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7.1.2 Regional Health Authorities

7.1.3 HIV/AIDS Coordinating Unit (HACU)

7.1.4 Queens Park Counselling Centre and Clinic (QPCC&C)

7.1.5 The National SRH Committee

7.2 Office of the Prime Minister

7.2.1 National AIDS Coordinating Committee (NACC)

7.2.2 Office of the Prime Minister, Gender and Child Affairs Division

7.3 The Tobago House of Assembly

7.4 Ministry of Finance

7.5 Ministry of Planning and Development

7.6 Office of the Attorney General and Legal Affairs

7.7 Ministry of National Security

7.7.1 The Office of Disaster Preparedness and Management

7.7.2 Other Related Initiatives

7.8 Ministry of Education

7.9 Ministry of Social Development and Family Services

7.10 Ministry of Community Development, Culture and the Arts

7.11 Ministry of Sport and Youth Affairs
ACKNOWLEDGEMENTS

The Ministry of Health wishes to acknowledge all those who provided valuable contributions to the development of the Sexual and Reproductive Health Policy including Civil Society and Faith Based Organizations who participated in the consultations. Sincere thanks go to the United Nations Population Fund (UNFPA) which provided technical and financial support. Deepest thanks also goes to the Sexual and Reproductive Health Technical Working Group which provided on-going support to the drafting of the Policy. The Ministry also wishes to extend its thanks to the following for their support:

Dr. Caroline Alexis-Thomas (Consultant);
Ms. Angelina Lucia Garcia, Research Officer II, Directorate of Health Policy, Research and Planning Unit, Ministry of Health;
The Pan American Health Organization/World Health Organization;
The Joint UN Programme on HIV/AIDS (UNAIDS);
The Tobago House of Assembly Office of the Chief Secretary, HIV and AIDS Response Programme;
The Tobago House of Assembly, Division of Health and Social Services; and
The Catholic Archdiocese of Trinidad and Tobago.
Universal Access to Sexual and Reproductive Health (SRH) is one of the indicators within the new Sustainable Development Goal (SDGs) three (3) on health. The Programme of Action of the International Conference on Population and Development (ICPD) and the former United Nations Millennium Development Goal five (5) also speak to Universal health to SRH. The Ministry of Health, as the Government entity responsible for the health and wellbeing of the people in Trinidad and Tobago, has taken the lead in the development of this national SRH policy as a means of facilitating Universal Access to SRH.

SRH not only affects an individual, but impacts on intimate relationships, families, communities and the nation overall as it strives 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 to be provided should be age appropriate and free from any stigma or discrimination.

Since 2010, the Ministry of Health through its SRH Technical Working Group with support from United Nations Population Fund (UNFPA), the Pan American Health Organization (PAHO)/World Health Organization (WHO) in collaboration with its other UN sister organizations and other partners have supported assessments of the national SRH situation. Findings revealed that SRH services are being offered vertically with limited integration at service delivery points, particularly in the areas of HIV, cancers of the reproductive tract, other sexually transmitted infections and maternal health. Assessments revealed that there are also key populations who do not access SRH services regularly for a number of reasons including the time services are being offered; the need for parental consent; and/or stigma expressed by healthcare professionals. To facilitate comprehensive service provision, this policy addresses the integration of SRH services, so that each client receives a minimum package of SRH services, including during emergencies or times of crises.

An action plan is being developed for the implementation of this policy, which will be monitored through a national SRH Committee. As Government moves towards ensuring healthy lives and the promotion of wellbeing for all at all ages, consistent with the SDG, this policy is quite timely as it will help the Government and its partners to achieve Universal Access to SRH while also addressing some of the SRH needs of its population.

The Honourable Terrence Deyalsingh, Minister of Health
Ministry of Health, Republic of Trinidad and Tobago, April 2016
SIGNATURE PAGE

Repealing Clause: There is no existing National Sexual and Reproductive Health Policy

Effective Clause: The National Sexual and Reproductive Health Policy, becomes effective from the date of when approved and signed by the duly authorized Officers below.

Proposed review date: This National Sexual and Reproductive Health Policy should be reviewed every two years or as is deemed necessary in response to changes in the environment.

__________________________________________  Date:
Medical Director, Projects and Programme

__________________________________________  Date:
Director, Health Policy, Research and Planning

__________________________________________  Date:
Chief Medical Officer

__________________________________________  Date:
Permanent Secretary

__________________________________________  Date:
Minister of Health
## DEFINITION OF TERMS

| **Abortion** | The termination of a pregnancy before the foetus has attained viability i.e. become capable of independent extra-uterine life. It is traditionally assumed that viability is attained at 28 weeks of gestation. Abortion can be spontaneous or induced; complete or incomplete. Spontaneous abortion may be called miscarriage in daily language (WHO, 1970). |
| **Adolescence** | WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy (WHO, 2016). |
| **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 course of a woman’s menstrual cycle. By recognizing the changing characteristics in cervical mucus, women can predict when they may ovulate. In turn, this may help them determine when they’re most likely to conceive, which they can use, depending on if they want to become pregnant or not (Mayo Clinic, 2015). |
| **Gender** | Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (WHO, 2015). |
| **Gender-Based Violence** | An umbrella term for any harmful act that is perpetrated against a person’s will and that results from power inequalities that are based on gender roles. (Health and Human Rights Info, 2015). 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 health (including Sexual and reproductive health) of women, men, girls, and boys. In some instances, gender based violence may result in death. |
| **Gender Equality** | Equal rights, responsibilities and opportunities for women and men and girls and boys (UN Women, 2015). |
**Equity**

In the context of this SRH Policy 'Equity' refers to fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata (WHO, 2015).

**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 (WHO, 2015). 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. They also have a bearing on people’s access to and uptake of health services and on the health outcomes they experience 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 (WHO, 2015), 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 do not or infrequently access SRH services. This includes persons with disabilities; the elderly; sex workers; men; men who have sex with men and other members of the lesbian, gay, bi-sexual, transgender (LGBT) community; persons diagnosed with infertility; persons living with HIV and AIDS; migrants; adolescents and youth; the Poor; Illiterate People; Substance Users; and persons in their post fertility years.

**Post Abortion Care**

This is an approach for reducing deaths and injuries from incomplete and unsafe abortions and their related complications (IPAS, 2015).

**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, foetus and infant during pregnancy, childbirth and postpartum (Human Rights Matrix, 2015).
<table>
<thead>
<tr>
<th><strong>Sex</strong></th>
<th>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 (WHO working definition, 2015)</th>
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<tbody>
<tr>
<td><strong>Sexual and Reproductive Health</strong></td>
<td>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.” (UNFPA). Implicit in this are the rights of men and women 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. (UNFPA, 2015)</td>
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<tr>
<td><strong>Youth</strong></td>
<td>The National Youth Policy 2012 - 2017 defines youth as young people between the ages of 12 and 29 years.</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>ASPIRE</td>
<td>Advocates for Safe Parenthood: Improving Reproductive Equity</td>
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<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>BOM</td>
<td>Billings Ovulation Method</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CARIMAN</td>
<td>Caribbean Male Action Network</td>
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<td>CMOH</td>
<td>County Medical Officer of Health</td>
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<td>CNCDs</td>
<td>Chronic Non-Communicable Diseases</td>
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<td>CRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<td>CSOs</td>
<td>Civil Society Organizations</td>
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<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<td>ED</td>
<td>Erectile Dysfunction</td>
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<td>FC</td>
<td>Female Circumcision</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FPATT</td>
<td>Family Planning Association of Trinidad and Tobago</td>
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<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>HACU</td>
<td>HIV and AIDS Coordinating Unit (within the Ministry of Health)</td>
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<tr>
<td>HCP</td>
<td>Health Care Providers</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IGDS</td>
<td>Institute for Gender and Development Studies</td>
</tr>
<tr>
<td>ISF</td>
<td>International Solidarity Foundation</td>
</tr>
<tr>
<td>IVF</td>
<td>In Vitro Fertilization</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bi-Sexual, Transgender</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSDFS</td>
<td>Ministry of Social Development and Family Services</td>
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<tr>
<td>Acronym</td>
<td>Abbreviation</td>
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<tr>
<td>MPD</td>
<td>Ministry of Planning and Development</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NEOC</td>
<td>National Emergency Operation Centre</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NOC</td>
<td>National Operations Centre</td>
</tr>
<tr>
<td>NPTA</td>
<td>National Parent Teachers Association</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<tr>
<td>ODPM</td>
<td>Office Disaster Preparedness Management</td>
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<tr>
<td>PAHO/WHO</td>
<td>Pan American Health Organization/World Health Organization</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President Emergency Fund for AIDS Relief</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider Initiated Testing and Counselling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>Persons Living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PPU</td>
<td>Population Programme Unit (within the Ministry of Health)</td>
</tr>
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<td>PRS</td>
<td>Poverty Reduction Strategy</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>QPCC&amp;C</td>
<td>Queen’s Park Counselling Centre &amp; Clinic (within the Ministry of Health)</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RHAs</td>
<td>Regional Health Authorities (which are part of the Ministry of Health)</td>
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<tr>
<td>S&amp;GBV</td>
<td>Sexual and Gender Based Violence</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>T&amp;T</td>
<td>Trinidad and Tobago</td>
</tr>
<tr>
<td>TTAM</td>
<td>Trinidad and Tobago Association of Midwives</td>
</tr>
<tr>
<td>TTHTC</td>
<td>Trinidad and Tobago Health Training Centre</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UNWOMEN</td>
<td>United Nations Entity for Gender Equality and the empowerment of Women</td>
</tr>
<tr>
<td>UWI</td>
<td>University of the West Indies</td>
</tr>
<tr>
<td>UTT</td>
<td>University of Trinidad and Tobago</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>YMCA</td>
<td>Young Men Christian Association</td>
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<tr>
<td>YWCA</td>
<td>Young Women's Christian Association</td>
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1.0 INTRODUCTION

The development of the National Sexual and Reproductive Health (SRH) Policy for Trinidad and Tobago provides an effective response to current and emerging health issues through the provision of safe, integrated, quality health services that are patient-centred. It is in keeping with the Government’s commitment to improve standards of care; the strengthening of primary care; patient-centred treatment; and service integration, which supports access to a “Universal Health Package” for the national community. It is also in keeping with Trinidad and Tobago’s international, regional and national commitments such as:

- The Programme of Action accepted by one hundred and seventy nine (179) countries including Trinidad and Tobago in Cairo in 1994 at the International Conference on Population and Development (ICPD) and reconfirmed by the Government of Trinidad and Tobago in 2014 at the UN General Assembly;

- Sustainable Development Goal (SDG) 3 of ensuring healthy lives and promoting wellbeing for all at all ages including targets for reducing infant and maternal mortality, ending AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases, which has replaced Millennium Development Goal (MDG) five (5) which speaks to improving maternal health and universal access to reproductive health;

- The World Health Organization (WHO) Guidelines for SRH;

- The Regional Integrated Strategic Framework (ISF) to address Adolescent Pregnancy in the Caribbean;

- 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; and


The importance of linking and integrating various components of SRH together, particularly HIV, is now widely recognized and there is international consensus around the need for effective linkages between responses to HIV and SRH including recommendations for specific actions at the levels of policy, systems, and services. Some of these documents include:

- Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (May 2004)

- New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (June 2004)
• UNAIDS policy position paper ‘Intensifying HIV prevention’ (June 2005)
• World Summit Outcome (September 2005)
• Call to Action: Towards an HIV-Free and AIDS-Free Generation (December 2005)
• UNGASS Political Declaration on HIV/AIDS (June 2006)
• The UNSG Global Strategy on Women, Children’s and Adolescents Health (2016-2030).

The majority of HIV infections are sexually transmitted or are associated with pregnancy or breastfeeding (T&T has low transmission due to PMTCT). The risk of HIV transmission and acquisition can be further increased due to the presence of certain sexually transmitted infections (STIs). Linkages between core HIV services (prevention, treatment, care and support) and core SRH services (Family Planning; Maternal, Neonatal Health; the prevention and management of sexually transmitted infections (STIs), Reproductive Tract Infections (RTIs), promotion of sexual health, prevention and management of gender-based violence, prevention of unsafe abortion and management of post-abortion care) in national programmes are therefore believed to generate important public health benefits (IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW AND YOUNG POSITIVES, 2009). The Pan American Health Organization (PAHO), has further noted the existence of multiple points of intersection among the underlying causes of HIV/STI, such as gender inequities and other power asymmetries that prevent people and groups from exercising their rights, as well as a variety of conditions associated with SRH in general, which have led to the international call for convergence in the responses to such problems (PAHO, 2010).

Furthermore, countries in the Caribbean have committed to SRH integration through UNFPA’s Multi-Country Programme Action Plan (MCPAP) 2012 - 2016 which seeks to achieve the following outcome:

• Strengthened capacity of national and subregional institutions and organizations to advocate and deliver comprehensive and integrated sexual and reproductive health services, including in emergency situations, and particularly for vulnerable groups

• This need to integrate SRH services is also reflected in the Trinidad and Tobago HIV and AIDS National Strategic Plan (NSP) for the period 2013-2018 which calls for the development of a national SRH policy. Below are some of the activities within the NSP that speak directly to SRH integration:

  • Integrate HIV/STI testing and counselling into all primary, secondary and tertiary services for all users;

  • Scale up and train all front line healthcare workers in Provider-Initiated HIV Testing (PITC);
• Scale up Provider Initiated Testing and Counselling (PITC);
• Upscale HIV Counselling and Testing in RHAs (all community clinics, hospital institutions and outreach within wellness programmes);
• Incorporate HIV Counselling and Testing into MOH’s Health and Wellness education programmes addressing NCDs;
• Identify and promote integrated health services that include HIV/STI testing and counselling targeting men in the general population, as well as the elderly;
• Decentralize and increase the number of treatment sites for adults and children, including: a HIV adult site at NCRHA; a HIV paediatric site at NWRHA; and the provision of treatment in rural areas;
• Institute targeted HIV screening in patients with opportunistic infections including cancers and pneumonia; routine vaccination of PLHIV according to national immunization guidelines and offer Hepatitis B vaccination in all Hepatitis B negative Persons Living with HIV (PLHIV) as well as pneumovax and an annual influenza vaccine.
• Conduct HIV testing for all persons who are being treated for TB;

Furthermore, while Trinidad and Tobago is classified by the World Bank as a high income country, despite this classification, it still faces a number of development challenges, including how it addresses SRH. With fluctuations in maternal deaths over the period 2005-2014, Trinidad and Tobago faced challenges in meeting MDG Goal 5 of reducing maternal deaths by three quarters (MDG Report, 2014) and ensuring universal access to reproductive health, particularly by key populations. Despite having universal institutional deliveries, maternal mortality is still relatively high with rates of 22.2 per 100,000 live births in 2011; 20.2 in 2012, (Trinidad and Tobago Annual Performance Report 2013 as quoted in the MDG 2014 report); and 84 out of 100,000 (PAHO 2015 Basic indicators), indicating a need to address maternal mortality and morbidity including the quality of services provided.

SRH needs in Trinidad and Tobago have also expanded from issues arising from high fertility rates during the 1960 to 1980 period, to issues related to cancers of the reproductive system, the Human Immunodeficiency Virus (HIV) and sexual dysfunctions in men and women. Similarly, the country continues to face issues around adolescent pregnancy, sexual and gender based violence (S&GBV), other STIs and access to SRH information and services, including family planning, particularly amongst key populations.

This SRH policy was informed by these challenges, consultations with national stakeholders, assessments of SRH delivery and reviews of model SRH policies and good practices from other countries. The SRH policy intends to address these issues and facilitate universal access to SRH by offering an integrated package of SRH services; educating the public on SRH; focusing on quality of care and evidence-based decision making; building capacity of health care providers; addressing post abortion care; promoting community empowerment and ownership; providing adolescent SRH information and services; recommending legislative reforms; and facilitating the development of protocols and
2.0 SITUATION ANALYSIS

The following assessments of Sexual and Reproductive Health Services in Trinidad and Tobago were conducted in 2010 and 2011 by the Ministry of Health in collaboration with the United Nations Population Fund (UNFPA) and other partners:

1. Assessment of Sexual and Reproductive Health Services in Trinidad and Tobago-Phase 1: Population Programme Unit (2010),
2. Evaluation of the National Health System Response to HIV and STI in Trinidad and Tobago (2011),

Based on these assessments, national consultations were held with various stakeholders during the period 2012 - 2015 and in keeping with international and regional good practices/models, standards, agreements and commitments, this SRH Policy was developed. Findings from these studies and consultations revealed that SRH is not fully integrated in Trinidad and Tobago. Furthermore, there are issues with maternal health linked to chronic diseases, haemorrhage, late and poor attendance at antenatal clinics (due to issues such as late awareness of pregnancy and low confidence in the public health system), post abortion care and adolescent pregnancy. Failure in preventing unsafe abortion is also an important factor significantly contributing to maternal mortality and morbidity. Cancers of the reproductive tract and infertility problems are growing in prevalence. Sexual and other forms of gender based violence (GBV) and HIV and other STIs continue in prevalence with specific issues of access to SRH information and services amongst key populations.

2.1 Maternal Mortality & Morbidity

Lifestyle related health challenges including high levels of chronic diseases, which represent 60% of all deaths such as diabetes and hypertension also directly impact on maternal morbidity and mortality, particularly when some of these illnesses are diagnosed late in pregnancy (PAHO/WHO, 2012). While 95% of live births are attended by skilled health professionals and 95% of women attend antenatal clinics at least once during their pregnancy (MOH, 2014), there are avoidable deaths due to haemorrhage, pre-eclampsia, diabetes, premature labour, obstetric shock and infections (PAHO/WHO, 2012). Furthermore, only 77% of mothers and new-borns receive postnatal care within seven days of childbirth (PAHO/WHO, 2012).

In three (3) counties within T&T, over the period 2011 – 2013, there was on average, approximately 41% of women who attended their first antenatal visit during the first trimester (MOH, 2014). In one county, 17% of all births were for young women ages 19 and under and only 17% had attended their first antenatal clinic during the first trimester. This data indicates the need for women to be aware of the importance of early and consistent antenatal and postnatal visits to avoid complications. Furthermore, there is a need for males and females to be exposed to family planning options before and after pregnancy.
2.2 Adolescent SRH

Adolescent pregnancy is also vitally important as it has implications beyond SRH. The adolescent birth rate is presently 44.9 per 1000 women aged 15-19 (MOH data 2012) with the Ministry of Education reporting 2,500 pregnancies amongst school aged girls each year (MOE, 2015). A 2013 regional study conducted by the University of the West Indies, Health Economics Unit noted some of the socio-cultural drivers of adolescent pregnancy in the Caribbean which include early sexual initiation; misplaced notions of masculinity and femininity; sexual abuse; and religion and child marriage (UWI, 2013). It further lists health system-related drivers as limited access to health services by adolescents; limited use of contraception methods; and stigma and discrimination towards sexually active young people (UWI, 2013). It cites a World Bank Report of 2003 that postulated that no other region in the world has an earlier age of sexual initiation than the Caribbean region (UWI, 2013).

In Trinidad and Tobago, the issue of early sexual initiation is substantiated by the Global School Based Health Survey (PAHO, CDC, and MOH 2007). The 2007 report revealed that 32.0% of males 13-15 years of age reported that they had sexual intercourse. Of that amount, 19.9% had sexual intercourse for the first time before the age of 13. In addition, 23.9% had multiple sex partners during their life and 29.9% had sexual intercourse in the previous 12 months. The 2011 Global School Based Health Survey notes that 27.1% of the young people age 13 - 15 years had sexual intercourse and of those who ever had sexual intercourse, 62.2% of students 13-15 years reported sexual initiation before age 14 (MOH, 2011).

Adolescent pregnancy affects the current health of girls, their school success, impacts on their future health and productivity, their children, families and the communities. Child marriage and unions, early sexual initiation and high prevalence of child abuse, combined with adolescents’ lack of access to SRH services and comprehensive age-appropriate sexuality education through the Health and Family Life Education (HFLE) curriculum in schools, are among the factors that contribute significantly to adolescent pregnancies. The Caribbean Integrated Strategic Framework on Adolescent pregnancy adopted by CARICOM in 2015 notes that “Addressing and reducing adolescent pregnancy will contribute towards fulfilment of the reproductive and sexual rights of adolescents, while at the same time improving maternal and child health; increase the number of girls completing their education; contribute towards greater gender equality; reduce incidence of sexual violence; and increase economic productivity, human capital and employment, which all lead to the full realisation of the rights and potential of adolescents”.

2.3 HIV & Other STIs

HIV and other STIs remain an issue for the Caribbean and Trinidad and Tobago in particular. The adult HIV prevalence rate in Trinidad and Tobago at 2012 was 1.5% (GARP, 2014). In 2014 the HIV prevalence rate rose to 1.65% (HACU 2014). Furthermore the 2014 Government of Trinidad and Tobago MDG Report notes an
increase prevalence amongst young people 15-24 over the period 2009 to 2011. HIV prevalence rate within this cohort of the population increased from 1,300 per 100,000 persons (or 1.3 percent) in 2009 to 1,800 per 100,000 persons (or 1.8 percent) in 2011. In PAHO’s 2012 “Health in the Americas” profile for Trinidad and Tobago, it notes that there were 258 newly diagnosed cases of syphilis in 2007, 194 in 2008, and 131 in 2009. New cases of gonorrhoeae increased from 370 in 2007 to 578 in 2008, and 605 in 2009. Trichomonas’s decreased from 83 cases in 2007 to 46 in 2008 but rose to 121 cases in 2009.

### 2.4 Related Cancers

In Trinidad and Tobago, the main types of cancers are those of the reproductive organs, such as cancers of the breast, the uterus and the cervix in women and the prostate in men (MOH Annual Statistical Report 2009). As of 2006, cancer remained the third leading cause of death for all ages of men and women in Trinidad and Tobago (PAHO, 2012). Screening for these cancers and early treatment saves lives and also lowers the burden of cost that these cancers bring to the health system and therefore, should be added as an integrated service. Furthermore, among the abovementioned, cancer of the cervix can largely be prevented by vaccination of preadolescent girls. Greater awareness is therefore needed on the benefits of the vaccine.

### 2.5 Sexual and Gender Based Violence

In respect to sexual violence, reports of rapes, incest and other sexual offences have increased from 550 in 2013 to 829 in 2014 (MNS, 2014). Furthermore, the Trinidad and Tobago Police Service Crime and Problem Analysis (CAPA) Unit notes that, according to police statistics in 2014, 976 children were victims of serious crimes, of which 705 were sexual offences (Children’s Authority, 10 June 2015). The prevention and management of sexual and gender based violence (S&GBV) are all SRH concerns that require a collective integrated response.

### 2.6 Current SRH Service Delivery

Presently, SRH services are being offered vertically with limited integration at service delivery points, particularly in the areas of family planning; maternal health (antenatal, childbirth, postpartum and post abortion care); HIV and other STIs; treating sexual violence; screening for cancers of the reproductive organs; and addressing infertility management. The Population Programme Unit (PPU), a Vertical Unit of the Ministry of Health, has the primary responsibility for the delivery of family planning services as a Vertical Programme under the Ministry of Health with its own staffing arrangements. To address human resources constraints, training in in various SRH services across points of care should be considered to ensure all clients receive comprehensive services. Similar arrangements exist for the management of sexually transmitted services under Queen’s Park Counselling Centre & Clinic (QPCC&C), another Vertical Unit of the Ministry of Health.
Antenatal clinics within the Regional Health Authorities (RHAs) provide maternal health services, the HIV/AIDS Coordinating Unit (HACU) within the MOH addresses HIV and AIDS prevention, care, treatment and support and the Interim HIV Agency, which is now in the Office of the Prime Minister, coordinates the national HIV response. However, given the vertical nature of these programmes, full and comprehensive SRH services are not guaranteed. Furthermore, sexual violence is not treated in the healthcare setting as an SRH issue. There are limited counselling services available at the primary care level which is needed is the delivery of SRH. There is an absence of an effective referral system, and while health is addressed in the present emergency/

**INTEGRATING SRH AND HIV INVOLVES AMALGAMATING A WIDE RANGE OF SERVICES**

**Diagram 1**
disaster system, healthcare providers need to be aware of the key SRH concerns during an emergency/disaster. With the commitment to establish a new Unit on Women's Health, the work of this unit will also have to be integrated with the other related SRH vertical programmes.

Findings from the SRH studies reveal that there are key populations such as working males, migrants, the poor, substance users, persons with disabilities, the elderly, incarcerated persons, persons living with HIV, sex workers and adolescents who do not access SRH services regularly. Many of the reasons noted for not accessing services include:

- the time services are being offered,
- the need for parental consent and,
- stigma expressed by healthcare professionals.

In an effort to make sure that all persons have access to SRH services, the policy addresses the integration of SRH services by offering clients a comprehensive package of SRH services.

Some of the benefits of an integrated SRH programme include:

- improved access to, and uptake of key HIV and AIDS and SRH services;
- better access for people living with HIV and AIDS (PLWHA) to SRH services tailored to their needs;
- reduced HIV and AIDS-related stigma and discrimination;
- improved coverage of underserved and marginalized populations, such as substance abusers, sex workers or MSM, as all seeking SRH services will be offered a full package of integrated services;
- greater support for dual protection against unintended pregnancy and STIs, including HIV, for those in need, especially young people;
2.7 Legal & Policy Environment

SRH concerns are compounded by a legal and policy environment that either prohibits or does not provide a framework for access to SRH services amongst adolescents, unless they are married. In fact, “Under the Marriage Act (13 of 1923), girls are permitted to marry at age 12 while boys can marry at age 14. The Marriage Act applies to both Christian and civil marriages. The Muslim Marriage and Divorce Act permits girls to marry at age 12 and boys at age 16. The respective ages under the Hindu Marriage Act are 14 for girls and 18 for boys. Under the Orisha Marriage Act, girls are permitted to marry at age 16 while boys may marry at age 18.” (UNAIDS Legislative Assessment 2012). This is contrary to the principles of the Convention on the Rights of the Child as there is a gap between the age of consent to sexual activity and the permissible ages of marriage. Furthermore, while multiple partners and sexual activities are glorified in popular music, there are also strong religious influences that perceive the provision of SRH information or services to adolescents is a ‘licence to have sex’.

Presently, there is an absence of a National Policy framework to ensure universal access to SRH programmes and services in Trinidad and Tobago. There is a draft HIV and AIDS policy, a National Post Exposure Prophylaxis Policy, a Prevention of Mother to Child Transmission (PMTCT) of HIV Policy, a Health Sector HIV Workplace Policy and a HIV and AIDS Testing Policy, but no overall Sexual and Reproductive Health (SRH) policy.

While there is an absence of a National Policy framework to ensure universal access to SRH programmes and services in Trinidad and Tobago, there are many pieces of legislation that address issues in SRH. According to the Offenses Against the Persons Act of 3 April 1925, as amended, abortion is illegal, although under general criminal law principles of necessity; an abortion can be legally performed to save the life of a pregnant woman. According to the Family Planning Association of Trinidad and Tobago “Situation Analysis of Unsafe Abortion in Trinidad and Tobago” Senior Council Douglas Mendes’ provides an interpretation of the law noting that a healthcare provider in Trinidad and Tobago can perform an abortion legally if it is deemed by the healthcare provider that the pregnancy is to the mental/physical detriment of the mother. This is based on the position of England (as it is where the statutory records of Trinidad and Tobago are copied from) regarding the matter after the ‘Bourne Case’ where the general acceptance of abortions being legal when it is necessary to save a woman’s life was put into effect (FPATT, 2008).

The Domestic Violence Act, 1999, addresses gender-based violence, particularly within the home and amongst intimate partners, while the Sexual Offences Act, 1986, addresses sexual offenses primarily against adults. With the proclamation of the Children Act, 2012 in 2015 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 were introduced.
Under the Children's Act, a child under 18 cannot consent to sexual penetration including sexual intercourse, while a child under 16 cannot consent to sexual touching unless they are married or come within certain specified exceptions including being within a close age range (with the exception of same sex acts). 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 offenses can also be the subjects of mandatory reports. 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 unsure consequences for the adolescent or the HCP, including the potential for threats, violence and physical harm.

- unwillingness of adolescents to access SRH services for fear of being reported to the police which may result in more “back street” abortions and greater incidence of HIV and other STIs among young people.

The legislation will therefore need to be amended to address consensual sex amongst minors who do not come within the exceptions so that these barriers to access to services will be removed. Given early sexual initiation and multiple sex partners amongst adolescents, access to SRH must be addressed to provide the necessary care for our adolescents and to take real steps towards furthering the objectives of this policy. In fact, the Ministry of Health’s 2012 HIV Testing and Counselling Policy states:

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.

1. Clients less than 14 years of age will not be tested without consent from a parent or guardian.

2. 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.

Furthermore, the Marriage Acts (Marriage Act, Muslim Marriage and Divorce Act, Hindu Marriage Act, and the Orisha Marriage Act) of Trinidad and Tobago
should also be reconciled so that marriage can only take place amongst adults. Any new legislation related to SRH should be in line with the objectives of this policy and 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 the tensions between the ideology of SRH for all and the legal restrictions influencing the delivery of care to all.
3.0 Overarching/Policy Statement

The Government of the Republic of Trinidad and Tobago will guarantee universal access to comprehensive Sexual and Reproductive Health (SRH) to all persons in need and requiring it, that is of the highest standard through the provision of an integrated or expanded service delivery system. These SRH services will be facilitated by a multisectoral, life course approach and within the context of sexual and reproductive rights, to attain the highest quality of sexual and reproductive health of all persons in Trinidad and Tobago. This statement is consistent with the newly adopted Sustainable Development Goal 3 of ensuring healthy lives and promoting wellbeing for all at all ages.
4.0 Policy Objectives

The SRH policy seeks to address the following objectives:

1. Ensure every person in Trinidad and Tobago in need of SRH are offered and have access to comprehensive Sexual and Reproductive Health Services through the Public Health System at service delivery points. Vertical programmes in population, maternal health, HIV and STIs shall provide an integrated package of comprehensive SRH services (See Section 5) to all individuals who require SRH services at the primary care level. Protocols and/or standard operating procedures shall be developed to guide implementation. SRH shall be integrated in sector policy and programme development, service delivery, and information, education, and communications (IE&C). During emergencies a minimum initial service package (MISP) will be applied.

2. Educate the population on SRH: 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 providers, Pharmacists, Teachers and other non-conventional agents (e.g. artists) should be used to deliver the messages and information. Non-conventional or group-specific strategies will be deployed to reach key populations in consultation with civil society. New technologies, including electronic health (e-health or 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 lobby for policy, legislative, and programmatic changes to attain the highest level of SRH.

3. Reduce adolescent pregnancy through the provision of comprehensive ASRH 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 Health
Post-abortion care includes five essential elements (IPAS, 2015):

1. Treatment of incomplete and unsafe abortion 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 and abortions;
4. Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities;
5. Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.

[PAS 2015]

and Family Life Education (HFLE) programme, age appropriate Comprehensive Sexuality Education (CSE) will be addressed. Adolescents must have information and the 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. Services to be delivered should be adolescent friendly delivered by specifically trained and motivated providers in a confidential environment free from stigma. Programmes to reach out of school, and in institutionalized settings (prison, homes etc.) adolescents and youth shall be developed and implemented.

4. **Reduce maternal and newborn mortality and morbidity:** This will be addressed by offering a package of integrated SRH services and by creating awareness on the importance of early and consistent attendance at antenatal visits, particularly for mothers who have chronic illnesses. For all women who experience complications of abortion (regardless of induced or spontaneous), comprehensive post abortion services to save lives will be accessible. Failure in providing good quality and timely post abortion care is one of the main causes of maternal mortality, and WHO estimates on average at least 13% of maternal deaths in the world are due to this failure.

5. **Increase quality and uptake of services through strengthening health systems:** 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. Strong supportive systems must be in place (such as psychosocial support), with 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 refresher courses particularly in the areas covered by the Comprehensive Package of Key SRH Services. In clinical services, there are six elements which contribute to the delivery of quality sexual and reproductive health services:

1. Communities shall be empowered to own the healthcare system, monitor the quality and hold programme managers accountable for the performance of the system.

2. 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 health system strengthening. The Ministry of Health through its Population Programme Unit will establish a multi-stakeholder National SRH Committee who will monitor the implementation of this policy and oversee its coordination. Greater linkages will also
be established with civil society including through contractual arrangements, such as Service Agreements in identified aspect of SRH services 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 relevant international agreements and standards and guide all other SRH related policies, programmes and interventions. This policy will be in effect for all members of the population in Trinidad and Tobago and will guide all SRH related policies, programmes and interventions. Laws that allow child marriage (under the age of 18) should also be abolished.

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).

Based on these objectives, the National SRH policy for Trinidad and Tobago and Tobago will be guided by the following principles:

1. Respect the rights of each individual to make voluntary and informed SRH choices.

2. Sexual and Reproductive Health services should be Available, Accessible, Affordable, Acceptable and of 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.

8. Effective and equal participation in decision-making
processes and empowerment of the identified vulnerable groups.

9. 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.

10. Social Justice which recognizes the social rights of all individuals to a decent quality of life including access to proper medical services thereby ensuring that SRH programmes are accessible to the whole population including key populations.
5.0 POLICY SCOPE/COVERAGE

The SRH policy is a national policy and will therefore be in effect for all members of the population in Trinidad and Tobago in need and requiring access to SRH services. The national SRH policy will serve as a guiding and organizational framework to promote SRH in view of improving access to care and services and will guide all SRH related policies, programmes and interventions. In keeping with the objectives of the policy, a comprehensive package of SRH services are to be made available to all.

5.1 Comprehensive Package of SRH Services to be Delivered

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

<table>
<thead>
<tr>
<th>Family Planning Services</th>
<th>Range of birth control methods including voluntary abstinence and natural fertility method (Billing’s method), Long Acting Permanent Methods, Inter-uterine devices, Information and Education</th>
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<tr>
<td>Safe Motherhood Initiatives</td>
<td>Pre-conception</td>
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<td>Safe Delivery</td>
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<td>STI management during pregnancy</td>
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<td>Anaemia management</td>
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<td>STI/HIV and AIDS Services</td>
<td>STI and HIV and AIDS Education</td>
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<td>Condom promotion and distribution</td>
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<td>HIV testing and counselling</td>
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<td>PEP</td>
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<td>STI screening and testing, including Hepatitis B</td>
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<td>STI treatment and support</td>
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<td>Termination of Pregnancy/ Miscarriage related services</td>
<td>Family Planning Services</td>
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<td>Management of complications</td>
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<td>Post abortion counselling</td>
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<td>Adolescent Sexual and Reproductive Health</td>
<td>SRH Information and Education</td>
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<td>STI and HIV and AIDS Education</td>
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<td>Reproductive Health commodities</td>
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<td>HIV testing and counselling</td>
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<td>HPV Vaccine</td>
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<td>Provision of information and services to prevent unwanted pregnancies and/or negative outcomes during pregnancy and delivery</td>
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<th>SRH Counselling and IEC Development</th>
<th>Information</th>
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<td>Education</td>
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<td>Training</td>
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<td>Development of material</td>
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<th>Fertility Services</th>
<th>Prevention of Infertility</th>
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<td>Screening</td>
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<td>IVF and other methods</td>
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<tr>
<th>Elimination/Reduction of Cancers of the Reproductive and related Organs</th>
<th>Cervical Cancer screening</th>
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<tbody>
<tr>
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<td>Breast Cancer Screening including Clinical Breast Examination and Mammogram</td>
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<td>Prostate cancer screening including digital prostate examination and PSA</td>
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<td>HPV Immunization &amp; Screening</td>
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<th>SRH/CNCD Management</th>
<th>Tobacco Use</th>
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<td>Alcohol Use</td>
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<td>Blood Sugar, Blood Pressure, Cholesterol</td>
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<td>General Health-Diabetes Management</td>
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<td>-Hypertension Management</td>
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<td>Mental Health</td>
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<td>General dental and nutrition services</td>
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<th>Sexual &amp; Gender-based violence management</th>
<th>Psychological and Psychosocial Support Services</th>
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<td>HIV and STI testing</td>
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<td>PEP</td>
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<td>Emergency Contraceptives</td>
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<td>Men's Health</td>
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<td>Health Education and Counselling</td>
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<td>Andropause</td>
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<td>Fertility-Prevention and Screening</td>
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<td>CNCD- Urology Services for Erectile Dysfunction/</td>
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<td></td>
<td>Impotence and Prostate Care screening</td>
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<td>HIV/STI-prevention and treatment services</td>
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<td>Gender-based violence prevention and management</td>
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<td>Family Planning Services (as described above)</td>
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<td>Cancers of the Reproductive System-prostate</td>
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<td>(prevention and early screening)</td>
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<td>Urology services</td>
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<td>Throat, anal cancers</td>
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<th>Women's Health</th>
<th>Menstrual disorders</th>
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<td>Gynaecological disorders and infections</td>
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<td>Menopause</td>
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<td>Family Planning Services (as described above)</td>
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<td>Cancers of the reproductive system-cervical cancer (pap smears)-breast cancer (teaching self-breast examination and clinical breast examination)</td>
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<td>Gender-based violence prevention and management</td>
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<td>Sexual dysfunction</td>
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<td>HIV/STI-prevention and treatment services</td>
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<td>Clinical referral for specialist gynaecological services</td>
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<td>Full spectrum of information and education services</td>
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<th>Post Fertility</th>
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<td>Cancer Screening</td>
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<td>Gender-based violence prevention and management</td>
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The Comprehensive package of SRH services will be integrated on a phased basis using the following approach, based on existing SRH capacity and conditions, to allow time to adjust to the logistical and service delivery systems to accommodate programme growth:

1st Phase  STI, HIV and Family Planning Services;
2nd Phase  STI, HIV, Family Planning, screening of cervical cancer services;
3rd Phase  STI, HIV, Family Planning, screening of cervical cancer and prostate cancer, breast examination, infertility investigation, and screening for CNCD services;
4th Phase  Other SRH services;

In facilitating this integration of SRH services, the following must be considered:
- The required infrastructure and referral systems
- Updated sexual and reproductive health programme guidelines
- Competency of personnel
- Training of staff and supervisors
- Medical support
- Supplies and Logistics
- Integrated Record Systems
- Delegation of activities
- Estimation of resource needs and identification of funding sources

The necessary resources (human, financial, technical, material, and physical, including reproductive health commodities) shall be acquired to support the development, implementation, monitoring and evaluation of SRH policies, action plans, and activities. Service delivery points shall be increased and/or upgraded to support the implementation of National SRH Programme, particularly to promote an adolescent and/or key population friendly environment. As such, additional guidelines and/or standard operating procedures will be developed for the delivery of specific SRH services.

5.2 Minimum Package of SRH Services to be Delivered in Emergencies and Disasters

Following a crisis event, the supply and delivery of the comprehensive SRH package typically becomes interrupted. In such an event preventive means, treatment and care administration is threatened. Nonetheless, SRH is a human right and a bio-psycho-social need. At a minimum, basic and essential SRH services should be available and accessible at the onset of any emergency or disaster. These SRH service provisions are afforded via the Minimal Initial Service Package (MISP), each word meaning 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
MISP is a coordinated set of priority activities (performed at the onset of an emergency/disaster) designed to prevent and manage the consequences of sexual violence; reduce HIV transmissions; and prevent excess maternal and newborn morbidity and mortality. MISP is a part of the Humanitarian Charter and provides a Minimum Standard of care that guides the practice of a collective humanitarian response.

<table>
<thead>
<tr>
<th>Family Planning Services</th>
<th>Range of birth control methods including voluntary abstinence and natural fertility method (Billing’s method) Information and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Motherhood Initiatives</td>
<td>Pre-conception Pre-natal Safe Delivery Postnatal PMTCT STI management during pregnancy Anaemia management</td>
</tr>
<tr>
<td>STI/HIV and AIDS Services</td>
<td>STI and HIV and AIDS Education Condom promotion and distribution HIV testing and counselling PEP STI screening and testing STI treatment and support</td>
</tr>
<tr>
<td>Termination of Pregnancy/Miscarriage related services</td>
<td>Family Planning Services Management of complications Post abortion counselling</td>
</tr>
<tr>
<td>Adolescent Sexual and Reproductive Health</td>
<td>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</td>
</tr>
<tr>
<td>SRH Counselling and IEC Development</td>
<td>Information Education Training Development of material</td>
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<tr>
<td>SRH/CNCD Management</td>
<td>Mental Health</td>
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</table>
| Sexual & Gender-based violence management | 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 | Information  
| | Education  
| | Training |
6.0 PROGRAMMATIC OUTCOMES & INDICATORS

Based on international and regional agreements and national commitments, the SRH Policy will seek to achieve a number 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. The following matrix brings together the outcomes, objectives and indicators for effectively implementing this policy. Further details are provided in the Draft Action Plan that will guide the implementation of the policy.

Outcome: SRH Policy effectively implemented
Objective: Ensure coordination and implementation of policy
Indicators (Source: MOH)
- There is a costed Action Plan to support implementation of the Policy;
- The policy and related protocols are being used to guide SRH and the delivery of services; to influence legislation and resource allocation, accreditation of health facilities; and to influence other related policies;
- Number of sensitization sessions conducted to sensitize stakeholders on the policy demonstrating knowledge of and use of the policy in multi sectoral settings (i.e. in schools/education, training programmes);
- Maternal mortality ratio reduced Baseline: 84 per 100,000 (PAHO, 2015);
- Reduction of adolescent pregnancy and new cases of STIs, especially among key population Baselines: Adolescent Birth Rate: 44.9 per 1,000 women aged 15 – 19 (MOH, 2012); HIV Prevalence Rate Ages 15 – 24: 1.8% (MPD, 2015); Training needs assessment conducted;
- Training plan developed;
- National SRH Committee Established to oversee the implementation of the policy and Meetings Convened:
- Quarterly reports and updates of policy implementation produced and disseminated to SRH Committee members with a record of the percentage of meeting action items resolved per quarter;
- Systems developed for coordination of national condom distribution and programming activities involving state and NGO sector to avoid duplication of efforts and possible neglect of specific communities;
- Number of National Campaigns and Social media activities implemented that address SRH;
- 100% of staff in place at the Population Programme Unit (PPU) and associated systems developed for coordination of a functional national commodity security system;
- Quarterly review of client feedback by the National SRH Committee;
7.0. ROLES AND RESPONSIBILITIES

The national SRH policy requires the participation of many stakeholders functioning in a coordinated, coherent, and integrated manner to improve SRH of the population of Trinidad and Tobago. The successful implementation of the National SRH Policy will depend greatly on the functional capacity of a number of key stakeholders, including the various SRH related units of the Ministry of Health, Civil Society, the Private Sector and International Partners (See Appendix III for current composition of the SRH TWG and Appendix IV for proposed composition of the National SRH coordinating committee). Once agreed by the Ministry of Health and these stakeholders, the SRH TWG will form part of a Cabinet appointed National SRH committee under the leadership of the Ministry of Health, 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.

7.1 Ministry of Health

The Ministry of Health (MOH) is the national authority charged with oversight of the entire health system in Trinidad and Tobago. The Ministry 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 a Cabinet appointed multi-sectoral National SRH 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 Ministry of Health 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 Ministry of Health through its Population Programme Unit (PPU), which will serve as the Secretariat for the National SRH 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 Ministry of Health, with support from the National SRH 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 Ministry of Health 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 Queens Park Counselling Centre and Clinic (QPCC&C), the HIV and AIDS Coordinating Unit (HACU), the PPU and other relevant major partners.

The Ministry of Health 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 Ministry of Health, guided by the National SRH 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 Ministry of Health will ensure that this predetermined comprehensive package of SRH services is included in the Annual Services Agreement with all the Regional Health Authorities.

In the event of an emergency or disaster, and following consideration of the scale of the event, the MOH will designate competent MOH officials with the responsibility of coordinating MISP until full SRH services can be renewed. Upon direction of the MOH, Municipal Corporations will serve as the lead to manage and coordinate the key areas of this policy across local government, in collaboration with the Ministry of Health, the County Medical Officer of Health, the Public Health Department, as well as other stakeholder entities involved in ensuring the delivery of SRH services. MOH 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.

The Ministry of Health, as guided by the National SRH committee, shall be responsible for ensuring that any infringements of sexual and reproductive rights are addressed.

### 7.1.1 Population Programme Unit

The Ministry of Health’s Population Programme Unit (PPU) will serve as the Secretariat for the National SRH Committee, ensuring coordination amongst all agencies, institutions and organizations involved in the provision of SRH services in the country.

The PPU in collaboration with the Regional Health Authorities, other vertical SRH units within the Ministry and other relevant agencies will be responsible for the development of annual national workplans for the delivery of the National SRH Programme. Upon the advice of the national SRH Committee, the PPU 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 PPU in collaboration with the Regional Health Authorities, and other relevant agencies will be responsible for 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.

The PPU, upon direction of the National SRH Committee, will provide the technical support to ensure that the predetermined 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.

7.1.2 Regional Health Authorities

The Regional Health Authorities will be responsible for the implementation of the evidence-based SRH Programme and services to all persons, inclusive of key populations in Trinidad and Tobago. The Regional Health Authorities will be responsible for procuring the required medical commodities to support the SRH programmes and services using the procurement system developed by the PPU. The Regional Health Authorities will be responsible for the training and continuous updating of the health care staff on issues relating to SRH.

The Regional Health Authorities 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.

7.1.3 HIV/AIDS Coordinating Unit (HACU)

The HIV and AIDS Coordinating Unit (HACU) of the Ministry of Health 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 donor agencies through its relationship with QPCC&C and the PPU. This will include preparation and dissemination of HIV and AIDS workplan, budgets and reports, including specific information on special populations, within the SRH network as is necessary for programming.
7.1.4 Queens Park Counselling Centre and Clinic (QPCC&C)

The Queens Park Counselling Centre and Clinic (QPCC&C) will be responsible for the delivery of Sexually Transmitted Infection (STI) services in accordance with this policy and the National STI Action Plan. 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, if needed). QPCC&C will work, in collaboration in other agencies, to ensure that STI services are incorporated into existing and expanding SRH services.

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.

7.1.5 The National SRH Committee

The Ministry of Health, through Cabinet shall establish a National SRH Committee comprising relevant stakeholders to provide policy direction, advocate for funding and support of SRH. This committee will guide planning, implementation processes, and monitoring and evaluating the progress of the SRH Policy and Action Plan. It will also provide the technical support to ensure that the pre-determined 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 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 and working in collaboration with the MOH’s PPU, 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 the national SRH 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 SRH Committee. Joint reporting with other agencies shall be supported as far as possible to prevent duplication of effort and resources. Every two (2) 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.
7.2 Office of the Prime Minister

7.2.1 National AIDS Coordinating Committee (NACC)

The Office of the Prime Minister (OPM) will establish a National AIDS Coordinating Committee (NACC) that will be responsible for coordinating the delivery of HIV and AIDS related programmes in accordance with the National HIV and AIDS Strategic Plan. Additionally, NACC is expected to ensure there is alignment of all national and sectoral policies related to HIV with the National SRH policy. While different ministries may have HIV co-coordinating units, the NACC is responsible for leading the coordination of the multi-sectoral response to HIV and AIDS in Trinidad and Tobago. The NACC is responsible for over-seeing the integration of SRH services into all HIV services across Trinidad and Tobago.

7.2.2 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 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 gender based violence (S&GBV) are addressed and they will also refer clients to relevant referral services. Gender Affairs will also maintain a database of which will serve as a source for evidence based planning and analysis.

7.3 The Tobago House of Assembly

The Tobago House of Assembly (THA), through the Office of the Chief Secretary and the Tobago HIV/AIDS Response Programme, the Division of Health and Social Services (DHSS) and the Division of Education Youth Affairs and Sport (DEYAS) shall be responsible for engaging in the following strategies for Tobago, which includes:

- Establishing a SRH Unit
- Seeking funding in the annual government budget for the delivery of the National SRH Programme in Tobago
- Developing the annual work plan for SRH in Tobago
- Accessing training programme 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 programme using the life-cycle approach
• Delivering an integrated SRH programme
• Monitoring and evaluation, including conducting research on SRH

The THA will be represented on the National SRH Committee to ensure the coordination and implementation of relevant action plans in Tobago.

7.4 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 Division to ensure the effective implementation of the National SRH Policy.

7.5 Ministry of Planning and Development

The Ministry of Planning and Development and its relevant Units/Divisions shall work in collaboration with the relevant stakeholders to reconvene the Population Council and, to operationalize the secretariat for the Council to ensure that elements of this policy are captured in the implementation of the National Population Policy. The Central Statistics 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.

7.6 Office of the Attorney General and Legal Affairs

The Office of the Attorney General and Legal affairs 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.

7.7 Ministry of National Security
7.7.1. 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 seek to facilitate, as soon as possible, the transition of SRH delivery from MISP to the comprehensive SRH package, during phases of recovery. The ODPM, will also seek to 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 exante emergency disaster management via preparation, prevention and mitigation undertakings.

7.7.2. Other Related Initiatives

Partnerships will be sought with the Citizen Security Programme to address SRH concerns at the community level in high risk/“hotspot” communities. Collaboration will also be sought 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. Efforts will also be made to collaborate with the Ministry’s HIV/AIDS Coordinating Unit which organizes HIV and AIDS Awareness Youth Challenge Walks.

7.8 Ministry of Education

The Ministry of Education shall be responsible for the effective implementation of the age-appropriate Health and Family Life Education (HFLE) curriculum 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), including the Trinidad and Tobago Health Training Centre (TTHTC) for developing the curriculum and providing training programmes related to SRH in order to build capacity for the public, private, and
non-governmental sectors.

7.9 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.

7.10 Ministry of Community Development, Culture and the Arts

Collaboration will be sought with the Ministry of Community Development, 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.

7.11 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 sexual and gender based violence. The Ministry will work within its existing programmes to raise awareness on SRH such as the Adolescent Intervention Programme, the District Youth Services, Global Young leaders, National Youth Volunteerism Programme, Social Education and Skills Enhancement Programme, its Youth Empowerment Centres (which targets men 15-17 years old) and the Youth Health Caravan. Since young people do not always recognise or acknowledge their health challenges, this is a unique approach to sharing lifestyle related information to reach youth in their communities in an effort to support the empowerment of young people.

7.12 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 Ministry of Health and other relevant state agencies in the area of promoting SRH 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 training on SRH. CSOs will also be represented on the National SRH Committee.

7.13 Private sector

The Private sector shall be encouraged to partner with the Ministry of Health and other relevant state agencies in the area of 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.

7.14 The Trinidad and Tobago Health Training Centre

The Trinidad and Tobago Health Training Centre (TTHTC) in collaboration with the Ministry of Education shall be responsible for supporting the refinement of the curriculum (HFLE, training of HCP, etc.) and providing the identified training for the core areas of SRH and integrated service delivery. TTHTC will also be encouraged to participate in related training programmes so new knowledge can be integrated into the relevant curriculum.

7.15 International Organizations

International cooperation shall be strengthened to acquire the relevant technical assistance in the area of SRH through support for research, provision of strategic information, training/capacity building, technical guidance and reviews and through South to South collaboration. 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.
8.0 CONCLUSION

The National SRH Policy seeks to ensure that all persons in Trinidad and Tobago have equitable access (facilitating 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 obtaining sustainable development. The comprehensive package of SRH services to be provided by all Primary Healthcare facilities includes:

a. Family planning and responsible parenthood before and after pregnancy to ensure adequate birth spacing to optimize the health of mother and child;
b. Antenatal, safe delivery and post-natal care for mothers and infants with the promotion of the involvement of fathers;
c. Prevention and appropriate treatment of infertility;
d. Prevention of abortion and management of the consequences of abortion;
e. Prevention, screening, care and treatment of STIs and HIV and AIDS;
f. Information, education and counselling, as appropriate, on human sexuality and reproductive health;
g. Prevention and surveillance of violence against women and children, care for survivors of violence and other actions to eliminate traditional harmful practices, such as Female Genital Mutilation (FGM) or otherwise referred to as Female Circumcision (FC);
h. (Adolescent SRH services;
i. Elimination/reduction of cancers of the reproductive and related organs;
j. SRH CNSD management;
k. Men's SRH
l. Other women's health issues such as gynaecological disorders and infections; and
m. Appropriate referrals for further diagnosis and management of all of the above.

By integrating SRH services, the policy will support 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 and human rights based approach will be taken to implement the policy. This will ensure that the SRH needs of all members of the population are covered throughout a person's lifetime. Gender will be considered in the approach to the delivery of SRH information and services, promoting the full equality between the sexes, the involvement of males in all aspects of SRH and joint responsibility on all aspects related to their own sexuality and for child-rearing.

The MOH and its stakeholders, through this policy, will ensure that the population is educated on SRH. For young people, age appropriate comprehensive sexuality education will be delivered through HFLE in efforts to delay early sexual initiation, prevent and address sexual and gender based violence and adolescent pregnancy
so that young people can achieve their full potential. Other conventional and 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.

Maternal and newborn mortality and morbidity will be reduced by offering an integrated 
comprehensive package of SRH services; creating greater awareness and promoting 
behaviour change amongst mothers (and potential mothers) so that their attendance 
at antenatal visits is early and consistent to prevent any potential complications and 
through further capacity building of HCP. Comprehensive post abortion services to 
save lives, regardless if it is induced or spontaneous, will be provided for all women who 
experience complications.

Critical knowledge and programmatic gaps shall be identified through research which 
would inform stakeholders on key issues surrounding SRH. Mechanisms shall be 
implemented to provide evidence to address SRH issues on a timely basis in Trinidad 
and Tobago that would contribute to policy and programme development, and clinical 
practice or practical application. Collaboration with relevant stakeholders shall be 
encouraged to support research on SRH in order to inform policy development and 
decision making. Government, NGOs, and private medical practitioners providing 
SRH services shall be guided by this SRH policy.

To complement the policy, written protocols and guidelines shall be developed, 
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 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.

Technical and financial collaboration with a wide range of international organizations, 
regional governments, national entities and non-government organizations are 
essential for the implementation of the National SRH Policy. Referral systems will 
be strengthened vertically to provide higher levels of quality care, for example, from 
primary to secondary levels of care and horizontally to link programmes, for example,
STI and CNCDs in Men’s Health Clinic. Greater linkages will also be established with civil society to ensure the delivery of a comprehensive package of SRH services to all in Trinidad and Tobago.

The National legislative framework of the Republic of Trinidad and Tobago shall be reviewed and adapted where necessary to create the legal conditions for the implementation of the National SRH Policy in accordance with international conventions, agreements, and commitments, ratified and accepted by the Republic of Trinidad and Tobago and by the input of the national community including government, private sector and civil society. (Appendix I provides the list of the international conventions, agreements, and commitments).

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.

These 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.
Appendix I


HIV and Other STIs. Port of Spain. Red Initiatives.


WHO Regional Office for Europe. 2015. “What do we mean by ‘sex’ and ‘gender’?” WHO Regional Office for Europe. www.who.int
Appendix II:

List of International Conventions, Agreements, and Commitments Ratified by the Government of Trinidad and Tobago and National Policies Related to Sexual and Reproductive Health

2. Convention of the Rights of the Child (CRC)
4. Millennium Development Goals (MDGs)
5. National Youth Policy
7. UN Declaration on Migrant Population
8. National School Health Policy? There is the national HIV and AIDS Policy
9. Policy on Decentralization and Integration of the Sexually Transmitted Disease Services in Trinidad and Tobago (draft)
Appendix III:

List of Sexual and Reproductive Health Indicators for Global 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 amenorrhoeaic. 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 rate

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.

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 (15–24 years of age) 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

Percentage of the population with access to sexual and reproductive health services (disaggregated by gender and age)

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

a. 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.
**Appendix IV:**

Members of the National Sexual and Reproductive Health Technical Working Group

<table>
<thead>
<tr>
<th>Organization</th>
<th>Department/Unit</th>
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<tbody>
<tr>
<td>Ministry of Health</td>
<td>Population Programme Unit</td>
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<tr>
<td>Ministry of Health</td>
<td>Health Programmes and Technical Support Services</td>
</tr>
<tr>
<td>Pan American Health Organization/World Health Organization (PAHO/WHO)</td>
<td>Family Health and Disease Management</td>
</tr>
<tr>
<td>United Nations Population Fund</td>
<td>Sub-regional Office for the Caribbean, Trinidad and Tobago Branch Office</td>
</tr>
<tr>
<td>Family Planning Association of Trinidad and Tobago</td>
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<tr>
<td>Ministry of Health</td>
<td>Queen’s Park Counselling Centre and Clinic</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Eastern Regional Health Authority</td>
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<tr>
<td>Ministry of Health</td>
<td>HIV/AIDS Coordinating Unit</td>
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<tr>
<td>Ministry of Health</td>
<td>North West Regional Health Authority, Health Policy, Research and Planning</td>
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<tr>
<td>Ministry of Health</td>
<td>County Caroni</td>
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<tr>
<td>Trinidad and Tobago Health Training Centre</td>
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<tr>
<td>Ministry of Health</td>
<td>Health Education Division</td>
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<tr>
<td>Ministry of Health</td>
<td>Health, Policy Research and Planning</td>
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<tr>
<td>Ministry of Health</td>
<td>Office of the Chief Nursing Officer</td>
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Appendix V:
Proposed Composition of National SRH Coordinating Committee

1. Policy Makers
2. Service Providers
3. Health Professional Organizations
4. Advocacy groups
5. Grass-root organizations
6. Client Representatives
7. Faith-Based Organizations
8. Community Groups
9. Tobago Representation
10. Representatives of Key Populations
Appendix VI

Proposed Core SRH Training
1. HIV and STI
2. Basics in Contraceptive Technology
3. Counselling
4. Sexuality across the Life Cycle
5. Infertility/Fertility Management
6. Methods of Contraception including the Billing’s Method
7. Development of IEC material
8. Prevention and Screening for Reproductive Organ Cancer
9. HTC and PITC
10. Customer Relations
11. Provision of SRH programme throughout the Life Cycle