Government of the Republic of Trinidad and Tobago

Ministry of Health

National Sexual & Reproductive Health Policy

August 5th 2020

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- The Tobago House of Assembly (THA); and
- The Catholic Archdiocese of Trinidad and Tobago.

GLOSSARY OF TERMS

Adolescence	The WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to19. It represents one of the critical transitions in the life span of individuals and is characterized by a tremendous pace in growth and change that is second only to that of infancy.[1]
Billings Ovulation Method	The Billings ovulation method, also called the ovulation method and the cervical mucus method, is a type of natural family planning that is based on careful observation of mucus patterns during the life-course of a woman with regular menstrual cycles. By recognising the changing characteristics in cervical mucus, women might predict when they may ovulate. In turn, this may help determine when a woman is most likely to conceive, which can be used to guide fertility, depending on if one wants to become pregnant or not.[2]
Equity	In the context of this SRH Policy, 'Equity' refers to a fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic, or geographic strata.
Gender	Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women only.[3]

[1] WHO, 2016
[2] The Lancet, 1972
[3] WHO, Gender

Gender-Based Violence	An umbrella term for any harmful act that is perpetuated against a person's will and that results from power inequalities that are based on gender roles.[4,5] It includes sexual abuse of children, rape, domestic violence, sexual assault and harassment, human trafficking of all persons and several harmful traditional practices which damage the SRH health of women, men, girls, and boys. Gender-based violence (GBV) also results in death in T&T.
Gender Equality	Equal rights, responsibilities and opportunities for women and men and girls and boys.[6]
Gender Roles	Social, cultural traits that societies assign to males and females. "...patterns of behaviour and obligations defined by a society as appropriate for each sex.[7] According to the WHO, Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. The term also has a bearing on people's access to and uptake of health services and on the health outcomes that are experienced throughout the life-course.
Integrated Service Delivery	The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system[8], thus enabling service delivery to be more accessible, equitable and efficient.
Key Populations/ Vulnerable Groups	This refers to specific groups who are specifically targeted in this policy as they may not or infrequently access SRH services. This

[4] UNHCR, 1992
[5] UNHCR, 2017
[6] UNHCR, 2000
[7] WHO, 2011
[8] WHO, 2016

	includes persons with disabilities; the elderly; sex workers; men; persons diagnosed with infertility; persons living with HIV and AIDS; migrant populations; adolescents and youth; the poor; the illiterate; substance users; and persons in their post fertility years.
Miscarriage	The termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life.[9] Our current law allows for maternity benefits of live births, as well as stillbirths after 26 weeks.[10]
Post Miscarriage Care	This is an intervention for reducing deaths and injuries from incomplete and unsafe miscarriages and their related complications.[11]
Safe Motherhood	It implies a reduction of maternal mortality and morbidity. It encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynaecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, fetus and infant during pregnancy, childbirth and postpartum.[12,13]
Sex	This refers to the biological characteristics that define human beings as male and female. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.

[9] WHO, 1970
[10] GORTT, 2016
[11] WHO, 2012
[12] The World Bank, 1987
[13] WHO, 1996

Sexual and Reproductive Health	It is a state of well-being related to one's sexual and reproductive life. It implies "that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."[14] Implicit in this are the rights of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[15]
Youth	There is no universally agreed international definition of the youth age group. For statistical purposes, however, the United Nations without prejudice to any other definitions made by Member States defines 'youth' as those persons between the ages of 15 and 24 years.[16] This is also the definition used in The National Youth Policy, 2012 - 2017.[17]

[14] UNFPA, 2014
[15] WHO, 2015
[16] WHO, Youth
[17] GORTT, 2012

ACRONYMS & ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ASPIRE	Advocates for Safe Parenthood: Improving Reproductive Equity
ASRH	Adolescent Sexual and Reproductive Health
BOM	Billings Ovulation Method
BCC	Behaviour Change Communication
CARIMAN	Caribbean Male Action Network
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CMOH	County Medical Officer of Health
CNCDs	Chronic Non-Communicable Diseases
CRC	(United Nations) Convention on the Rights of the Child
CSOs	Civil Society Organizations
CSE	Comprehensive Sexuality Education
DWH	Directorate of Women's Health
ED	Erectile Dysfunction
EMTCT	Elimination of Mother to Child Transmission
FBOs	Faith Based Organizations
FC	Female Circumcision
FGM	Female Genital Mutilation
FPATT	Family Planning Association of Trinidad and Tobago
GBV	Gender-Based Violence
GBVU	Gender Based Violence Unit
GoRTT	Government of the Republic of Trinidad and Tobago
HACU	HIV and AIDS Coordinating Unit
HCP	Health Care Providers
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IGDS	Institute for Gender and Development Studies
ISF	International Solidarity Foundation
IVF	In Vitro Fertilization
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MILATT	Military - Led Academic Training Academy
MISP	Minimum Initial Service Package
MDGs	Millennium Development Goals
MOE	Ministry of Education
MOH	Ministry of Health
MSDFS	Ministry of Social Development and Family Services
MPD	Ministry of Planning and Development

NEOC	National Emergency Operation Centre
NGOs	Non-Governmental Organizations
NOC	National Operations Centre
NPTA	National Parent Teachers Association
NSP	National Strategic Plan
ODPM	Office Disaster Preparedness Management
PAHO/WHO	Pan American Health Organization/World Health Organization
PEPFAR	President Emergency Fund for AIDS Relief
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPU	Population Programme Unit
PRS	Poverty Reduction Strategy
PSI	Population Services International
QPCC&C	Queen's Park Counselling Centre & Clinic
RH	Reproductive Health
RHAs	Regional Health Authorities
RTIs	Reproductive Tract Infections
S&GBV	Sexual and Gender Based Violence
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRMNCAH	Sexual, Reproductive, Maternal, Neonatal, Child, Adolescent Health
STIs	Sexually Transmitted Infections
TOR	Terms of Reference
T&T	Trinidad and Tobago
TTAM	Trinidad and Tobago Association of Midwives
TTHTC	Trinidad and Tobago Health Training Centre
UHC	Universal Health Coverage
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNWOMEN	United Nations Entity for Gender Equality and the empowerment of Women
UWI	University of the West Indies
UTT	University of Trinidad and Tobago
VAW	Violence against women
VCT	Voluntary Counselling and Testing
YMCA	Young Men Christian Association
YWCA	Young Women's Christian Association

FOREWORD

The Ministry of Health (MOH), as the Government of the Republic of Trinidad and Tobago (GoRTT) entity responsible for the health and wellbeing of the people in Trinidad and Tobago, has taken the lead in the development of this National Sexual and Reproductive Health (SRH) Policy as a means of facilitating universal access to SRH. Universal access to SRH is one of the indicators to measure progress towards the achievement of the 2030 Sustainable Development Goals (SDGs).[18] The Programme of Action of the International Conference on Population and Development (ICPD)[19], the Montevideo Consensus on Population and Development,[20] and SDG 3, also pertain to Universal Access to SRH.

SRH not only affects an individual, but impacts on intimate relationships, families, communities, and the nation overall as we strive for sustainable development. Individuals need to have access to information, comprehensive services, treatment and various reproductive health commodities so that they can make decisions regarding the number of children they may choose to have and/or how to remain healthy and protect themselves from various illnesses. The information and services provided are to be aligned to the current and future needs of the population and free from any stigma or discrimination.

Since 2010, the MOH, through an SRH Technical Working Group with support from United Nations Population Fund (UNFPA) and the Pan American Health Organization (PAHO)/World Health Organization (WHO) in collaboration with its other UN sister organisations and other partners, have supported assessments of the national SRH situation.

At that time, their findings revealed that SRH services were being offered with limited integration at service delivery points, particularly in the areas of HIV, cancers of the reproductive tract, sexually transmitted infections (STIs) and maternal health. Assessments revealed that there were also key populations who do not access SRH services regularly for several reasons including the time services are being offered, the need for parental consent and stigma displayed by some healthcare professionals. To facilitate comprehensive service provision, this policy addresses the integration of SRH services, so that each client can receive a minimum package of SRH services, including during emergencies or times of crisis.

In order to achieve the GoRTT's Vision 2030, the strategy calls for bold and transformative reforms in our public sector administration, management institutions and systems, our values, attitudes and behaviours, and in the way we pursue economic growth (Vision 2030, National Development Strategy 2016-2030).[21] As the Government moves towards ensuring healthy lives and the promotion of well-being for all at all ages consistent with the SDGs, this policy is quite timely as it will provide policy direction to the Government and the stakeholders to achieve these goals. An action plan will be developed for the implementation of this SRH policy, which will be monitored through a National Committee, with the recently created Directorate of Women's Health of the Ministry of Health, taking the lead.

The Honourable Terrence Deyalsingh, Minister of Health
Ministry of Health, Republic of Trinidad and Tobago, August 2020

[18] UN General Assembly, 2015
[19] UNFPA, 1994
[20] ECLAC, 2013
[21] GORTT, 2016

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1.0 BACKGROUND

The development of the National Sexual and Reproductive Health (SRH) Policy for Trinidad and Tobago (T&T) provides an effective response to current and emerging health issues through the provision of safe, integrated, quality health information and services that are patient-centred. It is in keeping with the Government's commitment to improve standards of care; the strengthening of primary health care; patient-centred treatment; and service integration, which supports access to a "Universal Health Package" for the national community.

1.1 GLOBAL CONTEXT

The Pan American Health Organization (PAHO) has noted the existence of multiple points of intersection among the underlying causes of HIV and STIs, such as gender inequality and a variety of conditions associated with SRH in general. This led to the international call for convergence in the responses to such problems.[22] In line with other international and regional frameworks listed below, countries in the Caribbean committed to SRH integration through the United Nations Population Fund's (UNFPA) Sub-regional programme document for the English-speaking and Dutch-speaking Caribbean 2017-2021,[23] which seeks to achieve the following outcomes:

- Increased national capacity to strengthen enabling environments for integrated sexual and reproductive health services, targeting underserved populations, including in emergencies;
- Increased national capacity to advocate for and deliver policies and programmes for access to sexual and reproductive health for adolescents;
- Strengthened legal and protection systems for the implementation of laws, policies and programmes to prevent sexual violence against women and girls; and,
- Strengthened national capacity to generate, analyse and utilise data and evidence for national policies and programmes linked to sustainable development.

[22] PAHO, 2010
[23] UNFPA, 2016

Some of the key international, regional and national commitments for SRH services are as follows:

- The Programme of Action accepted by one hundred and seventy-nine (179) countries, including T&T, in Cairo in 1994 at the International Conference on Population and Development (ICPD)[21] and reaffirmed by the GORTT in 2014 at the UN General Assembly[24];
- The 2030 Agenda for Sustainable Development[20], SDG 3 (ensure healthy lives and promote well-being for all at all ages), SDG 5 (achieve gender equality and empower all women and girls), and SDG 10 (reduce inequality within and among countries). The SDG 3 targets include: 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. The SDG 5 targets include: 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action[25] and the outcome documents of their review conferences;
- The World Health Organization (WHO) Guidelines for SRH[26];
- The Montevideo Consensus on Population and Development (2014);[22]
- The Regional 2014 Integrated Strategic Framework (ISF) to Reduce Adolescent Pregnancy in the Caribbean;[27]
- The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Beijing Platform of Action which addresses gender inequality and women's empowerment including issues of violence against women and access to health;
- The Cabinet of the GoRTT Maternal and Child Health Plan (2014)[28];
- The Maternal and Child Health Manual of the Ministry of Health (2015)[29];
- The Caribbean Action Plan on Health and Climate Change (2018)[30]; and

[24] GORTT, 2014
[25] UN General Assembly, 1995
[26] UNFPA, 2017
[27] CARICOM and UNFPA, 2014
[28] GORTT, 2014
[29] GORTT, 2015

- 56th Directing Council, 70th Session of the Regional Committee of WHO for the Americas: Plan of Action for Women's, Children's, and Adolescents' Health, 2018-2030.[31,32]

Further, there is international consensus on the importance of linking and integrating SRH services, particularly HIV and other STIs, for effective delivery of services which has been addressed in several documents, including:

- Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (2004)[33];
- New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (2004)[34];
- UNAIDS policy position paper - 'Intensifying HIV prevention' (2005)[35];
- World Summit Outcome (2005)[36];
- Call to Action: Towards an HIV-Free and AIDS-Free Generation (2005)[37];
- United Nations General Assembly Political Declaration on HIV/AIDS (2016)[38];
- Global Health Sector Strategy On Sexually Transmitted Infections 2016–2021: Towards Ending STIs (2016)[39]; and
- The Global Strategy on Women, Children's and Adolescents Health (2016-2030).[3]

Data collected by the MOH revealed that most HIV infections in Trinidad and Tobago are sexually transmitted. Other HIV transmissions are associated with pregnancy, childbirth and breastfeeding but T&T has a low transmission from these routes due to a robust program of Prevention of Mother to Child Transmission (PMTCT). The risk of HIV transmission and acquisition can be further increased due to the presence of certain STIs. Linkages between core HIV services (prevention, treatment, care and support) and core SRH services (such as Family Planning; Maternal and Neonatal Health), the prevention and management of STIs,

[30] PAHO, 2019
[31] PAHO, 2018
[32] PAHO, 2018
[33] UNFPA, 2004
[34] UNFPA and UNAIDS, 2004
[35] UNAIDS, 2005
[36] UN General Assembly, 2005
[37] WHO, 2005
[38] UNAIDS, 2016
[39] WHO, 2016

Reproductive Tract Infections (RTIs), promotion of sexual health, prevention and management of GBV, prevention of unsafe miscarriages and the management of post-miscarriage care in national programmes, are believed to generate important public health benefits.

1.2 LOCAL CONTEXT

Several assessments of the SRH Services in Trinidad and Tobago were conducted between 2010 and 2012 by the MOH in collaboration with the UNFPA and other partners. These include:

1. Assessment of SRH Services in Trinidad and Tobago-Phase 1: Population Programme Unit (PPU) in 2010[40];
2. Evaluation of the National Health System Response to HIV and STI in Trinidad and Tobago in 2011[41]; and
3. Final Report on Assessment of Male Specific SRH Provided in the Health Sector in 2012.[42]

Based on these, as well as continuous national consultations with key stakeholders during the period 2012-2019, it was determined that the SRH programme was not fully integrated in T&T in terms of programme management, service delivery and other related services in keeping with international and regional good practices/models, standards, agreements and commitments. The need for a finalised SRH Policy was also identified as essential to addressing these issues.

Maternal Outcomes: There are several issues which contribute to increased maternal morbidity and mortality such as a high risk population based on ethnicity and socioeconomic factors, late start to- and poor attendance at antenatal clinics, haemorrhage, management of post miscarriage care, medical disorders pre-existing before pregnancy (e.g. obesity, cardiac disease, sickle cell anaemia, epilepsy, diabetes, hypertension, fibroids), advanced maternal age, high parity, and adolescent pregnancy. Family planning and the prevention of unsafe miscarriages are also important factors identified that may result in improving maternal

[40] UNFPA, 2010
[41] PAHO, 2011
[42] PPU and UNFPA, 2011

health outcomes. Deaths from miscarriages are now extremely rare according to data for the past ten (10) years received by the MOH.

Cancers: Cancers of the reproductive tract are an ongoing concern, though these are reportedly reducing in incidence as well as deaths, according to data from the Elizabeth Quamina Cancer Registry (2020). Cancer of the breast, cervix and of the uterus were the most frequently recorded.

The Directorate of Women's Health: From 2015 onward and with the establishment of a dedicated unit the Directorate of Women's Health (DWH) in 2017, to provide leadership at a national level in order to address matters related to maternal and neonatal health, research and audit of related subject matter as well as breastfeeding, there have been significant improvements in these areas. Notably there was strengthening and greater enforcement of standardised protocols, national collaboration and coordination, staff training and building competencies, clinical guidelines, and the upgrade of equipment and facilities, among other initiatives.

Data collected by the DWH, revealed that maternal deaths in the country declined from nine (9) in 2015 to three (3) in 2017, and four (4) in 2018 and in 2019. Maternal mortality cases are now rare from avoidable causes, with unavoidable causes such as amniotic fluid embolism, and indirect causes such as heart disease and sickle cell disease, being the main contributors for the last four (4) years. This represents a fall in the Maternal Mortality Ratio from 65 per 100 000 live births in 2015 to under 30 per 100 000 live births for the period 2017 to 2019.[43] The recommended worldwide target for this 2030 SDG is 70 per 100 000 live births but the PAHO/WHO has set a target of 30 per 100 000 live births for the Region of the Americas[44] Trinidad and Tobago has achieved both the global and regional 2030 targets with respect to the Neonatal Mortality Ratio as well. There has been a steady reduction from over 12.0 per 1000 live births in 2015, to under 7 per 1000 live births for 2019.

The T&T Police Service**:** Sexual and other forms of GBV, HIV and other STIs are a growing concern as the population has become more vocal on this issue as objective data and media coverage of GBV related homicides have been published in the public domain. According to

[43] GORTT, 2019
[44] PAHO, 2017

data from the 2017 Trinidad and Tobago Women's Health Survey, a national quantitative cross-sectional survey of 1079 women ages 15–64, 30% of ever-partnered women experience physical and/or sexual violence by an intimate partner in their lifetime.[45] In fact, the Trinidad and Tobago Police Service launched two critically required units, the Gender-Based Violence Unit (GBVU) in January 2020 and the Sexual Offences Unit in May 2020. These units will also establish databases for Sexual Offenders, and for Domestic and Gender-Based Violence reports.

There are other SRH issues in Trinidad and Tobago including an overall low fertility rate of 1.6 (placing the country below replacement levels). Teenage pregnancy remains an issue for the GORTT. A 2019 summary of proceedings of a Joint Select Committee of the Parliament on teenage pregnancy[46] reported that approximately 9% of the births for 2017-2018, were to females aged 19 or younger, with 3% of births to girls younger than 18 years. There was a 32% decrease in teenage pregnancies among girls aged 13-16, and an unspecified increase among the 17-19 age group between 2014 and 2018. However, there were no significant changes in the overall rate of teenage pregnancy over the period. This may reflect the supportive legislation (see section 2.0) against 'child marriage' where the GORTT no longer recognises marriages under the age of 18 years.

Other SRH issues include sexual dysfunction in men and women, other STIs and access to SRH information and services, including family planning, particularly among adolescents and other key populations. In some cases, children and adolescents present themselves without parental consent and the staff members are constrained by legal reporting issues and administering healthcare without appropriate consent.[47]

Presently, SRH services are being offered through a mixed method of service delivery with some being delivered vertically by the MOH and others by the RHAs, with limited integration at service delivery points. The RHAs have the primary responsibility for the delivery of SRH activities including infant, antenatal, maternal, post-natal, infertility and gynaecology clinics. Opportunities for adolescent SRH services are limited in the public

[45] IDB, 2018
[46] GORTT, 2019
[47] GORTT, 2011

sector and NGOs such as the Family Planning Association of Trinidad and Tobago (FPATT), have intervened to support these services.

The Population Programme Unit (PPU): The GoRTT established the PPU in 1969 to facilitate the delivery of fertility management services to citizens. This vertical service has been the major provider of family planning services in the country. These services include fertility management in all primary care facilities, primary Pap smear screening for cervical cancer, first line counselling in SRH, specialist referrals, and education and training programmes. The PPU has had leadership and strategic challenges in the past few years leading to stock outs of contraceptives and pap smear kits, need for updated evidence-based information to clients, staffing at clinics, distribution issues, and the need for an updated range of contraceptive choices. With the cooperation of the DWH, training was conducted, post-miscarriage and post-partum contraception services were improved, new contraceptives were introduced including the levonorgestrel implants and a new three-month progesterone preparation and all patient information resources were updated and placed on the MOH's website. A more responsive system of supply chain management is being developed and implemented with the aid of the UNFPA.

The HIV and AIDS Coordinating Unit (HACU): The MOH's National AIDS Programme was renamed the HACU through Cabinet minute No. 166 of August 2006[48]. HACU is responsible for policy formulation, standard setting, funding, regulatory functions and coordination of the activities of the RHAs. Regarding policy formulation, some of the key policies include the National HIV Testing and Counselling Policy, Health Sector Workplace HIV and AIDS Policy, the Prevention of Mother to Child Transmission Policy and the Post Exposure Prophylaxis Policy.

The National AIDS Coordinating Committee (NACC) and the Queen's Park Counselling Centre & Clinic (QPCC&C): The NACC, which is under the Office of the Prime Minister, coordinates the national HIV response. Similarly, the QPCC&C, another vertical unit of the MOH, provides services for the treatment and management of STIs and operates with two (2) centres in North and South Trinidad as well as satellite local clinics.

[48] GORTT, 2006

The Medical Research Foundation of Trinidad and Tobago (MRFTT): The MRFTT serves as a regional model for HIV care in the Caribbean delivering a comprehensive package of HIV/STI prevention, care and treatment and integrated health services to populations at higher risk for, and those diagnosed and living with HIV and STIs. The MRFTT is dedicated to providing a range of biomedical, behavioural and health interventions to effectively address the medical, psychosocial and social support needs of its clients from time of initial diagnosis and through their continuum of care toward achieving viral suppression.

Mother to Child Transmission: The Elimination of Maternal To Child Transmission of HIV and Syphilis Programme (EMTCT plus)[49] is one project that is now being strategically synchronised by the DWH along with the previous coordinator (HACU) that requires multisectoral and multi-unit coordination and cooperation. The goal is to achieve a formal assessment of country elimination by 2022, which means meeting the defined targets by 2021 or earlier.

Summary

Given the multi-unit and multi-level nature of these programmes, full and comprehensive SRH services are not guaranteed. Furthermore, sexual violence is often not treated in the healthcare setting as a primary SRH issue but assigned to the domain of the police services. There are limited counselling services available at the primary care level. There is limited functionality of the referral system, and while health is addressed in the present emergency/disaster system, healthcare providers are not fully aware of the key SRH live-saving interventions that need to be offered during an emergency/disaster. With the DWH at the MOH, further integration of SRH services is expected.

Currently, in the absence of a National Policy framework to ensure universal access to SRH information and services in Trinidad and Tobago the following polices are used:

- the HIV and AIDS Policy,[50]
- the National Post Exposure Prophylaxis Policy,[51]
- the Prevention of Mother To Child Transmission (PMTCT) HIV Policy,[52]

[49] WHO, 2017
[50] GORTT, 2019
[51] GORTT, 2010

- the Health Sector HIV Workplace Policy[53], and
- the National HIV Testing and Counselling Policy[54].

Findings from anecdotal and locally reported SRH related conferences, research and reports reveal that there are key populations such as the poor, working males, substance users, persons with disabilities, the elderly, incarcerated persons, migrants, persons living with HIV, sex workers and adolescents, who do not access SRH services regularly. Reasons noted for not accessing services include:

i. the inconvenient times allocated for these services,
ii. underage clients requiring the consent of a guardian or parent and,
iii. stigma and attitudes expressed by healthcare professionals.

This SRH policy takes into consideration the above-mentioned challenges, consultations with national stakeholders, assessments of SRH delivery and reviews of models of SRH policies and good practices from other countries. As a result this policy intends to address these issues and facilitate universal access to SRH by orienting towards the delivery of an integrated package of SRH services; placing emphasis on educating the public on SRH; focusing on quality of care and evidence-based decision making; capacity building of health care providers; addressing post miscarriage care; promoting community empowerment and ownership; providing adolescent SRH information and services; recommending legislative reforms; and facilitating the development of protocols and guidelines to improve the quality of services and the health system overall.

1.3 NEED FOR AN SRH POLICY

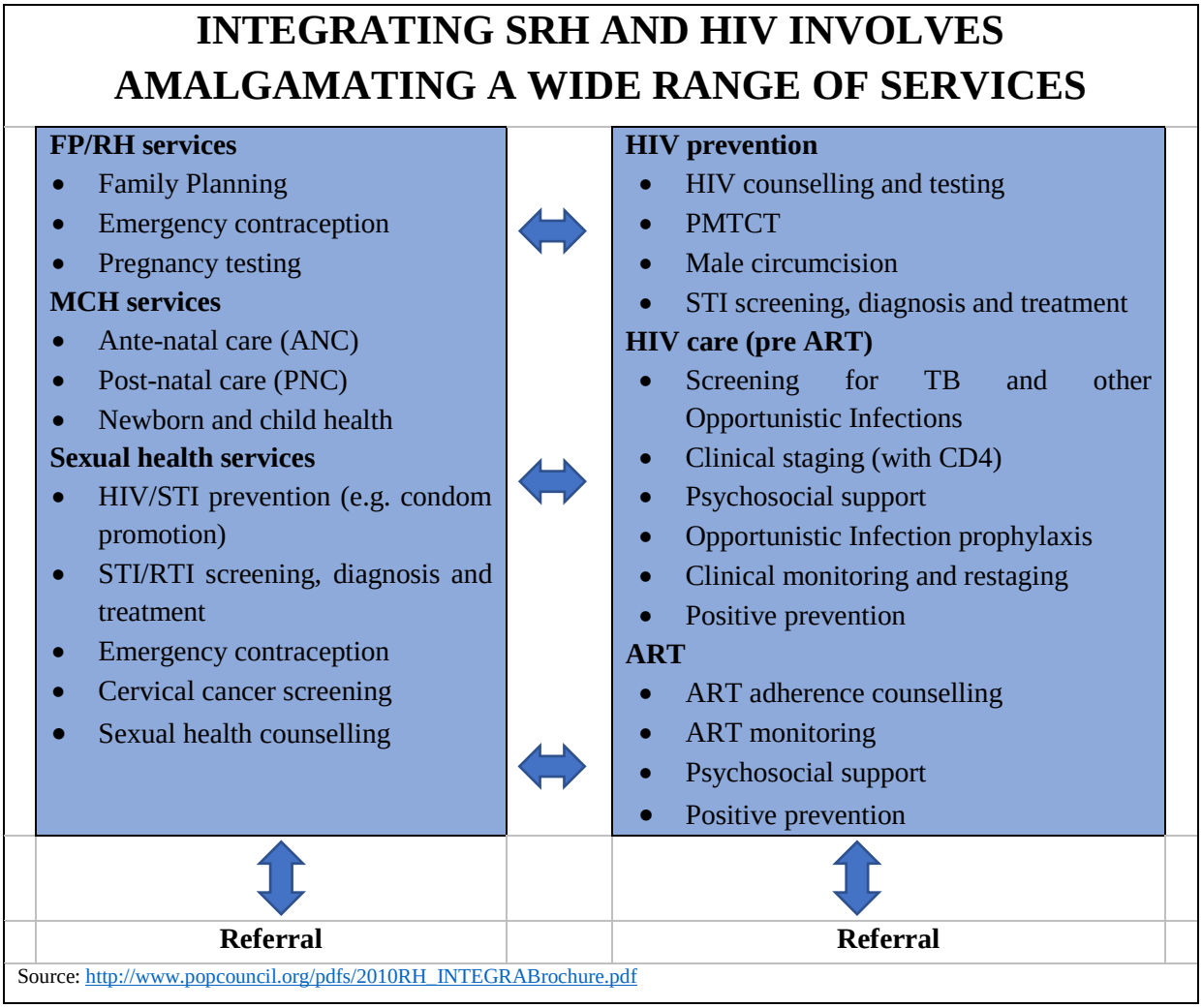
To make sure that all persons have access to SRH services, this policy addresses the integration of SRH services by offering clients a comprehensive package of SRH services. The key benefits of an integrated SRH policy and programme will include:

- the improved access to and uptake of key SRH services, including HIV, AIDS and GBV;

[52] GoRTT, 2010
[53] GoRTT, 2010
[54] GoRTT, 2012

- the improved coverage of vulnerable populations including persons with disabilities; the elderly; sex workers; men; persons diagnosed with infertility; persons living with HIV and AIDS; migrant populations; adolescents and youth; the poor; the illiterate; substance users; and persons in their post fertility years;
- the greater support for dual protection against unintended pregnancy and STIs, including HIV, especially the youth population;
- an improved quality of care, including maternal and child health outcomes; and
- an enhanced programme effectiveness and efficiency.

1.4 INTEGRATING SRH AND HIV



Source: http://www.popcouncil.org/pdfs/2010RH_INTEGRABrochure.pdf

1.5 RELATED LEGISLATION AND POLICIES FOR SRH

There are several pieces of legislation that address issues in SRH. These include:

- the **Sexual and Offences** Act of 1986;[55];
- the **Marriage Act** (amended in 2017 to ensure that the age of marriage is 18 years and above)[56];
- the **Domestic Violence Act** of 1999[57]; amended by the Domestic Violence (Amendment Bill), No. 36 of 2020[58]
- the **Children Act** 46:01[59] and
- the **Offences Against the Persons Act**.[60]

The official position of the MOH is as follows:

> ***Abortion is illegal in Trinidad under the Offences Against the Person Act, Chapter 11:08 (Sections 56 and 57)***. *Every woman, being with child, who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, and any person who, with intent to procure the miscarriage of any woman, whether she is or is not with child, unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, is liable to imprisonment for four years.*
>
> ***General criminal law principles of necessity, however, allow an abortion to be performed to save the life of the pregnant woman***. *Moreover, Trinidad, like a number of Commonwealth countries whose legal systems are based on English common law, follows the holding of the 1938 English Rex v. Bourne decision in determining whether an abortion performed for health reasons is lawful. In the Bourne decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a*

[55] GoRTT, 2000
[56] GoRTT, 2017
[57] GoRTT, 1999
[58] GoRTT, 2020
[59] GoRTT, 2012
[60] GoRTT, amendment 2005

precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health.

Further the Council of the Medical Board of Trinidad and Tobago has included the elements of the principles of necessity in its Code of Ethics in the Practice of Medicine, which does not have legislative standing but is meant to offer guidance.[61]

As such, in Trinidad, the grounds on which abortion is permitted, is to save the life of the woman or to preserve her physical and mental health. Of course, the medical practitioner will have to validate and to justify the same.

The **Domestic Violence** Act, 2020, addresses GBV, particularly within the home and amongst intimate partners and makes provision for Protection Orders and Emergency Protection Orders, and the establishment of a National Domestic Violence Register for Domestic Violence Complaints. The **Sexual Offences Act**, 1986, addresses sexual offences primarily against adults. In 2015, with the proclamation of the **Children Act (**2012), a wider and more comprehensive range of criminal offences, (including the offences of sexual penetration and sexual touching) for the protection of children against various forms of sexual abuse and other mistreatment, was introduced.

The mandatory reporting provision at section 31 of the **Sexual Offences Act** outlines the legal obligation of health care providers and other responsible adults (such as teachers and parents) to make a report to the Police where they have reasonable grounds for believing that a sexual offence has been committed in respect of a minor (under the age of 18). This mandatory reporting requirement clearly targets adult perpetrators although children between the ages of 12 and 18 who commit sexual offences can also be the subjects of mandatory reporting. This reporting requirement is regardless of whether the sex was reported to be consensual or not. While it is designed to protect minors who experience sexual abuse, it can also have the following implications, amongst others:

- reluctance by Health Care Providers (HCP) to provide services to adolescents as they will be required to report any sexual activity they might observe to the police, with

[61] MBTT

unsure consequences for the adolescent or the HCP, including the potential for threats, violence and physical harm; and

- unwillingness of adolescents to use SRH services for fear of being reported to the police which may result in more non medicalized termination of pregnancy and greater incidence of unwanted pregnancies, HIV and other STIs among young people.

The legislation will therefore need to be reviewed with a view to address consensual sex amongst minors who do not come within the exceptions so that these healthcare barriers will be removed.

Given early sexual initiation and multiple sex partners amongst adolescents, access to SRH information and services must be addressed with the implementation of real steps towards furthering the objectives of this policy. One earlier publication from the MOH, the 2012 HIV Testing and Counselling Policy stated:

- *"The epidemic profile of Trinidad and Tobago indicates that minors are vulnerable to HIV infection. In this context this Policy seeks to facilitate minors' access to testing. This should be done in accordance with accepted practices for offering health services to minors.*
- *Clients less than 14 years of age will not be tested without consent from a parent or guardian.*
- *Clients 14 years and older but less than 18 years of age will be tested only if the health care provider deems the client emotionally mature and able to understand the testing process and the implications of the result."*

Further, any proposed amendments of the legislation related to SRH should be in line with the objectives of this policy and the relevant international agreements and standards; and guide all other SRH related policies, programmes and interventions.

Aside from the legal and policy frameworks, there are ethical factors that should also be considered, such as the Hippocratic Oath that speaks to beneficence, non-maleficence, autonomy, including informed consent, medical confidentiality and distributive justice. This

will help assist to resolve any conflict between the ideology of SRH for all and the legal restrictions influencing the delivery of care to all.

2.0 GENERAL POLICY STATEMENT

The GoRTT will guarantee universal access to comprehensive SRH to all persons in need and requiring it, that is of the highest standard through the provision of an integrated service delivery system. These SRH services will be facilitated by a multi-sectoral, life course approach and within the context of sexual and reproductive rights, to attain the highest quality of SRH of all persons in T&T. This statement is consistent with the SDG 3 of ensuring healthy lives and promoting wellbeing for all at all ages and SDG 5: Achieve gender equality and empower all women and girls.

To this end, the GoRTT commits to incorporate the full set of sexual and reproductive health services into universal health coverage (UHC), with special attention to the most underserved population. SRH services include a broad range of service to cover the needs of women and girls such as contraception, safe miscarriage care post-miscarriage care, maternal health care (antenatal, delivery and post-natal), prevention and treatment of infertility, RTIs, prevention and treatment of all sexually transmitted infections, including HIV, reproductive cancers, comprehensive sexuality education (CSE), and services to address sexual and gender-based violence.

3.0 GUIDING PRINCIPLES OF THE POLICY

The guiding principles underpinning this policy are based on current scientific, epidemiological knowledge of the prevalence and determinants of SRH services. The principles are designed to guide delivery of SRH services at every level of the health system and provide a basis for evaluating progress. The following constitute the guiding principles for the SRH Policy:

1. Respect the rights of each individual to make voluntary and informed SRH choices;
2. SRH services should be Available, Accessible, Affordable, Acceptable and of the highest standard of quality;
3. Ensure that information and services provided are age appropriate & culture specific which builds on a clear understanding of local knowledge, practices, perceptions and behaviour in relation to SRH, including gender sensitivity, confidentiality, and responsiveness;
4. Recognition of gender equality and equity;
5. Transparency and Accountability in promoting a sense of responsibility and good governance at all levels in the implementation and monitoring of the SRH Policy;
6. Zero tolerance on stigma and discrimination of service users;
7. Due concern for equity in resource allocation and equitable outcomes of policy measures; and
8. Sustainability and efficiency in the allocation of resources for appropriate interventions as well as strengthened managerial capacity to ensure cost-effectiveness and sustainability of SRH programmes.

4.0 POLICY OBJECTIVES

The SRH policy seeks to address the following objectives:

To ensure that every person in Trinidad and Tobago in need of SRH information and services is offered and has access to comprehensive SRH Services through the Public Health System at service delivery points.

In the context of UHC, the provision of an integrated package of comprehensive SRH to all individuals who require these services is critical given the changing needs and expectations of the population. Updated and evidence-based protocols and/or standard operating procedures shall be developed or strengthened to guide the implementation. SRH shall be integrated in multi sector policy and programme development, service delivery, and information, education, and communications (IEC). During emergencies, a minimum initial service package (MISP) for reproductive health should be offered including:

1. ***Educate the population on SRH and rights***

   All available means, including mass media, social media and community interaction, should be utilized to inform and educate the general public on SRH issues. In addition to health care workers, teachers and other non-conventional agents (e.g. artistes) will be used to deliver the messages and information. New technologies, including electronic health (e-health) and m-health, will be used as far as possible to reach these key populations. Stakeholders shall be encouraged to speak out on key issues related to vulnerability and SRH and advocate for policy, legislative, and programmatic changes to attain the highest level of SRH.

2. ***Reduce adolescent pregnancy through the provision of comprehensive Adolescent SRH information and services***

   Adolescent SRH shall be addressed through access to comprehensive age appropriate sexuality education information and services for in and out of school adolescents and youths (including adolescents and youths in institutions). Through the Ministry of Education's (MOE) Health and Family Life Education (HFLE) programme, age appropriate CSE will be delivered. The MOH is currently finalising a Health in Schools Policy with key stakeholders including the MOE.

Adolescents should have the information and skills needed to be able to make informed behavioural choices. Appropriate teacher training, peer education and parent participation must be ensured for the success of CSE. SRH services should be responsive to the needs of adolescents and adolescent friendly and delivered by specifically trained and motivated providers in a confidential environment free from stigma. Programmes to reach out of school and those in institutionalised settings (prison, homes, and health institutions) adolescents and youth, shall be developed and implemented.

3. ***Improve maternal and newborn health***

Recent improvements in maternal and newborn outcomes will be strengthened and coordinated through the DWH including programmes already in progress such as the package of integrated SRH services of critical live-saving and evidence-based interventions including pre-natal care, intra and postpartum care including Basic and Comprehensive Emergency Obstetric and Neonatal Care including post miscarriage care.

A renewed focus on programmes to increase the reach of pre-pregnancy services especially for women with chronic non communicable diseases (CNCD) and other medical conditions such as cardiorespiratory, haematological, and obesity. The awareness on the importance of early and consistent attendance at antenatal visits, particularly for mothers who have chronic illnesses should be a priority.

Post-miscarriage care includes five essential elements:

1) Treatment of incomplete and unsafe miscarriage and complications;
2) Counselling to identify and respond to women's emotional and physical health needs;
3) Contraceptive and family-planning services to help women prevent future unwanted pregnancies;
4) Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities; and
5) Community and service-provider partnerships to prevent unwanted pregnancies, to mobilise resources to ensure timely care for miscarriage

complications, and to make sure health services meet community expectations and needs.

4. ***Increased quality and uptake of services through strengthening health system***

SRH services shall be confidential, comprehensive and friendly to all users, particularly, to vulnerable or key populations. Health care providers shall be adequately trained and motivated to respond to the needs of diverse populations. National health systems shall be strengthened in compliance with international standards to facilitate access and the delivery of quality SRH services. In this regard, standards of care, norms and protocols will be developed or updated as necessary along with an improved supply chain management system to align resources, people and services. Strong systems such as the GBVU, must be assisted with psychosocial support, trained law enforcement officers and social workers to address sexual abuse. Primary health care facilities will be the main entry point for the delivery of services to all persons. As such, HCP shall be trained and offered continuing professional development courses particularly in the areas covered by the Comprehensive Package of Key SRH Services. Communities shall be empowered to own the healthcare system, monitor the quality and hold programme managers accountable for the performance of the system.

5. ***Ensure coordination and implementation of policy***

This policy will require coordination amongst a number of stakeholders, oversight and monitoring of its implementation as part of the health system strengthening. The MOH through the DWH will establish a multi-stakeholder National Committee. This will be related to Sexual, Reproductive, Maternal, Neonatal, Child, and Adolescent Health (SRMNACH). A proposal and terms of reference are currently being finalised. The National Committee will monitor the implementation of this policy and oversee its coordination. Greater linkages will also be established with NGOs and CSOs including Service Agreements to ensure the delivery of the comprehensive package of SRH services to all in Trinidad and Tobago.

6. ***Ensure any new SRH-related legislation is in line with the principles of this policy and with the relevant international agreements and standards, and guide all other SRH related policies, programmes and interventions***.

   The relevant laws should be reviewed and where necessary, amended, to allow for the provision of SRH services to all sectors of the population. This will guide all revisions and updates to the SRH policy as well as programmes and interventions.

7. ***Strengthen SRH information systems for decision-making.***

   This will require data production/collection, analysis, dissemination and use for decision making and will involve the standardization (revision of tools) and collection of data and information from health services as well as nation-wide systems (vital registration, population-based surveys and qualitative and quantitative research) to inform the use and impact of SRH services. The Perinatal Information System (SIP) has already begun and is being escalated in a phased approach. It is a comprehensive evidence-based system involving hard and soft copies of clinical medical records for pre-pregnancy, sexual and reproductive health, prenatal, intrapartum, postpartum and neonatal care. It allows real time, national access to electronic records and encompasses additional components related to GBV, Cervical Cancer screening, EMTCT Plus, Family Planning as well as data, research, audit and immediate country reports on key indicators. The hard copy version was made mandatory for use at all the RHAs in August 2018 by the MOH.

5.0 POLICY SCOPE/ COVERAGE

This policy is applicable to all stakeholders in the private and public sectors in T&T, offering a spectrum of SRH services that is to be made available to all and supported by an integrated network of highly skilled service delivery providers. There is expected to be an outlay of resources to promote and improve access to care in a reliable, safe, consistent and effective manner to achieve the highest quality of care within acceptable equitable, ethical, social, community and cultural norms.

The scope of the SRH policy is as follows:

- to integrate SRH services with key components of care to facilitate greater treatment and care using an appropriate model of care;
- to develop the appropriate strategies, programmes and interventions aligned to local, regional and international agencies for SRH services;
- to develop or enhance the monitoring and evaluation tools and reporting framework aligned to local and international indicators for SRH services;
- to develop appropriate and effective communication and education programmes to create awareness and respond to concerns about prevention, treatment and pre-and post SRH services; and
- to develop and/or enhance appropriate management and operational tools including governance, system design, clinical protocols and guidelines, operational procedures and surveillance systems in the administration and operations of SRH programmes and services.

6.0 EXPECTED POLICY OUTCOMES

The expected outcomes of the SRH Policy include the following:

1. A significant increase in the percentage of the population using SRH services aiming to contribute towards the reduction in the inequalities in accessing SRH services and the fulfilment of SRH and Rights across the T&T population;
2. The establishment of a modern and consistent legislative, policy and regulatory framework governing the delivery of SRH services with best practice standards and protocols;
3. An effective SRH surveillance system to allow for evidenced-based decision making through effective monitoring and evaluation of systems, people and services; and
4. All members of the population have access to educational resources, prevention, treatment and care of comprehensive SRH services

7.0 KEY POLICY INDICATORS and TARGETS

We are cognizant that some of these targets may have already been achieved and if so, these are required to be maintained.

1. By 2030, reduce the global maternal mortality ratio to ≤70 per 100 000 live births and ≤30 per 100 000 live births as recommended for the PAHO Region;
2. By 2030, end preventable deaths of newborns and children aged <5 years, aiming to reduce the neonatal mortality ratio to at least ≤12 per 1000 live births (global target) and ≤7 per 1000 live births (PAHO Region); and under-5 mortality rate to at least ≤25 per 1000 live births (global) and ≤14 per 1000 live births (PAHO Region);
3. By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes;
4. By 2030, reduce by 10% the age-specific fertility rates for the 10-14 and 15-19-year age groups[62];
5. By 2025, all adolescent girls and boys have access to age appropriate comprehensive sexuality education in schools, communities and social media networks;

[62] PAHO, 2017

6. By 2022, adopt or review as necessary the common legal standards concerning ages of marriage, consent, prosecution of perpetrators of sexual violence and access to social protection and sexual and reproductive health services;
7. By 2025, increase the number of health facilities offering adolescent friendly services according to international standards of quality of care by 25%;
8. Increase the healthy life expectancy in females by at least one (1) year added by 2030; and
9. By 2030, a reduction by one-third of the homicide rates from GBV against females

8.0 SRH HEALTH CARE SERVICE MODEL

8.1 Integration of SRH Services

The rationale for integration of SRH services in T&T is to increase the effectiveness of the health care system to meet people's SRH needs, while ensuring accessibility, acceptability, reliability and effectiveness of services using a client centred care approach. The integration of these SRH services include

- the prevention of SRH ill health;
- the provision of information and counselling; and
- the provision of screening, diagnosis and curative care with an effective referral of various SRH problems to the appropriate level of care.

The integration of SRH services needs to occur at the point of service delivery, at the health sector level, and within the national development planning processes. At the point of service, integration requires that health care providers have knowledge, skills, and attitude to provide SRH services and to refer patients for other necessary services not provided at the site. The type of SRH services provided at any given level will be determined by the capacity of health care providers, available equipment and supplies, and a feasible and effective referral system. Social and cultural norms need to be considered in order to provide acceptable services. SRH raises issues of human rights, equity, and discrimination which must be addressed.

The mobilisation of key elements and stakeholders are an integral part of integration at the point of prevention, service delivery and after care. This mobilization is required to ensure realistic outcomes and improvement in both the population's SRH health and the effectiveness of SRH programmes and interventions.

8.2 Package of SRH Services

A proposed model of integration of the package of SRH services at the primary care level is recommended on a phased basis using the following approach:

1st Phase	STI, HIV, cervical cancer screening, and family planning services;
2nd Phase	GBV training, comprehensive prostate cancer, breast examination, infertility investigation, and screening for CNCD services; and

3rd Phase — any other SRH services, build additional capacity e.g. specialists in community, telemedicine, enhanced level of laboratory, and radiology support on site.

The present system of referral for secondary and tertiary level services should continue to be strengthened including for cancers of the reproductive tract, infertility services, specialist maternity and neonatal services, and post miscarriage care.

A phased implementation is recommended based on current SRH capacity and conditions to allow time for the logistical and service delivery systems to be developed and implemented to accommodate programme growth. The details of the comprehensive package of SRH services are shown in Appendix I.

In facilitating this integration of SRH services, the following must be considered:

- Management and oversight of the SRH services;
- The required infrastructure and referral systems;
- Updated sexual and reproductive health programme guidelines;
- Availability and competency of personnel;
- Training needs of staff and supervisors;
- Medical support;
- Supplies, logistics and information system support;
- Integrated Record Systems;
- Delegation of activities; and
- Estimation of resource needs and identification of funding sources.

The necessary resources (human, financial, technical, material, and physical, including reproductive health commodities) shall be strengthened or acquired to support the development, implementation, monitoring and evaluation of policies, action plans, and activities. Service delivery points shall be increased and/or upgraded to support the implementation of this Policy. As such, additional guidelines and/or SOPs will be developed for delivery of the specific services.

8.3 Minimal Initial Service Package (MISP)

Following a crisis event, the supply and delivery of the comprehensive SRH package typically becomes interrupted. In such an event the provision of SRH information and services is threatened. Nonetheless, SRH is a human right and a bio-psycho-social need. At a minimum, SRH life-saving intervention should be available and accessible at the onset of any emergency or disaster e.g. the 2020 global COVID-19 pandemic. These SRH service provisions are afforded via the MISP, each word indicating the following:

Minimum: Basic, limited, essential RH services
Initial: For use in an emergency, without a site-specific in-depth RH needs assessment
Services: Reproductive Health care for the population
Package: Coordination and planning, supplies and activities

MISP is a coordinated set of priority activities (performed at the onset of an emergency/disaster) designed to prevent and manage the consequences of GBV; reduce STIs and HIV transmission; prevent excess maternal and newborn morbidity and mortality and prevent unwanted pregnancies.

The implementation of the MISP requires collaborative partnerships among primary and support service and goods providers and recipients. It also requires supporting infrastructure; a knowledge base with various capacities of stakeholders; and resources and networks to lessen the risk of a stable and comprehensive SRH system being interrupted.

Essential SRH provisions are to be made, in a timely, cost-effective, safe, high-quality, and highly reliable manner. MISP requires planning and preparation for response and initial recovery during an emergency or disaster. These efforts are geared towards finding durable solutions, while empowering and assisting people disproportionately affected by emergencies/disasters. At these times, the Office Disaster Preparedness Management (ODPM) will work with the MOH and other stakeholders to implement the MISP.

8.4 Key Areas of focus for SRH Service Delivery

Based on the ever-changing social norms and practices within the local and global environment, there are emerging and evolving areas that this policy must address that adversely affect the present and future health of the population including the:

a) SRH needs of the Ageing population,
b) SRH needs of the Adolescent population,
c) issues and management of GBV and violence against women (VAW),
d) management of infertility, and
e) management of contraception and fertility (in the context of low fertility below replacement levels).

For the above initiatives, the key policy objectives and actions for development are as follows:

- the appropriate strategies, programmes and interventions aligned to local, regional and international standards with monitoring and evaluation tools and a reporting framework aligned to local and international indicators;
- appropriate and effective communication and education programmes to create awareness and respond to concerns about prevention, treatment and pre-and post-health care;
- legislation and policies aimed at facilitating universal access and addressing any gaps identified in SRH;
- appropriate management tools including governance, system design and clinical protocols and guidelines and operational procedures in the administration, and operations of these programmes;
- integration of counselling services for all these elements of care and utilisation of appropriate public health education for effective delivery and impact;
- effective scaling-up of SRH services to be integrated with the provision of the above services supported with the appropriate resources including skilled staff, financial and other resources required; and
- protection of the rights of persons accessing these programmes and the privacy, confidentiality, respect and informed consent regarding the above related programmes.

8.5 Service Delivery Points

The following facility types will be the service delivery points for information, prevention, treatment and care and overall management:

- Health centres;
- District Health Facilities;
- Hospitals;
- Community Outreach Programmes;
- NGOs e.g. Domestic Abuse, FPATT, Trinidad and Tobago Cancer Society;
- Information and communication avenues as well as Health App, Hotlines.

8.6 Universal Access to SRH

The facilitation of universal access and the need to accelerate the implementation of key evidence-based interventions towards SRH are driven by good governance and improving health service delivery:

1. **Building good governance** for SRH requires not only strong political commitment but also calls for government and different constituent sectors, other social organizations and citizens to engage each other in decision making to promote ownership and a multi-sectoral approach for a rapid scale up and sustainability of the interventions towards universal access to SRH. The required actions are to:

    - Develop an appropriate governance structure to manage and integrate SRH services through the Directorate of Women's Health and the National SRMNCAH Committee;
    - Strengthen multi-sectoral coordination among relevant ministries and agencies, such as health, finance, gender, social affairs and justice; and increase funding for comprehensive SRH services;
    - Develop a costed SRH plan with evidence-based national targets which is prioritized within health sector planning processes and overall national development plans and are coherent with policy and legislative frameworks;

- Establish an accountability framework for monitoring of progress, performance and finance for SRH programmes;
- Promote community empowerment in SRH activities as part of strengthening leadership and empowerment of individuals, households and communities to demand for quality SRH services; and
- Engage governmental sectors and non-governmental actors such as health professional bodies, legal experts, human rights groups, women's associations, political leaders and parties, religious and community leaders to champion SRH issues.

2. **Improving health service delivery** involves a range of elements that should be incorporated into the actions to ensure universal access to SRH including availability, accessibility and quality integrated essential SRH services. The required measures are to:

    - Implement and scale up an integrated quality SRH service package in a continuum of care, including family planning, prevention of sexual violence and management of survivors of violence, post miscarriage care, cancer screening, prevention and management of STI/HIV, adolescent reproductive health and nutrition (Appendix I);
    - Develop and implement a community mobilization strategies/plans including behaviour change communication interventions to increase the utilization of SRH services;
    - Strengthen service-delivery management capacity and institutionalize quality assurance mechanisms to ensure availability of functioning health facilities, and SRH commodities security (including local production of medicines, commodities, and medical supplies for SRH); and
    - Develop and implement integrated monitoring and supervision plans addressing essential SRH intervention packages at all levels to ensure quality and efficient SRH service delivery.

9.0 SRH SUPPORT DELIVERY INITIATIVES

9.1 Human Resources for SRH Health

In addressing human resources challenges, it is important to consider the need to ensure a continuum of care for the individual and provision of comprehensive care to address reproductive health needs in an integrated manner which depends on a wide range of cadres from doctors, nurses, midwives and paramedical professionals. The required actions are to:

- Develop and implement policies to ensure appropriate production, equitable distribution of SRH health providers and retention (e.g. multi-prong approaches combining decentralized training and management of human resources as well as staff rotation rules from urban to rural areas and providing incentives and increased motivations);
- Review and update pre-service and in-service training curricula for standardized competency-based training approach;
- Strengthen the capacity of training institutions to deliver quality competency-based education and training through development and adoption of standards, practice regulations, accreditation criteria, regular monitoring and supervision;
- Strengthen the competencies for integrated supportive supervision at all levels and for all areas of work;
- Conduct regular mapping on reproductive health competencies based on functioning human resources information systems to ensure congruence between competence development and reproductive health service needs; and
- Human resource planning and development, should include the formulation of new job descriptions, re-assignment of responsibilities, re-training and re-orientation of SRH health providers in both public and private sectors complemented with training and development and succession planning at all levels, for sustainability of a high quality service. There should be incentives and the use of a formalised process of continuous medical education programmes to ensure continuous development of skills and competence development.

9.2 SRH Surveillance

The Ministry of Health in collaboration with its key partners shall integrate and strengthen SRH services-surveillance into the National Health Surveillance System.

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Such surveillance shall allow for documentation of the impact of specific SRH health interventions and track the progress to SRH health goals.

The standardisation of data collection and reporting with indicators (national, regional and international) for the management and provision of SRH services will facilitate evidence-based priority setting and inform overall health policy and strategies. The development and integration of an SRH surveillance system into the National Health Surveillance System shall allow for improved and more efficient health information management.

Further, to strengthen information system for tracking SRH outcomes, the required actions are to:

- Strengthen capacities for data collection and analysis about health status overall and SRH, its underlying determinants and the functioning of health services at local, district and national levels with appropriate and qualified human resource and the required equipment;
- Strengthen integration of data including data from the SIP, for family planning, STIs and HIV and AIDS, cervical cancers, infertility, GBV and harmful practices into existing HMIS, data from communities, and private sector;
- Strengthen reporting and monitoring of projects, programmes and indicators with supporting ICT solutions in the provision of accurate, reliable, validated and timely information; and
- Ensure the security, confidentiality, and prohibited access to authorised persons in the use and reporting of data.

9.3 SRH Health Quality Management

High-quality services are essential for delivering effective SRH interventions. To achieve SRH services of the highest quality the following should be undertaken:

- Ensure that the capacity of service providers at all levels meets the increasing demand for SRH services by providing high-quality pre- and in-service education;
- Ensure that the performance of service providers meets national standards through regular monitoring, on-the-job supportive supervision and performance appraisal;
- Ensure that all facilities are continuously equipped with adequate drugs, commodities and other essential supplies;
- Uphold adherence to the accreditation system for the delivery of SRH and future health care packages to ensure compliance with national standards of care;
- Establish a quality assurance program to continuously monitor and guide further improvements in the quality of SRH services;
- Supply service providers with the appropriate tools and guidelines for effective service delivery.

The MOH adopted a Total Quality Management strategic approach in the delivery of quality health services to the population. In keeping with this strategy, SOPs and quality systems shall be developed and implemented in the delivery of health education services to achieve health services accreditation standards. The process flow and the alignment of services to equipment, human resources, layout and technology should be seamless to allow for the provision of optimum SRH health care to the population.

9.4 Regulation of SRH Services

The Ministry of Health shall, through consultation with the relevant stakeholders, facilitate the drafting of guidelines, regulations and legislation designed to govern the delivery of high quality SRH services and protect public safety.

SRH services are delivered based on the rules and regulations as per the various legislative Acts. As the needs of the population change, the demands on the delivery of SRH services must also change. This dictates changes to the regulatory framework and the statutory bodies created to effect and enforce such regulation including ensuring alignment with all legal and policy frameworks.

The MOH shall ensure that regulations and guidelines are kept current with the required demands on the SRH health care practice. This shall include, review and amendments to the various related legislation as deemed necessary and the formulation of new legislation and regulations to govern the use and practice of SRH services.

9.5 SRH Health Research – Evidence-based SRH Health

The National SRH Health Policy for Trinidad and Tobago seeks to promote research to facilitate evidence-based decision making and policy formulation with respect to the delivery of SRH health care and facilitate monitoring and evaluation of all strategic interventions highlighted in this policy.

10.0 SRH HEALTH MONITORING AND EVALUATION SYSTEM

Monitoring and evaluation mechanisms are critical for the timely availability of data for planning, programming and decision-making and should be strengthened, integrated, and streamlined with a unique set of defined indicators for measuring coverage, utilisation, quality, and resources, as well as monitoring output and impact.

Evaluation will be conducted quarterly and annually, making use of existing tools where appropriate, and will be built into SRH program activities from the planning stage. Midterm and year-end reviews of the implementation of the Policy will be undertaken to inform revision or development of new policies. The Policy calls on partners to support operational research on SRH to inform policy development and decision making for the achievement of the SDGs.

Based on international and regional agreements and national commitments, the SRH Policy will seek to achieve several outcomes. Indicators have been identified as means of measuring progress on achieving these outcomes and will be used to monitor the implementation of the policy and provide a platform for learning and policy/intervention improvement.

As a result, increased attention is needed to the ongoing collection, analysis, interpretation, and use of population-level data related to SRH services. The core types of data to be collected include:

- disease incidence and prevalence;
- prevalence of risk factors for various types of SRH services (i.e. adolescent pregnancy);
- access to and use, safety, efficacy, and quality of SRH services; and
- social, economic and financial aspects of SRH service delivery.

Further, as previously indicated, an action plan should be developed that will guide the implementation of the policy with monthly and quarterly reporting. This will determine the effective use of resources and the impact of the various SRH programmes and initiatives on the population.

Implementation of a Monitoring and Evaluation (M&E) System for SRH health will provide a mechanism to measure and report on performance and for determining if SRH health programmes are achieving the desired outputs and outcomes. It also provides valuable information which can be used to revise programmes if objectives are not being achieved. A list of SRH indicators are shown in Appendix III.

The implementation of an SRH health M&E system would involve the development of an M&E plan that addresses M&E- advocacy, communications and culture; human capacity for M&E; M&E partnerships; data collection tools and methods; the development of a M&E database; data analysis and dissemination.

11.0 ROLES AND RESPONSIBILITY

The National SRH Policy requires the participation of many stakeholders functioning in a coordinated, coherent, and integrated manner to improve the SRH of the population of Trinidad and Tobago. The successful implementation of the National SRH Policy will depend on the functional capacity of a number of key stakeholders, including the various SRH related units of the MOH, Civil Society, the Private Sector and International Partners (See Appendix III and Appendix IV for proposed composition of the National SRMNCAH Committee). Once agreed by the MOH and these stakeholders, the SRH Technical Working Group will form part of a Cabinet appointed National committee under the leadership of the MOH, who will ensure coordination of this policy. The major partners include but are not limited to, the following public-sector, private-sector and civil society entities.

11.1 Ministry of Health

The MOH is the national authority charged with oversight of the entire health system in Trinidad and Tobago. The MOH plays a central role in the protection of the population's health and in ensuring that all organisations and institutions that produce health goods and services conform to standards of safety.

In respect to SRH, the MOH will be responsible for ensuring that all persons receive the highest quality of SRH services and as such will have the lead role in establishing the proposed Cabinet appointed multi-sectoral National Committee that will guide, monitor and evaluate the implementation of this policy. This mechanism will help to facilitate greater accountability for the delivery of a comprehensive National SRH Programme by the key stakeholders and monitor the legal framework for protecting the rights of the population to the highest attainable standard of SRH.

The MOH will take the lead in promoting and supporting epidemiological, clinical, and operational research in relation to SRH to enhance the development and design of adequate related programmes. This includes the establishment of national standards, norms, and protocols for all SRH Care interventions.

The MOH (through its DWH which will serve as the Secretariat for the National Committee) will have overall responsibility for the coordination of all agencies, institutions and

organizations involved in the provision of SRH services in the country. The MOH, with support from the National Committee, will be responsible for ensuring that the goals, priorities, and action plans related to the National SRH Policy are reflected in national policy documents including the National Development Policy Framework and Strategies, the annual National Budget Estimates, and other relevant documents.

The MOH in collaboration with the Ministry of Planning and Development and the Ministry of Finance will be responsible for enhancing the reporting structures and processes and the mobilization and allocation of resources within the national budget for the effective and efficient implementation of the National SRH Policy, Programme and Services by its internal units, such as the PPU, the QPCC&C, the HACU, the DWH and other relevant major partners.

The MOH will be responsible for developing the health information system that has the capability and capacity to produce, analyse, disseminate, and use reliable and timely information related to SRH.

The MOH, guided by the National Committee, will be responsible for updating the comprehensive package of SRH services that should be made available to all persons and will be reviewed every two years, along with this policy. The MOH will ensure that a comprehensive package of SRH services is included in the Annual Services Agreement with all the RHAs.

In the event of an emergency or disaster, and following consideration of the scale of the event, the MOH will have designated focal points with the responsibility of coordinating the implementation of the MISP until full SRH services can be renewed. Upon direction of the MOH, the ODPM and Regional Corporations will serve as the lead to manage and coordinate the key areas of this policy across local government, in collaboration with the MOH, the County Medical Officers of Health, the Public Health Department, as well as any other stakeholder entities involved in ensuring the delivery of SRH services.

The MOH's Emergency Support Function representatives, assigned to the National Emergency Operation Centre (NEOC), will be present to assist in response and recovery efforts of the partially-/fully-activated NEOC.

11.1.1 Directorate of Women's Health

The MOH's DWH will serve as the Secretariat for the National Committee, ensuring coordination amongst all agencies, institutions and organisations involved in the provision of SRH services in the country.

The DWH in collaboration with the RHAs, other MOH-SRH units and other relevant agencies will be responsible for the development of annual national work plans for the delivery of the National SRH Programme. Upon the advice of the National Committee, the DWH will ensure the development of guidelines and the provision of technical expertise and support for monitoring the implementation of Action Plans, including training plans and relevant services.

The DWH, upon direction of the National Committee, will provide the technical support to ensure that the comprehensive package of SRH services is implemented according to the Annual Services Agreement with all the Regional Health Authorities and will be responsible for developing the programme monitoring and evaluation framework of all SRH activities in the public, private, and NGO sector.

11.1.2 The Population Programme Unit

The PPU in collaboration with the DWH, the RHAs, and other relevant departments, will be responsible for liaising with the official agencies charged with the development and implementation of the procurement and supply chain management systems, inclusive of forecasting and procuring contraceptive commodities, Pap smear and pregnancy kits, and development and dissemination of communications materials.

11.1.3 Regional Health Authorities

The RHAs will be responsible for the implementation of the evidence-based SRH Programmes and services to all persons, inclusive of key populations in T&T. The RHAs will be responsible for the training, accreditation standards, quality management and continuous updating of the health care staff on issues relating to SRH.

The RHAs will be responsible for conducting research, reporting on key indicators for their region and monitoring and evaluating on issues relating to the SRH programme and services at the health facility level.

11.1.4 HIV/AIDS Coordinating Unit (HACU)

The HACU of the MOH will be responsible for the coordination of integration of wider SRH services within the health sector response for programmes under its purview in accordance with this policy and the National HIV and AIDS National Strategic Plan.

In keeping with this mandate, HACU will also be responsible for the support of the joint reporting of STI/HIV and relevant other SRH services to national and international agencies through its relationship with the QPCC&C and the PPU. This will include preparation and dissemination of HIV and AIDS work plans, budgets and reports, including specific information on special populations, within the SRH network as is necessary for programming.

11.1.5 Queen's Park Counselling Centre and Clinic (QPCC&C)

The QPCC&C is responsible for policy formulation, clinical guidance development and program implementation and M&E regarding the delivery of Sexually Transmitted Infection (STI) services in accordance with its Cabinet approved functions. QPCC&C will be responsible for integration of SRH services into STI services, ensuring the delivery of the comprehensive package of SRH services to clients namely HIV related services (such as testing, prevention and/or treatment and care), family planning and maternal health care (including prevention of mother to child transmission of syphilis and other STIs).

QPCC&C will be responsible for preparation and dissemination of health information on sexually transmitted infections, including specific information for key populations. QPCC&C will engage in joint reporting of STI and other SRH services to national and international donor agencies.

11.1.6 The National SRH Committee

The MOH, through Cabinet shall establish a National SRH Committee comprising relevant stakeholders to provide policy direction, advocate for funding and support of SRH amongst other functions. Technical expertise and personnel are limited in T&T however, and there is

a need for alignment of any National SRH Committee with the GoRTT's Vision 2030 Strategy and the PAHO's "The Sustainable Health Agenda for the Americas 2018-2030: A Call to Action for Health and Wellbeing in the Americas" and the "Plan of Action for Women's, Children's and Adolescent's Health (2018-2030)".

A broader Committee is therefore being proposed to encompass Sexual and Reproductive (SR), Maternal (M), Newborn (N), Child (C) and Adolescent (A) Health(H) called the "RMNCAH", rather than several committees with the same personnel and similar agendas, given the situation in T&T with few expert personnel multi-tasking on multiple committees. The TOR of this committee are currently in the draft stage. With respect to SRH, this committee will guide the planning, implementation processes, and monitoring and evaluating the progress of the SRH Policy, Action Plan and budget allocation and expenditure. It will also provide the technical support to ensure that a comprehensive package of SRH services is implemented according to the Annual Services Agreement with all the RHAs and will be responsible for developing the programme monitoring framework of all SRH activities in the public, private, and NGO sector.

The National SRH Committee will be held accountable to the Ministry of Health for the implementation of the National SRH Policy and will be responsible for the coordination of the programme components implemented by the health, non-health and non-governmental sectors, working in collaboration with the MOH's DWH, who will serve as the Secretariat.

The National SRH Committee will be responsible for developing a monitoring and evaluation mechanism to ensure the implementation of this policy and programmes as envisioned, on the basis of the outcomes, outputs and indicators outlined in this policy and reflected in the Action Plan as well as other international agreements. This mechanism will be used to monitor the implementation of the policy on a quarterly basis by the National SRMNCAH Committee. Joint reporting with other agencies shall be supported as far as possible to prevent duplication of effort and resources.

Every 3-5 years, or as requested, the National SRH Committee will ensure that the implementation of the Policy shall be independently evaluated in collaboration with Government, civil society, community representatives and other stakeholders to inform revision or development of a new SRH policy and related Action/Implementation plans.

11.2 Office of the Prime Minister

11.2.1 National AIDS Coordinating Committee (NACC)

The NACC is a multisectoral body established to co-ordinate the national response to HIV and AIDS. The re-establishment of the committee was approved by the Cabinet of the GORTT. The committee comprises representatives from government ministries, persons living with HIV, civil society, faith-based organisations, academic and research institutions, trade unions, private sector, youth, Tobago House of Assembly and UN organisations. The NACC is supported by a Secretariat in the Office of the Prime Minister. Their mandate is to:

- build and deepen multisector partnership with the public, private and non-government sectors to achieve national commitment, support and ownership of the response to HIV and AIDS;
- determine the future evolution of the NACC into a statutory body;
- co-ordinate and support activities pursuant to the reduction of the people's susceptibility to HIV and AIDS;
- Establish goals and targets of the priority strategic areas;
- Monitor and evaluate the implementation and attainment of national goals, objectives and targets with respect to HIV and AIDS as identified in the national strategic plan;
- Define a national HIV policy and provide guidance on sectoral policies;
- Champion and accelerate the legislative agenda required to support HIV and AIDS responses, programmes and plans;
- Undertake multidisciplinary research on issues related to the social, economic and psychological antecedents and impacts of HIV and AIDS on individuals, families, communities, businesses and other sectors;
- Build capacity of stakeholders to mount an effective response;
- Co-ordinate and provide guidance on the activities of HIV Co-ordinators in the various ministries; and
- Approve budgets and funding required for implementation of HIV response processes.

11.2.2. Office of the Prime Minister, Gender and Child Affairs Division

Collaboration will be sought with the Gender and Child Affairs Division to prevent and address issues of sexual and gender-based violence as well as access to age appropriate, comprehensive sexuality education amongst minors. In terms of the life skills and social development programmes, Gender and Child Affairs Division will be responsible for ensuring that negative cultural gender norms that promote sexual and GBV are addressed and they will also refer clients to relevant referral services. The Gender and Child Affairs Division will also maintain a database of GBV which will serve as a source for evidence-based planning and analysis. SRH issues under the remit of the Children's Authority and the **Children's Act** will also be addressed.

11.3 Tobago

The Tobago AIDS Coordinating Committee (TACC) was re-established in 2018 with the responsibility for coordination in the Office of the Chief Secretary. It is a multi-sectoral body established to coordinate the national response to HIV and AIDS. TACC focuses on the management of HIV/AIDS policies, activities and programmes and will advance these policies through its programme and projects. In addition, the committee will monitor the island's response to HIV/AIDS with the aim of improving the delivery of healthcare to HIV/AIDS patients through the Health Promotion Clinic, its implementation arm. The THA has already made significant headway with several SRH programs. These include:

- In 2018 a new memorandum of understanding (MOU) was signed with the Family Planning Association of Trinidad and Tobago (FPATT) aimed at advancing sexual and reproductive health and rights in Tobago. The MOU will establish an agreed framework for the coordinated operation of FPATT, the Tobago Regional Health Authority (TRHA) and the Division. This will ensure efficiency in establishing a sexual and reproductive health programme in Tobago. The partnership will also help promote and protect sexual and reproductive health and rights for all Tobagonians;
- Progress with GBV and Gender Inequalities;
- Established a "Pink Room" for Women's Health and Breast Services and a "Blue Room" for Men's Health including SRH; and
- Several initiatives targeted at the youth including education, empowerment and other SRH issues.

The Tobago House of Assembly (THA), through the Division of Health, Wellness and Family Development and the Division of Education Youth Affairs and Sport has continued to engage the MOH and be represented at the National Committee and they develop strategies designed for the Tobago population, which may include:

- Establishing/strengthening an SRH Unit;
- Appropriate funding in the annual government budget for the delivery of the National SRH Programme in Tobago;
- Ensuring SRH services are represented in their annual work plan;
- Accessing training programmes to acquire the necessary knowledge and skills to support SRH in Tobago;
- Developing an information and surveillance system in collaboration with the Ministry of Health in Trinidad;
- Expanding access to SRH programmes using the life-cycle approach;
- Delivering an integrated SRH programme; and
- Monitoring and evaluation, including conducting research on SRH.

11.4 Ministry of Finance

The Ministry of Finance shall be responsible for making the budgetary allocations available to Civil Society and the Ministries of Health, Education, National Security, Community Development, Culture and the Arts, Sport and Youth Development, Social Development and Family Services, and the Office of the Prime Minister, Gender and Child Development Divisions to ensure the effective implementation of the National SRH Policy, with specific budget allocations of SRH.

11.5 Ministry of Planning and Development

The Ministry of Planning and Development (MPD) and its relevant Units/Divisions shall work in collaboration with the relevant stakeholders to ensure that elements of this policy are captured in the implementation of the relevant national policies. The Central Statistical Office, which is currently under the MPD, will continue to provide quality data to facilitate evidence-based decision making.

The MPD will, through the Population Council, also assist in the monitoring of this national SRH policy. The MPD in collaboration with the Ministry of Health and the Ministry of Finance will ensure adequate annual budgetary allocation, for the implementation of this policy and related action plans. The National Transformation Unit will assist in evaluation for the outcomes of this Policy implementation. The Technical Cooperation Unit of the Ministry of Planning will also assist in facilitating the international donors support.

11.6 Office of the Attorney General and Legal Affairs

The Office of the Attorney General shall be responsible for creating the legal conditions for the implementation of the National SRH Policy and to make the necessary provisions consistent with international convention requirements. It will provide technical advice and legislation related to SRH and processes needed to amend and align legislation.

11.7 Ministry of National Security

The Ministry of National Security shall be responsible for taking the appropriate action required in dealing with all matters arising in the abuse, fraud and misuse of resources in the delivery of SRH services. Through its various arms including the GBVU and the Child Protection Unit, issues related to this policy will be reinforced and monitored. This Ministry is to liaise with the Ministry of Health with respect to coordinating the stakeholders with administering health and other services to victims of sexual and GBV.

11.7.1 The Office of Disaster Preparedness and Management

The Office of Disaster Preparedness and Management (ODPM) will be responsible for the management of coordination activities in the event of a national emergency/disaster. These coordinated activities will occur among government-agency representatives known as Emergency Support Function (ESF) representatives, within the NEOC. The NEOC also works in collaboration with the NOC. ODPM will coordinate, in conjunction with the Ministry of Health, delivery of the MISP, as relates to the response and recovery efforts. The Office will also facilitate the transition of SRH delivery from MISP to the comprehensive SRH package, during phases of recovery. The ODPM will also work alongside the Health Cluster/Sector directly and/or indirectly (through the Municipal Disaster Management Units (DMUs) and the Tobago Emergency Management Agency (TEMA)) to mainstream proactive

or ex-ante emergency disaster management via preparation, prevention and mitigation undertakings.

11.7.2 Other Related Initiatives

Partnerships will be sought with the Citizen Security Programme to address SRH concerns at the community level in high risk communities, with the, Military - Led Academic Training Academy (MILATT), a two-year, full-time residential social intervention programme for at-risk young men aged 16 - 20 years, as well as the Specialized Youth Services Programme, which unifies youth development efforts as a means of reaching young people who are most at risk. The collaboration will be improved with the HACU, which organizes HIV and Aids Awareness Youth Challenge Walks.

11.8 Ministry of Education

The MOE and the MOH are collaborating on the finalisation of the Health in Schools' Policy. The MOE shall be responsible for the effective implementation of the age-appropriate HFLE in all primary, secondary, vocational, and tertiary institutions or programmes in Trinidad and Tobago. The MOE will also be responsible for the training of teachers and administrators on the HFLE curriculum and ensuring that parents, administrators, and other stakeholders are sensitized to the methodology, including initiatives aimed at out of school youth. Programmes directed to promote the education of parents, should enable parents to support the process of maturation of their children, so that their children can achieve their full potential, particularly in the areas of sexual behaviour and reproductive health.

The MOE is responsible for establishing a National HFLE committee who will oversee and establish a sustainable system for data collection and monitoring of the delivery of HFLE in schools. The MOE and the MOH will be expected to work in collaboration with Tertiary-level academic institutions (e.g. UWI and UTT) for developing the curriculum and providing training programmes related to SRH in order to build capacity for the public, private, and non-governmental sectors.

11.9 Ministry of Social Development and Family Services

Collaboration will be sought with the Ministry of Social Development and Family Services (MSDFS) to establish peer support and mentoring programmes related to SRH and in the facilitation of psycho-social support to key populations. In their life skills and social

development programmes, the MSDFS will be responsible for referring clients to relevant SRH services. MSDFS will also ensure that the National Parenting Programme is aligned to the SRH Policy as it relates to educating parents on SRH.

11.10 Ministries of Community Development and Culture and the Arts

Collaboration will be sought with the Ministries of Community Development and Culture and the Arts to establish peer support and mentoring programmes related to SRH as part of the community development programmes. The Ministry will support SRH awareness at the Community level. Information on SRH and the SRH programmes, inclusive of services, shall be part of the community outreach programmes.

11.11 Ministry of Sport and Youth Affairs

Collaboration will be sought with the Ministry of Sport and Youth Affairs on issues related to youth and their access to SRH including the establishment of peer support and mentoring programmes related to SRH and in addressing S&GBV. The Ministry will work within its existing programmes such as: The Adolescent Intervention Programme, the District Youth Services, Global Young Leaders, National Youth Awards, National Youth Volunteerism Programme, Social Education and Skills Enhancement Programme its Youth Empowerment Centres and the Youth Health Caravan to raise awareness on SRH. Since in this age group, health encounters are very infrequent except for accidents and emergencies, this is a unique approach to sharing lifestyle related information to reach youth in their communities to support the empowerment of young people.

11.12 Civil Society Organizations

Civil society organizations (CSOs), inclusive of the faith-based organizations (FBOs), community-based organizations (CBOs), and academia will be encouraged to partner with the MOH and other relevant state agencies in the area of promoting SRH health to its constituents and the wider public. CSOs will be responsible for sharing and disseminating data on population related SRH issues, facilitating referrals and the dissemination of information on SRH to its constituents. CSOs will also be responsible for the delivery of SRH to key populations and participating and/or delivering of training on SRH. CSOs will also be represented on the National SRH Committee.

11.13 Private Sector

The Private Sector shall be encouraged to partner with the MOH and other relevant state agencies in promoting SRH as well as in data collection. The Private sector will be responsible for the dissemination of information on SRH to its constituents and for participating in training opportunities on SRH.

11.14 Regional and International Organizations

International cooperation will provide technical assistance around SRH through support for research, provision of strategic information, training/capacity building, technical guidance and reviews utilizing, where possible, South to South collaboration. The International Cooperation Desk of the MOH and the Technical Cooperation Unit of the Ministry of Planning and Development will assist in facilitating the Coordination of this support.

International and regional partners shall be encouraged to participate in continuous dialogue in relation to the implementation and monitoring of the achievement of the SDGs and other international agreements that relate to SRH, such as the regional ISF to address adolescent pregnancy in the Caribbean. International and regional partners shall be encouraged to develop mechanisms that will facilitate resource sharing, sharing of information and reporting between donor and development agencies, and joint reviews of SRH interventions**.**

12.0 CONCLUSION

The National SRH Policy seeks to ensure that all persons in Trinidad and Tobago have universal access to comprehensive, quality SRH information and services. This is in keeping with Trinidad and Tobago's international and national commitments as it moves towards achieving the mandate under the SDG 3 and SDG 5.

By integrating SRH services, the policy will contribute to the strengthening of health systems in a harmonized way to deliver the health care needed to all individuals in Trinidad and Tobago.

A life course approach will be taken to implement the policy and this will ensure that the SRH needs of all members of the population are covered throughout a person's lifetime.

The MOH and its stakeholders, through this policy, will ensure that the population is educated on SRH and other conventional, non-conventional and group specific strategies will be deployed in consultation with civil society to reach the general public and other key populations. Community participation shall be encouraged in order to stimulate public dialogue and increase communication on issues related to SRH and sexual and reproductive rights in order to reach these key populations and ensure that all persons in Trinidad and Tobago are well informed on all matters related to SRH and sexual and reproductive rights.

To complement the policy, laws, protocols and guidelines shall be developed or updated, consistent with international standards, which will support the implementation of the National SRH Policy and the integration of the national SRH programme and services. SRH policy guidelines, service standards, norms and procedure manuals shall be evidence-based and made available by the MOH, in collaboration with stakeholders, for use in all institutions (Government and NGOs), at all levels and shall be reviewed periodically. All personnel providing services shall be required to demonstrate commitment to the established guidelines and attend regular in-service training to update their knowledge, attitudes and maintain skills. Dialogue, incentives, and penalties where necessary, will be utilized to support compliance.

South to South Collaboration, on-line and in-service training will be sought to improve the capacity of HCP in the delivery of SRH services. This will help to strengthen the national

health care system by increasing the quality of services and ensuring compliance with international standards.

The effectiveness and efficiency of the National SRH Policy and Programme will be measured by the ability to achieve the desired SRH outcomes. Data production, collection, analysis, and dissemination will be strengthened in order to measure progress and to inform decision making. The policy will therefore support the standardization and collection of data and information from health services as well as nation-wide system.

The changes identified in this policy will therefore help to increase the overall quality and uptake of services; facilitate better coordination of SRH; and ensure any new SRH-related legislation is in line with the principles of this policy. It will further help Trinidad and Tobago achieve sustainable development by ensuring that no one is left behind in accessing SRH services and information.

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14.0 APPENDICES

14.1 Appendix I: Comprehensive Package of SRH Services to be Delivered

The package of key, comprehensive SRH services to be delivered include:

Family Planning Services	Range of birth control methods including voluntary abstinence and natural fertility method (Billing's), barrier, short and long acting methods, hormonal and non-hormonal, intrauterine devices etc. Information and Education Permanent methods e.g. Tubal Ligation and Vasectomy
Maternal Health Care	Respectful Maternity Care Pre-pregnancy conception Pre-pregnancy high risk clinics Prenatal care EMTCT plus STI management during pregnancy Safe Delivery care Postnatal care Contraception counselling during pregnancy and postpartum Breastfeeding services
STI/HIV and AIDS Services	STI, HIV and AIDS Education Condom promotion and distribution HIV testing and counselling and treatment PEP STI screening, testing, treatment and support including hepatitis
Miscarriage related services	Family Planning Services Safe miscarriage care Post miscarriage counselling and care (and management of complications) Post miscarriage contraceptive services including possible insertion of IUD
Adolescent Sexual and Reproductive Health	SRH Information and Education STI and HIV and AIDS Education Reproductive Health commodities HIV testing and counselling HPV Vaccine programme Provision of information and services to prevent unwanted pregnancies and/or negative outcomes during pregnancy and delivery
Fertility Services	Prevention of Infertility Screening Referral services to assisted reproduction

Elimination/Reduction of Cancers of the Reproductive and related Organs	HPV Immunization & Screening Cervical Cancer prevention and screening Other gynaecological cancers such as endometrial and ovarian cancer Breast Cancer Screening including Clinical Breast Examination and Mammogram Prostate cancer screening including digital prostate examination and PSA
SRH/CNCD Management	Tobacco Use Alcohol Use Substance Abuse Blood Sugar, Blood Pressure, Cholesterol BMI General Health- Smoking cessation, Exercise and nutrition counselling, diabetes mellitus and hypertension management Mental Health General dental services
Sexual & Gender-Based Violence	Identification and care of cases of VAW Psychological and Psychosocial Support Services HIV and STI testing PEP Emergency Contraceptives
Men's Health	Information Health Education and Counselling Andropause Fertility-Prevention and Screening CNCD- Urology Services for Erectile Dysfunction/Impotence and Prostate Care screening HIV/STI-prevention and treatment services Gender-based violence prevention and management Family Planning Services (as described above) Cancers of the Reproductive System-prostate (prevention and early screening) Urology services Throat, anal cancers
Other Women's Health issues	Menstrual disorders Gynaecological disorders and infections Endocrine disorders Menopause Sexual dysfunction Clinical referral for specialist gynaecological services Full spectrum of information and education services
Women not in reproductive age	Climacteric Menopause HIV/STI Cancer Screening Gender-based violence prevention and management

14.2 Appendix II: Minimum Package of SRH Services to be Delivered

The MISP of SRH services to be delivered during emergencies or disasters includes:

Family Planning Services	A range of contraceptive services Information and Education
Safe Motherhood Initiatives	Pre-conception Pre-natal Safe Delivery Postnatal PMTCT STI management during pregnancy Anaemia management
STI/HIV and AIDS Services	STI and HIV and AIDS Education Condom promotion and distribution HIV testing and counselling PEP STI screening and testing STI treatment and support
Miscarriage related services	Family Planning Services Management of complications Post miscarriage counselling
Adolescent Sexual and Reproductive Health	SRH Information and Education STI and HIV and AIDS Education Reproductive Health commodities HIV testing and counselling Provision of information and services to prevent unwanted pregnancies and/or negative outcomes during pregnancy and delivery
SRH Counselling and IEC Development	Information Education Training Development of material
SRH/CNCD Management	Mental Health
Sexual & Gender-Based Violence	Psychological and Psychosocial Support Services HIV and STI testing PEP Emergency Contraceptives
Men's Health	Information Health Education and Counselling HIV/STI-prevention and treatment services Gender-based violence prevention and management

	Family Planning Services including the Billings Method
Women's Health	Menstrual disorders Gynaecological disorders and infections Menopause Family Planning Services including the Billings Method Gender-based violence prevention and management Sexual dysfunction HIV/STI-prevention and treatment services Clinical referral for specialist gynaecological services
Post Fertility	Menopause Andropause HIV/STI Gender-based violence prevention and management

14.3 Appendix III: List of Sexual and Reproductive Health Indicators for Monitoring

1. Total fertility rate
Total number of children an average woman would have by the end of her reproductive life.

2. Contraceptive prevalence rate
Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time. Women of reproductive age refers to all women aged 15–49 who are at risk of pregnancy, i.e. sexually active women who are not infertile, pregnant or amenorrhoeic. Contraceptive methods include female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea, where cited as a method.

3. Maternal mortality ratio
The number of deaths of women due to complications of pregnancy and childbirth per 100,000 live births in that year.

4. Antenatal care coverage
Percentage of women attended, at least four times during pregnancy, by skilled birth attendant. Skilled birth attendant refers to doctors (specialist or non-specialist) and/or persons with officially recognized midwifery skills, who can manage normal deliveries and diagnose or refer obstetric complications.

5. Births attended by skilled health personnel
Percentage of births attended by skilled birth attendant. Skilled birth attendant refers to doctors (specialist or non-specialist) and/or persons with officially recognized midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications.

6. Availability of basic essential obstetric care
Number of facilities with functioning essential obstetric care per 100,000 population. Basic essential obstetric care should include availability of essential medicines, for example parenteral antibiotics, intramuscular oxytocin, magnesium sulphate for eclampsia and equipment for the manual removal of placenta and retained products.

7. Availability of comprehensive essential obstetric care
Number of facilities with functioning comprehensive essential obstetric care (EOC) per 500,000 population. Comprehensive essential obstetric care should include basic EOC plus availability/equipment for caesarean section, anaesthesia and blood transfusion.

8. Perinatal mortality rate
Number of perinatal deaths per 1000 total births. Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life. For international comparison, the WHO recommends identifying all stillbirths from 1000 g and above, or 28 completed weeks if the weight is unknown.

9. Low birth weight prevalence
Percentage of live births that weigh less than 2500 g.

10. Positive syphilis serology prevalence in pregnant women
Percentage of pregnant women attending antenatal clinics whose blood has been screened for syphilis, with positive serology for syphilis.

11. Prevalence of anaemia in women
Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for non-pregnant women.

12. Percentage of obstetric and gynaecological admissions owing to abortion
Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services which are due to abortion (spontaneous and pre admission induced, but excluding planned termination of pregnancy).

13. Prevalence of infertility in women
Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contraception and non-lactating) who report trying for a pregnancy for two years or more.

14. Reported incidence of urethritis in men
Percentage of men (15–49) reporting episodes of urethritis in the last 12 months.

15. HIV prevalence among pregnant women
Percentage of HIV positive pregnant women tested at the antenatal clinics.

16. Knowledge of HIV related prevention practices
Percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV (abstinence, barrier contraceptive methods and avoidance of drug abuse by injection) and who reject three major misconceptions about HIV transmission or prevention.

17. Prevalence of malignant cancers of the reproductive system
a. Percentage of persons screening for cervical, prostate, and breast cancer according to national protocols
b. Percentage of persons diagnosed with cervical cancer
c. Percentage of persons diagnosed with prostate cancer
d. Percentage of persons diagnosed with breast cancer

18. Knowledge about pregnancy-related information
Percentage of the population that knows about essential issues related to pregnancy.

19. Access to Care
a. Percentage of the population with access to sexual and reproductive health services (disaggregated by gender and age)
b. Percentage of the population receiving quality sexual and reproductive health services (disaggregated by gender and age)

20. Post-Fertility
Percentage of persons (post-fertility) accessing sexual and health services

21. Adolescent Sexual and Reproductive Health

a. Percentage of persons (15-24 years) aware of sexual and reproductive health services
b. Percentage of persons (15-24 years) accessing sexual and reproductive health services in youth-friendly services

22. Responsible Sexual Behaviour
Percentage of the population engaged in responsible sexual behaviour (disaggregated by gender and age).
Responsible sexual behaviour is defined or understood as behaviours which can include a delay in the first sexual encounter, lowered numbers of sexual partners, increase in the use of condoms and contraceptives (Center for Disease Control and Prevention (CDC). It also involves persons taking responsibility for being aware of how their status regarding STDs can affect those they are involved with sexually (McGraw-Hill Dictionary of Modern Medicine).

23. Total Fertility Rate
An estimate of the number of children a cohort of 1,000 women would bear if they all went through their reproductive years.

24. Prevalence of HIV/AIDS (%) in the population 15-49 years old
Percent of the total population 15 to 49 years of age who, at year end, and diagnosed as being HIV positive.

25. Laws and regulations that guarantee women's access to SRH care, information and education
Presence of laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education.

Additional Proposed SRH-related SDG Indicators:

26. Birth registration
Percentage of children under 5 whose births have been registered with a civil authority, disaggregated by age.

29. Need for FP satisfied with modern methods
Percentage of women of reproductive age (aged 15-49) who have their need for family planning satisfied with modern methods.

30. Universal Health Coverage
The level of access to health coverage.

31. Gender Based Violence from a current or former intimate partner
Proportion of ever-partnered women and girls aged 15 years and older subject to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months, by form of violence and by age group.

32. Gender Based Violence from a non-intimate partner

Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months, by age group and place of occurrence.

33. Child Marriage

Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18.

34. Female Genital Mutilation rates

Percentage of girls and women aged 15-49 who have undergone female genital mutilation/cutting, by age group.

14.4 Appendix IV: Entities related to the proposed SRMNACH Committee and Sub Committees/Working Group

Organisation	Department/ Unit
Ministry of Health	Corporate Communications Directorate of Women's Health Health Education Division Health, Policy Research and Planning HIV/AIDS Coordinating Unit Population Programme Unit Office of National Administrator Nursing Services Queen's Park Counselling Centre and Clinic
Regional Health Authorities	Primary and Secondary Care (e.g. Service managers, Clinical Specialists)
Tobago	THA, TRHA
Pan American Health Organization/ World Health Organization	Family Health and Disease Management
United Nations Population Fund	Sub-regional Office for the Caribbean, Trinidad and Tobago Branch Office
MRFTT	
Universities and training centres	UWI, USC, UTT, Trinidad and Tobago Health Training Centre
Other	FPATT Other Ministries' representatives (e.g. Gender, Youth, Education, Communications) International organisations Health and Allied Health Professional Organisations Other Tobago Representation Advocacy groups CSOs, FBOs

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