-seeking based on the perception of threat to the adolescent's goals.

Second, within each level of context the specific factors that influence ASRH help-seeking in Grenada are highlighted in addition to the broad categories used in Figure 2-5. The findings in this study is consistent with the principles of ecological theories (section 2.6.3), including the interrelationship between and within context. The role of religion or religious affiliation did not emerge as a key socio-cultural influence on ASRH help-seeking behaviour, although it clearly influenced a male adolescent participant's decision to remain sexually abstinent and to seek help to ensure sexual abstinence amidst peer and partner pressure to engage in sexual activity. Based on this finding, there is a need to further investigate the role of religion and religious affiliation in ASRH help-seeking behaviour. The specific way in which the contextual factors interact shows that help-seeking is a complex process, contributing to the difficultly at times in separating the socio-cultural influence from the programmatic influence.

Third, despite the focus on contextual factors, adolescents in this research are also viewed as having the capacity (i.e. agency) to involve in some rationale decision-making. However, due to the manner in which behaviour and expectations are socially constructed, adolescents' exercise of their agency in SRH help-seeking decision-making may get lost in the melange of contexts. Therefore concepts, such as *susceptibility, severity, barriers and self-efficacy* used in the HBM and TRA/TPB can be useful in an ecological help-seeking model.

8.5   What are the Solutions to Address ASRH Help-Seeking?

The findings of this study have raised awareness of the experiences and perceptions of adolescents in Grenada regarding coping with SRH concerns. It also provided a framework to understand the contextual influences on adolescent help-seeking behaviour. According to Bankole and Malarcher (2010), policies and programs are needed that reflect the realities of adolescents' lives and meet their SRH needs comprehensively and urgently. Based on the implications of the findings, this section provides recommendations for public health practice in the areas of policy, programs and services, and research. However, recommendations are not proposed in specific, time-bound, measureable terms because of my position as the researcher in relations to the health system. It is hoped that through a dissemination meeting of the findings in Grenada to relevant stakeholder, including adolescents and regional donors,

the specificity of the recommendations will be addressed. Notwithstanding, the following recommendations takes into account participants' recommendations, best practices in the field regarding help-seeking, and their feasibility for the Grenada context.

8.5.1   Recommendations for Policy

The policy recommendations address gaps identified in the existing policy, legislative and service framework related to ASRH. The following recommendations are targeted toward planners and policy makers in the health and education sector, NGOs, and donor agencies.

a) Considering the lack of a single coherent policy on ASRH, and plans to develop a *National Adolescent Health Policy,* it is therefore recommended that ASRH is included as a priority area in the *National Adolescent Health Policy.*

   i.   The six key processes for developing health policy as recommended by the WHO (2001) should be conducted: a) collect information; b) develop consensus; c) obtain political support; d) implement pilot projects; e) review; and f) solicit international support and input.

   ii. While addressing local needs, the strategies for ASRH should also take into account the goals of international and regional conventions, (e.g. ICPD 1994, CRC, MDG, and PAHO Regional Strategy for Improving Adolescent Health).

   iii. The policy development process should involve a cross-section of stakeholders, including adolescents to ensure that the policy is reflective of their perspective, communities, national, regional and international stakeholders

   iv. Based on incomplete policy development and implementation processes identified in this study, the MoH should ensure that the *National Adolescent Health Policy* is completed so that relevant sectors related to ASRH can operationalize the policy into a functional working document to guide implementation of ASRH education, programs and services.

   v.   ASRH should be address in the Policy through multisector collaboration and integration to promote an AFS culture.

b) Consider reviewing and updating existing ASRH-related policies and legislations. This will help to ensure that adolescents have fair protection under the law, and that they are not discriminated against because of age, gender or sexual orientation. The

findings of this study could be used as a starting point to identify some areas to discuss and review. While this can be seen as a long-term objective, short-term priorities could include the *"Age of Sexual Consent/Statutory Rape"* law and the *"Education Policy on Pregnant Students"*.

c) Considering that there is the perception among some adolescents and stakeholders that adolescents under a certain age (age 16 or 18) require parental consent to access SRH services, this issue should be clarified. It is recommended that if such a requirement exists, parental consent should be required for adolescents under age 16 to be consistent with the age of sexual consent and the average age of secondary school completion. This will help to ensure a level of consistency across policies, which will reduce uncertainty in implementation. However, setting the age limit at 18-years to be consistent with the age of majority could hinder access to SRH services, while not reducing sexual activity or negative SRH outcomes.

   i.   Additionally, the Gillick competency test and the Fraser Guidelines used in the UK and some other Commonwealth countries to determine whether a child age 16 or younger is able to consent for his or her own SRH care treatment without parental consent could be adapted and utilized as a policy to supplement parental consent requirement.

   ii. It should also be clearly stated how parental consent is to be provided. For example, is it adequate to provide written consent from a parent or guardian, or do the parent/guardian have to be present with the adolescent at the health facility?

d) It is possible that a confidentiality policy for SRH services in general exists, considering that an adolescent participant discussed a health centre staff being disciplined for breaching confidentiality regarding her being pregnant. However, consideration should be given to developing explicit confidentiality guidelines pertaining to ASRH services from professionals, including teachers, counsellors, social workers, pharmacists, nurses, doctors and other health professional.

   i.   Based on the findings in this study, consideration should be given regarding acceptable grounds for disclosure of adolescents' private information, including test results and purpose of visit to parents or other family members and other professionals. It is advised that the guidelines should clearly state

that any third party disclosure must first be requested, negotiated and/or explained to the adolescent.

e) Written policies and legislations should be available and accessible to professionals and lay people, including adolescents and parents.

   i. For professionals, dissemination could be included as part of in-service training or professional development sessions. For adolescents, dissemination could be integrated into the HFLE curriculum, posters at schools, public and private health facilities, NGOs offices, and via the media.

8.5.2 Recommendations for Programs and Services

Several issues identified in this research, if addressed, could contribute toward creating a supportive environment (socio-cultural and programmatic contexts) for ASRH help-seeking. The following recommendations for ASRH programs and services are targeted to the health, education, social services and NGO sectors:

a) A multisector effort should be made to mobilize communities to change community and social norms regarding adolescent sexuality and SRH help-seeking. Based on the findings in this study, some of the specific areas that could be addressed include parent-adolescent communication, stigma and issues of gender-power that negatively affect ASRH help-seeking.

   i. NGOs should play a leadership role in community initiatives, as the NGOs in Grenada are strong advocates for marginalized groups and issues, and are more directly involved in working with communities than is the Government sector. Considering that key informants discussed financial and human resources as a barrier to effectively addressing ASRH concerns, it is suggested that NGOs incorporate ASRH programming, especially related to out-of-school adolescents and adults into their regular community development program. The MOE could collaborate with the NGOs to adapt and implement the HFLE curriculum in community settings. This would help the MoE to achieve its mission for the HFLE program.

   ii. Additionally, the Ministry of Social Development can engage parents and adolescents through the National Parenting Program regarding sexuality communication, and develop a module on parent-adolescent sexuality

communication, making parents aware of some of the strategies adolescent may use when they have a SRH issue they want to talk about, and how to navigate those 'difficult' discussions.

    iii. Donor agencies, such as UNICEF and UN Women Caribbean Office could provide technical and financial assistance to develop and test the curriculum material related to ASRH help-seeking.

b) Considering the professionals' negative attitude and behaviour during ASRH help-seeking, professionals including health workers, schools guidance counsellors, HFLE Team Leaders, and law enforcement officers should be trained to provide AFS.

    i. Training modules could incorporate the desirable characteristics of a helper for ASRH concerns (e.g. being respectful, calm and warm, won't embarrass them – Figure 7-3) identified in this research, in addition to characteristics for providers (e.g. confidentiality honoured), health facilities (e.g. adequate space and sufficient privacy), and materials (e.g. educational materials available on site) recommended by WHO (Senderowitz, 1999; WHO, 2002). In that way the chances are increased that services provision would be more acceptable to adolescents.

    ii. In addition to building the capacity of existing professionals, future professionals should be trained in AFS, such as through the Nursing School, Teachers' College, and the Royal Grenada Police Force Training School. The Ministry of Health should assume the leadership role in planning for the capacity building of professionals linked to ASRH service provision.

c) AFS models should be integrated and piloted within primary health care, the Grenada Planned Parenthood Association, and in schools via the *Health Promoting School Initiative*[12]. Currently the *Health Promoting Schools* initiative in Grenada is limited to nutrition, oral hygiene and optometrist services, but could potentially be expanded to include SRH service. However, an acceptable package of SRH for the school-system would have to be explored. At a minimum, it could serve as a referral mechanism,

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[12] WHO defines the Health Promoting School (HPS) as "one that is constantly strengthening its capacity as a healthy setting for living, learning, and working. An HPS fosters health and learning at all times through school policy; curriculum, teaching and learning; school organisation, ethos and environment (both physical and psycho-social); and partnerships and support services" (WHO, 2009).

where students with SRH concerns seek help through the *Initiative* and are referred to the appropriate source for help.

    i. Although adolescents expressed concerns about being seen in the health facilities by others they know, being overheard, and confidentiality, they did not express a desire to utilize separate SRH services. However, providers trained in AFS should not be assigned to health centres in the area surrounding their community to promote the perception of confidentiality and privacy. The needs of adolescents should be considered in the design of health facilities for AFS.

d) The quality of information and education about SRH help-seeking should be increased in schools, and quantity increased in health facilities and the media, if possible.

    i. To complement lessons on help-seeking as part of the HFLE curriculum, HFLE teachers should be provided with a SRH Helpers' Resource Guide rather than depending on teachers to prepare the list of help sources. This will help to ensure that the lists are available and complete with all relevant professional sources, and trustworthy websites.

    ii. Additionally, help-seeking should be included as a topic from primary school rather than Form three, when coping mechanisms, which may not include help-seeking behaviours, may be already formed.

    iii. Considering the high cost key informants discussed for utilizing the media for health promotion, organizations related to ASRH could pool their resources together to develop a help-seeking media campaign to increase knowledge about available and adolescent friendly sources of help. PSI's *"Got it? Get it."* condom use media campaign could be used as a model, as adolescents were able to easily recall the campaign, its key message and associate the presence of logo with confidential access to condoms.

    iv. Social media, such as facebook and twitter, and mobile texting could be used to disseminate information and advice regarding SRH including, about sources help-seeking, and about policies and legislations related to ASRH.

    v. It is recommended that during regular doctor visits, general practitioners should provide information about sources of ASRH help-seeking to adolescents and/or parents and guardians, or have information posted or in leaflet form to give to clients.

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e) The Gillick competency test and the Fraser Guidelines should be adapted and piloted for use in Grenada. This could be a useful supplement to any policy developed regarding the parental consent for SRH care services.

8.5.3 Recommendations for Research

Several issues raised in this thesis are deemed worthy of further research.

a) The current study did not employ a comparative design and as such the data analysis was not conducted specifically to find gender differences. However, there were some glaring findings that implied there were differences in the help-seeking behaviours and influence of contextual factors by gender. Therefore, a comparative study is recommended to further investigate the different contextual factors that influence male and female adolescents' SRH help-seeking behaviour. One area that could be researched is male and female identification of their SRH concern, particularly to determine whether psychological signs are indeed one of the most, if not the most important determinant for boys' identification of their SRH concerns.

b) The findings from this study should be used to design quantitative studies on Grenadian ASRH help-seeking behaviour to determine whether the findings can be generalizable to adolescents in Grenada, especially similarly vulnerable groups included in this study. For example, a quantitative study can investigate the social network and professional sources of help that adolescents use for SRH concerns experienced during a specified time period, and the barriers adolescents face to seeking help.

c) An intervention and evaluation study should be conducted on the feasibility and effectiveness of seeking help from social network sources who are trained in the provision of ASRH information and advice, because social network sources comprise a key source of help for adolescents.

d) A qualitative study should be conducted to explore private and public health providers and parents' perspectives on ASRH help-seeking, this perspective was not captured in this thesis. Adding health providers and parents' perspectives would help to provide a more comprehensive picture of Grenadian ASRH help-seeking experience. It is possible

that adolescents and sources of help may have different perspectives on help-seeking which may hinder future help-seeking by the adolescent or his/her peers. One of the issues that the study among health providers could explore is how parental consent for accessing SRH services is addressed.

e) A qualitative study could be conducted to explore the influence of context on the SRH help-seeking behaviours of a sample of adolescent health service users. These adolescents would be recruited at the point of service utilization. This would hopefully help to improve adolescents' memory recall about service utilization and contextual factors.

f) A qualitative study similar to the current study could be conducted with adolescents from different Caribbean islands to determine whether the findings hold true, which would suggest specific Caribbean ASRH help-seeking pathways and theories of how the Caribbean context affect ASRH help-seeking behaviour.

g) Help-seeking initiatives undertaken should be monitored and evaluated to determine their effectiveness in improving help-seeking and improving SRH outcomes, such as pregnancy, early sex, contraceptive use, and STI/HIV. Only through systematically monitoring and evaluating help-seeking programs and services would managers be able to make changes that reflect the needs of adolescents and the capacity of the helpers.

8.6   Conclusions

This exploratory qualitative study showed how the socio-cultural and programmatic contexts influence Grenadian adolescents' help-seeking behaviour for their sexual and reproductive concerns. The policy environment related to ASRH is considered weak because disparate policies are unlinked and inconsistent, and it is not uncommon for policy development to be incomplete or policies outdated and/or not implemented. Despite these shortcomings, in addition to policy content that may be viewed as unsupportive of ASRH, SRH-related policies and legislation address critical issues of education, reproductive health services, and legal protection against sexual violence. These form a good foundation to develop and implement a cohesive and comprehensive ASRH policy environment. However,

this can only be done if there is the political will, and/or advocacy from key stakeholder groups including adolescents, communities, and NGOs for the requisite policies

Adolescent friendly healthcare services do not exist, but some adolescents do seek help from services developed for adults although they have a preference for private services. However, considering adolescents reported believing that the weaknesses in health services could change through staff training to treat adolescents respectfully and confidentially is encouraging. Ideally these are issues that should be incorporated into a comprehensive policy approach to addressing ASRH.

The findings show that Grenadian adolescents who seek help often do so through complex pathways influenced by factors of the help-system and by attitudes in society about adolescent sexuality and SRH help-seeking. Although adolescent help-seeking take place via a four-stage pathway, adolescents navigate the help-seeking pathway differently with female family members playing an important role in the identification of SRH concerns and identification of the need for help among adolescent girls. Help-seeking occurs more immediately when adults are involved in the identification of the concern and/or the need for help. However, the health care system is more responsive to adolescents' SRH needs when an adult is involved in the care-seeking process. It is clear that both policy and programmatic changes are needed to make health services adolescent friendly to facilitate help-seeking with or without the involvement of adults.

Several of the barriers to developing AFS are due to socio-cultural factors pertaining to sexuality communication, community social support, social stigma and gender-power relations, which adolescents rightly believe are more difficult to change. While there is evidence that sexuality communication in Grenadian society is more open than in the past, the timing, style and content of intergenerational sexuality communication contributes to the SRH vulnerability of both male and female adolescents. Community social support for adolescent sexuality is varied, especially for girls. However, despite moral and religious values that hinder community support for premarital sexual activity among adolescents, completion of secondary schooling is perceived to be an increasingly acceptable social marker for adolescents' initiation of sexual activity. This has the potential to revolutionize discourses on sexuality education and SRH service availability in Grenada. Social stigma in Grenada is gendered and mainly influences girls' help-seeking behaviour. Addressing social stigma is important to improve the socio-

cultural and programmatic contexts to facilitate ASRH help-seeking. Gender-power imbalances in adolescent heterosexual relationships result in violence and girls' inability to identify: SRH concerns and need for help, and to seek help; therefore, helpers should address/account for issues of gender-power.

In the programmatic context, the negative attitude and behaviour of some professionals, especially health providers and teachers toward adolescents and their inability to maintain the confidentiality of adolescent help-seeking were also barriers to help-seeking. However, these were closely linked to values and expectations in the socio-cultural context. Distance between adolescents' residence and health facility was mainly a barrier to the extent that it was perceived to contribute to a lack of confidentiality. Other programmatic factors, such as, financial cost of services and knowledge of services were less important barriers to help-seeking; however, they warrant consideration in developing AFS. Nonetheless, adolescents perceived that factors in the programmatic context were easier to change than factors in the socio-cultural context.

Despite the barriers, adolescents do utilize a range of helpers from their social support network and health services. What appears to be a preference for utilizing social support sources means that the range of help sources should be competent to effectively help adolescents with their SRH concerns. In addition to barriers to help-seeking, a few facilitators to ASRH help-seeking were also identified; however, most facilitators were based on addressing existing barriers. Open sexuality communication prior to experiences of SRH concerns is possibly one of the most important facilitators of help-seeking from parents, rather than open communication in general.

It is concluded that to facilitate ASRH help-seeking, the existing barriers have to be addressed otherwise adolescents who seek help for SRH concerns will continue to do so in an unsupportive socio-cultural, programmatic, and policy and legislative environment. Following the findings of this study, recommendations were made to help create a more supportive environment for adolescents to cope with their SRH concerns. However, given the limited financial and human resources, and attitudes in society the involvement of regional and international organizations is critical, in addition to strong and persistent advocacy efforts for ASRH interventions from adolescents and NGOs.

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Appendix A – **Literature Search Strategy**

Databases used:

Global Health
PsychINFO
POPLINE
Web of Science
Google Scholar

Grey Literature sources:

Google
WHO
PAHO

Key Concepts and Search Terms:

Concept 1 – **Contextual Factors**	Concept 2 – **Health Behaviour**	Concept 3 – **Help-Seeking Behaviour**	Concept 4 – **Adolescents**
Social Sociocultural Political Socioeconomics Religion Employment Community involvement Culture Family Friends Peers	Health behaviour Sexual health Reproductive health Sexual behaviour Contraception Birth control Pregnancy HIV AIDS Abortion STIs Menstruation	Help-seeking Health seeking Counselling Information Information seeking Health service utilization	Adolescent Teenagers Youth Young people
Concept 5 – **Sources of Help**	Concept 6 – **Regions & Countries**		
Community leaders Teachers Religious leaders Parents Physicians Nurses Pharmacists Policy makers Friends	Caribbean Grenada Jamaica Developing countries Developed Countries		

Appendix B – **List of documents reviewed**

Name of Document	Date of Document	Author of Document
Convention on the Rights of the Child	20th October, 1989	
Concluding Observations of the Committee on the Rights of the Child: Grenada	11th June, 2010	
National Policy on Health and Family Life Education (HFLE) Grenada, Carriacou and Petit Martinique	1st September, 1998	
HFLE Curriculum, Grenada	2008	Ministry of Education
Education Act	2002	Ministry of Education
Ministry of Education's Policy Regarding Student Pregnancy	Unknown	Ministry of Education
Sexuality, Gender, HIV Vulnerability & Human Rights in Grenada : A Shadow Report to the United Nations Human Rights Committee	1st July, 2007	Grenada Caribbean HIV/AIDS Partnership (GrenCHAP), Hope Pals Foundations & the Grenada Human Rights Desk
Criminal Code: Abortion		
Unlawful Carnal Knowledge - Remaking Section 179 of the Grenada Criminal Code	25th July, 2010	DR
Child Protection Act		
Protecting Children Affected by AIDS in the Caribbean: Recommendations for Legal reform in Grenada	1st July, 2006	Jacqueline Sealy-Burke
Grenada National Strategic Plan for Health: Health for Economic Growth and Development 2008-2012	2006	
National HIV/AIDS Assessment Law, Ethics and Human Rights Project Grenada	1st January, 2008	Kieth H.W. Friday (Consultant)
Adolescent and Youth Regional Strategy and Plan of Action 2010-2018	2010	PAHO/WHO
International Planned Parenthood Federation: From choice, a world of possibilities - Strategic Plan 2005-2015	2007 reprint	IPPF
Sexual Rights: An IPPF Declaration	1st May, 2008	IPPF
GRENCODA Briefing Report	nd	GRENCODA
GPPA Annual Report	2008	Winston Duncan
NPP Annual Report	2010	Lindonne Glasgow
NPP Strategic Plan	2008	Ministry of Social Development & Stakeholders

Appendix C – **Focus Group Instruments**

Adolescent Focus Group Guide: Girls in Communities

Maximum Duration: 2 hours

Introduction and objective of the focus group: Thank you all for coming out today! My name is _____, and this is _____. We are here today to help you talk about how young girls deal with concerns or worries they have about growing up and developing sexually. We would like you to share what you know about help that may be available for young people sexuality issues. Sharing your views and experiences with us will help us to identify ways to improve services and other resources to help girls grow up happy and healthy, so that they can achieve their full potential. _____ (insert note taker's name) will be taking notes of the discussion.
(2 minute)

Introduction of participants: We know that most of you already know each other, but we would like to get to know you better. Let's just go around the room and say our names.   Thanks everyone! ***(3 minutes)***

Establish ground rule: Before we begin we should set some ground rules. In that way we will all feel that we can talk freely and get the most out of the discussion. ***(3 minutes)***

- Taking part in the discussion: We are interested in knowing what you think, so please be open and share your views. There are no right or wrong answers in this discussion, and we don't all have to agree with each other. It is important that we hear all your opinions and not just one person.

- Keeping the discussion confidential and safe: I'm sure we would all prefer that what we say here today is not repeated to other people outside this group. Please treat others as you would like to be treated, and DO NOT repeat who was here and what they said. Also we will not share your name with others or identify you in any reports where we discuss this study.

- Right to leave at anytime: Remember if for any reason you become uncomfortable, you can choose to leave at anytime. However, the information that you share with us up to that of the discussion will be kept as part of the study.

- Taping and writing things down: Remember that _____ (insert note taker's name) will be writing notes from the discussion. Also we will be taping the whole discussion so that we do not miss any of your comments. So we ask that you allow others to finish speaking before you have your say. It shows respect for them and it makes it easier to write the information from the tape.   The tape will be kept private and not shared with others.

- The role of the facilitators: In order to keep the flow of the discussion, _____ (note taker) and I would prefer not to answer individual questions during the discussion. At the end we would provide you with a resource list and would be happy to try and answer other questions that you may have.

- Are we clear about the ground rules? Are there any other ground rules that you think we should add?

Tell me what you like about living in Rose Hill.

Tell me what you don't like about living in Rose Hill.

How would you describe your ideal place to live?

A. *GIRL TALK:* Duration 30 Minutes

INSTRUCTIONS FOR FACILITATOR

> **The objective of this activity** is to build rapport and create a comfortable environment for adolescents to talk about the issues they face as they develop into young women. It will allow adolescents to reflect on the socio-cultural context and their influences on growing up and developing sexually.

1. What do you think about the story?

PROBE AS NEEDED:

   a. Do you think these are real issues that girls your age deal with? Tell me more about that.
   b. What do you think are some things that Asha should be concerned about? (LIST ON FLIPCHART). Tell me about why you think Asha should be concerned about ____ *(repeat concerns identified by the group).*
   c. Do you think younger girls have some of these same concerns?
   d. Are there other issues not mentioned in the story that girls might be concerned about?

2. Tell me about people in RH expect girls your age to behave? What do you think people would say about the things *(specify issues group members identified)* the girls were talking about (attitude, acceptability of behaviour, double standards). Which people (parents, community members, teachers, pastors/priests, peers)?

PROBE AS NEEDED:

   a. What do you think people would say about young girls your age being in relationships and having sex? Which adults (e.g. parents, other adults, peers, priests/pastors, teachers, health workers)?
   b. What do you think people would say about pregnancy and abortion among young people?
   c. What do you think people would say and do about young people getting STIs?
   d. Can you tell about messages that you have heard on the radio, TV, or read in newspapers, magazines or the internet about having sex?

3. How much do you think girls your age pay attention to what other people say and messages in the media about these issues? How about younger girls?

B. *TAKE A WALK IN MY SHOES:* Duration 30 minutes

INSTRUCTIONS FOR FACILITATOR
The objective of this activity is to allow participants to talk about how girls identify their need to seek help and the rationale for the choices they make as they seek help for concerns or worries about growing up and developing sexually. The focus should be on the influences of social and cultural norms, as well as SRH programs available for adolescents.

4.   Normally when you have a concern, any concern, who do you go to for information or advice? (LIST ON A SEPARATE SHEET OF FLIP CHART PAPER)

PROBE AS NEEDED

a.	Parents	d.	Friends
b.	Other relatives	e.	Religious leaders
c.	Teachers	f.	Media

a.   What types of issues would you talk to _____ (insert sources) about?

5.   How do you think Asha knows she needs to get help? (seriousness of concerns, knowing that she cannot deal with the concerns on her own) **OR** If you were in Asha's situation, what would make you think you need to get help?

6.   Think about the things that you thought Asha should be concerned about. Remember she's about your age and she lives in RH. What advice would you give to Asha about getting **(1) information** and **(2) services** to deal with those concerns? (use flip chart where concerns are listed and have participants brainstorm)
PROBE AS NEEDED

a.   What kind of help do you think Asha needs for her concerns (information services, or no help)?
b.   What would actually make her get help for her concerns *(specify concerns for discussion)*? (knowing where to get help, having someone she trust, previous experiences of self and others)
c.   Where can Asha go to get (1) information and (2) services for the concerns you identified?   Will Asha be able to get help from persons in the community? Which persons?
d.   *What about going to ___ (GRENCODA, Medical station, Health Centre, Grenada Planned Parenthood Association, Pastor/priest, teacher)?*

7.   What do you think would make it difficult or prevent Asha from getting the help we said she needs to get *(refer back to responses from question 2)*?
PROBE AS NEEDED

a.   Attitude and/or behaviour of others (parents and other family members, friends, teachers, religious leaders, health workers).
b.   Stigma
c.   Lack of someone to talk to
d.   Service availability
e.   Awareness of where to go for information and services
f.   Transportation and service cost

8. How do you think the story end?

PROBE AS NEEDED

 a. Do you think Asha was pregnant? If, yes do you think she kept the baby?
 b. Do you think she had an STI?

9. How can these issues affect girls' future?

C. WORDS-IN-A-BAG: Duration 20 Minutes.
The objective of this activity is to provide a means of understanding participants' perceptions and interpretations of sexual and reproductive health.

10. What comes to mind when you think about, see or hear the following words, phrases and images from the bag may include:

- Puberty (developing breast, pubic hairs, having period)
- Relationships (boyfriend)
- Sexual intercourse (sex)
- Pregnancy
- Contraceptives
- STIs
- Rape, forced sex
- Hitting or being hit by a partner
- Gays, Lesbian

PROBE AS NEEDED

- Where do you learn about these issues?
- Do you think you have sufficient information about these issues?
- Do you think that there are sufficient places for girls to get services to deal with these issues?
- How would you describe the ideal situation for girls to deal with these issues and those Asha had to deal with in the story?

D. Ending questions and Recommendations: Duration 20 minutes
The objective of these final questions is to get participants' recommendations about how adolescent sexual and reproductive health help-seeking could be encouraged and facilitated. What will make a difference in their lives!

11. What can be done to encourage girls to seek help early sexual or reproductive health concerns? (What can parents, government, community, GRENCODA do)
12. What would make it easier for girls to talk to their mothers and/or fathers about the issues we discussed?
13. If you had the power to change anything that would make it easier for young girls to deal with their concerns about growing up and developing sexually, what would you change?

Thank you so much for your time and taking part in TEEN TALK!!! This was very helpful and I had a great time! Before we end, is there anything that you would like to ask? Please have some refreshments before you leave.

Remember the ground rules that we started with, it is important that we do not discuss who was here and what they said today. If any of you are interested in listening to the recording or reading the notes from the tape of today's discussion, please let me know. Again, thank you for your time!!! We will call you later to make sure everyone got home okay.

PROVIDE EACH PARTICIPANT WITH THE RESOURCE LIST

Focus Group Script: GIRL TALK

<u>Characters:</u>
Asha
Andrea
Michelle

Asha: Girls I went to my boyfriend Joe's house on Saturday. One thing led to another and we ended up doing it…you know…having sex. And worse yet my period didn't come last month. We didn't even use protection.

Michelle: Is pregnancy the only thing you're worried about Asha? What about getting some kind of disease? Are you sure you're the only person Joe is having sex with?

Andrea: I hear that if you pee when you're finished having sex you won't get pregnant. I've been hearing stories that Joe likes to hit girls and likes to have things his way. Seriously, you need to get some help!

Asha: Andrea I don't know where you get your information from! Joe loves me! If Joe was hitting anybody, I'm sure they deserved it. Those girls are just jealous of us.

Michelle: I don't know about this hitting thing. Maybe you could go to the clinic.

Andrea: You should talk to your mother, because it will be worse if someone sees you in the clinic.

Michelle: Yesterday I was talking to my 11 year old sister, because I don't want her little womanish friends giving her wrong information. She's in form 1. Would you believe she has breast and is seeing her period already?

Asha: Leave it up to parents we won't know about sex until we turn 50. The first time a boy told me he liked me I ran to Jes for advice.

Michelle: Well on Sunday the preacher was talking about how the body is a temple and how everything nowadays is sex, sex, and more sex. My mother shouted out, "Preach pastor, it's BET and TEMPO that cause that (laughter)."

Andrea: No one is saying that being with someone makes a girl feel good. Boys are lucky; they don't have to deal with all these issues *(laughs)*.

Asha: Well maybe the pastor has a point, because if I had waited to have sex I would not be in this situation now. What all you think I should do?

Focus Group Script: BOYS ON D' BLOCK

Shawn: Joe what happen, boy? You missed a real good 'lime' on Saturday. Boy, drinks flowing like water and 'nuff' girls in the place.

Joe: My girl Asha came to check me on Saturday so I couldn't make that lime.

Shawn: I hope you used some rubbers. By the way, any of all you ever been tested?

Richard: Please, you think we look like we have any diseases? You have to let these girls know who is boss, even if it means giving them a good slap or two sometimes.

Joe: Yes, we need to show them who is in charge! I use condoms sometimes with other girls but not with my main girl.

Shawn: You need to be like me, settle down with one girl and treat her like a queen.

Joe: Boy too many girls out there to have just one.

Shawn: You needed to be in church on Sunday, Joe. The pastor was talking about how everything nowadays is sex, sex, and more sex. Ah lady shouted out, "Preach pastor, it's BET and TEMPO that cause that (laughter)."

Richard: The girls on TEMPO do look real sweet! My sister CANNOT dress like that for men to watch her; I don't care how old she is.

Joe: On ah serious note, Asha said that her period didn't come last month, what you all think I should do?

Appendix D – **Interview Instruments**

Adolescent Interview Guide: All Adolescents, except adolescent mothers

Duration 90 minutes

- Introduction and Objective of in-depth interview: Thank you for taking the time to speak with me. My name is _____. I am one of the interviewers with the 'Teen Talking about Sexual and Reproductive Health' research project. I would like to talk with you about your experiences dealing with things that concern or worry you about growing up and developing sexually. These discussions are held with you and other boys and girls your age to learn about your experiences and ideas, so that we can design programs to help young people to grow up to be healthy men and women to achieve their full potential.

- Answering questions: There are no right or wrong answers to the questions I will ask you. I am interested in knowing what you think, so please be open and share your experiences and ideas. If you prefer not to answer any particular question, that's fine.

- Keeping the interview confidential and safe: Anything you say here today will be kept private and confidential. When we tell people about we have found out from these interviews, we will not mention any names. For example, we'll say things like most of the boys think….or, a female participant said….

- The right to leave at anytime: Remember if for any reason you become uncomfortable or upset, you can choose to leave at anytime. You and I can also decide if it would be possible to continue the interview at another time. I will try to make you as comfortable as I can. If necessary I will refer you to a professional counsellor. If you do decide to leave and not continue with the interview, your information will be destroyed and not used as part of the study

- Taping and writing things down: I will be writing notes as we speak, but I will also be taping the whole discussion. By taping we will not miss any of your comments as we think carefully about what you have said. The tape will be kept private and not shared with others.

Give participant gift card valued at EC $10.00 and transportation reimbursement if necessary.

    A. Personal Background

      How old are you? _____

      Do you go to school, work, or do both? _____

      If student: what level are you in? _____

If working: what work do you do? _____

Who do you live with? _____

How do you see your life in 10 years? _____

B. Socio-Cultural Context

1. Tell me about where you live?

PROBE AS NEEDED:

- What do you like about where you live?
- What do you not like about where you live?
- Tell me about your relationship with your parents (or those who you live with).
- How do you think adults in your neighbourhood view you as a young person? Which adults?
- What do you think is expected of you growing up in _____ (insert name of neighbourhood)? (school, work, church, family, sexuality - relationships, sex, contraception)
- How do you feel about those expectations? Do you think those expectations are fair or realistic?

C. Mapping Activity (10 minutes)

2. Think about your life and concerns you have had about your sexuality. Draw a map showing me how you went about getting help to deal with a SRH concern in the past. Draw on the map where you got: (1) **I**nformation; (2) **A**dvice; and (3) **s**ervices for the concern. (For later discussion)

D. Concerns about growing up and developing sexually

3. Think back to when you were between 10 and 15 years, tell me about your experiences growing up and developing sexually at that time *(puberty, girlfriend/boyfriend, school, relationship with parents)*

PROBE AS NEEDED:

- What are some good things about growing up?
- Was there anything you were concerned or had difficulty with growing up? Any concerns related to sexuality?
- Can you give me an example of some of the concerns or worries you experienced with your sexuality?
- How did you learn about sexuality?

4. Tell me about people or places you would get information, advice or services from to deal with the concerns or worries you had about growing up and with your sexuality when you between 10 and 15 years?

PROBE AS NEEDED:

- Did you go to parents, friends, other relatives? Give me an example of the type of concerns you would go to them for.
- Did you go to teachers, religious leaders, media – TV, internet, magazine? Give me an example of the type of concerns you would go to them for.

- Did you go to health centre, private doctor? Give me an example of the type of concerns you would go to them for.
- How did you feel about going to these person or places to get help?

5. **Card Sort:** Think about your life now, and sort the cards *(each card contains concerns identified in the focus groups or literature review)* into <u>three</u> (3) piles. The three piles should represent the concerns you have about your sexuality that are: **Most Important, Somewhat Important, & Not Important**. Discuss each pile in the following order: Not important, Somewhat important, & Most Important (ask what is participant what is the sexual or reproductive health issue that concerns him/her most).

PROBE AS NEEDED:

Tell me about the piles you made.
Why did you put _____ (each card) in the particular pile?
In general, what concerns of worries you most about your sexuality?

E. Experiences of Sexual and Reproductive Health Help-Seeking
6. Have you had to deal with any of the issues on the cards in _____ (specific pile)?

<u>If no:</u>

a. If in the next month you had to deal with any of the issues on the cards in ____ (specific pile), what do you think you would do?
b. What are some things do you think would cause you to deal with the issue in the way you have just described? What about_____
- ✓ Religion or religious views/teachings
- ✓ Parents' values and expectations of you
- ✓ Other people's expectation of you
- ✓ The way other young people in the community deal with similar issues
- ✓ Ease of getting information, advice, or services
- ✓ Trust
- ✓ Previous experience of someone you know

<u>If yes:</u>

a. Which issue(s) on the card have you had to deal with?
b. What was your concern with _____ (specific issue) at the time?

7. **<u>Refer to map:</u>** What concern are you seeking help for in the map? *(if this issue and issue illustrated in map are the same then you can discuss the map at this point. IF issues are different, continue to follow the guide and leave map for later discussion).*
a. How old were you at the time?
b. How did you deal with it? (If the interviewee has never sought help, discuss how they dealt on their own with a SRH issue and the outcome of that experience).
c. What are some things do you think would cause you to deal with the issue in the way you have just described? What about_____

✓ Religion or religious views/teachings
✓ Parents' values and expectations of you
✓ Other people's expectation of you
✓ The way other young people in the community deal with similar issues
✓ Ease of getting information, advice, or services
✓ Trust
✓ Previous experience of someone you know

d. Are there other concerns you have that are not on the cards? Tell me about them

Discuss Map

8. Tell me about what your map is showing – tell about the people and places and what they mean.

PROBE AS NEEDED:

- What concern(s) were you getting help for in the map?
- Why did you decide to get help for _____ (specific concern)? (symptoms, severity, previous experience, knowledge/awareness)
- How long did it take you to get help after you realised you were concerned or worried about _____ (specific issue)?
- Can you tell me about any difficulties you might have had in deciding to get the help?
- Why did you go to _____ for help? *(type of concern, previous experience, trust, other people's expectations of you, parents values and expectations of you, attitude, religion/religious views, others young people in the community deal with similar issues, laws)*

9. What were your experiences like getting help? – good and bad things (comfort, privacy, length of time waiting, attitude, competence, distance, cost, finding someone who can help)

PROBE AS NEDEED:

- What was the attitude of the person who helped *(specify the type of help based on discussion)* you? Why do you think the person treated you the way he/she did?
- Did you feel that you could trust the person to be private and not share your concerns with others? Why?
- How would you feel about going back to those places or people in the future? Why?
- Would you recommend your friends to go to those places or people? Why?

10. Do you think there are enough people or places to help you deal with the concerns we discussed? Tell me more.

F. Recommendations

11. What would make it easier for you to overcome some of the challenges you experienced when trying to deal with your sexual and reproductive health concerns?

Thank you for taking part!

Card Sort

1 Sexually Transmitted Diseases	2 Becoming a teenage mother or father	3 How will my mother or father react?
4 Will I be able to finish school?	5 What will other people think about me?	6 Getting an HIV test
7 Will the relationship last?	8 Will boyfriend take responsibility for pregnancy?	9 What will my friends think about or treat me?
10 Not having sex	11 Parent(s) finding out	12 Getting condoms
13 Wanting to have sex	14 Who can I speak with?	15 Being hit by boyfriend/girlfriend

16 Using condoms	17 Finding a job	18 Taking care of a baby
19 Going to the doctor	20 Having to "Get rid of the baby"	21 Getting contraceptives
22 Becoming involved in a sexual relationship	23 Does my boyfriend or girlfriend really love me?	24 Sexual performance
25 Horning	26 Rape or being forced to have sex	27 Liking or being liked by someone of the same sex (gay/lesbian)
28 Getting HIV	29 How will I tell my mother or father?	30 Will the nurse or doctor keep my information private?

31	32	33
What is my boyfriend or girlfriend doing?	Will asking for help mean that I am weak.	Paying the doctor's fee
34	35	
The changes that my body is going through	Being called names	

Appendix E – **Sample of Programmatic Context Chart used for Analysis**

Data Source & number	Confidentiality	Parental Consent	Availability & Awareness of helpers	Attitude & Behaviour
RHFGM07	will advise Joe to go to a private Dr (Jason & Jerry) or counsellor (Jerry) sometimes the nurse in the HC tell other people in the clinic your business and then it reach on the street (Jamal); even by private Dr the nurse might be related to your family and could call and tell your mother if you didn't tell mother yet (Jason - 5-16 of 26_help-seeking);		boys can get services for crabs from the HC & nurses in the community (Jamal-17/27_available programs); mixed responses about whether having HC in the community would make help-seeking easier, Jason, Cal & Jamal said yes, others said it will make it harder (Jerry, Jim); will be easier b/c could walk there (Jason - 18-19/27_Available programs)	
GAVFGM11	Joe will trust the Dr or hospital & go quicker as a result (Will-19/109_health workers)		not aware of GPPA, but aware of Red Cross & HC; if Joe might get help quicker if he knows where to go (Cameron); disagreement about whether there are enough places in the community for adol to get help for SRH concerns (Will & Cameron-3-5/27_available programs)	In the community HC people will want to know wrong with them & watch them in kinda way (Will); Will be treated respectfully based on kind of nurse (Will)
RHFGF05	would tell Asha to go to the pharmacy to get services (Jenna), would rather go to a Dr b/c not all pharmacy is private b/c sometimes		If nurses know girl is in relationship and sexually active would encourage girl to use protection (Roxy) b/c girl is deep in it already	

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	they sell it for you but after they "sho shooing" behind your back, or go to private doctor b/c private Dr is more confidential b/c they don't know you much and don't know your background (Sara)(35-36/109_Health workers)		(Sara), and would tell you about good and bad about having sex (Jenna) (33-34/109_Health workers); Being nervous and afraid would make it difficult for Asha to go to the Dr or nurse b/c of what she think they might say about a young person with her problem (Jenna) (38/109_health workers)	
PFGF06	participants agree that nurses are trained to do clinical job but not in communicating and keep people's business "when it comes to people's business they gassing on low" (Rose, Melissa, Rhonda - 1-2/6_staff's receptivity); unwilling to talk to teachers about anything (Melissa), willing to talk to some teachers b/c some are not confidential, the younger teachers are not confidential they talking in the staff room after you talk to them (Rhonda) (16-17/96_School)	During pregnancy went to private Dr and went alone (Rose, Melissa, Rhonda - 32/109_Health workers)	agrees that apart from HCs there aren't other places in their communities for adol to deal with SRH concerns, & that it would be useful to have other places (Rose & Rhonda_10/27& 13-14_available programs); agreeing that girls know where to go to get contraceptives or to talk to someone about pregnancy prevention (13/27_available programs);	HC is worst place to get pap smear b/c when results come back they sitting and debate on it, they're watching to see what you have and "sho shooing" with the next nurse and they watching you in a kinda how when yo go for results (Rose) & before you know it people in your village know everything (Rhonda, Rose agrees) and they watching you all kinda how (Rose)(25-27/109_health workers)
NFGM01	they say taking HIV test is private but other people knowing your results before you, so it can't be private it that's happening; Gucci and Birdman disagrees that health workers are telling others about test results (Brian- 6-9/9)		There are people at NEWLO to get help from, but low self-esteem may make it difficult for Joe to get help (Brian - 1-3/9);	

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PIF33	did not want school to tell mother about rape but was informed that that they had to tell her but everything worked out (Linda 33-54/96_school);		feels there were sufficient places to deal w/ her pregnancy concerns, but unsure about adequate support for dealing after pregnancy, might just be unaware of where the places are (Linda -23/27_available programs);	Did not feel uncomfortable going to the Dr for pregnancy test (Linda - 71/109_Health workers); won't feel comfortable going to get condoms from the health centre b/c I would be shy, but would buy it in the supermarket if a friend goes with me; Dr and nurse would watch me funny and talk behind my back (Linda 33 - 74-78/109_Health workers)
KI4		lack of consistency among frontline workers regarding age of consent for services and actual provision of services; adol want the choice to disclose or not disclose, but w/o the choice they don't want to access services (KI4-35-37/43_help-seeking barriers);	major problems w/access to services & confidentiality, & at the legal or policy level it's an ad hoc response to ASRH care (KI4-35/43_Help-seekign barriers);	

Appendix F – **Ethics Documents**

Focus Group Information Sheet: Adolescent mothers

UNIVERSITY OF LEEDS

Project Title: Teens Talking About Sexual and Reproductive Health!

Researcher: Tonia Frame

umtf@leeds.ac.uk

420-5046; 442-1460

Introduction

You are invited to take part in the above study. Before you decide if you want to take part, it is important for you to understand why the study is being done and what it will involve. I will talk with you about this information. However, I will also give you a copy of this information sheet so you can discuss it with someone you trust. You can ask questions at any time.

If you agree to take part in this study, you will be asked to sign a consent form, which means that you are made aware of the information about this research contained in this sheet, and that you are taking part in the study of your own free will. If you are willing to participate, but you are unable to write, or have concerns about the security or privacy of your written information, you will be asked to tape-record your verbal consent to take part in the research. We will both keep a signed copy of the consent form, while I will keep a copy of the tape-recorded consent.

What is the purpose of the study?

This research is part of the researcher, Tonia Frame, PhD studies requirement. Tonia has received permission from the Program for Adolescent Mothers to identify and speak with young ladies in the program. The purpose is to find out about the experiences and concerns that adolescents who become pregnant have about growing up and developing sexually. This may have to do with things like relationship with others, staying healthy in sexual relationships, and dealing with pregnancy. We are also interested to find out how young people feel about programs offered by the government or groups related to these issues.

Why have I been invited?

You have been invited because you are:
- an adolescent mother between ages 16 and 19
- you attend the Program for Adolescent Mothers (PAM)

We would like you to share with us your views about how adolescents who become pregnant deal with experiences and concerns they have about growing up and developing sexually, and dealing with pregnancy and motherhood. We would also like you to make suggestions on what can be done to help young people deal with their concerns. Your responses are important to help us to better understand the sexual and reproductive health of young people in Grenada, so that we could make suggestions to the government and other organisations about ways in which they may be able to improve information and services to help young people deal with the concerns they have.

What will happen to me if I take part in the research?

You will be asked to take part in a group discussion, called a focus group, with 6-8 other young people who attend PAM. Focus groups will be conducted by two adults, and in any given group adult facilitators may be two females, or a male and female. One person will lead the discussion, the other will take notes, and the discussion will be recorded using a voice recorder. We will use storytelling and role play as ways of discussing the topics. The discussion will last about two hours.

If you take part in the group discussion, you may be invited later on to take part in a one-on-one interview with the person who conducted the focus group. Agreeing to take part in the focus group does not mean you have to agree take part in the one-on-one interview.

You will be provided with refreshments and would receive transportation fare, if necessary.

The audio-tapes will be written into notes so we can think carefully about what has been said. The tapes and notes will not have your name on them, so the information you tell us will be private. The information will be stored securely in locked storage for up to two year after it will be destroyed.

Do I have to take part in the research?

Taking part in the study is your choice. If you wish not to take part in this study, you do not have to give a reason, you can just say 'no'. If you choose to take part, you can decide to stop or withdraw at anytime without giving a reason. If there is a question you do not want to answer, you are also free to not answer. If you decide to withdraw, it will not be possible to remove your information from the study, because it will be part of the group discussion, but your personal information will be destroyed and you will not be invited to take part in the one-on-one interview.

What might be a good reason to take part in this study?

When we have a better understanding of young people's concerns and their experience of the support they have for these concerns, we can then start to improve the services that are available. The information you provide us may not be directly beneficial to you, but it can help other young people. You will be provided with a list of programs that provide adolescent sexual and reproductive health-related services and contact information of a trained counsellor where you can receive confidential services, if you choose.

What are possible risks to taking part in this research?

Although we will use stories and ask your views about the experiences of young people your age, you may find it difficult to respond at times, and may even become upset. However, you do not have to answer any questions that you do not want to answer. The facilitators have experience

working with young people and are trained to work with participants who may become upset. If you become upset, one of the facilitators will speak with you privately and may suggest that you speak with a trained counsellor. After you have spoken to the facilitator, you can decide if you want to continue with the discussion or withdraw from the research. It is your decision whether you will speak with the counsellor.

Will my taking part in this research be kept private?

Apart from the other young ladies taking part in the discussion and those organising the group, no one else will be told about your participation. Your name will not be used in connection with any of the information you share with us. Your honest answers to these questions will help us better understand what young people like you think, say and do about dealing with concerns about growing up and developing sexually. Reports or discussion of this research will not use your name or identify you personally.

What will happen to the results of the research?

The results of the study will be written and submitted to the University of Leeds in the UK in July 2011; a report will also be given to the Government of Grenada and other organisations that may be able to help address the concerns we will discuss. A meeting will also be organised where government, other organisations, and some young people taking part in the study will talk about how to use the information in the report. The results may also be shared with other researchers in the Caribbean and around the world in journals and conferences.

Contact for further information

If you have further questions about issues related to this research, please contact the main researcher.

Tonia Frame
420-5046
Chantimelle, St. Patrick

In case of an ethical issue contact St. George's University IRB Administrator:
Ms. Meg Conlon
439-2000 ext. 2221 or mconlon@sgu.edu
St. George's University
True Bue, St. George

Informed Consent Form: Adolescents

Project Title: Teens Talking About Sexual and Reproductive Health!
Name of Researcher: Tonia Frame

Please initial box

1   I confirm that I have read and understand the information sheet
       for the above study and have had the opportunity to ask questions.

2   I understand that my participation is voluntary and that I am free to withdraw at
       anytime, without giving any reason, and without any consequences.

3   I agree to take part in the above study

Name of Participant	Date	Signature

Name of Person Taking Consent	Date	Signature

PhD Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix G – **Help-Seeking Resource Guide**

Side 1

ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH RESOURCE GUIDE

GRENADA

♦ Health Promotion Department, Ministry of Health
(440-2649)

♦ National AIDS Directorate, Ministry of Health
 (440-2649)

♦ National Parenting Program, Ministry of Social Development
(440-7952)

♦ Domestic Violence Unit, Ministry of Social Development
(440-9752; 440-2296;
HELP LINE 388)

♦ Grenada Planned Parenthood Association, St. George (440-3341); Grenville (442-5442)

Side 2

♦ Legal Aid & Counseling Centre, St. George
(440-3788; 440-3785)

♦ Student Support Services, Ministry of Education
(440-2737; 440-1335)

♦ Program for Adolescent Mothers
(440-0002)

Health Centres

♦ The Esplande, St. George
(440-3371)

♦ Gouyave, St. John
(444-8414)

♦ Grand Bras, St. Andrew
(442-7623)

♦ Sauteurs, St. Patrick
 (442-9317)

♦ St. David's
(444-6249)

www.iwwanaknow.org

Www.plannedparenthood.org/teen-talk

Produced by:

Tonia Frame, Teens Talking about Sexual & Reproductive Health Project. Grenada. 2010.
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