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PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

Special Report

JOINT SELECT COMMITTEE ON
SOCIAL SERVICES AND
PUBLIC ADMINISTRATION

An Inquiry into Trinidad and Tobago's response to the prevalence of Non-communicable diseases (with a focus on Diabetes, Cardiovascular Diseases and Cancer)

FIRST SESSION (2025/2026) 13TH PARLIAMENT

OF THE REPUBLIC OF TRINIDAD AND TOBAGO

Special Report

Of the

Joint Select Committee on Social Services and Public Administration

On

An Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-communicable diseases *(with a focus on Diabetes, Cardiovascular Diseases and Cancer)*

Date Laid in the HoR: 08.05.2026 **Date Laid in the Senate: 12.05.2026**

An electronic copy of this report can be found on the Parliament website:

The Joint Select Committee on Social Services and Public Administration

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THE COMMITTEE

Dr. Desirée Murray
CHAIRMAN

Ms. Khadijah Ameen, MP
VICE-CHAIRMAN

Dr. Michael Dowlath, MP
MEMBER

Mr. Sean Sobers, MP
MEMBER

Mr. Symon de Nobriga, MP
MEMBER

Mr. Ravi Ratiram
MEMBER

Mrs. Melanie Roberts-Radgman
MEMBER

Mr. David Nakhid
MEMBER

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ABBREVIATIONS

A&E	Accident & Emergency
CAREC	Caribbean Epidemiological Centre
CARPHA	Caribbean Public Health Agency
CDAP	Chronic Disease Assistance Programme
DERPI	Diabetes Education Research and Prevention Institute Foundation
DHWSP	The Division of Health, Wellness and Social Protection
DHV	District Health Visitors
ERHA	Eastern Regional Health Authority
IDB	Inter-American Development Bank
NCRHA	North Central Regional Health Authority
NWRHA	North West Regional Health Authority
PAHO	Pan American Health Organisation
PHOs	Public Health Observatories
PTA	Parent Teacher Association
RHAs	Regional Health Authorities
SWRHA	South West Regional Health Authority
SIDS	Small Island Developing States
TRHA	Tobago Regional Health Authority
TTPS	Trinidad and Tobago Police Service
UWI	University of the West Indices
WHO	World Health Organisation

TABLE OF APPENDICES

COMMITTEE MANDATE AND ESTABLISHMENT

1.1. Section 66 of the Constitution of Trinidad and Tobago declares that not later than three months after the first meeting of the House of Representatives, the Parliament shall appoint Joint Select Committees to inquire into and report to both Houses in respect of Government Ministries, Municipal Corporations, Statutory Authorities, State Enterprises and Service Commissions, in relation to their administration, the manner of exercise of their powers, their methods of functioning and any criteria adopted by them in the exercise of their powers and functions.

1.2. By resolution approved by the House of Representatives and Senate on June 27, 2025 and July 29, 2025, respectively, the ***Joint Select Committee on Social Services and Public Administration*** was established.

1.3. Standing Order 91 of the Senate and 101 of the House of Representatives outline the general functions of a Committee of this nature. They are as follows:

a) "To examine Bills and review all legislation relating to the relevant Ministries, departments or bodies or as may be referred to it by the House;

b) To investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration and operations of the assigned Ministries, departments or bodies;

c) To study the programme and policy objectives of Ministries, departments or bodies and the effectiveness of the implementation of such programmes and policy objectives;

d) To assess and monitor the performance of Ministries, Departments and bodies and the manner of the exercise of their powers;

e) To investigate and inquire into all matters relating to the assigned Ministries, Departments and bodies as they may deem necessary, or as may be referred to them by the House or a Minister; and

f) To make reports and recommendations to the House as often as possible, including recommendations for proposed legislation."

Powers of the Joint Select Committee

1.4. Standing Orders 101 of the Senate and 111 of the House of Representatives outline the core powers of the Committee, which include *inter alia*:

- to send for persons, papers and records;
- to sit notwithstanding any adjournment of the Senate;
- to adjourn from place to place;
- to report from time to time;
- to appoint specialist advisers either to supply information which is not otherwise readily available or to elucidate matters of complexity within the Committee's or Sub-Committee's order of reference;
- to communicate with any Committee of Parliament on matters of common interest; and
- to meet concurrently with any other Committee for the purpose of deliberating, taking evidence or considering draft reports.

Membership

1.5. The Committee comprises the following members:

1.	Dr. Desirée Murray	Chairman
2.	Ms. Khadijah Ameen, MP	Vice-Chairman
3.	Dr. Michael Dowlath, MP	Member
4.	Mr. Sean Sobers, MP	Member
5.	Mr. Symon de Nobriga, MP	Member
6.	Mr. Ravi Ratiram	Member
7.	Mrs. Melanie Roberts-Radgman	Member
8.	Mr. David Nakhid	Member

Secretariat Support

1.6. The following officers were assigned to assist the Committee:

1.	Mr. Julien Ogilvie	-	Secretary
2.	Mr. Brian Lucio	-	Assistant Secretary
3.	Ms. Lorraine Berahzer	-	Assistant Secretary
4.	Ms. Rochelle Stafford	-	Researcher
5.	Mrs. Rea Anne Alexander-Thompson	-	Researcher

EXECUTIVE SUMMARY

2.1 At its 2nd meeting on November 19, 2025, the Committee, in determining its work programme for the 1st session (2026/2027) of the 13th Parliament, determined that it would be instructive to reflect on the work completed by the previous committee appointed in the 12th Parliament (2020 to 2025). Further to this reflection, members gave particular consideration to the work completed by the last committee on the prevalence of Non-communicable Diseases in Trinidad and Tobago. The Committee noted that a significant amount of evidence had been gathered concerning this issue through extensive stakeholder engagement. However, the findings and recommendations gleaned from the evidence had not been communicated to the Parliament or relevant state agencies.

2.2 As such, the Committee agreed to adopt the evidence, findings and recommendations of the Report prepared by the previous Committee appointed in the 12th Parliament on an ***Inquiry into Trinidad and Tobago's response to the prevalence of Non-communicable diseases with a specific focus on Diabetes, Cardiovascular Diseases and Cancer***.

2.3 The Committee also agreed to obtain a policy update from the Ministry of Health to supplement the evidence collected by the previous Committee.

2.4 Some of the significant findings which emerged based on stakeholder input included:

i. Heart Disease was the highest cause of death by non-communicable diseases for the period 2015 to 2018;

ii. On average, every day, approximately one person is diagnosed with breast cancer in Trinidad and Tobago, and two women die every three days from breast cancer;

iii. Cervical cancer is the fourth most common type of cancer affecting women in Trinidad and Tobago;

iv. The Ministry of Health has been experiencing shortages of required drugs for the treatment of non-communicable diseases, these include: Atenolol, Furosemide, Metformin, Candesartan and Rosuvastatin;

v. Long wait times, especially at the Accident and Emergency Department, are, in part, attributed to the significant demands placed on public health care institutions due to the prevalence of Non-communicable diseases in Trinidad and Tobago;

vi. Subventions to specific NGOs have been reduced or are generally insufficient to cover their mandate of addressing Non-communicable diseases. Additional funds are usually sourced from donations or corporate sponsorships.

vii. A primary challenge to the success of Health and wellness policy initiatives is the reliance on the individual's willingness to adjust their habits independently.

viii. There is a need to amend and further pursue several regulatory interventions that can assist the population to make healthier lifestyle choices, such as front-of-package labelling regulations, trans-fat policy and regulations, and fiscal policy measures such as taxation on high- sugar and high-fat products.

2.5 The Committee looks forward to reviewing the Minister's response to this Report, which becomes due sixty (60) days after it is presented to the Houses of Parliament.

REPORT

3.1 At its 2nd meeting on November 19, 2025, the Committee agreed that the state's efforts to address NCDs in Trinidad and Tobago should be included in its work programme for the 1st Session (2026/2027). The Committee acknowledged that the ever-increasing public health care bill created an economic burden and that the area of "Health Care" should be prioritised, with a view to scrutinising the government's policy decisions aimed at nudging the population towards healthier lifestyle choices.

3.2 As a starting point, the Committee agree to adopt the evidence, findings and recommendations of the Report prepared by the previous Committee appointed in the 12th Parliament on an ***Inquiry into Trinidad and Tobago's response to the prevalence of Non-communicable diseases with a specific focus on Diabetes, Cardiovascular Diseases and Cancer***.

3.3 In making its decision, the Committee noted the following:

a. The previous Committee appointed in the 12th Parliament had gathered extensive oral and written evidence from several governmental and non-governmental stakeholders.

b. the previous committee had completed its Draft Report for presentation to the House of Representatives and the Senate just before the 12th Parliament was dissolved;

c. Non-communicable diseases constitute an issue of national significance, posing a substantial and ongoing threat to the health and well-being of the population. Consequently, this issue requires urgent and ongoing legislative and policy oversight, including monitoring and evaluation mechanisms. By adopting the former committee's findings and recommendations, this committee has an immediate opportunity to gather feedback from the Ministry of Health and other key governmental stakeholders on policy challenges and solutions related to the prevalence of NCDs in Trinidad and Tobago.

3.4 Having regard to these considerations, the Committee agreed to adopt the evidence, key findings and recommendations of the previous Committee's Report and present them as a Special Report to the Houses in accordance with Standing Order 104(3) of the Senate and Standing Order 114(3) of the House of Representatives, subject to any further amendments that members may propose.

Policy updates- Fiscal 2025/2026

3.5 Further, at its 2nd meeting, held on November 19, 2025, the Committee agreed that its Special Report should include a brief policy update outlining the NCD-related projects, programmes and initiatives for fiscal 2025/2026. As such, by letter dated January 30, 2026, the Ministry of Health submitted details of its policy proposals. The Committee took note of the following:

a. **The planned Comprehensive Assessment of existing community-based and home-care services;**
b. **The development of a National Health and Wellness Plan; and**
c. **A World Health Organisation (WHO) partnership to combat Obesity.**

3.6 Additional details of these ongoing policy initiatives are outlined in **Appendix VII.**

3.7 The Committee presents this special report for the consideration of the Houses and looks forward to reviewing the Ministerial Responses to the findings and recommendations outlinedin Appendix I, pursuant to Standing Orders 100(6) and 110(6) of the Senate and House of Representatives, respectively.

Your Committee respectfully submits this Report for the consideration of the Parliament.

Dr. Desirée Murray
Chairman

Ms. Khadijah Ameen, MP
Vice-Chairman

Dr. Michael Dowlath, MP
Member

Mr. Sean Sobers, MP
Member

Mr. Symon de Nobriga, MP
Member

Mr. Ravi Ratiram
Member

Mrs. Melanie Roberts-Radgman
Member

Mr. David Nakhid
Member

March 10, 2026

Appendices

Appendix I

Key Issues, Findings and Recommendations adopted by the Committee

KEY ISSUES, FINDINGS AND RECOMMENDATIONS

OBJECTIVE 1: To examine the efforts of the State to counteract the effects of specific non-communicable diseases within the population (Namely: Diabetes, Heart Disease and Cancer)

PREVALENCE OF NCDS

The Prevalence of Non-Communicable Diseases within Trinidad and Tobago (Namely: Diabetes, Heart Disease and Cancer)

DIABETES

1.1.1. According to the International Diabetes Federation, an estimated 15% of the population in Trinidad and Tobago has diabetes.

1.1.2. There has been a notable increase in Type 2 diabetes in older persons as well as an increased prevalence of Type 2 diabetes in younger people. Paired with these is the increase in the number of medical consequences of this NCD, such as amputations, renal disease and loss of eyesight.

1.1.3. During the organisation's appearance before the Committee, the Diabetes Association of Trinidad and Tobago (DATT) stated that in Trinidad and Tobago, diabetic foot and foot diseases constitute a significant issue, and people with diabetic foot problems use most hospital beds[1].

1.1.4. The Ministry of Health (MoH) established the Diabetic Foot Management Initiative which subsequently resulted in the reduction of a major lower limb amputations by sixteen percent (16%) to date.[2]

[1] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.

[2] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

1.1.5. The MoH reported various rates of patients being screened at Diabetic Foot Clinics throughout various RHAs across Trinidad and Tobago[3]

	2023				
CATEGORY	SWRHA	NCRHA	TOBAGO	NWRHA	TOTAL
The Total Number of Patients Being Screened at the Diabetic Foot Clinics	10	262	200	25	496
Total number of patients in clinic at present	6	266		9	281
The Total Number of Patients Attending the Diabetic Foot Clinics with Foot Ulcers	6	8	76	0	90

Source: Non-communicable Diseases Unit, MOH

1.1.6 The Ministry of Health's (MoH) Perinatal Information System has a current database of over forty thousand (40,000) patients. The System showed that approximately one in nine to one in ten pregnant patients are diagnosed with diabetes during pregnancy.

HEART DISEASE

1.2.1 According to the Pan American Health Organisation (PAHO), the Caribbean has a 23% rate of hypertension compared to an overall global rate of 17.6%. Trinidad and Tobago, specifically, has a 25.8% rate of hypertension, 29% in men and 23.7% in women[4].PAHO reported that Trinidad and Tobago has the most cases of arterial hypertension in the region.

[3] MoH Annual Report 2023

[4] The Parliament of the Republic of Trinidad and Tobago. Minutes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.

1.2.2 According to the MoH, Primary Hypertension accounts for 90% of cases – this refers to Hypertension with no known identifiable cause. Secondary hypertension accounts for 10% – this refers to persons who may have had an underlying medical condition that led to hypertension[5].

1.2.3 The Committee was informed by the MoH that Hypertension in Trinidad and Tobago was shown to be more prominent among the Afro-Trinidadian population. Based on data from the MoH, this was attributed mainly to lifestyle[6].

1.2.4 According to the MoH, factors which contributed to 90% of persons who have primary or essential hypertension included non-modifiable risk factors such as ethnicity and genetics[7], as well as modifiable risk factors which can be reduced by examining dietary consumption, increasing physical activity, and reducing consumption of alcohol and use of tobacco.[8]

1.2.5 The MoH is seeking to create a paradigm shift away from the disease model, in which specific hypertension conditions, such as cardiovascular disease and strokes, are treated, towards a wellness model, which focuses on addressing modifiable risk factors.

CANCER

1.3.1 The Trinidad and Tobago Cancer Society reported that incidences of cancer are more prevalent in families where there is a genetic predisposition. Breast Cancer ranked as the number one type of cancer affecting women in Trinidad and Tobago[9].

[5] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.
[6] Ibid
[7] Ibid
[8] Ibid.
[9] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.

1.3.2 The MoH conducted an updated review of data contained within the Elizabeth Quamina Cancer Registry. The 2024 report captures data in Trinidad and Tobago on cancers from 2003 to 2020. The data revealed[10]:

- Forty-three thousand, three hundred and eighty (43,380) individuals were diagnosed with cancer.
- Ninety-seven point nine percent (97.9%) were over the age of 25. Thirty-nine percent (39%) of persons were between the ages of 60 to 74 years old.
- Forty-nine percent (49%) diagnosed were male and 51% were female.
- Thirty-six point two percent (36.2%) were Afro-Trinidadians and 23.0% were Indo-Trinidadians.
- The leading causes of cancer in men were prostate cancer, followed by colorectal cancer and then cancer of the lung and bronchus. The top three leading causes of cancer in women are breast cancer, followed by cancer of the uterus and then colorectal cancer.

1.3.3 At the Public Hearing held on November 15, 2023, it was stated by the MoH that, on average, every day, approximately one (1) person is diagnosed with breast cancer in Trinidad and Tobago, and two (2) women die every three (3) days from breast cancer.

1.3.4 According to the MoH, eighty-four percent (84%) of breast cancer diagnoses occur after the age of forty-five (45), which is similar worldwide, and ninety percent (90%) of deaths occur in women who are forty-five (45) years and over[11].

1.3.5 Currently, cervical cancer is ranked as the fourth most common type of cancer affecting women in Trinidad and Tobago[12].

1.3.6 The committee was informed by the MoH, that the number of women diagnosed with cervical cancer is approximately one hundred and thirteen (113) annually, of which 17

[10] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.
[11] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.
[12] Ibid

percent (17%) present early. It was reported that one person presents early every three days.

1.3.7 Cervical cancer numbers are decreasing slightly for several reasons, one of which is the Human Papillomavirus (HPV) Vaccination Programme, which commenced in 2013.

Deaths caused by each NCD in Trinidad and Tobago in recent years

1.4.1 Based on information received from the Ministry of Health (MoH), the latest data from the Central Statistical Office (CSO) provided the number of deaths caused by cancer, diabetes and cardiovascular disease:

Table 1: Number of Non-Communicable Diseases Related Deaths 2015-2018

Non-Communicable Diseases Related Deaths 2015-2018					
Group/Cause	**2015**	**2016**	**2017**	**2018**	**Total**
Heart Diseases	2,519	2,711	2,644	2,668	**10,542**
Diabetes Mellitus	1,743	1,788	1,857	1,953	**7,341**
Malignant neoplasms	1,661	1,840	1,855	1,908	**7,264**
Cerebrovascular diseases	976	1,024	1,037	1,027	**4,064**
Total	**6,899**	**7,363**	**7,393**	**7,556**	**29,211**

Source: Central Statistical Office (2018)

Data Capture in the Public Health System on NCDs

1.5.1 The prevalence of NCDs is captured by the Public Health Observatories (PHOs) at the RHAs via Administration and Discharge forms filled during patient–screening and diagnosis at the Accident & Emergency (A&E) Department. The data is collated for reporting to the respective RHAs and then disseminated monthly to the MoH.

1.5.2 Similarly, data capture in Tobago occurs at each facility. A host of systems and procedures are utilised to capture data in congruence with patient confidentiality principles.

NCD Surveillance and Monitoring

1.6.1 A Non-Communicable Diseases Unit was established at the Ministry of Health in 2023.

1.6.2 In 2011, the MoH conducted a survey entitled "The Trinidad and Tobago Chronic Non-Communicable Disease Risk Factor Survey (Pan American STEPS)". The survey was administered with technical input from the Caribbean Epidemiological Centre (CAREC), PAHO, the University of the West Indies (UWI) and the CSO.

1.6.3 The Risk Factor Survey aimed to develop and strengthen Trinidad and Tobago's capacity to better monitor NCDs and associated risk factors through consistent data collection. The main findings of the survey, summarised by category based on risk factors such as tobacco use, alcohol consumption, physical activity, overweight, and obesity, are outlined in Appendix VIII.

1.6.4 In 2024, the MoH completed the second iteration of the PAHO/WHO STEP Survey with a sample size of 5,404 participants ages 18 to 69, and the total responses received were 4,052. In its preliminary findings, the MoH notes[13]:

i. The current prevalence of tobacco use is 21.3%. There was a higher prevalence of males than females.
ii. The prevalence of alcohol consumption, which was determined by the percentage of persons who consumed alcohol within the past thirty days (30) of administering the survey, was 51.5%. Fifty-nine point six (59.6%) percent in males and 43.4% in females.
iii. There was a 10.9% increase in the prevalence of alcohol consumption between 2011 and 2024. In 2011, the prevalence of alcohol consumption was 40.6%.
iv. While males consumed more alcohol than females, there was a significant increase in the consumption of alcohol among females at 12.5%.

[13] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

v. Ninety-three point three percent (93.3%) of the population consumed less than the recommended five servings of fruit and vegetables per day.

vi. Regarding levels of physical activity, the MoH utilised the definition by the World Health Organisation (WHO), which states "A minimum of one hundred and fifty minutes (150) of moderate intensity activity per week."

vii. It was found that the median time spent on physical activity per day was one 102.9 minutes which was an increase in comparison to the previous study conducted in 2011.

viii. In 2018, the MoH took a position to include mental health as an NCD for the first time in Trinidad and Tobago. The 2024 iteration of the STEPS survey included a new module from PAHO/WHO, which assessed the levels of symptoms of depression among the population within the past twelve months.

ix. There was a 13.6% prevalence of symptoms of depression within the past twelve months, with the larger proportion being among females compared to males.

x. The factors used to assess the burden of NCDs within the population included; current daily smokers; persons who consumed less than five servings of fruit and vegetables per day, low levels of physical activity, being overweight – which is having a BMI of greater than or equal to 25 and having raised blood pressure – which is having blood pressure readings greater than or equal to 149/90.

xi. It was found that one point six percent (1.6%) of the population had zero of the aforementioned risk factors, whereas, 38.4% of the population had three or more of the five risk factors.

xii. There was a prevalence of 29% of persons having raised blood pressure. There was a prevalence of 15.8% of persons having a raised blood glucose level and 39.6% of persons displaying an elevated cholesterol level.

xiii. Based on the data, it was found that persons between the ages of 40-69 who had a 10 year cardiovascular disease risk of greater than or equal to 20% had a prevalence of 11.8%. Therefore, for this age group, there is a prevalence of 11.8% risk of having a cardiac or cardiovascular acute event within the next 10 years.

xiv. Findings of the STEPS survey will undergo a final review before they become available publicly.

1.6.5 The MoH anticipated that the second survey would be completed within fiscal 2023/2024. When the second Risk Factor Survey is completed, a comparison to the 2011 survey will be conducted. -This will provide an indication of changes in the patient's demographics, hypertension, diabetes, and eating habits.

1.6.6 In addition to the STEP survey, the MoH is currently conducting a Food Consumption Survey in partnership with various stakeholders, including UWI and PAHO. This survey will be completed in the third or fourth quarter of 2024 and will provide indicators of the successes of multiple initiatives over the past 10 or 12 years.

AUTHORITIES WITH RESPONSIBILITY FOR MANAGING NCDs

The Ministry of Health and the Regional Health Authorities

1.7.1 The MoH is the national authority overseeing the national health system. It plays a central role in ensuring that the provision of health services conforms to the principles of universal health coverage. Regarding NCDs, the Ministry's key strategic priority areas and programme activities are focused on the personal health and wellness of the population and strengthening its support systems.

1.7.2 The MoH reaffirmed its commitment and that of the RHAs to the provision of quality health care through initiatives geared specifically towards strengthening primary health care, which examines the prevention, management, and control of NCDs.

1.7.3 The MoH stated it is appropriately resourced with personnel to provide administrative support, oversight, and guidance and offer technical guidance to the RHAs.

The Division of Health, Wellness and Social Protection and the Tobago Regional Health Authority

1.8.1 The Division of Health, Wellness and Social Protection (DHWSP) and the Tobago Regional Health Authority (TRHA) work assiduously to improve the standard of health care provision in Tobago.

1.8.2 Both entities noted that NCDs are a leading cause of disability and mortality on the island. Enhanced focus is being placed on NCD education, early detection and treatment.

1.8.3 In its written submission, the agency further reported that plans are underway to improve accessibility and access to care, strengthen human resources, improve diagnostic services, enhance public education tactics, and increase collaboration with external health stakeholders.

PUBLIC AWARENESS AND PREVENTATIVE MEASURES

1.9.1 The MoH has adopted a multidisciplinary approach to sustainable solutions for the prevention, management, and control of the burden caused by NCDs at the national level. This approach aims to ensure that the population reaches the highest attainable physical and mental health standards, quality of life, and productivity at every age.

1.9.2 The approach recognises the critical role of the community, the health system, self-management support, delivery system design, clinical information systems, communication and behaviour change.

1.9.3 Some of the key activities implemented under the NCDs Programme include:

Governance and Management of NCDs	Formation of the National NCDs Steering Committee on April 18, 2023
	A National NCDs Symposium
Prevention	Health and Wellness Festivals
	TT Moves: *A Movement for Lifestyle Change* (Behaviour Change Campaign)
	Gestational Diabetes Management Programme
	Supply of Physical Equipment for both Primary and Secondary Schools
	School Health Promotion
	The Community-Based Healthy Youth Wellness TT Initiative
Screening and Clinical Management	Launch and Implementation of the Health Initiative for Men (July 8 and 9, 2023)
	The Women's Health Initiative
	Standardisation and Restructuring of Diabetes Wellness Clinics across all RHAs
	The HEARTS initiative, an initiative of PAHO/WHO in collaboration with the MoH, is focused on the initial management and control of cardiovascular diseases and hypertension.
	Tobacco Control and Regulation
	Mental Health Services

	The launch of the NCD hotline (800-4NCD) on August 06, 2024, aimed at strengthening the linkage to care and promoting self-management among persons living with NCDs. The service is toll-free and is accessible 24/7. It provides medical advice to callers who may be seeking to address queries regarding blood sugar readings, HbA1c readings and cholesterol blood test results.

Initiatives in Tobago

1.10.1 The Division of Health, Wellness and Social Protection of the Tobago House of Assembly and the Tobago Regional Health Authority (TRHA) strategies, projects and initiatives to promote awareness of preventative measures against NCDs include:

Public Health Education	Continuous public outreach to promote healthy lifestyles and screening for NCDs.
	Collaboration with public and private entities
School Health Education	Health education and screenings are available at schools throughout the island.
Blue and Pink Rooms	Clinics are designated for men and women, respectively.
Health Fairs	Held throughout the island to sensitise the public on matters related to health and wellness.
Nutrition education	Outreach specific to healthy eating and lifestyle.
Enhanced communication	Increased internal and external health communications.

Staff training	To ensure that employees are kept up to date on international best standards and practices as it relates to NCD prevention and treatment.
Special initiatives	Ad hoc initiatives outside those integrated into the healthcare delivery system, such as the "Don't Fear the Smear" campaign in March and April 2023, a multi-pronged initiative that sought to conduct pap, smears, and disseminate health education to women throughout Tobago.

Screening and Diagnosis

1.11.1 Screening is a critical component in detecting NCDs by the MoH. Data collected from screening is used to determine the number of persons accessing secondary and tertiary health care services. The screening procedures for cancer, diabetes and cardiovascular disease within the Public Healthcare System are outlined below:

Table 2: Types of screening conducted per condition

Condition	Screening Procedures	Diagnostic Procedures
Cervical cancer	Pap Smear	Biopsy, radiographic imaging services such as CT scans and MRI
Prostate cancer	Prostate Specific Antigen Test (PSA), Digital Rectal Exam	
Breast cancer	Breast Ultrasound, Mammogram	
Diabetes	HbA1C, random blood glucose, fasting blood glucose	75gm Oral Glucose Tolerance Test, HbA1C
Cardiovascular disease	blood pressure testing, echocardiogram, cardiac stress test	Blood testing such as cardiac enzymes, ECG, echocardiogram, cardiac stress test, additional radiographic imaging services such as CT scans and Doppler Ultrasound

1.11.2 Data on the number of persons screened for and diagnosed with cancer, diabetes and cardiovascular disease over the past five (5) years within the RHAs could not be readily obtained due to the lack of an Electronic Health Record to track one patient per record

throughout the public healthcare system. However, the current system records the number of screening procedures conducted per RHA.

1.11.3 The MoH indicated that the current systems and procedures used to detect NCDs need to be strengthened to ensure more persons have access to screening and diagnosis for early detection as a preventative measure. It was acknowledged that there is a need to strengthen the capacity of facilities, staff, and consumables, and partnerships with the private sector and NGOs need to be forged.

Screening in Tobago

1.12.1 It was reported that the TRHA utilises many screening and diagnostic tests, as seen in **Appendix IX**.

1.12.2 Where it is infeasible to conduct tests in-house, they are outsourced to reputable private laboratories.

Hindrances to patients accessing early screenings

1.13.1 The MoH advised that some persons may be unaware of their current health status and, therefore, unlikely to seek care or access screening promptly, if at all, due to the silent nature and absence of symptoms in diseases such as hypertension and dyslipidemia (high cholesterol).

Efforts to Improve the Lifestyle Choices of the Public

1.14.1 Lifestyle choices are the leading contributor to Trinidad and Tobago's hypertension rate. Lifestyle choices include poor diet, lack of exercise, stress levels, tobacco use, and alcohol consumption[14].

[14] The Parliament of the Republic of Trinidad and Tobago. Minutes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.

1.14.2 The MoH has targeted eliminating the five main negative lifestyle choices contributing to NCDs by encouraging increased exercise, water intake, fruit and vegetable intake, and decreased tobacco use.

1.14.3 The MoH is seeking to partner with the public through its 'all of Government and society' approach to improving lifestyle choices.

The TTMoves (Behaviour Change Campaign)

1.15.1 MoH's TTMoves banner aims to bring about a culture of lifestyle and behavioural change. The campaign was launched in 2019. However, it slowed down due to the COVID-19 pandemic. The campaign was relaunched in 2023.

1.15.2 The TT Moves campaign was in the process of being re-energised. A new tagline was added: "A movement for lifestyle change" to encourage public members to change their behaviour, make healthy choices in terms of their dietary measures, and generally be more active.

1.15.3 Mindful that persons may be at different stages of change in their behaviour within the population, the MoH tries to make the campaign as broad and straightforward as possible to cater to all persons.

1.15.4 The key messages of the campaign are to encourage members of the public to engage in healthier lifestyle practices through increased:

- water intake;
- consumption of fruits and vegetables; and
- levels of physical activities.

1.15.5 The MoH would also like to add "know your health numbers" to the key messages soon. It was recognised that several NCD risk factors, in particular hypertension, are

asymptomatic, and many people do not know their blood pressure or cholesterol levels. The TTMoves Health and Wellness Festivals are opportunities to provide access to screening in communities so people can become acquainted with their health numbers.

1.15.6 To further the reach of the TTMoves (Behaviour Change Campaign), the MoH has commenced and completed the strategic installation of signage at some health facilities across the country to display the campaign's key messages. A sign is to be erected at the San Fernando Teaching Hospital pending the completion of repairs to the building.

1.15.7 Six (6) Mobile Units were procured, branded and retrofitted to serve as NCD screening units. Whilst partially operational, procurement is underway to equip the units to be fully functional.

1.15.8 The MoH engaged a behaviour change consultant from the UWI to assist with its corporate communication strategy, focusing on targeted messaging to key populations affected by hypertension, such as the Afro-Trinidadian population.

Health and Wellness Festivals

1.16.1 Each RHA will host health and Wellness Festivals to boost public education and awareness of NCDS while providing access to personal screening and counselling with healthcare professionals.

1.16.2 The SWRHA hosted the first Health and Wellness Festival at the Naparima Bowl on August 26, 2023.

1.16.3 The SWRHA collaborated with state agencies such as the Public Health Inspectorate and NGOs such as Arrive Alive to address the social determinants of health. Through a "linkage to care" concept, persons were referred to regular mainstream services for follow-up. In addition to the initial Wellness Festival held in the South, the MoH held two

other Wellness Festivals in the North-West and East. The other RHAs have replicated the event.

1.16.4 The MoH uses the STEPS survey to measure the impact of health and wellness initiatives such as the TTMoves Campaign. However, it was noted that the impact of the Campaign and lifestyle changes sought will not be reflected overnight and may take years to be fully seen

Public Education and Awareness Initiatives in Tobago

1.17.1 The public education and awareness programmes recently implemented in Tobago are:

- Men's Health Programme;
- PAP Smear Initiative;
- Annual Medical Assessment Programme;
- Comprehensive STI Clinic;
- Increasing the capacity at the Oncology Units, Primary Care Health Centres, Blue Room (Men's Health) and Pink Room (Women's Health).

1.17.2 Challenges faced with implementing the programmes identified were infrastructure, such as state of roads and availability of public transportation, which discourages persons most at risk from attending outreach and screening activities; internet connectivity in rural areas excludes persons in said communities from information shared virtually; hiring and retention of speciality staff; and supply chain issues which impact on the availability of medications on the CDAP.

1.17.3 To further increase public education and awareness of NCDs, the TRHA recently employed staff for its Communication Unit. Plans are also in place to create a Health Education Unit.

Stress Relief Centre

1.18.1 Research done outside of Trinidad and Tobago spoke to a relationship between NCDs and mental health and vice versa. The MoH, in its approach to addressing the issue of NCDs, recognises mental health as an NCD[15].

1.18.2 The North Central Regional Health Authority established a Stress Relief Centre. On its first day of operation, over two hundred (200) persons visited the Centre, indicating the need to expand its inherent capacity and distribution to St Joseph.

Elderly and Community Outreach

1.19.1 District Health Visitors (DHV), sometimes accompanied by physicians, make house visits to provide health care services and deliver medication to persons who may be shut in and cannot access care. DHVs are based in each health centre, and some centres have multiple officers.

Walk-The-Talk Programme

1.20.1 Recognising that the public health care system was not reaching many people in its communities, the NCRHA has partnered with religious organisations throughout its communities since 2016.

1.20.2 The programme brings awareness to the population, provides screening and assistance to accelerate the treatment of persons with deteriorating conditions and detects persons who may not have a health-seeking behaviour to offer interventions.

1.20.3 The programme has reached over fifty thousand (50,000) persons and approximately five hundred (500) organisations from the Authority's catchment area. The Authority is sourcing more religious organisations for collaboration.

The MoH's Health Initiative for Men

[15] See Appendix III – Verbatim notes of 18th Meeting, November 15, 2023, Page 161.

1.21.1 The health initiative for men was launched and held over the weekend of July 8th and 9th, 2023. The initiative was a collaborative effort between the MoH and all RHAs. The MoH was encouraged by the overwhelming turn-out of over four thousand (4,000) men at the initiative for prostate screening and hopes to continue the initiative annually.

1.21.2 The MoH set a national target of twenty thousand (20,000) for men to know their status for prostate cancer within one year. At the first screening, there were roughly five thousand men (5,000) [16].

The National NCD Steering Committee

1.22.1 The National NCD Steering Committee oversees the implementation of activities related to the National Policy and Strategic Plan for the Prevention and Control of NCDs.[17] The Committee includes members of the MoH and Non-Governmental Organisations. The MoH has been pleased with its output since its implementation on April 18, 2023.

1.22.2 Subcommittees of the NCD Steering Committee were established to focus on additional key areas. One of the subcommittees will address the WHO Acceleration Plan, [18] which treats with obesity measures for both children and adults. Another subcommittee is examining an evidenced-based approach to clinical practice management for NCDs.

1.22.3 Beyond the NCD Committee, there is a vision to create an oversight committee that will include the critical Ministries, critical NGOs, PAHO, and CARPHA working together.

ADDRESSING DIABETES IN TRINIDAD AND TOBAGO

[16] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.
[17] https://health.gov.tt/sites/default/files/pdf/20170501-National-Strategic-Plan-Prevention-NCDs-2017-2021.pdf
[18] https://www.who.int/publications/i/item/9789240075634

1.23.1 The Ministry's life-course approach to addressing NCDs, in particular diabetes, includes pregnancy programmes, preconception initiatives, other initiatives for diabetes in pregnancy, and breastfeeding initiatives, which are key to preventing diabetes later in life.

1.23.2 In 2018, the MoH formed, for the first time, the National Breastfeeding Coordinating Unit.

1.23.3 The MoH encourages the population to breastfeed exclusively for the first six months to reduce diabetes in mothers and children. Breastfeeding initiatives are anticipated to dramatically reduce the effects of gestational diabetes in years to come.

1.23.4 Since the initiation of the initiatives, breastfeeding rates have moved from less than 10 percent (10%) in 2015 to between eighty and ninety-five percent (80%-95%) at all public maternity units to date[19].

1.24.1 In addition to the MoH's life-course approach, the MoH has implemented a series of Diabetes Wellness Clinics, which are focused clinics that take a multidisciplinary approach towards addressing and controlling diabetes in persons with levels deemed out of control. Such persons are referred to specialised clinics with endocrinologists to receive focused care to help better manage their blood sugar numbers. The specialised clinics or 'one-stop shop' also provide eye care, foot screening, dietician, and nutrition counselling.

1.24.2 Diabetes Wellness Clinics supplement the chronic disease clinics at local health centres that cater to persons with diabetes and hypertension. The MoH standardised and restructured the Diabetes Wellness Clinics across RHAs. As of 2023, there is one clinic in each RHA.

1.24.3 Under the MoH's TTMoves initiatives, information about the nature of diabetes, as well as its prevention, management, and control, will be shared with the public.

[19] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

1.24.4 Currently, stakeholders, including the MoH's Food Advisory Committee, the Ministry of Trade and Industry, and various MoH stakeholders, are discussing mandating the placement of information on the caloric content of foods on packaging.

Dialysis Treatment in the Public Health System

1.25.1 The MoH provided details on the average number of persons per year receiving dialysis in each RHA in table 3 below.

***Table 3 Average Number of persons per year receiving dialysis in each RHA for fiscal* 2020-2022**

Regional Health Authority	Average number of persons per year
NCRHA	2,336
NWRHA	846
SWRHA	823
ERHA	98

Source: Regional Health Authorities

1.25.2 The current cost for dialysis treatment is nine hundred and fifty dollars ($950.00) per session. The price per patient per month may range from seven thousand and six hundred dollars ($7,600.00) to eleven thousand four hundred dollars ($11,400.00) for eight to twelve sessions.

1.25.3 The number of dialysis sessions varies depending on the person's condition, but two or three treatment sessions per week are usually required.

The Gestational Diabetes Management Programme

1.26.1 The Gestational Diabetes Management Programme is part of a larger IDF-funded project that engaged consultants from the Helen Bhagwansingh Diabetes Education Research and Prevention Institute Foundation (DERPI). The IDF-funded project comprises various elements, including training of health care workers, training of patients in managing

diabetes, and provision of glucometers. Monitoring and Evaluation are built into the project and cater to the provision of sufficient testing strips along with glucometers.

1.26.2 The MoH currently has enough glucometers for patients diagnosed with diabetes in pregnancy. The MoH procured over three thousand (3,000) home glucose monitors under the Gestational Diabetes Management Programme for three thousand (3,000) expectant mothers and two hundred and eighteen (218) for use at antenatal clinics at the MoH's various health facilities and still in the phase of distributing glucometers.

INITIATIVES TARGETING CHILDREN

Targeting and monitoring the prevalence of NCDs among school children

1.27.1 Several initiatives that directly target children and adolescents were implemented in the past, and more are to come, for example, the MoH:

- purchased exercise equipment for 623 schools for TT$27.9M. This initiative was financed through the Inter-American Development Bank (IDB) loan and in partnership with the Ministry of Education (MoE); the MoH has since delivered equipment to 611 schools comprising 479 primary schools and 134 secondary schools and anticipates the completion of deliveries of outstanding equipment during the second quarter of 2024. The MoE is responsible for the maintenance of the equipment;
- In 2017, implemented a ban on the sale of sugar-sweetened beverages in schools;
- In 2023, held a National Primary School Diabetes Quiz directed at Standard 3 students in primary schools throughout Trinidad and Tobago and
- In 2024, during the Easter vacation, the RHAs, in collaboration with the MoH, held two-week NCD Inspector Academies for children ages 5-11, during which the children had an opportunity to learn healthy lifestyle habits. They were exposed to food and nutrition, gardening, and physical activities such as yoga and dance. The initiative was built on the premise that children are the agents for change.

1.27.2 It was noted that parents, the National Parent Teacher Association (NPTA) and extended families should be involved in projects and programmes to increase the awareness among the student population. The Ministry of Sport is one of the MoH's most significant collaborative partners in addition to the Ministry of Education and the Ministry of Agriculture, Land and Fisheries.

1.27.3 The MoH, through its School Health Visitors Programme, addresses NCD prevention at the school health level. School Health Visitors conduct assessments of weight and height, perform check-ups, and conduct immunization of students[20].

1.27.4 School outreach is conducted by the TRHA and facilitated via Primary Care Services. The Division provides schools with health education, immunisation, self-management, and wellness check services.

1.27.5 Ad-hoc initiatives are also conducted by both the THA's Division and the TRHA.

1.27.6 Both the National Food Consumption Survey and NCD Risk Factor Survey were delayed due to the COVID-19 pandemic. The MoH is currently finalising the Terms of Reference for the surveys.

CANCER INITIATIVES

Prevalence of Tobacco Use in Trinidad and Tobago

1.28.1 A 2017 World Health Organization (WHO) Global Youth Tobacco survey on tobacco use by teenagers in Trinidad and Tobago indicated that:

- 14 percent of students, 17.3 percent of boys and 10.8 percent of girls used tobacco products;
- 11 percent of students, 13.6 percent of boys and 8.6 percent of girls smoked tobacco;

[20] See Appendix VII Verbatim Notes of 22nd Meeting

- 6.7 percent of students which equates to 8.6 percent of boys, 4.9 per cent of girls, smoked cigarettes; and

- 4.1 percent of students, 5.0 percent boys and 3.2 percent girls used smokeless tobacco.

Initiatives to reduce Tobacco usage in Trinidad and Tobago

1.29.1 The MoH asserted that public education is key to changing perceptions about tobacco usage. It is critical:

- that persons be made aware of the dangers of smoking to discourage them from starting, and
- to provide support for those who currently smoke through smoking cessation Clinics.

1.29.2 Some of the initiatives of the MoH in this regard are:

Table 4: Initiatives offered by the Ministry of Health

Graphic Health Warnings	A key activity under the MoH's NCDs Programme included the full implementation of graphic health warning pictures in September 2022 on the packing and labelling of all tobacco products and cigarette dispensers in wholesale and retail outlets to deter tobacco use. The MoH has not conducted empirical studies to determine the impact of this initiative however, the MoH will: • provide data on the STEPS study, which comprises a complete component on tobacco use about new users and age groupings, when it becomes available and • Discuss with the Ministry of Trade and Industry the availability of data about importation of tobacco products,

	which can be used to assess the effectiveness of the Tobacco campaign.
Sensitisation Sessions	Further, as of June 16, 2023, sensitisation sessions on the requirements of the legislation, illicit tobacco trade and the effects of smoking on the health and well-being of the population were conducted with seventy (70) sellers of tobacco products in the following five (5) counties: • St George; • Caroni; • Victoria; • St. Patrick; and • Tobago. Sessions will continue in the remaining counties shortly. **<u>Refer to Objective 3 for details on the proposed updates to the legislation.</u>**
Educational Sessions	In January 2023, the MoH conducted health education sessions at various schools on key topics such as E-Cigarettes and vaping, healthy alternatives to smoking and the health risks of smoking. Additional schools are being scheduled to conduct similar sessions shortly.
Smoke Cessation Clinics	Apart from public education initiatives, the MoH has smoking cessation clinics at the RHAs and is seeking to increase the number of patients at the cessation clinics. Smoking Cessation Clinics also increased from two (2) to six (6). These clinics operate within the following health facilities: • Arima Health Facility; • Couva District Health Facility; • Siparia District Health Facility; • Indian Walk Health Centre; • Point Fortin Health Centre; and • Cumuto Health Centre.

	The roles and functions of these clinics and services are attached as Appendix XI. It is envisaged that within the next six (6) months, the Smoking Cessation Clinics will be expanded to other health centres to facilitate more clients.
Mass Social Media Campaign	In commemoration of World No Tobacco Day in May 2023, under the theme *'We need food and not tobacco'*, the pilot of a mass social media campaign was launched at the Siparia Community Center. Specific emphasis was placed on healthier alternatives to smoking, including; • smoking cessation support; • mental health and wellbeing; and • nutritional alternatives to tobacco such as increasing the intake of vegetables, fruits and water. Seventeen (17) persons attached to the Smoking Cessation Clinic at the Siparia District Health Facility and members of the Siparia Community enrolled in the initiative and were trained in home gardening over six weeks.

1.29.3 Notwithstanding the interventions put in place to support the reduction of tobacco use, the main challenge faced is behaviour change as evidenced by the limited engagement and participation at Smoking Cessation Clinics and other implemented measures due to personal choice, resistance to change and rigidity among members of the public.

The effectiveness of cancer detection methodologies and cancer treatment protocols

1.30.1 Based on the latest information from the Cancer Registry in Trinidad and Tobago, the detection rate of cancers was 209.4 per 100,000 in 2020.

1.30.2 Trinidad and Tobago aims to eliminate cervical cancer by 2030 with several strategies, including new screening tests. Additionally, for the first time in Trinidad and Tobago, at the launch of International Women's Week in 2023, formal policies were put in place regarding screening programmes for breast cancer.

1.30.3 Although the MoH targets preventable cancers such as breast and cervical cancer through screening, it was stated that some cancers do not have a screening programme. The MoH's current screening programme targets women at average risk between the ages of forty-five (45) and seventy (70).

1.30.4 As indicated previously, the HPV Vaccination Programme has been effective in contributing to the decrease in cervical cancer numbers. As such, the more HPV vaccines a country delivers, the more significant the reduction of the incidents of pre-cancer and cervical cancer.

ACCESS TO MEDICATION

1.31.1 The MoH experienced the following challenges with the importation of some items for the management of NCDs over the last five (5) years:

- Global supply chain issues resulting in shipping delays as a result of unavailable flights/or shipping schedules;
- Access to items coming from the European Region due to BREXIT issues;
- Unavailability of products due to the unavailability of raw materials; and
- The export bans imposed by various countries and the repurposing of manufacturing units as a result of the urgent need for COVID-19 treatment products, especially Personal Protective Equipment (PPE).

1.31.2 Several strategies were used to resolve these challenges, including:

- Engaged the respective High Commissions and Embassies seeking assistance in obtaining supplies from areas where export bans were in effect;

- Engaged local distributors to find mechanisms to increase their market sources. In so doing there was the need to increase the rate at which Drug Registration was undertaken to ensure availability of registered products from non-traditional market sources; and
- Partnered with NIPDEC, particularly regarding distribution to allow for streamlining of supplies, thereby ensuring availability at the respective institutions. The quantities being procured were also increased to compensate for the shipping delays and the increased volume of clients accessing the Public System.

Shortage of Drugs

1.32.1 In the past, the MoH noted shortages in the following drugs required for the treatment of NCDs:

- Atenolol;
- Frusemide;
- Metformin;
- Candesartan; and
- Rosuvastatin.

1.32.2 Relevant measures were taken to mitigate the chronic shortages, including increasing the quantities procured. Through its submission, the MoH assured that alternatives to some of these drugs were available at the time.

1.32.3 The MoH stated that currently, there is no shortage of drugs and that the required drugs are available. However, the Committee noted from its interface with the public that some persons had to visit various CDAP-approved pharmacies out of their geographical remit to fill their Chronic Disease Assistance Programme (CDAP) prescriptions. The Committee also noted instances of hoarding of CDAP drugs by pharmacies and the sale of CDAP drugs by CDAP-approved pharmacies.

1.32.4 The MoH acknowledged that similar complaints occasionally come to the Office of the Chief Medical Officer (CMO) through the MoH's Corporation Communications Unit. Once the Office of the CMO receives a complaint, it is forwarded directly to the National Insurance Property Development Company Limited (NIPDEC)'s CDAP unit for resolution and followed up on by the MoH.

1.32.5 The MoH reported that a unique identifier for accessing medication through the CDAP programme was implemented to address the issue of clients hoarding medication.

1.32.6 Concerning the sale of CDAP drugs, the items procured by NIPDEC on behalf of MoH for the public sector are the same as those sold by the private sector. The MoH tries to maintain batches separately to be able to identify CDAP drugs. Occasionally, Monitors for the CDAP programme visit pharmacies to monitor CDAP stock.

1.32.7 When MoH receives a complaint about the sale of CDAP drugs, the Monitors investigate. Should the Monitors conclude that a pharmacist was errant, a mechanism through the Pharmacy Board of Trinidad and Tobago can be applied.

1.32.8 At the public hearing on June 26, 2024, the MoH called for clients to submit their complaints so that they could be investigated expeditiously and the service provided improved.

Challenges with CDAP

1.33.1 There have been challenges with the administration of the CDAP from the programme's inception. To address these challenges, the MoH:

- increased and encouraged pharmacies to come on board the programme to be able to provide the service to the public;
- increased the schedules for delivery to pharmacies;
- increased the number of times the pharmacies can order medicine, giving them the ability to order supplementals and

- expanded access to the service at any pharmacy instead of only at the pharmacy where the client was registered.

1.33.2 CDAP was initially directed at persons over sixty-five (65). An assessment of the CDAP was done in 2003. Further to this assessment, access to the programme was expanded to all. There were further assessments on the programme where medication for other diseases was included.

1.33.3 The programme commenced with providing medication for eight diseases and currently provides for eleven (11) diseases. The most recent addition, based on the assessment and the acceptability by members of the public, was made in 2019 in relation to the **Hearts Initiative**. This initiative seeks to improve the management of hypertension in the primary healthcare setting.

1.33.4 According to the MoH, the **Hearts Initiative** focuses on reducing the burden of cardiovascular diseases through effective management of hypertension and high blood pressure across all health centers. There are over sixty six thousand (66000) persons being enrolled and twenty eight thousand, two hundred and thirty seven (28,237) or forty three percent (43%) of them having achieved control of their hypertension to date.

Table 5: Number of patients registered and accessing services under the Hearts

RHAs	Number of Patients Registered under the Hearts Programme	Number of Patients with Managed and Controlled Hypertension under the Hearts Programme	Percentage Control Rate under the Hearts Programme
NCRHA	23,358	11,673	50%
NWRHA	5,611	1,614	29%
SWRHA	9,743	3,552	36%
ERHA	12,901	1,951	15%
TRHA	4,198	2,019	48%
Total	**55,811**	**20,809**	**37%**

Source: Regional Health Authorities

1.33.5 The basket of drugs, which remains the same, emanates from a survey conducted in the hospital setting to determine the most consumed medication and those accessed most.

1.33.6 All drugs procured by the MoH for the public health sector, including the CDAP programme, come from a World Health Organisation-approved laboratory. Further assessments are underway.

1.33.7 It was indicated that the upcoming review of the CDAP will examine the probability of expanding the type and quantity of medicines and the availability of items on the CDAP listing. Two main factors that will be examined are cost and accessibility.

1.33.8 As at June 2024, approximately 186,000 clients are registered on the CDAP programme. The MoH added a unique identifier to avoid duplication of registered persons on the programme, an issue that occurred approximately three to four years ago, and to allow for real-time information on the number of persons accessing the service. As at June 26, 2024, approximately 87,050 clients accessed the service for the year 2024[21].

1.33.9 It was reported that there was a slight increase in the cost of medicines made available via the CDAP.

[21] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Second Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 3, Jun 26, 2024.

Sustainability of the CDAP

1.33.1 It was stated by the MoH that there is now a fee of $68,000[22] that Private pharmacies must pay to enter the CDAP, and the dispensing fee has also changed to $8 per item.

STAFFING ISSUES

Shortage of Specialists in Child Clinics and Assessment Units

1.34.1 There continues to be a shortage in specialised fields such as endocrinology and pediatric-trained doctors. The MoH will be liaising with the Ministry of Education to determine the availability of scholarships in these specialised areas.

Challenges with Retaining Subspecialists

1.34.2 Retaining subspecialists in nursing and medical care is a continuously challenge for the RHAs; for example, retaining ICU-trained nurses is difficult in Trinidad and Tobago and other Small Island Developing States (SIDS). This was attributed to more attractive employment packages and working conditions offered by other countries.

1.34.3 To supplement nurses' shortfalls, the MoH uses foreign nurses through the international cooperation desk and bilateral agreements with other countries. For example, through a longstanding agreement, nurses have been brought from Cuba to Trinidad and Tobago for several years.

1.34.4 It was further stated that the MoH is examining other bilateral agreements and Government-to-Government initiatives that can be implemented. This is being done simultaneously to train local nurses in the subspecialties.

[22] Ibid

EQUIPMENT AND RESOURCES

1.35.1 The MoH continuously upgrades and purchases new equipment for NCD screening, diagnostics, treatment, and care under Public Sector Investment Programme (PSIP) funding. The most recent installation was an MRI scanning machine at the St. James Medical Complex, along with eight (8) ultrasound machines, eight (8) X-ray machines, and four (4) C-arms.

Challenges with Equipment

1.36.1 The following were the challenges identified with equipment resources in the respective RHAs:

Table 6: Details of Challenges per RHA

RHA	*DETAILS OF CHALLENGES*
SWRHA	The SWRHA indicated that major medical equipment essentially functions well. The SWRHA has one MRI machine and three CT scans: two at the San Fernando General Hospital and one at the Point Fortin Hospital. The current MRI is functional but aged and has had intermittent challenges with downtime. As a result, an appointment for an MRI may be scheduled 8-9 months later. To address these challenges, SWRHA prioritises its warded patients and collaborates with NCRHA to provide access to outpatient MRI services at the North Central public health facilities. SWRHA also works with the MoH through the PSIP and Administrative system to source a new MRI. In relation to CT scans, the machine assigned to the Emergency Department at San Fernando is aged and was down for approximately four to five months. As of June 25, 2024, the SWRHA supplied, installed, and commissioned a 120-slide CT scanner at the San Fernando General Hospital, bringing the number of CT scanners back up to two.

	The SWRHA also has X-rays, ultrasounds, and other equipment and can rely on backups from its Emergency Department and District Health Facilities as an interim measure when breakdowns occur. As a result, an X-ray can be done at the Point Fortin Hospital within the same day and a couple of weeks at the San Fernando Hospital. Daily, staff is alerted on the availability of tests. Where tests are unavailable when equipment is not running, SWRHA, through its Corporate Communications Department, places public notices, particularly in the emergency departments, to notify the public. The Authority also has a system where if tests are not available, the matter is escalated by the respective doctor to the Head of Department, onwards to the Medical Chief of Staff and Director of Health. The RHAs have the autonomy, where required, to outsource tests that public institutions do not do.
ERHA	The ERHA lacks some of the more extensive equipment, such as MRI machines. The full operationalisation of the Sangre Grande Hospital will allow MRI services to come on stream. In the interim, the ERHA depends on a partnership with other RHAs to serve the population. Due to this arrangement, ERHA patients experience longer wait times as they are placed in a pool with the national public to access MRIs at other RHAs. The ERHA acknowledges that the arrangement adds to the volumes at other RHAs. It was also stated that the severity and urgency of the MRI cases are prioritised from the clinical perspective. For example, oncology patients are prioritised.
NWRHA	The lack of equipment was also identified as a challenge at NWRHA. CT machines, dialysis machines, and other types of machines run for longer hours than the prescribed manufacturer's specification because of the patient load experienced in the Public Health Care System. It is also more challenging to plan equipment maintenance. Access to spare parts from local suppliers is also difficult and results in further downtime.

	In relation to radiology equipment, the NWRHA commissioned a new radiology suite at the Port of Spain General Hospital in 2023, which includes new CT machines, digital portable X-ray machines, and a digital X-ray machine. In April 2024, the NWRHA commissioned a new MRI machine at the St James Medical Complex, which has assisted tremendously. To alleviate the critical need for MRIs, the NWRHA has a referral agreement with at least two major private sector providers nationally for critical MRIs.
NCRHA	Unlike the other RHAs, the NCRHA has a 98% uptime and is at a favourable stage regarding equipment. The authority undergoes rigorous planned preventative maintenance on all its medical equipment. Over the past five years, the NCRHA has received medical equipment ranging from infusion pumps, CT machines, and an MRI machine. The new Arima General Hospital also has CT machines, MRI and gas machines and an Intensive Care Unit with various medical equipment. The Couva Hospital has an MRI machine, CT and medical equipment. Notwithstanding, the NCRHA has a backlog of radiological responses. The Authority's strategy to treat the backlog involved sending reports from the Eric Williams Medical Sciences Complex to the Arima General Hospital and Couva Hospital, which has assisted in reducing the backlog.

LONG WAIT TIMES

1.37.1 The MoH attributed the waiting times, especially at the A&E Departments, to the significant prevalence of NCDs in Trinidad and Tobago, which continues to be an epidemic.

Measures being taken to treat with Long Waiting Lists

1.38.1 The RHAs are taking the following measures to treat long waiting lists:

Table 7: Measures to address long waiting lists at the RHAs in Trinidad

NCRHA	The NCRHA acknowledges the problem with waiting times. One initiative of the NCRHA to address this problem is an In-Touch programme run by its liaison unit, where doctors and a nursing team visit "revolving door patients" – patients who visit the emergency department more than once a month. The initiative was started due to the inherent capacity of the emergency department caused by NCDs. Another initiative of the NCRHA is the Walk The Talk Programme, as detailed previously. The NCRHA also has a high incidence of cardiology patients. To address this, the NCRHA has reduced the intake of patients to the cardiology clinic through a pilot programme where persons can be seen directly in their communities by trained Person-Centred Planning tools. This initiative has led to shorter wait times at the clinic, and as such, training was expanded further outwards to all health centres. More patients who usually come to the cardiology centre will be devolved when training is complete. It was stated that at the Primary care facilities the NCRHA refurbishment and systemic works was done at the Chaguanas District Health Facility and a premium emergency department was opened to engage with patients who would have previously gone to the Eric Williams Sciences Complex. It was further explained that at Chaguanas, there are approximately one hundred (100) patients that would have previously been transferred, now accessing care at district health facilities[23].

[23] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twnety-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

	Similar refurbishments are now being conducted at the Arima District Health Facility and this should be completed at the end of the month as per mandated by the Ministry of Health. The NCRHA stated that they will have inherent capacity at the Arima District Health Facility to engage in treatment of patients that would have previously been transferred. The capacity at district health facilities is being enhanced to deal with the emergency treatment of some patients which would help decrease the number of persons being transferred to the Eric Williams Medical Services Complex.
SWRHA	The wait time at the SWRHA generally impacts persons who are not critically ill or level 3, as triage time is relatively quick and efficient, with the experience averaging 10 minutes. However, the average time for blood work and imaging tests is approximately 4-6 hours. The average length of stay in the hospital is generally approximately 4-5 days for most conditions. The SWRHA has found that, on average, approximately one-third of persons who visit the emergency department with a chronic disease will not be admitted to the ward and could have sought help at the health centres.
NWRHA	Apart from challenges with triage times and quality of primary care, the NWRHA has seen a 300% reduction in bed capacity at the Port of Spain General Hospital following the earthquake in 2018, which has resulted in a more extended stay for persons in the A&E Department. At the first public hearing on November 15, 2023, it was indicated that the wards' bed capacity was almost 100% capacity. At the Committee's third public hearing on June 26, 2024, it was informed that NWRHA's specific problem with waiting times at its A&E Department arose when the Central Block at the Port of Spain General Hospital was condemned and demolished, resulting in a reduction of beds from 500-600 to just over 100 beds. The Committee learnt that "*There is never an empty bed at Port of Spain General Hospital*", and admitted patients are subjected to wait in the A&E until another

	patient is discharged to secure a bed at the hospital. The NWRHA has since procured 540 additional beds, which will be commissioned at the end of March 2025, when the Central Block is operationalised. To alleviate the situation, the MoH has assisted the Authority with funding to open a 60-bed unit at the St James Medical Complex initiated during the COVID-19 pandemic and is now used to refer low acuity patients from the Port of Spain General Hospital (POSGH). Additionally, it was indicated that patients who cannot be seen at POSGH are shuttled to the nearest institution, the Eric Williams Hospital. The two institutions have an existing working relationship and understanding between the Directors of Health. Until the commissioning of the 540 beds, the Authority acknowledged that some limitations would affect the patient journey from triage in A&E to the wards.
ERHA	The ERHA is challenged with patient volumes due to the wide geographical area it covers, which is linked to access to patient care. The ERHA covers one-third of the island from Matelot to Guayaguayare, Biche, and Brothers Road, which speaks to the geographical spread that some patients traverse to receive services. The ERHA also has a high inflow of tourists. The ERHA has 16 primary healthcare facilities with A&E Departments in Toco, Rio Claro, and Mayaro, which allows secondary care services to be brought closer to the population.

MEDICAL RECORDS

The Digitising of Past Records

1.39.1 During the COVID-19 pandemic, a specific system was implemented to digitise patients' records for vaccine management and issue of COVID-19 vaccination cards.

1.39.2 A Patient Electronic Health Record is broader as it includes information on vaccination, patient visits and clinical history. PAHO supported the MoH with technical advice and best practices in the public health electronic system. The MoH is currently completing the evaluation for a Health Information System for the RHAs and intends to roll out the system nationally. The aim is to have a one-patient-one-record concept with a unique identifier for each patient and where records can be accessed at any public health institution.

1.39.3 In the interim, each RHA has some element of a Health Information System and, by extension, an electronic health record for their patients, which are at varying degrees of completeness regarding how much information is captured on the health records.

1.39.4 The practice at the MoH has been to digitise patient records for the past five years. However, not every record is digitised. Should a patient revisit the health institution, their record is then digitised. It is only digitised after this visit because some persons may no longer need to access the system or be alive.

Status of Digitisation of Patient Records by the RHAs

1.40.1 As part of a national effort led by the MoH to digitise patient records, the overall strategy at the respective RHAs is to commence digitising records of the Emergency Department, the out-patient clinics, the wards at the respective hospitals and health centres sequentially. It was mentioned that while the Ministry of Digital Transformation is also working on a unique ID for all citizens, the MoH will continue working towards a unique identifier for patients in the health sector, which would fit into the overall digitisation strategy of the Ministry of Digital Transformation.

1.40.2 The RHAs in Trinidad are at different stages of implementation:

SWRHA	Currently, it is converting its paper-based records into digital records and has electronic access to other aspects of care, particularly labs, radiology, and pharmacy.
NWRHA	Based on a recent survey on the development of health information systems for all RHAS, the NWRHA is 60% complete.
ERHA	The ERHA has a Lab Information System and a Pharmacy Information System. As the pilot for the National Health Information System, the ERHA commenced digitising its A&E Department's patient records as its first phase.
NCRHA	Recently partnered with the NWRHA for patient registration and pharmacy module at the Arima General Hospital using an international company, New Fields Technology. In addition, in 2023, the NCRHA introduced an Eric Williams Medical Sciences Complex Medical Records/Patient Referral Unit.

Management of Patient Records

1.41.1 Patient confidentiality is paramount and prescribed in policies and the Freedom of Information Act, Chap. 22:02 (FOI Act). Across the RHAs, there is a protocol for releasing patient records, which is adhered to.

1.41.2 According to the SWRHA, while there may be a courier system problem in transferring patient records from one outpatient clinic to another when patients with multiple chronic diseases attend multiple clinics within a short period of time, a complete loss of record does not frequently occur.

1.41.3 According to the SWRHA, patients can access copies of their records by filling out request forms available at the RHAs' medical record department. Alternatively, patients can also apply for the same under the FOI Act.

1.41.4 Other notable challenges in the operations of RHAs which arose during the inquiry are stated in **Appendix IX.**

Findings

Based on the preceding evidence, the Committee's findings are as follows:

Prevalence of NCDs

i. The prevalence of Diabetes, Hypertension and Cancer in Trinidad and Tobago remains a cause for concern. Correspondingly, deaths caused by NCDs in Trinidad and Tobago have shown a steady increase over the period 2015 to 2018.[24]

ii. Hypertension is more prominent among Afro-Trinidadians than other races and is mainly attributed to lifestyle choices.[25]

iii. Commendably, the MoH is focusing more on modifiable risk factors to reduce the prevalence of hypertension in Trinidad and Tobago.

Surveillance and Monitoring of NCDs

iv. Both the STEPS and Food Consumption Survey are awaiting completion, and when completed, they will be used to analyse the success and/or impact of various past initiatives.

v. The new Electronic Health Record system proposed will assist in capturing data on the number of persons screened and diagnosed with cancer, diabetes, and cardiovascular disease and will enhance the efficiency of patient records management.

Screening and Diagnosing

vi. Medical screening is a critical component in early illness detection and determining a person's predisposition to illness. Despite the apparent challenges, it is one of the main strategies the MoH uses to reduce the burden of the number of persons accessing secondary and tertiary health care services.

[24] See point 3.1.28 – Number of non-communicable disease deaths 2015-2018. Source: Central Statistical Office (2018)
[25] Appendix III – Verbatim Notes of 18th Meeting, page 123.

vii. Strengthening current systems and procedures for detecting NCDs is needed to ensure that more people have access to screening and diagnosis.

viii. The capacity of facilities, staff and consumables to facilitate screening and diagnosis must be strengthened. Partnerships with the private sector and NGOs can assist in providing the capacity needed.

ix. The Committee noted from its Town Hall Meetings that persons faced challenges accessing screening tests due to the unavailability of equipment or testing services in the public healthcare system.

x. The TTMoves Health and Wellness Festivals provide access to screening in communities so people can become acquainted with their health numbers. The Committee commends the TTMoves initiative and other measures to prevent NCDs through healthy lifestyle choices.

Public Awareness and Prevention

xi. Procurement is underway to equip six (6) mobile NCD screening units to be fully functional.

xii. The TRHA faces challenges such as infrastructure, connectivity, supply chain, and human resources when implementing public education and awareness programmes, which can negatively impact reducing NCDs in Tobago.To increase public education and awareness of NCDs, the TRHA increased staff at its Communication Unit and plans to create a Health Education Unit.

xiii. The Behaviour Change Specialist is currently reviewing a communication strategy developed by the NCD Steering Committee to strengthen the approaches of this strategy further.

xiv. One of the main deliverables of the NCD Steering Committee will be the appropriate application of the WHO Acceleration Plan and an evidenced-based approach to clinical practice management for NCDs in Trinidad and Tobago.

xv. The proposed oversight Committee, comprising all the critical ministries, NGOs, and international Health Organisations such as PAHO and CARPHA, will be useful in addressing the issue of NCDs.

xvi. It was noted that the MoH's strategy for addressing the issue of NCDs involves a life-course approach which seeks to prevent NCDs before conception. This proactive approach is highly commendable.

xvii. Establishing a Stress Relief Centre by the Ministry of Health highlights a critical recognition of the growing need for mental health support and its relationship with NCDs.

xviii. There is a need to expand capacity at the Chaguanas NCRHA Stress Relief Centre and provide capacity in the St Joseph area.

xix. An issue emanating from the Town Hall meetings was men's reluctance to seek treatment. To encourage men to access screening, the frequency of screening services that target men may need to be increased to improve the level of reach.

xx. The MoH is focusing on a wellness model to treat hypertension.

xxi. The MoH's Food Advisory Committee, the Ministry of Trade and Industry, and various stakeholders of the MoH are currently discussing mandating the caloric content of foods and packaging.

xxii. Based on feedback from the Diabetes Association of Trinidad and Tobago, people experience challenges accessing eye and foot screening in the public health care system, and

improvement is needed in this area.The MoH plans to expand initiatives targeting and monitoring school children for the prevalence of NCDs.

xxiii. Family and PTA involvement in initiatives targeting school children is critical to the success of the initiatives and the reduction of NCDs amongst the school population.

xxiv. The Terms of Reference for the National Food Consumption Survey and NCD Risk Factor Survey are needed to track obesity. NCDs and children's consumption patterns were delayed and are being finalised.

xxv. To address the deficiency in data collection and subsequent collation and analysis about childhood obesity in Tobago, the THA Division is working assiduously on creating a Public Health Observatory. The TRHA uses education campaigns and holds annual camps dedicated to promoting healthy eating and physical exercise by children to counteract childhood obesity.

Tobacco Control and Regulation

xxvi. The prevalence of Tobacco use amongst the population is significant, particularly usage by teenagers and needs to be reduced.

xxvii. It is noted that public education is key to changing the perception about tobacco usage (a proven cause of lung cancer), and it is critical to target persons who have not yet started smoking and provide support to smokers through the Smoke Cessation Clinics.

xxviii. The MoH undertook to provide data on the STEPS study when it becomes available regarding tobacco use and to discuss with the Ministry of Trade and Industry the availability of data on the importation of tobacco products that can be used to assess the effectiveness of the Tobacco campaign.

xxix. Sensitisation sessions on the legislation requirements, illicit tobacco trade and the effects of smoking on the health and well-being of the population will continue in counties where they have not yet been held.

xxx. Smoke Cessation Clinics will be expanded to other health centres to facilitate more clients.

xxxi. Despite the MoH interventions to support the reduction of tobacco use, behaviour change remains the main challenge the MoH faces. Limited engagement and participation at Smoking Cessation Clinics and other measures implemented by the MoH have been due to personal choice, resistance to change, and rigidity among members of the public.

Initiatives to Address Cancer

xxxii. Trinidad and Tobago seeks to eliminate cervical cancer by 2030.

xxxiii. It is noted that the HPV Vaccination Programme has been effective in contributing to the decrease in cervical cancer numbers.

xxxiv. The MoH has the opportunity to capture information on family members of patients who may be at risk of developing cancer at its cancer centres.

xxxv. The Committee noted from its Town Hall Meetings that there were calls for a cancer treatment facility in Chaguanas.

xxxvi. Additionally, the Committee noted that some persons felt there was a lack of information on cancer treatment.

Access to Medication

xxxvii. xix. Over the past five years, the MoH has had challenges with the importation of some medication for the management of NCDs, which have since been resolved by implementing several strategies the MoH took. The effects of these challenges on

persons accessing medication were expressed during the Committee's Town Hall meetings.

xxxviii. The MoH took relevant measures to mitigate chronic drug shortages, such as increasing the number of orders and providing drug alternatives.

xxxix. The review of the CDAP will examine the probability of expanding the type and quantity of medicines and the availability of items on the CDAP listing. It will also examine two main factors: cost and accessibility.

xl. The MoH added a unique identifier to address the issue of duplicate registered persons on the CDAP that occurred approximately three to four years ago.

xli. The MoH adopts a sensitisation approach to safeguard the public from drugs with altered expiration dates.

xlii. Long wait times to access medication and a shortage of chemo and prostrate medicines were also noted from public engagements, and a digitised cross-institution system was recommended to resolve this issue.

Challenges with Staffing

xliii. While it is noted that the Ministry of Health will liaise with the Ministry of Education to determine the availability of scholarships in specialised areas as a recourse to the shortage of doctors in specialised fields such as endocrinology and paediatrics, it is also noted that it will take some time before graduates can practice in the public health care system. The need for doctors in specialised fields is current and urgent.

xliv. Retaining subspecialists in both nursing and medical care is continuously challenging for the RHAs because of the employment packages offered and the working conditions of other countries.

xlv. It was reported that the migration of qualified local nurses is partly attributed to recruitment agencies coming to Trinidad and Tobago.

xlvi. It is noted that it would be difficult to maintain certain services in public health care facilities without international recruitment of nurses.

xlvii. International cooperation and bilateral agreements with other countries to utilise foreign nurses have benefited Trinidad and Tobago, and the growth of collaboration with other territories is welcomed. It is anticipated that this, coupled with the simultaneous training offered to local nurses in subspecialties, will assist in addressing the shortfalls in the public health care system. The Memorandum of Understanding between the NWRHA and the University of Trinidad and Tobago to train clinical professionals in management is a commendable measure aimed at enhancing the management capacity of middle management staff.

xlviii. While staff shortages were a challenge, the Committee also noted, via its Town Hall Meetings, that some qualified graduates in the Medical Field are finding difficulty being placed in the Public Health Sector. It was also noted that applicants do not receive responses to applications for employment in the Public Health Sector.

xlix. Town Hall Meetings also revealed a lack of scholarships in niche opportunities such as Health Management and Administration or Track Evaluation.

Challenges with Equipment

l. From the Committee's interaction with the public, it was noted that some participants were forced to seek alternative care from the private health sector due to equipment shortages in public health care.

li. Three of the four RHAs in Trinidad identified challenges due to the lack of equipment to perform critical tests.

lii. The SWRHA has a useful and proactive practice of notifying the public daily whether tests are not available under various circumstances via public notices and social media placed in the emergency departments.

liii. The RHAs have the autonomy to outsource tests not done in the public health care system where required.

liv. Arguably the ERHA's reliance on the other RHAs to provide MRI services to its patients, pending the full operationalisation of the Sangre Grande Hospital, contributes to longer wait times for patients to access MRIs at those RHAs.

lv. The NCRHA's strategy for treating with the backlog of radiological responses at the NCRHA involves a redistribution of the reports to other hospitals.

Long Wait Times to access Public Health Services

lvi. The prevalence of NCDs in Trinidad and Tobago contributes to longer wait times, especially in the A&E Departments at General Hospitals. It was revealed that primary health care facilities should treat these patients ideally.

lvii. A significant concern at the Town Hall Meetings, was the consistently reported long and tedious wait times experienced by persons, including the elderly, to access services often without food or access to visitors during this period. For example, the SWRHA confirmed that the average time for necessary tests is currently approximately 4 to 6 hours. The absence of a structured queue system for treating patients and limited seats for those already subjected to long wait times were also identified as issues.

lviii. As a measure to reduce longer wait times in the A&E, the RHAs are generally seeking to divert services from the A&E departments and reach patients at the community level through initiatives such as the NCRHA's In-Touch Programme, Walk the Talk Programme as well as segregating patients to be seen separately at hospitals.

Medical Records

lix. At the town hall meetings, cases of misplacement and loss of patient records, poor patient record management, and calls for the digitisation of records were noted. Misplaced files were also blamed on the cyber-attack in 2023.

lx. The MoH and the RHAs are progressing towards the Patient Electronic Health Record System, which will be accessible at any public health institution, contain a unique identifier for each patient, and assist in improving patient record management.

lxi. The RHAs are at different stages in implementing the Patient Electronic Health Record System.

lxii. Although each RHA captures common data, there is a concern that the respective RHAs are implementing different digitisation systems, which may hinder interoperability in the future.

lxiii. The cyber-attack experienced by the SWRHA in 2023, highlights the need for adequate steps to ensure robust cyber security to safeguard the existing systems and the imminent Patient Electronic Health Record System.

Treatment of the Elderly and Persons with Special Needs

lxiv. The Committee noted reports by some Town Hall participants that medical professionals and other medical staff treated the elderly and persons with special needs very poorly.

lxv. Transportation to clinical appointments for Special Needs and persons with disabilities was a challenge noted at the Committee's Town Hall Meetings.

The Need to Maximise Usage of Underutilised Facilities

lxvi. The Committee noted that many Public Health Centres close at 4:00 p.m. and can be considered underutilised. Maximising usage of these facilities can assist in alleviating some of the challenges facing public hospitals, such as long wait times and access to treatment, especially in rural areas. Notwithstanding, the Committee is mindful of the additional costs of having Public Health Centres operate for extended hours.

Other Findings

lxvii. Challenges with transferring patients' paper-based records within and between RHAs impact the referral process.

lxviii. Patients face challenges with additional expenses when referred outside of their catchment area. For example, transportation challenges with referrals from rural to urban centres/hospitals and accommodation with referrals from Tobago to Trinidad.

lxix. Some non-nationals may be willing to pay for services accessed through the Public Health Care system.

lxx. The attendance and punctuality of doctors are crucial to the successful functioning of the public health care system. Further, effective scheduling and attendance tracking can ensure that healthcare professionals are not overworked, which reduces the risk of burnout and errors.

lxxi. It was reported that some doctors have been engaging in patient redirection, albeit some for acceptable reasons, and patients have complained. This issue was also brought to the fore at the Town Hall Meetings.

lxxii. The need for national discussions to address the public/private conflict of interest is noted and accepted.

lxxiii. RHA officials advised the committee that doctors engaged in patient redirection are identified through the public complaints mechanism, which is dependent on patients lodging a complaint. However, the level of public awareness about these feedback channels was dubious.

lxxiv. The MoH reported that patients may be reluctant to report such conduct due to fear of victimisation. This was also a concern raised by participants at the Town Hall Meeting.

lxxv. The Committee noted an instance where no water was available at a public health institution, affecting the sanitation of facilities and patients.

Recommendations

In light of the foregoing, the Committee recommends the following:

A. As part of its Ministerial Response, the Ministry of Health provided an update on the following:

i. STEPS survey and its key findings about NCDs;

ii. Food Consumption Survey and its key findings;

iii. The outfitting of the NCD screening units and the status of its operationalisation;

iv. Evaluation for a Health Information System for RHAs and the subsequent national rollout

v. The communication strategy developed by the NCD Steering Committee;

vi. The WHO Acceleration Plan and the evidenced-based approach to clinical practice management for NCDs;

vii. **Discussions regarding mandating the presentation of caloric content on packaging of food items;**

viii. **The conduct of sensitisation sessions on proposed legislative amendments for counteracting the illicit tobacco trade and the effects of smoking on the health and well-being of the population and**

ix. **The review/audit of the CDAP programme to assist with identifying any loopholes which are being exploited.**

B. **The Ministry of Health should strengthen its current systems and procedures to ensure adequate access to screening, which is critical in preventing NCDs. Additional attention should be paid to the screening of men.**

C. **Mindful that additional capacity and resources may be needed to strengthen screening activities, the Ministry of Health should foster partnerships with the private sector and NGOs to provide the needed capacity. For example, it could offer an Adopt-a-Health Centre programme similar to the Ministry of Education's Adopt-a-school programme.**

D. **The Ministry of Health should ensure that the necessary preventative maintenance systems and arrangements are adhered to as far as is practicable to improve the lifespan of hospital equipment.**

E. **The Committee acknowledges the challenges faced in Tobago with implementing public education and awareness programmes. The TRHA may need to revisit the locations of its outreach and screening activities and should engage in outreach in rural areas pending resolve of the hindrances. Consideration can be given to implementing an initiative similar to the North Central Regional Health Authority's Walk-The-Talk Programme.**

F. **The Tobago Regional Health Authority should provide a status update on the proposed Health Education Unit.**

G. The Division of Health, Wellness and Social Protection, Tobago House of Assembly should provide an update on the Public Health Observatory in its Ministerial Response.

H. The establishment of a Stress Relief Clinic by the Ministry of Health is commendable given its inverse relationship to NCDs. The Ministry of Health should seek to establish additional clinics throughout Trinidad and Tobago.

I. The Ministry of Health should increase the frequency of men's Health initiatives to have more men participate in screening and treatment services.

J. The Ministry of Health should keep the Committee abreast of the outcome of the discussion with the Ministry of Trade and Industry about the availability of data on imported tobacco products that can be used to assess the effectiveness of the Tobacco Campaign. In this regard, an update should be provided to the Parliament by April 2025.

K. The Ministry of Health should consider the perceived stigma of participating in Cessation clinics and the need for an alternative approach to attract participation. As a first step to encouraging participation in cessation clinics, the Ministry can explore non-monetary incentives and promotional strategies, including digital technologies such as Telephone-based tobacco quitlines, as is used in the United States. The role of family and friends in providing emotional support should also be taken into consideration when planning strategies.

L. The Ministry of Health should examine the feasibility of establishing a cancer treatment facility in the Central and Eastern areas to increase patient accessibility. The Committee commends the MoH for establishing the cancer treatment centre in south Trinidad.

M. The Ministry of Health, in its review, engaged in public consultation to gain first-hand information about the challenges faced by citizens who access the system.

N. The Ministry of Health, in implementing its Health Information System, makes provisions for digitised cross-institution systems to assist in reducing long wait times to access medication.

O. The Ministry of Education should explore the feasibility of increasing the number of postgraduate Medical Sciences scholarships in specialised areas where the country has a significant skills deficit. Scholarships and bursaries should also be offered in areas of Health Management and Administration or Track Evaluation.

P. The Ministry of Health will collaborate with the Ministry of Foreign and CARICOM Affairs to identify potential international cooperation and bilateral agreements that can be advanced to fill current gaps in nursing, particularly in the subspecialties in Trinidad and Tobago, by using foreign nurses pending the availability of locally trained nurses. The Committee should be provided with a progress update on this recommendation by March 2025.

Q. The Ministry of Health should mandate that RHAs adhere to preventative maintenance protocols for MRI and other screening equipment to assist with extending their life span. Furthermore, it is recommended that RHAs utilise the provision to outsource critical tests for patients when their critical machinery is non-operational or is down for maintenance.

R. With immediate effect, the Ministry of Health should instruct all RHAs to implement the practice adopted by the SWRHA where daily public notices are strategically placed in convenient locations, including the A&E departments, to advise on the tests that are unavailable and the reason for the same. These notices should also be posted on the RHAs' social media pages.

S. The Ministry of Health will collaborate with the ERHA to advance the full operationalisation of the Sangre Grande Hospital and commence MRI services as soon as possible. In so doing, it is anticipated that the wait times experienced at the other RHAs to which patients from the ERHA were redirected may be reduced.

T. The Ministry of Health should implement a comprehensive healthcare time and electronic attendance system that provides effective scheduling and attendance tracking for doctors. The system should be designed to ensure that doctors are not overworked.

U. The Ministry of Health ensure that all RHAs implement a mechanism for receiving complaints from the public. The complaints mechanism should ideally be anonymous to avoid victimisation unless the person complaining chooses to be named. It should also include a manual and digital method for lodging said complaints. The Ministry of Health and all RHAs should promote their respective mechanism for receiving complaints from the public at strategic locations at Public Health Care Institutions and on their social/digital media pages.

V. The RHAs should consider adjusting their customer service policy, with special consideration given to the extremely aged and differently abled.

W. As part of their monitoring, evaluation, and quality control systems, RHAs should use undercover clients to collect qualitative data on the public's customer service experience specifically to observe waiting times and overall environment at the RHAs. Additionally, Senior Managers of RHAs should conduct random visits to outpatient clinics and A&E departments for the said purpose.

X. The Ministry of Works and Transport, the Public Transportation Corporation and the Ministry of Social Development and Family Services should collaborate to provide adequate transportation for persons with special needs and persons with disability who have no familial support or assistance to move between their place of residence and public health facilities.

Y. The Ministry of Health will explore and report to the Committee in its Ministerial Response the implications of utilising all Public Health Centres 24/7 for basic healthcare treatment.

Z. To sustain the operations of public health facilities, consideration should be given to having non-nationals pay for services accessed.

OBJECTIVE 2: To examine the efforts of Civil Society to counteract the effects of specific non-communicable diseases within the population (Namely Diabetes, Heart Disease and Cancer)

Demographics of Membership

2.1.1 NGOs stated that their membership is predominantly women. They have stated that women tend to take more proactive measures regarding their health, which is entirely reflective of the membership of all NGOs. It was further stated that women dominate healthcare. While it does not indicate that women are more affected by NCDs, it is evident that men tend to seek medical interventions when their illness is at an advanced stage. NGOs have been trying to increase their male membership.

2.1.2 Specifically referring to the Diabetes Association of Trinidad and Tobago (DATT), it was stated that while there have been events targeted to men (like 5ks), they are not currently engaged in creating events exclusively for men, and it has not been a major priority at this point.

Outreach/Public Awareness and Education Drives

2.2.1 Collaboration between the Diabetes Association of Trinidad and Tobago and the Ministry of Health was reported. The DATT stated they are usually present at the Ministry of Health's TTMoves outreach activities. They are either involved by having a booth at the TTMoves events or as part of the planning process.

2.2.2 DATT hosts annual programmes, including some recent projects such as the sixth form internship programme, which is in partnership with the Ministry of Health and other agencies. It was reported that in its first year, one hundred fifty (150) sixth formers registered, and at the time, they were only able to accept thirty-five (35). In 2023, six

hundred (600) students registered; however, they could only accept thirty-five (35) students due to resource constraints[26].

2.2.3 DATT mentioned they have a very close relationship with the Ministry of Education, particularly regarding project implementation. As such, they target as many school groups as possible. Some of these programmes include the sixth form programme, the National Diabetes Primary School Quiz for Standard three students and recently, a debate for Form four students. DATT believes they may need to start public awareness, education, and intervention earlier, possibly in the pre-school age group.

2.2.4 The DATT also mentioned the accredited Diabetes Educator Programme. They have currently trained thirty-five (35) persons[27].

2.2.5 Specifically, as it pertains to Tobacco Control, the Trinidad and Tobago Cancer Society (TTCS) has conducted campaigns with Republic Bank and Scotia Bank for two major campaigns, "Can't Fool Me" and "No Smoking, No Vaping," in collaboration with the Ministry of Health and Ministry of Education.

2.2.6 Similar to the TTCS and DATT, the Heart Foundation of Trinidad and Tobago's primary mandate was to promote education and public awareness through health fairs, lectures, and other means of getting information to the public.

2.2.7 Another aspect of the Heart Foundation of Trinidad and Tobago's outreach efforts included public testing through their "Know Your Numbers" campaign –to get persons to actively test their blood sugar, pressure, BMI and other relevant statistics. While the foundation stated that they are not a medical association and that part of addressing Heart Disease is not integrated as part of its mandate, it still tries to assist persons with getting

[26] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.
[27] Ibid

the resources and assistance needed to get testing done.

2.2.8 The Heart Foundation's representative stated that the organisation acts as a "liaison between getting persons to advocate for themselves and their professional medical care." Through their education and sensitisation initiatives, they coach persons who are on many medications to monitor themselves and the impact these medications have and encourage these persons to have discussions with their doctors about the effects of the drugs instead of silently accepting medications for their symptoms. The foundation stated the importance of this coaching, considering the relatively overpopulated conditions at clinics and the quality of time persons can get there.

2.2.9 The TTCS stated that they had not received support for a continuous campaign from the Ministry of Health and Education. The TTCS stated that initiatives are mainly done and funded in-house or with the assistance of corporate sponsors. The organisation also stated an overall lack of response from Ministries regarding continuous campaigns.

2.2.10 Concerning the impact of awareness and education drives, it was stated that measuring the tangible results of interventions was challenging as there was not a monitoring and evaluation framework established within the events hosted by NGOs. While increased participation is evidenced through attendance, the impact of this participation in the long term cannot be determined.

International Affiliations

2.3.1 The TTCS became affiliated with the American Cancer Society in 2023 for the Global Relay for Life, a fundraising event and campaign for awareness worldwide[28].

2.3.2 The Heart Foundation of Trinidad and Tobago is also a member of the InterAmerican Heart Foundation, the American Heart Association, and the World Heart Federation. Through these affiliations, the Heart Foundation of Trinidad and Tobago has obtained

[28] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.

many research resources, which it, in turn, tries to disseminate nationwide to the public[29].

The NCD Alliance

2.4.1 It was stated by NGOs that meetings of the NCD Alliance were infrequent, and the Alliance could not effect any change because they are not as cohesive as they should be. It was further mentioned that the Ministry's point lead for the NCD Alliance in the NCD department should meet more frequently with civil society to allow for better collaboration[30].

2.4.2 It was stated that better planning is needed to ensure all parties can be involved in meetings. There is little action emerging from the Alliance. NGOs noted that for the Alliance to work, civil society groups must be given a 'seat at the table', and the Alliance itself needs to be more cohesive to achieve substantive change.

Challenges with Collaboration

2.5.1 The TTCS noted that efforts toward stronger collaboration have been inconsistent, emphasising the need for a unified voice among all stakeholders.

2.5.2 The TTCS also stated that Ministries often focus on "low-hanging fruit," leading to some NCDs receiving less ministerial support than other, more manageable diseases. This focus on easier wins was driven by the desire to enhance the image of supporting ministries.

Data Availability

2.6.1 The TTCS lamented that existing data tends to be outdated. 'Current' National statistics were reported to be at least five years old.

[29] Ibid
[30] Ibid

2.6.2 The TTCS is presently starting data collection on their own website. They previously depended on the Ministry of Health's registry before, and TTCS has currently resumed data collection by using the International Agency for Research on Cancer (IARC[31]). Despite that, it was reported that there were still shortcomings with the available data, as the IARC is a population-based registry, meaning that the data that is provided does not identify lifestyle habits. Findings are mainly correlational.

2.6.3 The TTCS stated that they are currently trying to work on in-house data collection.

Challenges with receiving state subventions

2.7.1 Government Subventions were significantly delayed and were reduced for the TTCS. Previously, TTCS received 1.5 million – but the organisation did not receive this subvention for five to six years (5-6 years). They subsequently had a negotiation and forfeited the subvention that was previously missing. As of 2023, the TTCS received seven hundred and fifty thousand dollars ($750,000) per year[32]. This sum is not sufficient for TTCS to run their operations[33].

2.7.2 It was stated that the TTCS monthly operating costs were approximately three hundred thousand ($300,000), which includes salaries for staff and the contractor for imaging for the mammograms and ultrasounds. Annually, operating costs are approximately $3,600,000[34].

2.7.3 Government subvention to the DATT is four hundred thousand dollars, $400,000 annually. However, they also get funds from other government services such as TTMoves programmes, the health services support programme for activities such as caps for overweight children, the National Diabetes School Quiz and diabetes symposium. This

[31] Cancer Today (iarc.fr)
[32] Appendix IV – Verbatim Notes of 20th Meeting, pages 184-185.
[33] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.
[34] Ibid

financial support was valued at approximately five hundred thousand dollars ($500,000) and the four hundred thousand dollars ($400,000) subvention[35].

Other sources of funding for Non-Governmental Organisations

2.8.1 It was noted that the TTCS hosts several main fundraisers, such as the CIBC for prostate cancer. They received one hundred and fifty thousand dollars ($150,000) for some years; however, in 2023, the organisation received a little over one hundred thousand dollars ($100,000.00). Specifically, for breast cancer and women's breast cancer screening, the society received two hundred and fifty thousand dollars ($250,000.00)[36]

2.8.2 Additionally, the TTCS received half a million dollars ($500,000.00) from Republic Bank, which was used to fund screening and their flagship fundraiser, "Bubbles for Life." Through this, the Society stated that it had raised approximately three hundred thousand dollars ($300,000) net. Funds remaining after expenditure are allocated for screening and operations of the Cancer Society.

2.8.3 Funds are also obtained through grants from deceased persons or family donations.

2.8.4 NGOs indicated that securing funding, particularly from corporate sponsors, remains challenging due to the perception that NGOs compete individually for limited support. The TTCS explained that if they receive backing from Republic Bank and Scotia Bank, the DATT may need to seek alternative sponsors. Sponsors tend to work exclusively with organisations that align closely with their mandate.

2.8.5 It was stated that despite the support gained from corporate sponsorship, it was not sufficient to meet their growing needs.

[35] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.
[36] Ibid

2.8.6 The TTCS stated that they were in debt with their imaging contractor despite the highly reduced services provided. Despite being in debt, the TTCS continues to commit to screening and finance more screening through fundraising. If needed, services are provided pro bono.

2.8.7 The DATT estimated approximately 1.5 million ($1,500,000.00) as its annual operating costs, which can fluctuate. It currently has two (2) paid staff members and volunteers through the OJT office. It was reported that this money does not come from the government, and they try to raise it as much as possible to get the work done. The DATT has stated that they can accomplish only so much with 1.5 million dollars[37].

Increase of Alternative Medication Scams

2.9.1 NGOs expressed concerns about the rise of alternative medications, often promoted by unqualified individuals as cures for various diseases, including NCDs, which have adversely affected those who rely on their services[38].

2.9.2 The Heart Foundation of Trinidad and Tobago further stated that money and other resources were being diverted from proper care for persons with NCDs due to the misinformation that was being presented by persons without medical backgrounds.

Access to Screening

2.10.1 The Heart Foundation of Trinidad and Tobago reported encountering numerous individuals who did not receive necessary diagnostic tests, such as ECGs and EKGs, upon initial diagnosis. They further explained that patients diagnosed with heart conditions through hospitals or those who have scheduled tests via the public healthcare system

[37] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.
[38] Ibid

often face delays. When testing is conducted the data may be nearly two years old and no longer valid. During this time, the patient's condition may have worsened.

2.10.2 The DATT reported that there are currently challenges with point-of-care testing, specifically for HbA1c. They are currently advocating for point-of-care HbA1c testing, which would assist doctors with adjusting patient medication immediately. DATT stated that in 2023, the Minister of Health said that the Ministry was acquiring HbA1c machines, point-of-care for every health centre. DATT stated that they are waiting on that[39].

Access to Medication

2.11.1 The TTCS stated that they had initial talks with the NWRHA in 2023 concerning collaborating on addressing equipment challenges. The TTCS reported that they were offered a subsidised price for some equipment, which they discussed with the NWRHA; however, the NWRHA has not had any further discussion about the offer with them.

2.11.2 TTCS mentioned that their members have complained about a shortage of specific breast cancer and prostate cancer drugs. Additionally, the TTCS stated that while newer drugs are currently in the formulary, they are still unavailable across pharmacies. As a result, patients had to purchase their drugs privately, which was often very expensive.

2.11.3 The DATT also stated that newer drugs that are proven to have a better effect on patients were not on the CDAP formulary. They explained that they were trying to advocate for getting specific drugs such as Lantus and some other analogs onto the formulary for children, however, that there was a high cost attached. The DATT stated that if medication is being provided to citizens for free (as through the CDAP program) then the selection of drugs has to be as economical as possible.

[39] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twentieth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.

2.11.4 NGOs claimed that the medication shortage is due to insufficient funds.

2.11.5 The TTCS reported that pharmaceutical companies have contacted them and are willing to discuss supplying drugs for free with the government. However, the TTCS was unable to gain any further traction on this discussion with the Ministry of Health.

2.11.6 While the TTCS expressed that they understood the hesitation about accepting drugs and that caution is advised when one is affiliated with a pharmaceutical company, it was stated that the least that could be done was to have discussions about what is being offered and what is being accepted or used in other countries.

Equipment Availability

2.12.1 The TTCS stated that their members told them there was dysfunctional equipment, which contributed to delayed screening services. This was reported across all regional health authorities. The dysfunctional equipment specifically mentioned were for mammograms and colonoscopies.

2.12.2 The TTCS stated that they had initial talks with the NWRHA in 2023 concerning collaborating to address equipment challenges. The TTCS reported that they were offered a subsidised price for some equipment that they discussed with the NWRHA; however, the NWRHA has not had any further discussion about the offer with the TTCS.

Suggested intervention strategies by NGOs

2.13.1 NGOs agree with policies that will discourage the promotion, advertising and marketing of unhealthy foods, especially in schools, as well as other interventions such as taxation and front-of-package labelling.

2.13.2 Specifically, within the education system, DATT stated that approximately 200 to 500 children live with type one diabetes—this type is an autoimmune disease with a very sudden onset. They have tried to educate teachers individually through the diabetic youth

support branch of the organisation. DATT is collaborating with TTUTA and NPTA to implement the project in 2024.

2.13.3 DATT launched their continuous glucose monitors in 2023, which help monitor blood sugar throughout the day. This helped parents who previously had to take time off work to test their children's blood sugar. DATT is currently trying to implement the CGM on a broader scale; however, they are costly. DATT explained that they are aware that the MoH is striving to acquire CGMs for children, and the effort is commended.

2.13.4 NGOs agreed that more forceful interventions or legislation should exist to prosecute persons who make unsubstantiated non-medical claims.

Findings

Based on the preceding evidence, the Committee's findings are as follows:

i. Most activities and initiatives by health-based civil society groups appear to be female-dominated. There have been calls to find ways to increase male membership.

ii. Organizations, such as the DATT, have been trying to increase men's interest in proactive health care by encouraging them through events such as sporting activities across different communities. However, there are still challenges to getting more men to participate.

iii. It was learnt that when women participate in health events, they often share the information with the men in their lives, even if men do not attend.

iv. Collaboration between civil society groups and ministries is evident; in some cases, collaborative efforts are longstanding. However, there may be some challenges with

continuous collaboration between certain groups and ministries.

v. While Civil Society may conduct numerous public awareness and education drives, limited assessment is done to understand the impact and reach of these sessions. This may be attributed to a lack of resources to undertake research. At most, high levels of attendance are evident, but there is some challenge in understanding the true impact of these sessions due to resource constraints.

vi. The establishment of unofficial networks between the Ministry of Health and Civil society (such as the NCD Alliance) is evident; however, the work achieved tends to experience delays in execution. Communication between NGOs and the Ministry of Health also appeared infrequent, specifically regarding the NCD Alliance.

vii. Additionally, regarding the NCD Alliance, there appear to be sporadic or few opportunities for deeper collaboration between NGOs and NCD point of contact persons at the Ministry.

viii. Available data is typically limited to broad categories such as sex, age, race or geographical location. More granular data collection is valuable for mapping and illustrating causal relationships related to NCDs. The lack of updated data limits the effect and accuracy of the intervention required.

ix. Fluctuations in subventions and funding for civil society to carry out its mandate have hindered the number of services and outreach it can feasibly deliver annually.

x. Current subventions are generally insufficient for NGOs to carry out their mandate.

xi. To supplement funding and resources, NGOs can use private donations, partnerships with corporate sponsors, or international partnerships to network and gain support.

xii. Culture plays a significant role in how people access health care, especially preventative healthcare. Persons tend to be fearful of diagnoses or disillusioned with the lengthy wait times in the public health care system and may turn to un-substantive non-medical alternatives in an attempt to cure their ailments.

xiii. Seeking proactive/preventative medical attention is still a cultural challenge. Many health-based NGOs struggle with shifting the mindset for proactive medical care, especially among men; these NGOs have admitted that it is not easy to change culture.

xiv. Despite having a myriad of public awareness initiatives, there is still a lack of response to getting tested – this was attributed to culture, fear and perceived stigma associated with specific NCDs such as diabetes.

xv. There has been an increase in the appearance of alternative medication offerings, which are usually unsubstantiated. This hinders the efforts of legitimate medical practitioners actively trying to curb NCD rates in the population.

xvi. It was learnt that civil society groups have access to networks and can communicate more frequently with external companies that may be able to offer equipment/medication at subsidised costs or free of charge. Despite having these partnerships and connections, they cannot take large-scale action on these offers. NGOs do not have the authority to accept drugs/equipment on a large scale; however, they are unable to get meetings with relevant authorities to do so.

Recommendations

In light of the foregoing, the Committee recommends the following:

A. Based on market research and trend analyses, NGOs could consider collaborating (either through the NCD alliance or otherwise) to develop a men's health promotion initiative in collaboration with the Ministry of Health/RHAs and the Ministry of Sport and Community Development to specifically target men across various age groups within the following year. The Ministry of Health could take the lead on this Initiative.

- **i. If collaborative efforts between the Ministry of Health and Civil Society groups or other Ministries have already begun, in the Ministry of Health's ministerial response, provide an update on the public reaction to these men's health initiatives and whether there are any plans to expand these initiatives in the upcoming year.**

B. The committee commends the collaboration between civil society groups and relevant ministries, specifically the Ministry of Health. It is recommended that this collaboration be expanded within the next year to make efforts more substantial and to assist civil society groups with resource constraints.

- **i. If increased collaborative efforts between the Ministry of Health and Civil Society groups have already begun, marketing and communication efforts should be improved within the next six months so that the public is aptly aware of what is being offered. This can be facilitated through social media campaigns, traditional media, and bulletin boards at hospitals, clinics, and high pedestrian traffic areas.**

C. NGOs, in collaboration with the Ministry of Health, can consider applying various nudging techniques to obtain information from the public who attend health fairs or outreach initiatives within the next two years. This can feature an opt-out option as well as some incentive (for example, priority screening and treatment) for obtaining their information for a period of time.

D. In their Ministerial Response, the Ministry of Health should provide an update on the NCD Alliance.

- **i. What has the Alliance accomplished since its inception?**

ii. What are the next steps in the Alliance's mandate; and

iii. How does the Alliance plan to include other NGOs to impact achieving its mandate significantly?

It is further recommended that the Alliance have frequent meetings and publish its works or proposed works on relevant social media platforms starting in 2025.

E. Within the next two years, the Ministry of Health, as the lead, in collaboration with the Ministry of Digital Transformation and civil society, should consider "beefing up" data collection efforts and creating longitudinal studies and databases that track lifestyle habits as they pertain to NCDs. Generalised data can then be publicised so the population can see real-time NCD trends via data visualisations. The committee acknowledges civil society's existing networks and affiliations with longstanding international organisations and recommends expanding these collaborative relationships with other charity-based global medical organisations that can assist with providing more screening services, especially in rural and underserved communities at different times of the year. This project can take place over two years.

F. In their ministerial response, the Ministry of Health should update the committee on the rollout of the HbA1c machines at all health centres and the status of obtaining CGMs for children.

G. In the upcoming year, the Ministry of Health should meet with civil society groups, discuss their partnerships with potential suppliers, and create networks that can assist with addressing shortfalls in the public health system, especially in terms of screening and access to medication.

H. Further to the previous recommendation, the Ministry of Health must provide an explanation in its Ministerial Response for the delay in the NWRHA's decision to partner with the Trinidad and Tobago Cancer Society and an unnamed third party to obtain subsidised prices for equipment for cancer screening/treatment.

OBJECTIVE 3: To determine the main policy changes, actions and interventions that are necessary to effectively respond to the increase in non-communicable diseases in Trinidad and Tobago

LEGISLATION AND POLICY

Tobacco Legislative and Policy Amendment

3.1.1 The Trinidad and Tobago Cancer Society (TTCS) stated that enforcing the Tobacco Control Act (2009) is one measure to reduce the usage of Tobacco, which directly impacts NCDs,

particularly cancer.[40]

3.1.2 In September 2022, the MoH attempted to enforce the Tobacco Control Act and the 2019 amendment by implementing graphic health warning pictures on the packaging and labelling of all tobacco products and cigarette dispensers to deter their use.[41]

3.1.3 In its written submission to the committee, the MoH stated that it conducted sensitisation sessions to raise awareness of the requirements of the Tobacco Control Act and the 2019 amendment.[42] (Refer to Objective 1, item 3.1.94.)

3.1.4 In the DATT's written submission and during a public hearing held on 20th March 2024, the DATT and TTCS highlighted the need to amend the Tobacco Control Act and the 2019 amendment to include vaping and the marketing of vaping to children.

3.1.5 The MoH noted that it is currently gathering baseline data and implementing preventative interventions. This process will inform potential legislative changes to the Tobacco Control Act and its 2019 amendment.[43]

3.1.6 In 2023 the MoH adopted a preventative approach to vaping among children and other key populations. Twelve health education sessions were conducted at various schools. Approximately 1200 to 1500 students were sensitised about the health risks, dangers, and alternatives to e-cigarettes and vaping.

[40] Cancer Society of Trinidad and Tobago. "Joint Select Committee Social Services and Public Administration Request for Written Submission for the Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with Specific Focus on Diabetes, Cardiology Disease and Cancer)." Cancer Society of Trinidad and Tobago, 2023, 1-7.

[41] Ibid.

[42] Ministry of Health. "Joint Select Committee Social Services and Public Administration Request for Written Submission for the Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with Specific Focus on Diabetes, Cardiology Disease and Cancer)." The Government of Trinidad and Tobago, Vol 1, 2023, 1-20.

[43] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

3.1.7 During a Public Hearing held on January 15th 2025, the MoH agreed to take a more aggressive approach in developing a policy on vaping.

Alcohol Legislative Amendment

3.2.1 The MoH manages the National Alcohol and Drug Abuse Prevention Programme (NADAPP) and seeks to examine ways to prevent alcohol abuse and consumption and works with various stakeholders about various addictions, including alcohol.

3.2.2 The MoH will discuss the issue of the sale and advertisement of alcohol in specific communities with NADAPP[44].

3.2.3 The MoH noted that restricting the advertising of alcohol is not currently being considered as part of its policy agenda. The MoH emphasised the significance of lifestyle changes rather than implementing restrictions through policy.[45]

Food and Drug Legislative Amendment

3.3.1 The DATT highlighted the need for legislation that mandates:[46]

- front-of-package labels;
- taxation on unhealthy food and beverage items and;
- restrictions on advertising and promoting unhealthy food and beverages.

[44] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.
[45] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.
[46] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-First Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 2, Mar 20, 2024.

3.3.2 The MoH noted that the issue of front-of-package labels are being discussed at CARICOM and the MoH will collaborate with the Ministry of Trade and Industry on the issue.[47]

3.3.3 The TTCS and DATT underscored the need for legislation restricting the advertisement of traditional and Complementary and Alternative Medicines (CAM) as a cure for NCDs.

The Sale of Sugar-Sweetened Beverages

3.5.1 In 2017, the Government of Trinidad and Tobago banned the sale or serving of sugar-sweetened beverages added sugars by manufacturers and other products) in all government and government-assisted schools.[48]

3.5.2 The MoH noted that no impact assessment was conducted on the ban on selling Sugar-Sweetened Beverages in Schools since its implementation in 2017 due to the COVID-19 pandemic.[49]

3.5.3 The MoH, in collaboration with the MoE, was scheduled to conduct an impact assessment of the ban on the sale of Sugar-Sweetened Beverages in Schools in the first quarter of 2024.[50]

Diabetes Management

[47] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.
[48] Ministry of Health. "Joint Select Committee Social Services and Public Administration Request for Written Submission for the Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with Specific Focus on Diabetes, Cardiology Disease and Cancer)." The Government of Trinidad and Tobago, Vol 1, 2023, 1-20.
[49] Ibid.
[50] Ibid.

3.6.1 The MoH indicated a policy change in 2018 with the introduction of clinical guidelines to manage diabetes and hypertension in pregnancy.[51] Implementing clinical guidelines meant the introduction of screenings for every pregnant patient who attended a public or private clinic for diabetes.[52]

3.6.2 The National Breastfeeding Policy was developed in 2020.

3.6.3 The DATT highlighted that no policy exists to aid children living with type 1 diabetes in schools and to train teachers on how to assist children while navigating that autoimmune disease. The DATT has re-engaged the Ministry of Education and Health on a policy for children living with diabetes.

Shortage of Subspecialists

3.7.1 The MoH made a policy decision to provide scholarships for training in subspecialty areas. Eight (8) scholarships were provided for a Doctor of Medicine programme in oncology.[53]

Access to Care

3.7.2 The MoH indicated that foreign nationals have access to primary health care and accident and emergency care in accordance with Cabinet's decision of June 2018.

3.7.3 The MoH highlighted that the Canadian Triage and Acuity Scale (CTAS), implemented in the Trinidad and Tobago public healthcare system, was traditionally led by nurses. However, a policy change has been introduced, allowing either a doctor alone or a doctor and a nurse to assess patients, determine their CTAS category, and decide on the appropriate treatment.

[51] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, Nov 15, 2023.
[52] Ibid.
[53] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 4, Jan 15, 2025.

Patient Redirection

3.7.1 The MoH stated that it is not the policy of the Ministry or RHAs for patients to be referred to doctors' private practice.[54]

3.7.2 The NWRHA and SWRHA indicated that patient referral from the public health sector to the private health sector by health care professionals is a conflict of interest and misconduct, though not specifically stated in the RHA Code of Conduct Regulations.

3.7.3 The MoH identified that no cases have been tried against healthcare professionals for patient redirection from the public to the private sector.

3.7.4 The committee notes the challenges with patient redirection to private institutions, as highlighted in town hall meetings. Patients reported being redirected due to long wait times for appointments, screenings, and scans and a lack of operational equipment.

Status of Proposed Policies

3.9.1 The National Food Consumption Policy has been delayed due to the execution of the National Food Consumption Survey, a key component that will inform the policy.[55]

Suggested Policies

3.10.1 The Ministry of Health acknowledged that several regulatory interventions can be pursued to aid the population in making healthier lifestyle choices. These include[56]:

[54] The Parliament of the Republic of Trinidad and Tobago. Verbatim Notes of the Twenty-second Meeting of the Joint Select Committee on Social Services and Public Administration. Public Hearing 1, June 26, 2024.
[55] Ibid.
[56] Ibid.

- Food Labelling regulations;
- Trans-Fat policy and regulations; and
- Fiscal policy measures include taxation on tobacco and soft drinks.

3.10.2 According to the Division of Health, Wellness and Social Protection, Tobago House of Assembly, feasible policy and regulatory actions that can be taken to propel the population to healthier lifestyle choices are as follows:[57]:

- The establishment of "Healthy Food Zones" in areas of schools, health care facilities, and government offices;
- Higher tax impositions on fast-food restaurants and manufacturers of high-sugar, high-fat and high-sodium food products;
- More visible anti-drug campaigns;
- Revised school curriculum to make physical education mandatory for primary and secondary schools.

Challenges to Success of Policy Initiatives

3.11.1 One hindrance identified was the impact of policy initiatives on the population and the population's ability to alter/adapt to new lifestyle approaches toward the prevention and treatment of NCDs.[58]

Findings

Based on the preceding evidence, the Committee's findings are as follows:

[57] Division of Health Wellness and Social Protection. "Joint Select Committee Social Services and Public Administration Request for Written Submission for the Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with Specific Focus on Diabetes, Cardiology Disease and Cancer)." Tobago House of Assembly, 2023, 1-16.
[58] Ministry of Health. "Joint Select Committee Social Services and Public Administration Request for Written Submission for the Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with Specific Focus on Diabetes, Cardiology Disease and Cancer)." The Government of Trinidad and Tobago, Vol 1, 2023, 1-20.

Legislation and Policy

Tobacco and Alcohol Legislative Amendments

i. The full enforcement of the Tobacco Control Act (2009) is a critical measure to reduce tobacco usage.

ii. Graphic health warnings on tobacco product packaging and dispensers were implemented in 2022 under the Tobacco Control Act, and the 2019 amendment aimed to deter new tobacco users by highlighting its harmful health effects through visual warnings. However, the efficacy of this particular strategy has not been officially assessed.

iii. While MoH's sensitisation sessions with Tobacco sellers focused on legal compliance under the Tobacco Control Act and the 2019 amendment, its success still depends on sustained public engagement and compliance. Refer to Objective 1 item 3.1.94.

iv. The use and marketing of vaping and e-cigarettes are excluded from the original Tobacco Control Act and the 2019 amendment and require regulation to reduce its use.

v. There may be a need for legislation on advertising the sale of alcohol.

Food and Drug Legislative Amendment

vi. The committee recognises the inquiry into Food Fraud in Trinidad and Tobago by the Joint Select Committee on Finance and Legal Affairs. The inquiry found that the MoH had adopted a relatively lenient approach in its attempt to encourage compliance with the provisions of the Food and Drugs Act (1960).[59]

[59] The Parliament of the Republic of Trinidad and Tobago. Joint Select Committee on Finance and Legal. An Inquiry into Food Fraud in Trinidad and Tobago. Date Laid in House and Senate: May 31, 2017/ June 01, 2017.

vii. It was noted that contrary to international standards, the Food and Drugs Act does not require nutritional facts as a minimum standard for label content.[60]

viii. The Chemistry Food and Drugs Laboratory has not been operational since 2014. As such, the CFDD does not verify nutritional information on product labels.[61]

The Food and Drug Act (1960) does not include mandated front-of-package labels to indicate high calorie, sugar, sodium, saturated fat, and trans-fat content on local and imported food and beverages.

ix. Additionally, restrictions on marketing and promoting unhealthy food and beverages are not included in the Food and Drug Act (1960).

x. The committee recognises serious concerns about the effects of the unregulated Complementary and Alternative Medicine (CAM) industry on customer health and safety. The DATT, TTCS, and the Heart Foundation have appealed to regulate the herbal medicine industry due to worries that local sellers exploit customers by misrepresenting their curative capabilities.

xi. The committee noted that no legislative framework restricts advertising traditional and Complementary and Alternative Medicines (CAM) as a cure for NCDs. In this regard, the Committee acknowledge the findings of a previous *inquiry into the Potential Benefits of Traditional, Complementary and Alternative Medicine in the Treatment of Non-Communicable Diseases Affecting the Trinidad and Tobago population*. They would be interested in being updated on the amount of progress the MoH has made in this regard.

The committee took particular note of the following policy interventions connected with the Government's response to combatting the increase in NCDs:

[60] Ibid
[61] Ibid.

i. In 2023, the National NCDs Steering Committee was established to coordinate national efforts in reducing the prevalence and impact of NCDs through policy implementation and strategic oversight.

ii. The absence of an impact assessment on the ban on sugar-sweetened beverages limits the ability to evaluate the policy's effectiveness in improving student health outcomes.

iii. The absence of a policy to aid children living with type 1 diabetes in schools may pose significant challenges for children to receive adequate care and support during school hours.

iv. The MoH and RHAs appear to have adopted a moral suasion approach to treating public complaints of medical doctors in public healthcare, redirecting patients to private institutions.

v. A policy change was implemented by the MOH to streamline patient care through the assignment of CTAS categories by a doctor or a doctor and nurse team.

Suggested Policies

vi. The MoH has identified several regulatory interventions promoting healthier lifestyle choices. The Committee considers it critically important that the MoH urgently commence consultations with the relevant stakeholders to advance the implementation of these strategies

Challenge to Success of Policy Initiatives

vii. Individuals' willingness to adapt to new lifestyle approaches challenges policy efforts to improve health outcomes.

Recommendations

In light of the foregoing, the Committee recommends the following:

A. **The committee endorses the recommendation of the TTCS to have the Tobacco Control Act (2009) fully enforced. The committee recommends increased or strengthened monitoring of enforcement of the Act to ensure long-term impact on the population's health.**

B. **The committee also endorses the recommendation by the TTCS, DATT and MoH to further amend the Tobacco Control Act (2009) to include vaping and e-cigarettes and restrict the marketing of these items. In this regard, the MoH should collaborate with the Office of the Attorney General and Ministry of Legal Affairs to finalise and enact these legislative changes by the end of fiscal 2024/2025.**

C. **The committee recommends the commencement of discussions to examine the need for legislative action to regulate advertising the sale of alcoholic beverages by the MoH and report to the Parliament on its findings within one year. Consideration should also be given to a public education campaign on the impact of alcohol, targeting key segments of the population.**

D. **The Committee acknowledges the recommendation of DATT and MoH for legislative measures on front-of-package warning labelling, restrictions on marketing and promoting unhealthy food and beverages and taxation on such items. The MoH is asked to consider the feasibility of these recommendations and provide the Parliament with its findings within the first quarter of 2025 (no later than March 31st 2025).**

E. **The committee recommends amending the Food and Drug Act (1960) to include front-of-package warning labels on local and imported food and beverages indicating an excess of critical nutrients. The PAHO has deemed this approach simple, practical, and**

effective in preventing NCDs.[62][63] The MoH should, subject to Cabinet approval, collaborate with the Office of the Attorney General and Ministry of Legal Affairs to prepare the legislative proposal/Bill for submission to Parliament by the fourth quarter of 2025.

F. In 2021, the government of the United Kingdom introduced restrictions on the marketing of foods and beverages classified as high in fat, sugar, and/or salt (HFSS). This included two key pieces of legislation: Price promotion and location restrictions and TV and online advertising restrictions.[64] The MoH should, subject to Cabinet approval, collaborate with the Office of the Attorney General and Ministry of Legal Affairs to prepare the legislative proposal/Bill for submission to Parliament by the second quarter of 2026.

G. The MoH, within two (2) months of the presentation of this report, should commence consultations with other relevant stakeholders to formulate amendments to the Food and Drugs Act.

H. The committee recommends the development of a policy to support children living with diabetes and other chronic illnesses in schools. The MoE can commence consultations with other relevant stakeholders to develop a policy to protect and support children with chronic diseases within one year.

I. In its Ministerial Response to this report, the MoE is asked to provide the number of education district health nurses assigned to schools in each district.

J. The committee endorses the Government of Trinidad and Tobago's effort to mitigate the impact of NCDs through its plan to expand the ban on sugar-sweetened beverages

[62] "Front-of-Package Labeling - PAHO/WHO | Pan American Health Organization." Www.paho.org, https://www.paho.org/en/topics/front-package-labeling

[63] UNICEF. A 'How-to' Guide for Countries. Front-of-Pack Nutrition Labelling: A "How-To" Guide for Countries UNICEF Technical Guidance Nutrition Guidance Series 2. Nov. 2021. https://www.unicef.org/media/118716/file

[64] Kerry Health and Nutrition Institute. "Restrictions on Advertising Unhealthy Foods - a Guide for Upcoming Laws." Kerry Health and Nutrition Institute, 9 Aug. 2021, https://khni.kerry.com/news/restrictions-on-advertising-unhealthy-foods-a-guide-to-navigate-upcoming-uk-hfss-legislation/#:~:text=In%202021%20the%20UK%20Government,TV%20and%20online%20advertising%20restrictions.

at government and government-assisted schools to all public sector entities.[65] **In its Ministerial Response to this report, the MoH is asked to provide the Parliament with a summarised plan for implementing this policy proposal successfully.**

K. The committee endorses the MoH effort to develop a hotline service for citizens needing medical support regarding NCDs. However, details on the plan of action and monitoring of this initiative is currently unknown. In its Ministerial Response to this report, the MoH is asked to provide a plan of action for this initiative.

L. The committee acknowledges the Division of Health, Wellness, and Social Protection's recommendation for a revised school curriculum and recommends that the MoE extend its guidelines to include two hours per week of high-quality physical education for Forms 4-5 in all government and government-assisted schools by the end of fiscal 2024/2025.[66]

M. The committee recommends that the MoH and RHAs consider the development and implementation of policy measures to address unethical patient redirection. The action of the MoH however must be with due regard to the terms and conditions of the employment contracts of doctors or collective agreements as the case may be. The MoH is requested to provide the Parliament with the proposed policy measures by April 2025.

N. In its Ministerial Response to this report, the MoH is asked to submit a status update on the progress of the impact assessment on the ban of Sugar-Sweetened Beverages in government, government-assisted and private schools.

O. In its Ministerial Response to this report, the MoH is asked to provide the parliament with a timeline for completing the vaping policy.

[65] The Government of Trinidad and Tobago. The Ministry of Finance. Budget Statement 2025. Presented by the Honourable Colm Imbert, 30th September 2024.
[66] Department for Education. 2024. "Enhancing Physical Education Provision and Improving Access to Sport and Physical Activity in School- Non Statutory Guidance." United Kingdom: Department for Education.

P. In its Ministerial Response to this report, the MoH and RHAs are asked to provide their policy on access to treatment of persons with disabilities and special needs. RHAs can also state if staff have received training on existing policies regarding disability.

Q. In its Ministerial Response to this report, the MoH is requested to provide a status update on the progress of the National Food Consumption Survey and the National Food Consumption Policy.

Appendix II – List of Officials

Public Hearing Held on November 15, 2023	
Ministry of Health and the Regional Health Authorities	
Name of Official	**Portfolio**
Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Maria Clapperton	Director, Non-Communicable Diseases
Mr. Anthony Blake	Chief Executive Officer- North West RHA
Ms. Angelina Rampersad-Pierre	Ag CEO Eastern RHA
Mr. Dalvin Thomas	Chief Executive Officer – North Central RHA
Dr. Brian Armour	Chief Executive Officer – South West RHA
Dr. Kellie Alleyne-Mike	Medical Director, St. James Medical Complex
Dr. Adesh Sirjusingh	Director, Women's Health
Dr. Tricia Cummings	Ministry of Health, CARICOM Focal Point for Cardiac Management
Public Hearing Held on March 20, 2024	
Trinidad & Tobago Cancer Society	
Dr. Asante Le Blanc	Chairwoman, Trinidad and Tobago Cancer Society
Diabetes Association of Trinidad and Tobago	
Dr. Andrew Dhanoo	President
Trinidad & Tobago Heart Foundation	

Mr. Amit Maharaj	Manager
Public Hearing Held on June 26, 2024	
Ministry of Health and the Regional Health Authorities	
Officials of Ministry of Health	
Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Stewart Smith	Senior Health Systems Advisor
Dr. Marcia Clapperton	Director, Non-Communicable Diseases Unit
Mrs. Anesa Doodnath-Siboo	Principal Pharmacist (Ag.)
Officials of North Central Regional Health Authority	
Mrs. Stacy Thomas-Lewis	Chief Operating Officer (Ag.)
Dr. Abdul Hamid	General Manager – Primary Health Care Services (PD)
Dr. Kimani White	Medical Chief of Staff (Ag.) EWMSC
Officials of Eastern Regional Health Authority	
Mrs. Angelina Rampersad-Pierre	Chief Executive Officer (Ag.)
Dr. Rajiv Bhagaloo	Medical Director
Dr. Jamila Augustine	County Medical Officer of Health
Officials of South-West Regional Health Authority	
Dr. Brian Armour	Chief Executive Officer
Mrs. Michelle Murray-La Foucade	General Manager, Policy Planning and Research

Mrs. Rachel Jardine-Burkett	General Manager Nursing
North-West Regional Health Authority	
Mr. Anthony Blake	Chief Executive Officer
Dr. Keisha Gangaram	Director of Health
Dr. Kellie Alleyne-Mike	Medical Director Cancer Centre of Trinidad and Tobago (Oncology)
Dr. Keegan Baggan	General Manager, Primary Care Services

Appendix III – Verbatim Notes of 18th Meeting

VERBATIM NOTES OF THE EIGHTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION HELD (IN PUBLIC) IN THE LINDA BABOOLAL MEETING ROOM, (GRAND COMMITTEE ROOM 2), GROUND FLOOR, PARLIAMENTARY COMPLEX, CABILDO BUILDING, ST VINCENT STREET, PORT OF SPAIN. ON WEDNESDAY, NOVEMBER 15, 2023, AT 10.18 A.M.

PRESENT

Mr. Paul Richards	Chairman
Mr. David Nakhid	Member
Ms. Vandana Mohit	Member
Mr. Roger Monroe	Member
Mr. Julien Ogilvie	Secretary
Mr. Brian Lucio	Assistant Secretary

ABSENT

Mr. Esmond Forde	Vice-Chairman [*Excused*]
Mr. Rohan Sinanan	Member [*Excused*]
Ms. Pennelope Beckles	Member [*Excused*]
Mr. Avinash Singh	Member [*Excused*]

MINISTRY OF HEALTH

Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Maria Clapperton	Director, Non-Communicable Diseases
Mr. Anthony Blake	Chief Executive Officer – Eastern Regional Health Authority
Mr. Davlin Thomas	Chief Executive Officer – North Central Regional Health Authority
Dr. Brian Armour	Chief Executive Officer – South West Regional Health Authority
Dr. Kellie Alleyne-Mike	Medical Director, St. James Medical Complex
Dr. Adesh Sirjusingh	Director, Women's Health
Dr. Tricia Cummings	Ministry of Health, CARICOM Focal Point for Cardiac Management
Mrs. Angelina Rampersad-Pierre	Ag. Chief Executive Officer - Eastern Regional Health Authority

Mr. Chairman: Hello everyone and welcome to the viewing and listening audience to this the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. This is the Committee's first hearing with stakeholders pursuant to its enquiry into Trinidad and Tobago's response to the prevalence of non-communicable diseases with specific focus on diabetes, cardiological disease

and cancer.

Members of the general public are invited to submit their comments and questions via the Parliament's social media platforms, YouTube channel *ParlView* or via its Facebook and Twitter accounts. At this time I would like to allow Members of the Committee to introduce themselves, starting with member Mohit.

[*Introductions made*]

Mr. Chairman: Thank you all. I am the Committee's Chairman, Paul Richards. We also have members Esmond Forde MP, Pennelope Beckles MP and Rohan Sinanan MP and Avinash Singh MP who are members of the Committee but who are not able to be with us due to conflicting schedules. Thank you all for being with us today.

The enquiry objectives are as follows. There are three main objectives in this enquiry. One, to examine the efforts of the State to counteract the effects of specific non-communicable diseases within the population, these are as I said before are diabetes, heart disease and cancer.

Two, to examine the efforts of civil society to counteract the effects of these non-communicable diseases, including diabetes, heart disease and cancer.

And three, to determine the main policy changes, actions and interventions that may be necessary to effectively response to the increase in non-communicable diseases in Trinidad and Tobago. At this time I would like to allow members of the stakeholder groups to please introduce themselves. Go ahead please.

[*Introductions made*]

Mr. Chairman: Thank you all for being here. Just before I allow the Permanent Secretary Mr. Ali, to deliver opening remarks, I just want to lay some context, take some time to lay some context to the importance of this kind of enquiry based on the statistics and data that we have been able to, the Secretariat has been able to gather

regarding non-communicable diseases, not only in Trinidad and Tobago and Caribbean, but around the world and its impact on people's health around the world.

Non-communicable diseases refer to a group of conditions that are not mainly caused by an acute infection and generally results in long-term health consequences that require long-term treatment and care. In this enquiry, we will be focusing on diabetes, cardiovascular disease and cancer. Here are some key facts about NCDs as reported by PAHO.

Non-communicable diseases, NCDs, kills 41 million people each year worldwide, 71 per cent of all deaths globally. In the region of the Americas, 55 million deaths are attributable to NCDs. Each year, 15 million people, 2.2 million of the region of the Americas, die from NCDs between the ages of 30 and 69. Over 85 per cent of these are considered premature deaths which occur in low and middle-income countries. Cardiovascular disease amounts for the most NCDs, 17.9 million annually, followed by cancers, 9.0 million; respiratory diseases, 3.9 million and diabetes, 1.6 billion globally. These four groups of diseases account for over 80 per cent of all NCD deaths. Tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets all increase your risks of dying from NCD.

In terms of Trinidad and Tobago recent data has indicated 14.8 per cent of the country's adult population is living with diabetes. And diabetes continues to generate a substantial burden on overall disease in the population. The increase of this non-communicable disease has placed an added strain on the country's health care system as you all will realize because of your positions.

In terms of the global outlook, the leading non-communicable disease throughout the world in the last two decades, 20 years, has been cardiovascular disease. In 2008, there were 17 million deaths to CDCs, CVD sorry, 48 per cent of NCD deaths and over 80 per cent of cardiovascular deaths.

In terms of the prevalence of cardiovascular disease in Trinidad and Tobago, cardiovascular disease is the number one cause of death in Trinidad and Tobago, physical inactivity, unhealthy diets, and obesity are fuelling what is described as a crisis of NCDs including hearth disease, stroke, diabetes in TT with heart disease as the leading cause of death.

PAHO says, T&T is one of the countries in the region with the most cases of arterial hypertension. It is reported that while the Caribbean has the highest rates of hypertension accounting for a quarter of the population, Trinidad and Tobago has an even higher hypertension number than the overall region. It is reported that the Caribbean has a 23 per cent rate of hypertension compared to 17.6 per cent overall, while Trinidad and Tobago, that number is 25.8 per cent, that follows from 29 per cent in men and 23.7 per cent in women.

In terms of cancer according to World Cancer Research Fund International there were approximately 18.1 million cancer cases globally in 2020. Globally, breast cancer and lung cancer were the most common cancers worldwide contributing to 15.5 per cent and 12.2 of the total number of new cases diagnosed in 2020. Colorectal cancer was the third most common with 1.9 million new cases in 2020 contributing to 10.7 per cent of cases.

And I think I will just end with a Caribbean perspective CARPHA. In a CARPHA report breast cancer is that main cause of cancer that is among Caribbean females accounting to 14 to 30 per cent, all deaths attributable to cancer.

So those statistics "kinda" paint, well not "kinda" but they do paint a startling reality that we must face in this country and hence this Committee has agreed to look at the efforts of the State in countering the effects of specific non-communicable diseases. We spoke, as I said before on diabetes, heart disease and cancer and what is working, what is not working and hopefully we will come up with some

recommendations to impact policy and operational issues to stymie this trend which is not going in the right direction. At this point I would like to invite the Permanent Secretary in the Ministry of Health, Mr. Asif Ali, to deliver opening remarks.

Mr. Ali: Thank you, Chairman. Good morning again, Chair, members of the Committee, CEOs of the RHA, my colleagues at the Ministry of Health and the viewing and listening public. At the risk of maybe repeating some of what you said, Mr. Chairman—

Mr. Chairman: Please repeat. People need to hear it.

Mr. Ali: So NCDs, non-communicable diseases, as you have said, they are a group of non-infectious diseases. They are not transmitted from person to person. You already mentioned the major NCDs, cardiovascular, heart attack, strokes, diabetes, chronic lung conditions and cancer. I need to emphasize that premature death from NCDs is largely preventable. I think that is an important point to make. You mentioned some of the risk factors that lead to NCDs and a lot of those risk factors are within our control as on an individual basis. You mentioned the food that we eat, the amount of physical activity that we engage in and other factors such as alcohol consumption and smoking.

At this point, I want to reaffirm the commitment of the Ministry of Health and the RHAs towards the provision of quality health care through initiatives geared specifically towards strengthening of primary health care which by extension looks at the prevention and the management and control of NCDs. At the Ministry what we are doing right now is we are doing a life-course approach in addressing the issue of NCDs. This holistic strategy focuses on promoting intergenerational health wellness and wellbeing throughout the various stages of an individual's life starting from birth and infancy straight through to adolescence, adulthood and then the elderly.

At the Ministry, we encourage everyone to join us as we work together to reduce the prevalence of NCDs nationally. While the Ministry continues to strengthen existing resources, we also encourage the nation and the population to join with us in making informed healthy lifestyle choices and this goes beyond simply the treatment of NCDs as we seek to implement sustainable measures that would help to prevent and detect the early onset of NCDs thereby maintaining the health of our population.

In this regard, Mr. Chairman and members, we hope that today's proceedings will allow the population to be better informed about NCDs and by extension contribute towards the prevention, management and control of these diseases. I thank you.

Mr. Chairman: Thank you, Mr. Ali. The first question is based on one of the data points that I called out earlier on. PAHO says that Trinidad and Tobago is one of the countries in the region with the most cases of arterial hypertension. It reported that the Caribbean has the highest rates of hypertension accounting for a quarter of the population, but Trinidad and Tobago has an even higher hypertension number than the overall region. It reported that while the Caribbean has a 23 per cent rate of hypertension compared to 17.6 per cent, that is just over a 6 six per cent difference, while T&T has a 25.8 per cent overall rating, 29 per cent in men and 23.7 per cent in women, why is Trinidad and Tobago's numbers trending in direction? Are there particular reasons that you can share with us? I know lifestyle choices, et cetera, but Trinidad and Tobago from my quick, cursory look probably invests more in medical health care than most of the Caribbean countries but our numbers are much higher suggesting there is some gap in objective, attaining the objectives. Why? What are the main reasons contributing to our overall rate being 25.8 compared to a 23 per cent rate for hypertension in the Caribbean?

Mr. Ali: Sure. Thank you, Chair. I will let Dr. Clapperton answer that. But just to make the point that you did mention spend in terms of in the health system and I did mention the point about treatment. So a lot of that spend currently is in terms of treatment, but at the Ministry, we are trying to focus more on prevention, as I said, so you will start to see a shift in that expenditure hopefully towards prevention. Because once you prevent and you reduce the severity and incidents of those diseases, treatment should correspondingly start to decrease. But I will let Dr. Clapperton—oh sorry, CMO will maybe jump in first. Thanks.

Dr. Parasram: Yeah. Just to start a little bit and then I will hand over to Dr. Clapperton. So every population in the Caribbean and the world is different in terms of the way it is made up, based on genetics, based on the food that we eat, based on our lifestyle, cultures are different. So to compare one country to a next is often times a little bit difficult when you look at it from a statistical perspective.

Having said that, our country has over many decades shown that hypertension which is more prominent in the Afro-Trinidadian, Afro-Caribbean population as we all know, tends to be higher than our Caribbean brothers and sisters. And contributing towards it, in my view after looking at the data, seems to be lifestyle more than anything else, hence the reason we are trying to shift, create a paradigm shift where we shift away from the disease model where we are treating the end result of hypertension. So we are treating the end result at this point which is cardiovascular disease, strokes and the lot of it, and we are trying to shift away and reinvigorate primary care on a whole.

So the focus at the Ministry of Health is now towards a wellness model and we really want to get that across to the public. To do that we need the cooperation of whole of government and whole of society. It is not a one Ministry thing. It is not a one—it has to be all Ministries, as Ministry of Agriculture, Land and Fisheries,

Ministry of National Security, for example, to create safe spaces for us and the Ministry of Sport and Community Development and many other Ministries, Ministry of Education because our children are what, I think, will drive change in the future. And this is not going to happen in one year or two years, it is something we will see over generations. But Dr. Clapperton can go a little—

Mr. Chairman: Well before you go to Dr. Clapperton, Dr. Parasram.

Dr. Parasram: Sure.

Mr. Chairman: I mean, part of the objective of our Committee is for the public to really get the message—

Dr. Parasram: Right.

Mr. Chairman: —and very often we use terms like lifestyle choices—

Dr. Parasram: Yeah.

Mr. Chairman:—that we need to break down because I really want the public to understand what we are talking about—

Dr. Parasram: In simple—

Mr. Chairman:—so that they can start to assimilate and process it.

Dr. Parasram: And we are talking about risk factors for these diseases, hypertension, diabetes, heart disease and the ones that we can do something about which we call modifiable risk factors. So diet, what you eat. Lifestyle, we talk about lifestyle choices. Lifestyle choices include diet but it has a lot to do with exercise, as well as, of course, stress levels as well could be considered a great factor in some instances the type of job that you do. So our focus was really on the modifiable risk factors. It includes tobacco use. It includes alcohol consumption as the main ones. When you talk about food, we are talking about fat consumption as well, triglycerides and certain types of fats, and our centre is really to go at each one. So we go at increasing exercise, we go at increasing water intake, increasing fruit and

vegetable intake, decreasing tobacco use. If we can get rid of it altogether in terms of use, decreasing alcohol consumption. So those are the five big ones, I think, that we want the public to partner with us and all of Government and society to get on board.

Mr. Chairman: I would ban tobacco but I will have fire and brimstone come down on my head.

Dr. Parasram: So we go towards—and that is why the TTMoves banner kicks in and you will hear from Dr. Clapperton and others as to how we have tried to create this sort of culture of behaviour change. And we have brought on to the Ministry a doctor who is assigned to UWI, works with UWI as a head of department in that field, behaviour science, but she is actually vetting our communication strategies so we will bring the behaviour-change component to all our corporate communication messages as they go out as well.

Mr. Chairman: Dr. Clapperton.

Dr. Clapperton: Thank you, Chair, and thank you, Dr. Parasram. To answer your question, Chair, just to add some more of a clinical perspective as to the nature of the illness that is hypertension. Hypertension or high blood pressure which is known more commonly as high blood pressure is as an illness that we can categorize as two forms. So there is primary hypertension and secondary hypertension. So in primary hypertension 90 per cent of the cases are due to primary hypertension or essential hypertension where there is no known cause. Right? The other 10 per cent are persons who would have secondary hypertension where there may be underlying medical conditions that would have contributed to them being predisposed to having an elevated blood pressure. That, once identified, can be managed and treated but 90 per cent of cases are persons who suffer from essential or primary hypertension where there is no known identifiable cause.

Specifically to our population if we look at risk factors that contribute to persons who have essential hypertension, you have what we call modifiable risk factors and then non-modifiable risk factors. So there are the things that we cannot change, and there are the things that we cannot do much about. The non-modifiable risk factors would be things like ethnicity and genetics as Dr. Parasram would have alluded to. And if you look at the make-up of our population, persons in the Afro population are at greater risks for hypertension. So looking at the make-up of our population we are already predisposed to and having these risk factors inherent that are non-modifiable. But what we can do something about would be the modifiable risk factors. So looking at our intake of salt in our dietary consumption, looking at our levels of physical activity, we can aim to increase levels of physical activity and reducing consumption of alcohol and the use of tobacco.

So we at the Ministry of Health, given the nature of the illness that is hypertension, we focus on modifiable risk factors in mitigating and reducing risk factors for hypertension in that way. So this is why a lot of the measures implemented would speak to encouraging members of the population to maintain their health and adopt a wellness approach towards health maintenance. And that is what the TTMoves banner would speak to, a movement for lifestyle change and encouraging members of the population to join with us to make these changes because as the name suggests, we can address the modifiable risk factors.

Mr. Chairman: Thank you. Member Nakhid you will follow up and then Member Mohit.

Mr. Nakhid: Okay.

Mr. Chairman: Your mike, Member. I think your mike is on.

Mr. Nakhid: Okay. Since you recognized so astutely that mostly our African population are targeted by hypertension, I know you do not drive policy but have

you informed the Ministry in the last how many years that there should be some public awareness programmes targeted towards those African populations that are affected? I have not seen any.

Mr. Ali: Sure. Chair, through you. So, member, as the CMO would have said, we have engaged a behaviour change consultant to assist us with our corporate communication, with our communication strategy in terms of looking at maybe doing some more targeted messaging. So we would have and both CMO and Dr. Clapperton spoke about the TTMoves banner and what it speaks about lifestyle change, exercise, healthy living, et cetera, eating, et cetera.

Mr. Nakhid: Sorry to interject. But that started this year.

Mr. Ali: Well, actually, no. It was relaunched this year. TTMoves has been around for the last—

Mr. Nakhid: 2019.

Mr. Ali: Yeah. Right. But I take your point and as the CMO said, we are looking at doing some more targeted messaging in terms of looking at those key populations and maybe modifying the messages to meet those populations. So that is something that we are actually actively looking at right now and doing that.

Mr. Chairman: All right. Thank you, member Mohit.

Ms. Mohit: Thank you, Mr. Chairman. I just want to look at the submissions a bit in terms of questioning, the National Steering Committee. In your submission it mentioned about the formation of a national NCD Steering Committee on April 18, 2023. What has the steering committee done since its implementation on April 18, 2023? And I want to go a little further, is the leadership of the Ministry—are you all pleased in terms of the performance of this committee thus far.

Mr. Ali: Thank you. I will let Dr. Clapperton speak to the work of the committee to date.

Dr. Clapperton: So thank you again to the Chair. So, the National NCD Steering Committee was formed on April 18, 2023 and this is a committee that has representation from members of the Ministry of Health and also non-governmental organizations. It has representation that is across the board and thus far the committee has discussed and proposed a communication strategy which is geared towards, again, behaviour change and this is as it relates to the non-communicable diseases. The communication strategy that was proposed and developed by this committee is currently being reviewed by our behaviour change specialist to further strengthen the approaches to this strategy.

In addition to this, thus far there has been additional sub formation of subcommittees off of this Committee to focus on additional key areas as we focus on the non-communicable diseases, one of which would be a subcommittee to focus on the WHO Acceleration Plan and this addresses the aspect of obesity which would speak to childhood and adulthood obesity measures. And the other subcommittee is to look at an evidenced-based approach to clinical practice management for non-communicable diseases.

Ms. Mohit: In terms of being pleased with the performance of the committee, I did not hear.

Dr. Clapperton: Yes. Well, in the short space of time in which the Committee was formed, I am pleased with the output of the Committee thus far.

Ms. Mohit: Mr. Chairman, an additional question. To those of you present, in terms of behavioural change and the Steering Committee, its goals and objectives and how you get the population to buy into it or those who face issues with these NCDs, in the public health system there is a long waiting list. It is outlined on page 23 of your report. So you have a long waiting list but you are trying to get persons to buy into behavioural change. How is the Ministry, in terms of all of your departments,

dealing with this issue? Because on one end you have a frustrated population listed who is waiting to see what is really wrong with me; how do I deal with what is wrong with me; how do I change my lifestyle? And then on one end you are preaching behavioural change. How are you dealing with this long waiting list?

Mr. Ali: Thank you, Chair. So, member, so you talked about two things there. One is screening. It is of persons knowing their status. And then the issue of treating with it if they do require linkage to care. What I will do, I will let the respective CEOs speak to what the RHAs are doing at that level because that is where the issue of service delivery really happens at the level of the RHAs. So, I will let the four RHAs maybe just talk about what they do—

Mr. Chairman: Thank you.

Mr. Ali:—in their respective RHAs.

10.45 am.

Mrs. Rampersad-Pierre: Thank you PS. In terms of the Eastern RHAs and all RHAs, strategies to address the issues that we are facing, and I will speak specific to Eastern, we have a very comprehensive primary care approach and it speaks to a lot of health education, and health promotion in order to ensure that the population take charges of their health. We have, at the Eastern RHA, several programmes that we execute through our school health team, our health education team, our community wellness groups, chronic disease support groups, and we are participating actively in all initiatives under the TT Moves banners, as well as to target our population in the Eastern RHA.

Mr. Chairman: Mr. Thomas.

Mr. Thomas: Well, I want to begin by saying that this ultimately affects the congestion in the emergency department, so we ultimately began there. We would have noted—so for example, if there are persons with chronic diseases, they

eventually, if it escalates to a point where they get very ill, they ultimately show up in the emergency department. The net effect is that we have inherent capacity at the emergency department, which is one of the reasons why we would have started there, certainly one of our initiatives, to target those persons who are recurring, what we call "revolving door patients", in the emergency department. So, if you show up in our emergency department at Eric Williams, primarily, more than once within one month, we show up at your house.

So, we basically have a programme called the In Touch programme, which is run by our liaison unit, and so from a social determinant of health, et cetera, so they go in, they verify, a doctor shows up with a nursing team and we verify what are the reasons. Usually they may not be taking their medication, you find a bag of medication in their houses, they are not taking it, they need consultations for—pharmaceutical consultations to remind them of the importance of taking the medication. So, we started there. However, we also engaged what we called the Walk The Talk programme, which was a primary care initiative where we engage churches, temples, and mosques in the communities, so on a Sunday or a Saturday, we would go and do preventative medicals for the entire congregation, and that is across the board. We are at so far 39,000 patients. So we are walking to your church, temple, or mosque, with a team of doctors and nurses and we do full preventable medicals for the entire congregation.

Mr. Chairman: But if I could just interject based on the question posed by Member Mohit, and I understand her question because a lot of the time while you may have the services of the hospital to deal and your stated intention is prevention, preventative medication as opposed to treating once the—becomes acute. When the population has a mindset that I am going to spend 10 hours, at the hospital awaiting treatment, the population is less likely to go to the hospital to identify there is a

problem to start with, to start treatment, and I think that is the question the Member is asking because then you have a problem of reluctance to seek medical attention to identify your problem before it is exacerbated. And while the issue is commendable that Mr. Thomas just identified, what are the stakeholders doing to deal with that issue of the long waiting time which is a public perception in the public health care system?

I will give you a practical example. I recently took a relative to Mount Hope Medical Sciences Complex. It was a hypertension issue, and the person was an elderly person. The intake was fantastic. Upon arriving there, within 15 minutes blood pressure was taken, general statistics were taken, and then somewhere around half an hour after that the initial information was taken. It took 10 hours to get following up treatment, 10 hours. So, the person was begging to go home. Take me home, and now there is going to be a reluctance because of that if there is an incident again. What are the systems being put in place to reduce this waiting time, to change the perception, so when people walk into the hospital, before they get there they feel I am going to be attended to in a timely manner, because that is part of the perception of the public.

Mr. Thomas: Okay, so I would prefer to use cardiology. So for example, we have high incidents of cardiology patients. What we have started doing for example, is we have disrupted the intake, that is to say, normally we will get a number of patients who come from the primary care. We have trained our PCP tools within the communities, so I just want for you to imagine that the cardiology clinic will be filled with a mix of patients. Some of those patients, one group of those patients are patients from the health centres, would receive a card throughout Trinidad and Tobago that says "chest pains", they coming into the cardiology clinic to be seen.

What we have done is we segregated those patients, so of the volume of

patients that normally show up into the cardiology mix of patients, we have segregated those and we are seeing those separately. There is another mix of patients who we have identified those patients, as patients who are chronic patients, who return over and over, simply to get their prescriptions and so on filled, we have segregated those patients. There is another category of patients that basically that would have had heart attacks and basically require to have what we call rehabilitation, we segregate [*Interruption*]—

Mr. Chairman: Is all this resulting in shorter waiting times?

Mr. Thomas:—Yes. So, what is effectively done is that we are building the capacity now to be seen in smaller groups of patients with sooner appointments for cardiology, and that is one of the examples. So, it is something where we have engaged successfully and we are expanding.

Mr. Chairman: So, do you acknowledge Mr. Thomas, and stakeholders, that there is a problem with waiting time at some institutions?

Mr. Thomas: Absolutely, and so for example, and I think this one is key, we have trained what we called our PCP tools in the communities so that a number of those patients who normally would come to secondary care or Eric Williams, now can be seen in the periphery. We have started a pilot with Dr. Cummings, that had been running, and now we have seen in the text, expand the training further outward to all heath centres. That training started three weeks ago. So, basically when that training is completed we will be able to devolve a lot of those patients who normally come into the centre. The reason for the wait is the sheer numbers of the persons who attend clinic on a monthly and daily bases.

Mr. Chairman: Member Mohit.

Ms. Mohit: Mr. Chairman, before we move on, can we be provided in this Committee with, let us look at cardiology in terms of angiograms. What is the

waiting list like for angiograms at the different RHAs, or if you can give an accumulated figure across the board?

Mr. Ali: Chair through you, can we provide that in writing for the Member?

Ms. Mohit: If you can put in writing, sure. Mr. Chairman, if I can move on to my second question?

Mr. Chairman: Yes, yes, you can.

Ms. Mohit: I am looking at the Wellness Festivals, the introduction of Wellness Festivals. Considering prevention strategies, the submission stated that Health & Wellness Festivals are scheduled to be held by each regional health authority. The first Health & Wellness Festival, was hosted by SWRHA on August 26th of this year? Can you provide some information for us as it relates the turn out for this initial event, and in addition, based on the first Health & Wellness Festival that was hosted by SWRHA, can you determine what can be improved or in terms of giving us that information for the upcoming festivals of the other RHAs?

Mr. Ali: Thank you Chair. So I will let CEO of South West give the feedback in terms of that first initial festival, and Member, we have actually held two others subsequently. We have had one at North West, and one at Eastern. So I will let those CEOs also maybe give a little feedback in terms of what occurred at those festivals. So we will start with South West.

Ms. Mohit: Sure.

Mr. Armour: Okay, thank you Chair. For the South West Regional Health Authority, we would have conducted it on the 26th of August, from 8.30 a.m. to about 2.00 p.m. We would have seen from our data about 575 persons accessing services within that relatively narrow window period, and that the Health & Wellness Festival, there were a lot of successes in our view where we really collaborated based on the programme design, as directed by the Ministry of Health, with input from all

the RHAs, because we want to have universal access when the other RHAs came on after South West, was to focus not only on a health fair which is the typical norm, but a wellness festival. All age groups were targeted from children to elderly.

All facets of the health care spectrum in terms of screenings, and mental health, and stuff were arranged and also too, we partnered with a lot of groups whether there be other states agencies, or other non-governmental organizations, offering what we would like to call other determinants of health, social determinants of health. So, we had the public health inspectorate. We had Arrive Alive. We had the typical screening entities. We had culinary groups that would show ways to prepare healthy food. We had mental health as a focus. We had blood donations as a focus, and really we had also too embracing the culture of Trinidad and Tobago, where it was done in a sort of convivial atmosphere with live music, media houses covering the event and generally an ambiance where you see simply, it is almost like you are walking in like a street fair and you basically attend the different booths. And the staff manning the booths are able to give you advice, health promotion, and health education and you could walk with your entire family. We had bouncy castles and all of that.

So, that sought of model is what we want to encourage the population to have a positive view towards health, and a positive health-seeking behaviour, and then even there, persons who were screened, and had abnormal readings, there is the linkage to care concept where we are able to refer you back to our regular mainstream services in the following week in order to get follow-ups. So, that it is a good entry point to encourage persons that health is not something to be afraid of if you have risk factors whether in your family history, get to know numbers and therefore, the systems can send you to the areas of care that are required. So, that is what was designed and we would have considered it a success and then the other

RHAs replicated it thus far.

10.55 a.m.

Ms. Mohit: In terms of improvement?

Mr. Armour: Improvement for us, well it was logistics. The venue was from 8.00 a.m. to 2.00 p.m. We would have liked it to be longer for the entire day, but at the time of the year a lot of venues were competing. Remember this is also post-COVID as well, so a lot of venues are getting back to their regular business and therefore anytime from August to December it is a bit competitive, at least for the South-West Regional Health Authority with the venues that have that space and calibre, and weather permitting as well, so we had some indoor areas and outdoor areas. But apart from that we found that the patronage was very good and we actually had persons outside the outhest catchment come into South West Regional Health Authority to avail our services, and I believe other RHAs would have that same experience, so the universal access concept was a plus for us.

Mr. Chairman: Just before Member Mohit continues, I neglected to allow the other two RHAs to give a report on the issue we raised earlier on with waiting times heading into the emergency room and other services being offered.

Dr. Armour: Okay. So with respect to wait times, yes there can be challenging emergency departments, so in terms of the health-seeking behaviour concept, which is what South West is mindful of, our health centres provide health education, health promotion. There are walk-in services at the health centres as well as scheduled appointment services.

Generally, once persons are well-managed, once they manage their chronic diseases with their family support and their own individual education support, generally persons have a seamless experience at the level of the health centres. It is for those sub cohorts of persons that are poorly controlled that either have frequent

repeat visits or that they do not seek health care, the natural history of disease may let them land up in the emergency department with a critical illness. And in the emergency department there is a triage system, if you are life threatening, motor vehicle accidents, a life or limb threatening injury, severe heart attack or stroke you are attended to really within minutes, seconds to minutes. You find that the concept of wait time are persons who are not that critically ill, what we will call Level III, those are persons who are alert and ambulant but they do have ailments that would require them to be warded.

As you have said Chair, the triage time is generally quick and efficient, the South West experience averages 10 minutes. You do then start to get lengthening of times when you have to do the necessary tests whether they be blood tests or whether they be imaging tests to really get a diagnosis before admitting to the ward. Average times are about four to six hours on average, areas for continual process improvement involve communicating with the patient, let them know this is the step you are at present, this is the next step that you need to go to, and also give caregiver support. So that occurs. The average length of stay in the hospital is generally about four to five days for most conditions, and therefore the other wait that perception of persons have is when you are discharged and you have to go to specialist outpatient clinics. At specialist outpatient clinics there is a demand for services, more specialized tests follow up, definitive corrective procedures, but in the context of the discussion today, we do not want the population to reach to that end of the spectrum. The first end of the spectrum is that we have health centres. South West has 31, from Icacos to Freeport, from Tabaquite to Moruga, accessible, as well as you have district facilities that also have primary care.

One final thing I would like to mention before I hand over to my colleague is that even in the emergency department, because, yes, we would say that all those

areas you do not have wait times except possibly in the ED. What we have found in the ED is that on average about one-third of persons who come even with chronic disease they are not going to be admitted to the ward. It is better that they would have sought help, seeking behaviour at the health centres, and what we do is then even in the emergency department there is a system where when we refer you, before you leave you actually get to see a doctor who actually tells you that, yes, your ailment could be treated at home, you do not need to be admitted, but these are the health centres that are closer to you and that you can get the requisite service there and follow-ups. So, we do recognize that the advertising, or not much advertising but letting populations know of where you can access health services in the primary care is still a process improvement, and the Ministry has spoken about the behaviour change communication in that regard, to raise public awareness. So that has been the experience of South West to date. Thanks.

Mr. Chairman: Is there one more person?

Mr. Blake: Thanks, Chair. So the context in North West Regional Health Authority is unique and we have special challenges. Not to reiterate what my colleagues would have said in terms of triage times, needing to improve primary care and so on, North West challenge has been, after the earthquake we moved from approximately 500-odd beds to approximately 110/120 beds at the Port of Spain General Hospital now, which is our major Accident and Emergency entry facility. So you are looking at bed space to be able to move persons from out of Accident and Emergency onto the wards, and you are looking at moving, having almost a 300 per cent reduction in your bed capacity at the hospital. It means that persons stay longer in the Accident and Emergency because we now have to actually discharge persons to be able to get a bed. We are almost at a 100 per cent capacity at Port of Spain General Hospital—

Mr. Chairman: How is that impacting the quality of health care?

Mr. Blake: Say again?

Mr. Chairman: How is that impacting the quality of health care?

Mr. Blake: Well, honestly, honestly, Chair, it would have impacted adversely, but I would like to speak about some of the measures that we have put in place.

Mr. Chairman: What are the elements of adverse impact that you can share with us?

Mr. Blake: Well, waiting times, obviously, for patients. Patients will have to stay in the Accident and Emergency for extended times on trolleys and so on, when in the past they would have been admitted in a timely fashion to the wards. But one of the things we have done is to open a 60-bed facility at the St. James Medical Complex that we use as a—what I would call a spill-over facility for Port of Spain General Hospital to assist with that capacity challenge that we have now. We have gone on a programme also of what we call "Revitalization of Primary Care", and you would have heard my colleague speak about the fact that we have a triage system, and if we improve the quality of the offering at primary care many less or much less persons would actually come to the A&E in that regard.

Mr. Chairman: I know you are data driven—

Mr. Blake: "Hm mm".

Mr. Chairman:—you have said there was a 300 per cent reduction in the bed capacity which resulted in patients seeking care, spending time on trolleys in corridors, et cetera?

Mr. Thomas: Yes.

Mr. Chairman: We have heard those reports. How much has that impacted mortality rates with people seeking treatment, because I am presuming 300 per cent is a lot? There would be some of those patients who may need critical urgent care and they are in a corridor when normally they would have been triaged into a more

appropriate care scenario. How much has that impacted mortality rates, if you can share that data with us, if at all?

Dr. Parasram: So, Chair, before CEO continues, just to give you a picture of what was happening. So when we lost those beds inherently the system caters for itself to some extent, so what happens is the closest, the next closest point of call is Eric Williams, so you would find that the patients that cannot be seen at Port of Spain will go to Eric Williams. There is an existing relationship between the directors of health, between two institutions, so that if they get to that critical point the PMOI gets involved as well. There is shuttling of people between the A&E in Eric Williams as well as Port of Spain General to ensure that that does not happen. St. James has an A&E as well, Arima General Hospital post COVID is now getting to its full complement of staff, and their services are picking up as well. So, even within Eric Williams and CEO for North Central could speak a little bit more to it. They have begun to declutter Eric Williams, so there is a knock on, Port of Spain, Eric Williams and then Arima. So Eric Williams' patients who are stable patients, stable medical patients are now going across to Arima.

Mr. Chairman: So are you saying it has not impacted patient mortality?

Dr. Parasram: I did not say that—well, in terms of mortality, in terms of patient flow and wait, that is how we have aimed to deal with it. In terms of saying with data to back it up I cannot say either way, it has to be a case-to-case to say whether it has impacted mortality or not.

Mr. Chairman: And those kinds of analyses are not commonplace?

Dr. Parasram: In terms of the CETA system, the way—and Dr. Armour would have begun to describe it. CETA system deals with the most critically ill person, and we deal with those that are type, what we class as Class 1 and Class 2, those are imminent risk of death. Those will be taken care of immediately. Class 3 and 4 can

be seen at the district health facilities as well, which St. James has one, and other DHS, and stabilized, and then dealt with at home and sometimes warded later on. So we avoid mortality in that way.

Mr. Chairman: All right. Member Monroe.

Mr. Monroe: Thank you very much, Chairman. And I must start off by saying thank you very much to the team from Ministry of Health for making yourselves available this morning to answer questions of this Committee. Let me start off by asking, in your submission you would have mentioned TT Moves Behaviour Change Campaign. I want to find out this morning what the status of this campaign is and would you say that the campaign or the Ministry of Health is achieving the results desired or expected from this campaign?

Dr. Clapperton: Good morning, Chair, Member, thank you for the question. So the TT Moves campaign is currently in a process where it is being reenergized from the first instance in which it was launched. We have added the new tag line, "A movement for lifestyle change". And, yes, we are catering to encourage members of the public to change their behaviour, make healthy choices in terms of their dietary measures, and to move more. But we must recognize that these changes will not come overnight and it is a challenge that we will all face. But as best as we can under the umbrella of TT Moves we can continue to encourage persons to move them along the stages of change.

We do recognize that persons within the population would be at various levels, those who would have already made some changes, those who are contemplating making these changes, and we try to make the behaviour change, or TT Moves campaign as broad as possible to cater for persons who are at the various levels in their stages of change, and we also try our best to make it as simple as possible. So, currently under the banner of TT Moves there are three things that we have started

to drive home in terms of the messaging. So we encourage members of the population to increase their daily intake of water, to increase their daily consumption of fruits and vegetables, and to encourage them to increase their levels of daily physical activity. And I dare say we would like to add a fourth soon, which is to know your numbers, because we do recognize that a number of the NCD risk factors, in particular hypertension, are asymptomatic, and we have a lot of persons walking around not knowing what their blood pressures, not knowing what their cholesterol numbers are.

And under, again, the banner of TT Moves these TT Moves Health & Wellness Festivals are opportunities which we provide access to care in the community for persons to have that linkage to care and have screening of their blood pressures, their cholesterol numbers, you know, and be more familiar with their health numbers. So TT Moves is currently being reenergized in this way, and we look forward to the support of all members of the population as we encourage everyone to move their wellness journey forward.

Dr. Parasram: Just in terms of the measurements: So you would have noted in our submission that we would have provided data from steps of 2011, there would have been a global youth survey as well. I think it is 2015. We are going to repeat the STEPS survey, which is the broadest—it is a PAHO coined term, STEPSs, and it is the broadest type of survey to do from a health perspective. So that is going to be repeated. We hope to complete it within fiscal '23/'24, that period of time, and it will give us a very good idea of what has changed between 2011 and present in terms of the demographic of the patients, hypertension, diabetes eating habits. In addition to it, we are doing a food consumption survey with partnership from various stakeholders including the UWI and PAHO. That is, again, due to be completed in the third or fourth quarter of calendar 2024, and those will give us very good

indicators as to the successes of various initiatives that would have occurred over the past 10 or 12 years, thereabouts.

Mr. Monroe: Thank you. My following question is based on some information that was made available by you all here this morning. Given the importance of managing NCDs nationally I would like to know, is the Ministry of Health targeting or monitoring our kids at schools, and if no, would this be considered to shape the lifestyle trends at an early stage in our young men and women's lives?

Dr. Clapperton: Thank you again for the question. So with respect to the Ministry of Health's approach to addressing the issue of non-communicable diseases, we are taking a life-course approach to addressing the issue of non-communicable diseases, and this begins in pregnancy in utero, also with breastfeeding initiatives. Dr. Sirjusingh could speak further on these initiatives moving forward. And as it relates to children and adolescents, there have been several initiatives as well where exercise equipment was purchased and placed in primary and secondary schools. There is also the implemented ban on sale of sugar sweetened beverages in schools in 2017. So there have been several initiatives in the past that directly target children and adolescent populations and there would be more in the pipeline to come.

Dr. Sirjusingh: My portfolio would be related to the care of women in pregnancy as well as the newborn period, our children. So we have a very innovative out-of-the-box sort of approach to this NCD problem that we are experiencing. We are actually trying to prevent NCDs before you are even conceived, so that is a novel approach. We are actually targeting our chronic disease patients, for example, our potentially pregnant populace, our reproductive women, to ensure that they seek healthy behaviours and they enter pregnancy well to prevent some of the issues that may develop during pregnancy. So that is the pre-conception part.

So, for example, if you are in the chronic disease clinic and you have diabetes

from birth—we have patients like this—or you have a chronic disease, Type 2 Diabetes, or hypertension, we want you to be well-controlled before you get pregnant. But then since 2018 we had a policy change at the Ministry of Health where we introduced clinical guidelines for the first time to manage diabetes in pregnancy as well as high blood pressure. But this novel project included having a standardized approach to how we cared for these patients who developed diabetes in pregnancy. What we did was we screened, and from now since 2018 onwards, we screened every single patient who attend our clinic, both in public and private, for diabetes which was not done before. This is diabetes in pregnancy.

So we pick up patients who may develop diabetes in pregnancy for the first time or those who may come into pregnancy not knowing they have diabetes. We take special care with standardized protocols and so on. We provide glucometers for these patients. We give them consumables. They take home those glucometers and can continue to use them after pregnancy. By taking care of these patients during pregnancy we can actually make them have lifestyle changes that will prevent diabetes both for the mother in the long term, because they have a 50 per cent chance of developing diabetes, and the infants, also we are going to reduce the chance of that infant developing that diabetes in the future.

Just to add on, we created the breastfeeding team at the Ministry of Health. In the year 2018 we have formed for the first time the National BreastFeeding Coordinating Unit. We created policies for the first time, and we are really doing a lot of work on breast feeding because that, if we encourage our population to breastfeed exclusively for the first six months that is also goings to reduce diabetes in these mothers as well as those children in the future. We may not be around to see all these benefits. That is a long-lead project, but this is going to make a dramatic reduction in the years to come. That is just some of the work that we are doing.

Mr. Monroe: Okay, thank you. My next question is, your submission stated that:

> The key area for Gestational Diabetes Management Programme was to provide at home blood glucose monitors to three thousand expectant mothers, and 218 would be used in antenatal clinics at various health clinics at our various health facilities.

Can you confirm whether those were received?

Dr. Sirjusingh: Yes. And that is part of this larger project. It was an IDB-funded project where we engaged consultants from the Helen Bhagwansingh Diabetes Education Research and Prevention Institute foundation, DERPI for short, and with this project, with an IDB loan, we had different elements of this programme which involved training health care workers, training our patients as well as providing these glucometers. So we have so far procured 3,000-plus glucometers, and all of the glucometers have been distributed to all of the health centres, all our antenatal clinics, and we are still in the phase of distributing the glucometers.

So we actually have another system, which is the Perinatal Information System, where we have over 40,000 patients now entered in that database which provides research and other data. From that, we have found that at this time approximately one in nine to one in 10 of our patients in pregnancy are diagnosed with diabetes in pregnancy. So we are in the process of distributing the glucometers. So that is a long project that is probably going to be happening over the next couple of years. We have enough glucometers for that group of patients.

Mr. Chairman: Is it that you also provide the testing strips along with them and they have replacement options?

Dr. Sirjusingh: Absolutely. So we provide enough testing strips, we have all of that catered for in the project with M&E built in as well. So in time you will have the data to supply with the outputs of this.

Mr. Monroe: Thank you. Also I saw stated in your submissions:

> Physical activity equipment has been procured and delivered to schools throughout Trinidad and Tobago.

Please provide further information as to the type of physical activity equipment which were delivered. And could you also consider the outstanding equipment to be delivered to special needs schools? Please indicate when this will be delivered. Thank you.

Mr. Ali: I do not have the specific equipment with me. I can provide that in writing to you Member. With regard to the special-needs schools, we expect to complete deliveries of the outstanding equipment during the second quarter of calendar 2024.

Mr. Chairman: Just as a—you may or may not have and you can supply if you do not have in writing, but this submission that:

> Physical activity equipment have been procured and delivered to schools.

How widespread was that delivery? What schools were involved? If you have the cost of that equipment? When can the full complement of equipment be expected to be delivered?

Mr. Ali: Sure, Chair. So the amount that we have spent on the school equipment is TT $27.9 million. The number of schools that we have targeted, 623 schools; we have delivered to 611 schools so far, that is broken down among 479 primary schools, 134 secondary schools. Yeah, I do not have the specific equipment but we can send that in writing.

Mr. Chairman: And those schools were primary and secondary, they there are special-Ed teachers assigned to supervise the use of this equipment, is it that kind of equipment?

Mr. Ali: I think most schools have a physical education component, so it would fall under that area.

Mr. Chairman: And is there a maintenance programme for this equipment, because you know we love not to maintain in this country?

Mr. Ali: So I think the Ministry of Education may be best placed to answer in terms of that. So what we would have done at the Ministry, through the IDB loan, we would have purchased the equipment in partnership and in consultation with the Ministry of Education, provide the equipment to the schools through Ministry of Education. They would then from there, take it over in terms the programmes and the maintenance. Obviously in terms of the programme if they require any sort of technical support from the Ministry we are obviously providing that support.

Mr. Chairman: Just before I go—

Mr. Ali: Thank you.

Mr. Chairman: Just before we go to Member Nakhid, in terms of the TT Moves Behaviour Change Campaign Member Nakhid would have indicated that it started in 2019 and probably would have had to stop due to COVID lockdowns, would that be correct?

Mr. Ali: Well it slowed down.

Mr. Chairman: It slowed down?

Mr. Ali: Yes.

Mr. Chairman: Have you been and how do you intend to continue measuring the impact of that?

Mr. Ali: CMO would have mentioned the STEPS survey, and that is one of the ways we had measured the impact of TT Moves campaign. I think both Dr. Sirjusingh and Dr. Clapperton also said that this sort of change is not an overnight change in terms of looking at persons' lifestyles and the held outcomes. That is literally years in the making. So in terms of looking at the ultimate impact, that is something that is done over the course of years to see**.**

Chairman: More longitudinal [*Inaudible*

Mr. Ali: Yeah. Yeah.

Mr. Chairman: Member Nakhid go ahead, please. Thank you.

Mr. Nakhid: Chair, before we go on to the screening and clinical management part I just have a standing question for Mr. Davlin Thomas. You mentioned something that sounded quite commendable about if there was chronic—people coming to the health centres on a regular basis, after the second visit you would realize it is something chronic you would go visit them? You have any verifiable data related to that?

Mr. Thomas: Oh yes we do. In fact so far we have seen over 3,000 persons.

Mr. Chairman: Over what time period? Over what time period?

Mr. Thomas: This is just as at January 2023; 3,400. So it is more now.

Mr. Nakhid: It is more?

Mr. Thomas: Yeah.

Mr. Nakhid: Okay. Chair, can we get that?

Mr. Chairman: Can you provide in writing the data on that please, I would appreciate it. Thank you. Go ahead Member Nakhid.

Mr. Nakhid: Your health initiative for men was launched, according to your submission, July 8th and 9th, 2023. Will this be an annual endeavour?

Dr. Clapperton: Thank you for the question. So the health initiative for men was launched and held over the weekend of July 8th and 9th 2023. It was a collaborative effort between the Ministry of Health and all Regional Health Authorities. We did have and we are encouraged by the overwhelming response because within that weekend we had over 4,000 men turning out and getting screened, and as you know prostate is one of the leading causes of mortality for men so we are very heartened and encouraged, and we do hope to continue these efforts annually.

Mr. Nakhid: We go on to the Tobacco Control and Regulation: Your submission mentions the full implementation and graphic health warning pictures in September 2022 on the packaging and labelling of all tobacco products to deter tobacco use. Can you determine whether this implementation had any impact on tobacco usage?

Mr. Ali: Thank you Member. I do not think we have gotten any empirical data in terms of to determine exactly how much of an impact it has had in terms of tobacco usage, so the answer to the question, no, I do not have that specific data at this point.

Dr. Parasram: But again, the STEPS study has a full component that is detailed for tobacco use in terms of new users, age groups and all of that, so once we have that data we can provide it later on as well. Empirically, the manager of Tobacco Control, the graphic warnings were really to deter people from even starting in the first instance. Persons who are already addicted, and we know tobacco to be one of the most addictive substances utilized. It is extremely difficult to stop and it usually requires transitional models of change and clinicians-led interventions. But the graphic warnings hopefully with time will dissuade new users from actually taking that first use, to appeal to the population.

Mr. Chairman: Has the Ministry considered liaising with the Ministry of Trade and Industry to determine if or in the absence of this data? Because, I mean, it is one thing to initiate a graphic warning campaign to deter people from tobacco use but it is something else to actually get the data to see if the campaign is working, and one of the ways we will find out if it is working is if people would be importing a product that is not being bought. So is there any collaboration with the Ministry of Trade and Industry to see if there is a reduction in the importation of tobacco products, or any data that could suggest that tobacco products are being used more or less in the country, because to me that is when you realize if the campaign is working or not in the absence of that, which is shooting at the stars?

Mr. Ali: So that is something that we could definitely speak to Ministry of Trade and Industry about, Chair. That is a suggestion that we would definitely follow up on.

Mr. Chairman: Is there any data regarding the use of tobacco in teenagers, because that is the main target by many tobacco companies? If you hook them young you have them for life. I have a gripe about tobacco, so you will excuse me.

Dr. Parasram: We would have provided some data to the Committee on tobacco use, I am just trying to locate it, if I can find it, sorry.

Mr. Chairman: Go ahead Member Nakhid, while they are seeking.

Dr. Parasram: Right. So I think the question was, can you advise the Committee on the current trends in tobacco usage in Trinidad and Tobago? According to a 2017 WHO Global Youth Tobacco survey for Trinidad and Tobago, results for tobacco use indicated 14 per cent of students, 17.3 per cent of boys and 10.8 per cent of girls used tobacco products; 11 per cent of students, 13.6 per cent of boys and 8.6 per cent of girls smoked tobacco; 6.7 per cent of students which equates to 8.6 per cent of boys, 4.9 per cent of girls smoked cigarettes; and 4.1 per cent of students, 5.0 per cent boys and 3.2 per cent girls smoked less tobacco, in the submission on page 18 of 20.

11.25 p.m.

Well, I would like to address what I consider and I heard the Chairman allude to it—I do not know if it was in JSC or in the Senate, the problem of alcohol. We focus on tobacco, but alcohol is—I mean it is unbelievable the consumption in Trinidad and Tobago and the effects that it has on communities. I would like you all to address that, as you are talking about tobacco. The alcohol usage, and the advertising of alcohol within certain communities in Trinidad and Tobago, especially the East-West corridor, in Tunapuna, St. Joseph, Champs Fleurs,

Laventille, Morvant, you see these massive billboards that we do not see in Bayshore and Goodwood Park and other communities. Why is that, and is there any attempt by be the Ministry of Health to circumvention or to stop that completely? Because I see it as unfair to the residents of those communities where they have those massive billboards of alcohol in especially poor and disadvantaged communities. Why is that?

Mr. Ali: Thank you, Chair. So Member in terms of the work that the Ministry is doing with regard to alcohol consumption, there is a unit within the Ministry of Health, NADAPP, National Alcohol and Drug Abuse Prevention Programme. So NADAPP works with various stakeholders in terms of various addictions, alcohol being one of them, in terms of how can we prevent alcohol abuse and consumption, so NADAPP is that agency within the Ministry that looks that particular area.

Mr. Nakhid: Okay, I understand. I do not want to stay on that point, but I am talking about how alcohol is sold and advertised within certain communities within the country. Has the Ministry of Health addressed that?

Dr. Parasram: Yes, we will certainly take it on board, I will discuss it with NADAPP and we will see. It sounds to me that there may be some need for legislation to deal with that in terms of advertisement and certainly on the softer side, some consultations with the person that advertise the alcohol for sale in those particular instances. So I will bring it to the attention of the NADAP's coordinator and with will treat with it.

Mr. Nakhid: Thank you. Considering the sensitization sessions that where conducted with 70 sellers of tobacco products in over five countries on the requirements of the legislation, illicit tobacco trade and the effects of smoking on the health and well-being of the population, can you determining the impact the sensitization sessions had on the communities where they were held? From your

submission, page 52.

Mr. Ali: Sorry Chair, through you—

Mr. Nakhid: Page 5.

Mr. Ali: Page 5. Member what is the question again, just remind me please?

Mr. Nakhid: Pardon?

Mr. Ali: The question—.

Mr. Nakhid: Can you determine the impact the sensitization sessions had on the communities where they were held? They were conducted in five different countries.

Mr. Chairman: So the consultations with the 70 sellers of tobacco products that you would have provided in the information and in these five countries, on the requirements of legislation, were there consultations and discussions on that in terms of the trade in tobacco products and the impact of smoking on the health and well-being of the population specific to Trinidad and Tobago? Would you have had information on that?

Mr. Ali: Sure, so I will get that information for you Member through the Chair from our manager of tobacco, but this would have spoken specifically as it says to the sellers of tobacco as opposed to the consumers. This is where when we were developing the graphic warnings and fully rolling out the legislation, we would have sought to engage the sellers so that they are aware of what is coming to sensitize them to what the Ministry has been doing. Alright? But, I will get that data in terms of the [*Inaudible*].

Mr. Chairman: So this—hold on to that—is it that the Ministry's Committee on this is focusing on possibly amending legislation to deal with tobacco packaging and tobacco advertising et cetera with a view to reducing the use even more, or targeting of certain populations. Is that the intention of this?

Mr. Ali: Well, I think it would be premature to—[*Interruption*]

Dr. Parasram: Well if I may be—the sensitization sessions were post the graphic warning coming into being. The manager would have done sensitization sessions with the sellers to ensure that they are aware of the legislation and they knew the penalties therein so that they could abide by it. And then when we did the monitor and evaluation thereafter—because they have inspectors in that unit that go out to all to sellers, they go out to the retail outlets, wholesale outlets to do inspections to ensure that they comply. They wanted to go upfront to them and tell them look, this is the legislation, it is new, so everybody is aware and we are all on the same page. So when we do the enforcement exercises you cannot say that you did not know upfront. So that was the purpose of it. The other counties were supposed to be conducted shortly thereafter.

Mr. Chairman: Thank you. You have established stress clinics at the North Regional Authority, your submission page 6 Q (ii), is there a particular premise that you decided to establish this stress clinic?

Mr. Thomas: Chair, through you, it is a stress relief centre. So the overarching premise came out of discussions with Prof. Hutchinson who is the head of our psychiatry and psychology department. Certainly, there was the issue of stigma for mental health engagements, and so we were careful to design an interface that absolved the person as much as we could who approached these clinics of the ubiquitous stigma that exist within Trinidad and Tobago and certainly the world.

So basically, after careful consideration we have decided to call it a stress relief centre. On the first prototype we noted that on the first day—and advertised indicating to the public that basically if you are engaging stress you can walk into the centre. On the first day we had over 200 persons and quickly understood that we needed not only to expand the inherent capacity at the centre, but to also to expand

the distribution. So that is to say that we are now the St. Joseph, we are now at—

Mr. Chairman: Now I commend you for that, and upon the recommendation of Prof. Hutchinson who is well known in the field of psychiatry, but this is a question to PS, the CMO and Dr. Clapperton. We are talking about NCDs and the prevalence and interventions for NCDs and it is scientific information, you can correct me if I am wrong, that high stress levels will make someone more vulnerable to specific diseases or exacerbate the effects of diseases they may have, is that correct? Has there been an assessment done? Because Mr. Thomas indicated that they had created a stress relief centre, which means there must have been some information that would have indicated that we have a stress issue in the country. We are not absent of stress, but are there inordinate amounts of stress in the country that is also impacting the health of people and the impact of non-communicable diseases. Can you all comment on that, is there an assessment done on stress-levels in people that maybe impacted their health in the country?

Dr. Clapperton: Thank you, Chair. So in terms of documentation or an official assessment, I will not be able to speak to that at this point of time. However, research done outside of Trinidad and Tobago would have spoken to a relationship between the non-communicable diseases and mental health and this could be in both directions as you would have mentioned previously. So persons who have anxiety or stress-related disorders and depression would be at greater risk for developing a non-communicable disease, and similar to this, persons who are diagnosed with a non-communicable disease, for example, diabetes, are at greater risk for developing mental health issues like depression later on.

11.35 a.m.

So there is—we are aware that there is a relationship that exists between the non-communicable diseases and mental health and this is why at the Ministry of

Health in our approach to addressing the issue of non-communicable diseases, we do recognize mental health as a non-communicable disease. So our directorate of mental health would have taken the lead on, you know, projects related to this in terms of addressing issues of mental health.

Mr. Chairman: So it may not be specifically related to measuring stress levels but certainly the impact on mental health and physical health as a whole, as a holistic approach?

Dr. Clapperton: A holistic approach.

Dr. Parasram: Yeah, but just for clarity in terms of stress. Stress is a loose term, right. What we measure is we will measure your blood pressure, for example, one of the things when we do the consultation with that individual who has elevated blood pressure will be taking a history. So we take the history to find out what would be the causes, could be family history, as she said, non-modifiable, it could be excessive salt intake, could be stress related. We know about the type A personality that exists. So it is not a defined term in terms of what you measure. If somebody is stressed and all your parameters are normal, your blood tests are normal, your blood pressure is normal, sugars are normal, then it is not necessarily a concern because you are not going to get the complications down the road but certainly if somebody is having high blood pressure, having elevated sugars, and stress is a major factor that is contributing, then in terms of the clinical pathway that we deal with it, we have to deal with stress. If we do not deal with it and we put you on four or five different tablets to try to deal with it, nothing is going to change. So we have to deal with the causes and that is what prevention is. So we deal with the causes first and then we deal with the symptoms.

Mr. Chairman: Thank you. Just changing gears now. Your submission mentioned the number of persons who have been screened and diagnosed with the NCDs we

are focused on today: cancer, diabetes and cardiovascular diseases over the past five years could not be readily available due to the lack of an electronic health record, I guess system, to the track one patient per record throughout the public health care system. I remember the Minister of Health during the COVID-19 pandemic announcing a digitization of patient records and the ease with which the then COVID-19 vaccination cards will be made available. Could you give us a status update on that digitization of patient records in the country and similar circumstances and similar surrounding issues?

Mr. Ali: Sure. Thank you, Chairman. Just to go back a bit to the issue of the COVID-19 vaccination cards, so that was a specific system for vaccine management. So what you are speaking about is beyond, broader than that. It is actually a patient electronic health record which would include vaccination and patient visits, clinical history, et cetera. Where we are at with that at a Ministry level, we are currently in the evaluation process for a health information system for the ERHA, that is for the entire RHA with the intention being subsequently afterwards to look at rolling out nationally. What is happening in the interim is that each RHA has some element of an HIS and by extension, an electronic health record for their patients to varying degrees of completeness in terms of how much is actually captured on that health record.

The intention is ideally as I said, once we have the ERHA tender completed and we roll out, we would then have an electronic health record not just for one RHA but it is a national record. So if you are a patient in the ERHA and you visit San Fernando, for example, on a weekend and you have to access the health facility there, the record will be accessible anywhere in the country. That is the ultimate objective. As I said where we are right now completing the evaluation for the system at the ERHA and the other three RHAs and, yeah, Eastern to a lesser extent already have

some element of a health record.

Mr. Chairman: Correct me if I am wrong, it does not sound—is it standardized across the RHAs? Because you said that they have different levels of digitization within their own systems with a view to rolling out the national system once that procurement is done. Is there a standardized approach that is undertaken by each RHA in digitizing their patient records presently?

Mr. Ali: So I will let the RHAs speak to that but what is standardized, it is the actual medical record, whether it is paper or electronic, so you have a standard medical record and that is what will be ideally digitized by the respective RHAs in terms of the extent that they would digitize as they go along, but there is a standard—

Mr. Chairman: Could the RHAs comment on that? How far you are with digitization of patient records? Because I am presuming if that is done, when the national system rolls out, it will be easier to transfer the information or collate it.

Mr. Blake: Thanks, Chair. So at the NWRHA, we do have a pilot system that we would have started in 2020. It started with our St. James Medical Complex facility, digitizing our pharmaceutical systems and our patient records there. That system has worked well so far and we have started to expand it to all our health centres nationally and actually we also have it at the St. Ann's hospital and the Port of Spain General Hospital.

Mr. Chairman: So all the records are completely digitized in that system?

Mr. Blake: Where pharmaceuticals are concerned in terms of the dispensing of pharmaceuticals, we are now rolling out the module that deals with patient registration and so on at the Port of Spain General Hospital.

Mr. Chairman: Are there timelines on that?

Mr. Blake: Well, I would say by the second quarter in this financial year, we should be completed in terms of the digitization, that pilot project.

Mr. Chairman: Dr. Armour. How far back do these records go?

Mr. Blake: Currently, we would have had a system existing before, a paper-based system. What we have been able to do is digitize those records. I think we looked at approximately five years of records to start because the paper records are extremely voluminous.

Mr. Chairman: All right. Dr. Armour.

Mr. Ali: Sorry, Chair, if I may, before Dr. Armour.

Mr. Chairman: Please go ahead. Sure.

Mr. Ali: Just in terms of your question in terms of how far back do we go with digitizing your record, what the practice has been and the Ministry has said is that as CEO Blake said, we will go back maybe five years but we do not digitize every record. So if for example, there are 500 patient records in the hospital, rather than go and digitize all 500 for the past five years, we digitize as the patient touches us again. So in other words, when you come to the clinic, we know that we are going to digitize your record because there are patients on the system who may no longer be alive, who may no longer be accessing the system, they maybe accessed the system only once or twice, but their record is there. So rather than digitize all the records at once, as you touch the system again, we would then go back and digitize your record.

Mr. Chairman: Thank you. Dr. Armour, I think.

Dr. Armour: Yeah. At the South West Regional Health Authority, we have made strides particularly within the last three to four years. We were at a point as of October to have paperless service at our emergency departments, that will be at San Fernando and Point Fortin, our flagship hospitals as well as the emergency departments in the DHFs. The last one that was coming on board was Princes Town. Even though it is in the public domain that we have had a recent incident, we are

still in the process of recovery expecting to resume services in full by November 20th.

So a patient care experience is that when you come in, there is no paper record. Everybody from the clerk to the doctor, nurse, orderly, everybody has a tablet and that the software allows, as you enter your data, as the patient moves from one cadre of professional to the next, the record is electronically transferred. So that as at the end of the day, the staff are well trained and that it is paperless. So that is the case in the emergency departments.

The medical records department, it is also electronic in terms of your block appointment systems. We have also started to do e-discharges so that from the wards when persons are admitted to the ward and they are discharged to the clinic, you now have to do an electronic discharge, that was in the process of being advanced in implementation. And also too, we have a concept of e-referrals where persons who are seen in the health centres, rather than the patient has to come to the hospital clinic to drop off a paper-based referral, several of our health centres are able to send an electronic referral if a doctor has to refer a patient to the hospital environment. So that is with respect to medical records.

With respect to pharmacy, well, it is electronic in terms of prescriptions, filling out of prescriptions based on that system. It redounds to patients—customer service, it becomes seamless and it redounds to staff efficiency and it also has some secondary gains with cost savings and so forth, so you can track a patient in a holistic concept. We also have the lab information system and the radiology information system. That is also electronic. And on all of our wards, where we are at now, even though we have done pretty well in the EDs, the medical records and pharmacy, we now have on the wards the hardware capacity where you can actually get your lab results so that it is processed in the lab, it is electronically sent to the wards and

clinics as well as your radiological images through the radiology software.

So each RHA based under the RHA Act is mandated to improve the efficiency and effectiveness of care as governed by the board. So with these sorts of efforts, with each RHA, we are now working with the Ministry of Health because we do recognize even for us a limit is if a patient now goes to another RHA and they need to get continuity of care and that is the project that we are embarking on. Sounds intuitively simple but of course is a cultural change with the staff and of course having that enterprise national solution to move us forward. But that is where we are with South West in the main with respect to the electronic record.

Mr. Chairman: All right. Just before I move to the other two, and I am presuming the information or the systems are the same in the other two. Would that be correct? So we could save some time or are they different?

Mr. Thomas: Well, some are slightly different.

Mr. Chairman: Dr. Armour, you mentioned an incident that set you back, would you care to share that with us? Was it a malicious incident?

Dr. Armour: It was. It was—

Mr. Chairman: Because the cyber security issue is a big one in Trinidad and Tobago now. Was it intention—well, malicious is intentional. Was it profound in terms of its impact on you?

Dr. Armour: Initially it was profound, we had to shut down the network and we had to turn computers offline. We would have been in an emergency mode internally at our level in order to ensure that working with national security agencies, we had to scan our network, all the end user devices and we would have had to rely temporarily on manual backup systems in terms of some paper-based systems as well as some manual backup data. And for us it is not only patient care, electronic data was impacted, it was also to some extent our administrative data. But all in all,

with the support of other RHAs because they would have assisted us as well as the Ministry of Health with their guidance, we consider ourselves well on our way to recovery. It was stated in the public domain yesterday and further today as of this morning, that we expect to resume our patient core services in full by November the 20th. Some of the systems I described have gotten back online and the administrative systems, we are still in the final processes of those getting back online.

Mr. Chairman: When did this happen?

Dr. Armour: At 3.45 a.m. on the 23rd of October, 2023.

Mr. Chairman: So pretty recently.

Dr. Armour: Pretty recently.

Mr. Chairman: Was any patient information compromised or accessed and disseminated?

Dr. Armour: I could advise at this point in time as advised by TT-CSIRT, that is the agency that was leaned on, the law enforcement, they have advised at this date and time that there is no evidence of such nor have we received any indication that that has occurred. But we are advised by TT-CSIRT who did a full investigation and we have been able to secure our data to safeguard the public interest.

Mr. Chairman: PS, as a result of that because we have had the recent hacks of so many entities in the country. How much emphasis is being placed on this in the overall health care system in Trinidad and Tobago because confidentiality of patient information is of course, part of your business?

Mr. Ali: Sure. Chair, thank you, so it is a lot. It is critical to us. So actually we would have met with TT-CSIRT and the four RHAs last week to discuss, one, the current state of the respective RHAs and their systems, and two, what corrective—well, not corrective, what action can we take to improve the security of the four RHAs and the Ministry of Health and our IT systems. The Ministry of

Digital Transformation would have also been part of those discussions to ensure that whatever systems we roll out or we implement, we have taken the adequate steps to provide that level of cyber security. Thank you.

Mr. Chairman: Member Mohit, go ahead please. Thank you.

Ms. Mohit: Thank you, Mr. Chair. Just additionally, PS, you mentioned that one system, so if patients are to go to any RHA, you have their information. But from what I am seeing different RHAs, they are explaining different digital systems. Is it that you plan to merge all at some point and have some, you know, one system where all information can be accessed?

Mr. Ali: Thank you, Chair. So let me try and explain, I am not an IT person so. So what we are doing and it treats with the concept of interoperability. So you may have different systems but the database and the data that is captured is common so those systems can speak to each other. So the intention may not necessarily be to replace the existing system with one system, you may have this system or another system, but they can speak to each other, accessing a common database. So the patient record is what is common, the actual interface may be different but the data is common.

Ms. Mohit: Okay. I know you mentioned that the Ministry of Digital Transformation, they have been involved in your conversations in terms of the electronic data system for the health system. What about PAHO? Any consultation or communication in terms of technical assistance?

Mr. Ali: Yes, so PAHO provides technical support to the Ministry of Health and also in this case in terms of our electronic system. So if we require any sort of support, PAHO provides that technical advice to us in terms of best practice, what happens out there, if we require any specific support, yes.

Ms. Mohit: Sure. One other question, Mr. Chairman. In terms of your submission,

mention was made of current initiatives, projects, programmes that are being implemented within the primary and secondary school systems to increase the awareness among the student population. Can you state for us whether there are any plans to expand the initiative projects and programmes for this targeted age group?

Dr. Parasram: So yes. So I think the short answer is yes. The initial campaign that we are trying to launch is a mass campaign to build awareness about NCDs, the modifiable risk factors but we recognize that really and truly, the children are our future as it relates to NCDs and getting a society that is healthy. Hence the reason we have put significant investments in the exercise equipment. But if we put exercise equipment in there and it is not used, I mean, it does not make sense. So we as a major partner, the Ministry of Education has been working with us.

And really to get exercise is not about schools alone, it is not about exercise equipment, we have to get the parents involved, we have to get the PTA involved, we have to get the extended families involved and that is why we said we need all of government, all of society to deal with this issue. Because we cannot hold your hand when you are at home, we cannot tell you what to eat at night, the parents have a big interest, we cannot tell you what to buy at the grocery stores aside from putting legislation in place to deal with certain aspects of it. So it requires all of us, and the children are really where I think the future is at as it relates to getting our country to a place where we are a healthier society on the whole. So our target will certainly be at the children going forward over the next few years and it is not a short-leave project, we are talking about decades. To see a healthy population, we are talking about 10, 20 years into the future.

So we are trying to put the seeds in place now so that in 10 years, we do not have the cluttering of the A&Es because what we are seeing now is a symptom of the NCD epidemic which has started 20 years ago. If we do not stop the epidemic—

and our greatest weapon to stop the epidemic is primary prevention. If we do not stop it now, in 20 years, I guarantee even with a new 500-bed tower in Port of Spain, a new Arima, a new Sangre Grande hospital, we will not have enough bed space.

Mr. Chairman: So how much emphasis is being placed on the diet of children?

Dr. Parasram: So I think the diet is one of the greatest—

Mr. Chairman: Because exercise is one thing but if you are putting in the junk—

Dr. Parasram: I mean—

Mr. Chairman: Just sorry about that, but a large part of it also is the education about fast foods and the impact of fast foods.

Dr. Parasram: I think they all go hand in hand, right, and creating a—we have an environment generally that is obesogenic, so we have the factors that lead you towards being obese. We have to do anti-obesogenic environments which speak to all of it. It speaks to diet, it speaks to exercise but to which part each one contributes is different but generally to a well individual that is healthy in all aspects including mental health because mental health is considered a great part and parcel of it and it goes both ways.

Mr. Chairman: Yes, member Nakhid.

Mr. Nakhid: As you mentioned the primary and secondary schools, what is the level of synergy with the Ministry of Sport, especially with primary and secondary schools? What level of synergy you all have with the Ministry of Sport?

Dr. Parasram: With education or through or directly with the Ministry of Sport?

Mr. Nakhid: Well, you are talking about getting that awareness programme and having that kind of activity.

Dr. Parasram: So as I said, it is an all-of-government approach and Ministry of Sport is one of our greatest partners in addition to the Ministry of Education so both of them I think would be, as well as the Ministry of Agriculture, would be our lead

agencies that we collaborate it. Ministry of Sport, yes.

Mr. Nakhid: So you are in partnership, you are not moving in silos. You are in partnership with the Ministry of Sport.

Dr. Parasram: No, no. Actually beyond the NCD Committee, there is a vision to create a tier above that in terms of an oversight committee which will have the critical Ministries as well as critical NGOs working together, PAHO and CARPHA so that we bring all of it together and that there is not as you say the silo mentality and all of us working to try to create a society that is healthier. It requires everybody. I mean, we cannot leave sport out of the mix and you will know better than anybody else that sport is an integral part of creating a healthy society.

Mr. Nakhid: Well then, what—any identifiable programmes that are in place right now with the Ministry of Sport?

Dr. Parasram: Well, they might be better placed to speak about their individual programmes rather than us but certainly they are a major partner for us.

Mr. Chairman: Member Mohit, one more question and then member Monroe. Okay, no, member Monroe, go ahead please. Thank you very much for your response.

Mr. Monroe: Thank you very much, Chairman. My next question may be to the PS. Your submission would have stated the cost of dialysis however, did not mention the actual cost of insulin. What I would like to know is what is the annual cost in managing NCDs?

Mr. Ali: Thank you, Chair. Member, you gave us a difficult question. We will have to—I do not think that we have that figure, member, because the cost of managing NCDs, it includes the cost of the clinicians, the cost of the equipment, the cost of the pharmaceuticals, the non-pharmaceuticals, all the consumables. I do not think we have—

Mr. Chairman: But I think the question comes from a statement attributable to the Minister of Health who indicated it may be in the budget or in another forum, that the cost of NCDs is one of the most significant costs borne by the Ministry of Health in intervention and treatment. So maybe we could supply it in writing if you cannot—

Mr. Ali: Sure. Yeah.

Mr. Chairman: Thank you.

Mr. Monroe: Go ahead? Thank you, Chair. Also your submission mentioned shortcomings in the outpatient services as it relates to treatment available for persons with diabetes, heart disease and cancer. What has the Ministry done to alleviate such challenges and also what do you recommend can be done to alleviate the current shortcomings in your outpatient services?

Mr. Ali: Through you, Chair, member, could you just point me to the page please?

Mr. Monroe: Page 15, question 6.

Mr. Ali: One second. Okay, great, thank you. So we would have identified at least three of the challenges. One would have been, as I see it here, the lack of an electronic system to manage the appointment system, the ability to provide timely diagnostic results and the need to expand the DHV programme. So CEO South West would have spoken and it is the same for other three RHAs, where they would have sought to implement that electronic system for appointments, that has started. As I said, it is at varying degrees at the respective RHAs. We have started doing that. Diagnostic tests, those are being done. One, we have point of care testing done at the primary care level. Two, where you have tests at the hospital using the lab information system, those diagnostic tests, the results are available to the clinicians a lot faster so that they can take action.

And with regard to the third point about the District Health Visitor

Programme, in 2021, the Ministry would have graduated, in partnership with the University of the West Indies School of Nurses, 99 DHVs. These are nurses who would have been trained in the DHV Programme and they have all been absorbed as a DHV in the respective RHAs, at the four RHAs. So we have increased our complement of DHVs—well, there were a lot of vacancies—by 99 persons. So we have from a human resource perspective addressed the shortage of the DHVs at it stood. So those are some of the things that we would have done at the Ministry level. If you want, I can get the RHAs to maybe speak a bit more about what they have done at their respective RHAs.

Mr. Monroe: Thank you.

Mrs. Rampersad-Pierre: All right. At the Eastern RHA similar to what my colleagues would have indicated, we do have an electronic client records or registration system. We do have the lab information system and our pharmacy information system. And as PS indicated, the Eastern RHA is the pilot for the national HIS so all our systems will become interoperable once that procurement is completed.

In terms of timely diagnostic results, we at the Eastern RHA have the requisite systems in place out at primary care as well as secondary care to ensure that those results are filtered into our clients in a timely manner and of course, the human resource capacity of the Authority is addressed currently and when the district health visitors come out, that will also increase our capacity.

Mr. Thomas: With regard to items 2 and 3 in particular, the ability to provide the timely diagnostic results as required, we not only engaged optimizing the time that we were able to produce a result for a diagnostic test, particularly lab test. What we did also was reconfigured, for example, for diabetes in particular, into what we call a solution shop model and started something that was called with the guidance of the

Ministry, the Diabetes Wellness Centre. This provided the patient the opportunity to receive multiple engagements or multiple components of diagnostic care or diabetic care at the same time and at the same place as opposed to along a continuum of care.

So normally what would have happened way in the past is that a patient would come into the diabetic clinic, see a doctor, the doctor would then prescribe tests, the patient would have those tests done over a time, sometimes the patient may deteriorate and further tests would be done later on. What we have done and perhaps the patient would have required ophthalmology because diabetes started to affect their eyes. What we have done now is when the patient arrives, we engage the—and this is a diabetic "patient" referral, the patient arrives to the Diabetes Wellness Centre, we engage in the tests that are required. The test results arrive in the second—after lunch but during the day, the patient would see an ophthalmologist, the patient would see the podiatrist, the patient would have diabetic education, dietetic education. And so that by the time the doctor arrives or the specialist arrives, we have the result for the test. So that when that patient makes the arch to seeing the doctor, they have the test results there and we basically, so the doctor, the specialist is armed to provide the best possible prognosis and projection for care and as well based on that, we bring the medication to the patient at the clinic.

So we have not only optimized the ability to do the test faster but we have—given that we have found that we can do it faster, we have reorganized for diabetics the way that we operate. So instead of a patient receiving those services along a long three/four-week continuum of care, they receive that at the Diabetes Wellness Centre at the same time on the same day.

Mr. Chairman: All right. Thank you. Member Monroe.

Mr. Monroe: Thank you, Chair. Highlighted in your submission as at 2022, the

cancer detection rate in Trinidad and Tobago was 209.4 per 100,000. Does the Ministry of Health have a medium-term target for reduction of this relatively high cancer rate within our population, example, a reduction within the next 10 years maybe of 5 per cent or so?

Mr. Chairman: First of all, I would like to add to that, if I could, would that be considered a high rate, 209.4 per 100,000? Would that be considered a high rate?

Mr. Ali: Sorry, Chair, member, again, could you just—the page, please, if you do not mind, thanks.

Mr. Chairman: It would be at page 15, question 6 or maybe not. This is just some cancer detection rate information. Sorry, it may not be that question.

Mr. Monroe: It is just some cancer detection rate information.

Mr. Chairman: Yeah, information. Yeah, it may not be cited as a question or submission.

Mr. Ali: Oh, okay.

Mr. Chairman: So the first question is would 209, generally 210 persons per 100,000 be considered a high cancer detection rate for a country? And if so, is there a plan to reduce it? Page 14, point No. 3.

Dr. Alleyne-Mike: Okay. Thank you, Chair. Dr. Alleyne-Mike. So I do not have the international data to compare it to but in terms of your question with regard to what the Ministry is doing. So I can speak from the point of view of being involved in the therapeutics. So one of the things that we are aware of is that the incidence of cancer tends to be greater in families where there is a genetic link. So particularly at the centre, we have direct access to patients that we are actively treating. We use that opportunity also to engage the patients and their family members in terms of the different options for screening so that we have a great opportunity to capture a large percentage of patients that would fall into that niche that would be most likely to be

at risk for developing cancer.

12.05 p.m.

And it is also an opportunity for them also to relay to friends and family as well, so looking at trying to enhance with what Dr. Clapperton would have mentioned previously in terms of the uptick for screening, the different RHAs, and programmes, and wellness fairs that they have, we add on to that with that aspect of targeting that group of people that are most at risk.

Mr. Chairman: Just to add to that, one of the data points is that according to WHO 2020 Cancer Country Profile for Trinidad and Tobago using 2018 data there were:

"3,369 total cancer cases"

—and—

"1,988"

—out of an estimated population of 1.3. And the same document showed in 2016 there were:

"4,027 premature deaths from NCDs"

—f which that made up cancer with:

"22.9 %"

So it kind of feeds into the question about how effective are our cancer detection methodologies and our cancer treatment protocols. I "doh" know who wants to take that and if we are seeing decreasing or increasing trends in the primary cancers which are breast cancer for women and prostate cancer for men, if that is correct.

Dr. Sirjusingh: Sure, I could address some of the issues with women's side. So yes, breast cancer is the number one cancer of our women in Trinidad and Tobago. So again, the data comes from the Elizabeth Quamina's National Cancer Registry and they have data up to the year 2020 on how the registry works.

So in terms of cancer reduction, of course, we would look at targeting cancers that are preventable with screening and so on. There are some cancers that do not have a screening programme. So breast cancer is one of those where we will try to detect cancer early, you would already have cancer. Cervical cancer is another one of those but we are trying to prevent cancer from occurring, so there are slightly different terminologies.

In Trinidad and Tobago, we actually for the first time had formal policies put in place in terms of our screening programmes for breast cancer. On average, every day, in terms of the numbers one case of breast cancer is diagnosed daily in our country in Trinidad and Tobago.

Mr. Chairman: One every day?

Dr. Sirjusingh: One every day. Putting it into numbers, it is a little more than that, it is 1.3 but at least one case per day.

Mr. Chairman: Which means if one is being diagnosed every day we can presume there is more than one?—

Dr. Sirjusingh: Yes.

Mr. Chairman:—occurring?

Dr. Sirjusingh: This is in terms of our detection and of these patients, this is different cohorts of course, two women die every three days from breast cancer, according to those statistics. 84 per cent of breast cancer cases occur after the age of 45 years, which is similar worldwide, and 90 per cent of deaths occur in women who are 45 years and over. So in Trinidad and Tobago, we actually do have a screening programme or policy which we did launch earlier this year at International Women's Week.

Mr. Chairman: I am kind of shocked at that. Is that a benchmark, if I could use that term, for the region and or the world, in terms of two women dying every three

days?

Dr. Sirjusingh: I will have to of course look at those numbers—

Mr. Chairman: Yeah, please.

Dr. Sirjusingh:—in terms of it.

Mr. Chairman: It just seems significant and profound to me.

Dr. Sirjusingh: It is significant that is why of course we have so many NGOs and other departments trying to bring this to the fore at all times throughout the year, but for the Ministry of Health we did have one big event earlier this year where we did try to highlight it. Every year now we have that on our portfolio, International Women's Day in March where we highlight this and we increase the number of persons being screened.

So our current screening programme for women at average risk, these are not high-risk women, between the ages of 45 to 70 years old, I take this opportunity to ask you every two to three years to visit your regional health authority where mammography is the mainstay for screening. And that is the programme we have in place. For women who are at higher risk, you speak with your clinician, and that is if you have had a first-degree relative who has had breast cancer, we start the screening much earlier and much more frequently.

For cervical cancer, cervical cancer numbers are actually slightly decreasing for a number of reasons, one of which is the HPV Vaccination Programme which started in the year 2013. The more HPV vaccines a country delivers you will reduce the incidents of pre-cancer and cervical cancer. Cervical cancer is the number four cancer in women in Trinidad and Tobago at this time. The numbers are approximately 113 cases per year, of which 17 per cent present early, which works out to about one case every three days being diagnosed. So all these are very high numbers of course.

So Trinidad and Tobago we have signed on to try to eliminate cervical cancer by the year 2030 with a number of strategies, including new tests for screening and so on.

Mr. Chairman: Member Nakhid, go ahead, please. Thank you.

Mr. Nakhid: On that note, your submission stated that cancer drugs are not available by the CDAP Programme because of the specific nature of the drugs —I think they could hear me—but they are available at specific cancer treatment units. Are there any challenges about the availability of cancer drugs at these units?

Mr. Ali: Thank you, through you, Chair. No, member, there are no challenges with the cancer drugs at the respective units, and the cancer drugs are not part of the CDAP but as I said, they are available at the respective RHA facilities.

Mr. Nakhid: Your submission stated that:

Interventions are being put in place to support the reduction of tobacco usage. The main challenge that you encounter is due to behaviour change. What do you think can better assist with changing perception about tobacco usage?

Mr. Ali: Thank you. I think public education is key. It is critical so that persons, one, those who are, as CMO alluded to, who have not yet started smoking are aware of the dangers of smoking and do not start, and for those who currently smoke to provide that support in terms of smoking cessation clinics to assist them with stopping smoking. We actually do have smoking cessation clinics.

Mr. Nakhid: Just to interject, give us an example of how much is your budget for a public awareness programme. What is your budget?

Mr. Ali: That is a difficult question. So, we have a budget for communication, for health promotion which would cover not just NCDs but other things.

Mr. Nakhid: Well tobacco specifically, do you have any idea how much you put into advertising campaigns, public awareness programmes, so that you can make the

public more aware of the dangers of tobacco smoke?

Mr. Ali: I will have to get that figure for you member. If I may just complete what I was saying?

Mr. Chairman: Yes, go ahead, please.

Mr. Ali: Yeah. In terms of those persons who are currently smokers, we do have smoking cessation clinics at the RHAs, we have some of those and we want to actually ramp those up and increase those so that persons who are actually already smokers we can assist them in terms of stopping smoking.

Mr. Chairman: To follow up, on member Nakhid's question and a conversation we had early on, it would be helpful for us if you could liaise with your Ministry of Trade and Industry to get a sense of the importation trends in tobacco products because that is to me is the only way doing past doing a national survey and asking people, do you smoke? How much do you smoke? You would find out if there is a success story in the intervention strategies for anti-smoking campaigns because in the absence of that, we would not know and we would not know the success if the money is being wasted if there needs to be a different approach to the campaign, if you need to target a different age group, because the tobacco importers will not continue importing products that are not lucrative for them.

And in a related matter, I do not know because to be fair it was not part of our initial submission to you, but is there emphasis being placed on vaping, because of the documented impact, negative impact, of vaping in terms of respiratory diseases?

Mr. Ali: Thank you. So, yes Chair, to answer your question. We are looking at vaping currently. Our Tobacco Control Unit is actually actively looking at the matter of vaping and we hope to have a policy developed soon as it pertains to vaping.

Mr. Chairman: Thank you, member Nakhid, you are finished?

Mr. Nakhid: I have one more question.

Mr. Chairman: Go ahead please, thank you.

Mr. Nakhid: This question is a bit off of the paper but from my constituents, I grew up in Champ Fleur so this is anecdotal, and from my research, WITCO started there when it was a very rural community. There were not many houses and communities around that area. Now there are, and the emissions coming out of WITCO, I mean, the level of cancer that has been noted in and around that area, Mt. Lambert, St. Joseph, and this is important to the national community. Are there any plans in the Ministry of Health maybe to relocate a factory like WITCO from what is now a very residential area?

Mr. Chairman: Well, just if I could intervene, the Ministry cannot relocate a factory—

Mr. Nakhid: No, but just I think I made recommendations.

Mr. Chairman: But they could make recommendations. I guess an additional question to that is, are any studies being done in and around those areas to identify the potential impact of the air pollution issues that may or may not be there and their impact on the general health of the population around those areas? That I think you can answer.

Dr. Parasram: So in terms of air pollution and that sort of thing it is not the remit of the Ministry of Health to measure air quality. That is outside of our remit. That is under the Ministry of Planning and Development if I believe in terms of measuring the air quality. If you are suggesting that there is a putative disease cluster around WITCO, then we can certainly examine and see if there is evidence that suggests that, and if there is then make recommendations following the identification of same.

Mr. Nakhid: That is exactly the question that has been posed by the constituents.

Dr. Parasram: Okay.

Mr. Nakhid: So you will look into that?

Dr. Parasram: Yeah. If you have raised it as an issue by a member of the public we can certainly investigate and see if there is any evidence to support that claim.

Mr. Nakhid: Okay, thank you.

Mr. Chairman: While you are at it, I may just add this, my personal concerns about the groundwater from that area by the Beetham there, in that very filthy chemical-filled drain, maybe something you want to check out or so and the impact of the pollutants from the landfill that may or may not be affecting the residents of the Beetham for decades in this country. Maybe something you want to investigate. Can we go to member Monroe, please?

Mr. Monroe: Thank you very much, Chair. My next question is based on public awareness initiatives. Your submission stated:

> Some strategies used in marketing against the consumption of unhealthy foods, specifically the commencement of the upgraded Health & Wellness Festival model through TT Moves.

Question 19.

Mr. Chairman: I think we may have covered this already.

Mr. Monroe: Yeah.

Mr. Chairman: All right, thank you so much. Let us just, because we are running out of time. I just want us to focus a bit on diabetes itself and the information that we have. And in a quotation from a 2018 newspaper article:

> "…there are more than 175,000 people currently living with diabetes in T&T and millions of dollars are being spent by the Government to treat patients."
>
> The report also states:
>
> Many persons are prediabetic and there is a:
>
> "…high prevalence of diabetes…"—is—"…genetic."

It is estimated the:

"…Government spends around $10,000…per month for dialysis…" Could you give us a sense of what the Ministry's initiatives are in dealing with diabetes? I think it is Dr.Clapperton who would have indicated that knowing your numbers is critical and how much emphasis is being placed on awareness related to diabetes, prediabetic, the types of diabetes, whether it be gestational or not, and how we are dealing with diabetes in Trinidad and Tobago as an NCD?

Dr. Clapperton: Thank you for the question, Chair. So again, I would just like to reiterate the Ministry's life course approach to addressing the issue of non-communicable diseases and in particular diabetes, and just to add to the contributions made by my colleague Dr. Sirjusingh as it pertains to the diabetes in pregnancy programmes, preconception initiatives, and other initiatives for diabetes in pregnancy, and also breastfeeding initiatives as this is also key in terms of preventative measure for diabetes later on in life.

In terms of the focused and targeted measures that we do have implemented at the Ministry of Health, and it was mentioned previously that we have implemented a series of diabetes wellness clinics which are focused clinics that enlist and take a multidisciplinary approach towards addressing and controlling persons who have been deemed to be to where their diabetes is out of control. And this is just to supplement something that we already do within our system, we do have the series of local health centres in our primary health care system that have chronic disease clinics that cater to persons with diabetes and hypertension.

Mr. Chairman: How successful has the Ministry been in addressing the cultural mindset, "Well, we have a lil sugar in we family. Dais no big deal. It eh kill meh grandmother or meh mother, it eh go kill me." And getting people to take that seriously because of its impact on your health. Because that is part of the cultural

landscape.

Dr. Clapperton: So we do identify with that comment as well and we are trying our best under the umbrella of TT Moves, which is not only a behaviour change campaign and also with the TT Moves wellness festivals to educate members of the public, not only providing services of health screening at these events but also to share information with persons about the nature of diabetes and what can be done to prevent, manage, and control.

Our diabetes wellness clinics have a series of services provided for persons who have been deemed or attended their chronic disease clinics at their health centres and found to have uncontrolled or HbA1cs above eight, right. And these persons are referred into these specialized clinics where they could receive focused care to manage their diabetes. And these clinics provide services where we have endocrinologists and we also provide eye care and foot screening, and dietitian and nutrition counselling at these clinics. So the concept is a one-stop shop for persons who have uncontrolled diabetes so they can have this focused care to help and better manage their blood sugar numbers. And we do have in the first instance some information coming out of those clinics in terms of the level of control because we do have in these clinics strict admission and discharge criteria by way of the HbA1c numbers. So we do have, for example, in one of the clinics we would have had a patient, for example, patient one was admitted with an HbA1c of 12 per cent and this patient after receiving care at these clinics would have been discharged with an HbA1c of 6.1 per cent, and this would have been a patient from NCRHA clinic in 2022.

Mr. Chairman: Are there any plans for the Ministry to start following global models of mandating caloric content of packaging, and foods? And I think in the case of the UK a couple of years ago limiting sugar intake in some instances

legislatively, plans to change the laws where that is concerned, it was considered drastic in the UK but it worked.

Mr. Ali: Thank you, Chair. So that is a conversation that is happening right now between the Ministry of Health, the Ministry of Trade and Industry, and our various stakeholders. So there is a committee called the Food Advisory Committee that sits within the Ministry of Health that includes all those players and that is a conversation that is taking place as we speak.

Mr. Chairman: Final questions. Member Mohit, we would start with you please. Thank you.

Ms. Mohit: Thank you, Mr. Chair. I note in terms of the NCD economic burden in 2018, the average cost per person in terms of dialysis would have been $10,000. Do you have a figure as it relates to 2023?

Mr. Ali: So the average cost per person would not have changed, member, through the Chair. So that is the approximate figure to dialyze a person for one month. What I can give you would be the number of persons—

Ms. Mohit: Currently on dialysis.

Mr. Chairman: That is how many sessions? Depends on the patient I guess?

Mr. Ali: It depends on the patient; it is normally two sessions a week. Three?

Dr. Clapperton: Two to three.

Mr. Ali: Yeah, again, two to three but it depends on the person. Let me just get the figure for you with the number of people on dialysis right now.

Ms. Mohit: And the number that you are providing would be for both at the RHAs as well as private-public?

Mr. Ali: No. So what I have here would be the private, 729 persons access care dialysis at the private centres. The RHAs would have the figures for the public system.

Ms. Mohit: Just to go a little further, how many persons are awaiting approval for dialysis?

Mr. Ali: At the Ministry right now, five.

Ms. Mohit: Five?

Mr. Ali: Yeah.

Ms. Mohit: Five persons?

Mr. Ali: At the Ministry, yeah.

Ms. Mohit: Just one additional question. In terms of the NCDs, I know chronic kidney disease is not one of those we are examining, but obviously, it is stated here because it relates to diabetes in some form or the other. What is the Ministry doing at this point or at this stage, or what stage are you all at in terms of dealing with chronic kidney disease as it relates to the various RHAs?

Mrs. Rampersad-Pierre: So, in terms of chronic kidney disease, that is addressed at the secondary care level, but before we even reach there, at the RHA level we are looking at a preventative model so that people do not get to that point. But at secondary care those who come in and require dialysis we address that and we dialyze and we also treat on a case-by-case basis for chronic kidney disease. But just to reiterate there is a heavy focus on prevention in order to address the reduction in us having to deal with chronic kidney diseases.

Ms. Mohit: You mentioned RHAs would have the figures in terms of those who are on dialysis if they cannot provide it now, in the interest of time can you provide it in writing for us?

Member: Yes.

Ms. Mohit: Sure.

Mrs. Rampersad-Pierre: At Eastern RHA we currently have 80.

Mr. Chairman: Thank you. Member, Monroe.

Mr. Ali: Chair, if I may, sorry. On page 14 of our submission, number four—

Ms. Mohit: I did not see it.

Mr. Ali:—we would have given the numbers for the respective RHAs in terms of dialysis.

Mr. Chairman: Yes, it is there, thank you. We have it documented, it is on page 14. Member Monroe, go ahead, please.

Mr. Monroe: Thank you, Chair. Question directed to Acting CEO for the Eastern Regional Health Authority. Given the success of the last Community Health Outreach Programme in the northeastern communities held by the ERHA, residents would like to know, this is a question posed to me through the residents, can they look forward to regular health outreach programmes in the many rural communities given the vast geographical distance, maybe on a monthly basis where the Eastern Regional Health Authority would come into the communities instead of waiting for them to take the journey to come to the health facilities at worse case scenarios?

Mrs. Rampersad-Pierre: All right, so yes, we do cover a one-third slice of the island. However, we have outreach activities from Matelot, as far as Matelot in the north and Guayaguayare in the south. Recently we had a diabetes walk, November, which we engaged the communities on the north coast. So we do go out to the respective communities and conduct outreach programmes. There are several initiatives on a monthly basis maybe not on the grand scale as the wellness festival that we had recently but it is focused outreach programmes. Our focus this month is diabetes, so you would see a lot of that. We would have had outreach for fruit Fridays and water Wednesdays.

So yes, the Eastern RHA continues to go out into the rural communities health and provide health and outreach programmes, small scale as well as the grand scale as we recently had at the wellness festival. So yes, the residents can look forward to

that.

Mr. Monroe: Okay. Thank you very much.

Mr. Chairman: Member Nakhid.

Mr. Nakhid: The last risk factor survey was in 2011 and it noted from your submission we had a 26.7 rate of childhood obesity. I think that is a lot higher now. Give us some updates.

Dr. Parasram: So as I said before that was the 2011 survey, normally happens every 10 to 12 years. It is a large health survey that is a PAHO-driven tool that we use. So the next update, the next completed version of that will happen next year hopefully, all things being equal. And once we get that data we will be able to tell you how it compares to the 2011 data if it has improved, if it has gotten worse and that will give us an objective point of view without trying to make any comments from an anecdotal standpoint.

Mr. Nakhid: So we will have to wait until that survey is done to have any idea about—because childhood obesity seems quite a problem especially since COVID, two years a lot of kids were locked down.

Dr. Parasram: I mean, to make a statement without the proper evidence I will be a little bit amiss to say something that I do not have the data to back up. So I want to wait on the study before I could make a proclamation on that, on the level of obesity that currently exists. Beyond 2011, though we did present the 2015 data which suggests a high level of obesity as well. Not as high as probably 26.7 but it was high as well in 2015 when the Global Youth Survey was done in a select group of people.

Mr. Chairman: Thank you. My question will come from some questions that I have been getting from the media, which goes back to an earlier point Dr.Armour raised and divulged some information. If you could just give us a chronology of what actually happened with the data breach at your institution. I have gotten four

requests for more information on that while I am sitting here since you divulged that information. What actually happened on the day, when did you realize the breach occurred, and what steps were taken in the time following that?

Dr. Armour: Okay. So, at 3:45 a.m. due to our routine monitoring, we realized that some of our data was inaccessible, the term that they used that they were encrypted, and therefore that prompted the due diligence protocol to simply shut down the network, call law enforcement, and certainly to prevent any propagation within the network to shut down the entire network. So that was prompt action taken at that time.

So some of the storage data that was online have been locked but what we have been able to do is to recover a large measure of our data based on our local redundant backups that we do have. Some are locally at departments; some are older versions of data. So that is essentially what happened from the end user perspective. Administrative systems were impacted, the computers were off, if you would appreciate like human resources, finance departments and so forth. But we were able to, for example, preserve payment to staff salaries which was an electronic software that was maintained, so staff received their pay, that was preserved.

Also too, core patient systems were preserved we did have the ability to still process lab results, still process radiology results, and still able to record and interview patients and treat with their illnesses which is our core business. So those systems were maintained and therefore in the recovery mode we have been able to reconstitute a large part of our data. Part of it involving law enforcement was to clean our network for the malicious software. That effectively involved having to literally go to each and every computer, as I said, from Icacos to Tabaquite, Freeport to Moruga and physically scan the computers as well. So that arduous task was done and for that I want to state on public record to thank the support of the other RHAs

to assist us there as well as other agencies and providers.

So we have crossed that hurdle and we are back to full recovery. Patient care was not impacted, critical employee services were not impacted, and therefore we are on the way forward and we are taking guidance from the Ministry of Health and law enforcement in terms of the way forward, and even during that time, we have done all the remedial measures to the interim satisfaction of TT-CSIRT that has unable us reach where we are, to connect back to networks, to connect back to our software, to resume the digital business of the authority.

Mr. Chairman: Was it determined to be a deliberate act, and has any agent or person been identified as the perpetrator?

Dr. Armour: I would have to say that that investigation is ongoing. It is in the hands of law enforcement so that will be TT-CSIRT that would be best poised to provide the answer to that question. But in terms of it has been deemed malicious, in terms of it is malware and therefore the way forward is just simply a matter of prevention as we speak about prevention in that regard. We just have to prevent the attacks and just have that level of security that is required moving forward and keeping up to date with the current cyber world environment that is out there.

Mr. Chairman: Thank you. In closing, would the PS or CMO care to deliver closing comments?

Mr. Ali: Thank you, Chair. Just on behalf of the team that is here, thank you very much for allowing us to share some of the work we have been doing at the Ministry and the RHAs in terms of the whole-of-government, whole-of- society approach, and to share with the public the issue of NCDs and as I said when I started, while the Ministry of Health and the RHAs and the rest of the state machinery has a role to play in providing that enabling environment, there is definitely a place for civil society. We have seen that support and collaboration with them and obviously at

the level of the individual to make those informed lifestyle choices to look after their own health. And thank you again to the Committee for some of the suggestions that were made we will definitely take those on board as we go forward.

Mr. Chairman: Thank you so much. We would like to thank you, the Permanent Secretary, Mr. Ali, Dr. Parasram. Dr. Clapperton, Mr. Blake, Mrs. Rampersad-Pierre, Mr. Thomas, Dr. Armour, Dr. Alleyne-Mike, Dr. Sirjusingh, and Dr. Cummings. Thank you all for being with us and sharing information with the Committee, and we appreciate your time and your contribution, and those of you who delivered comments and questions to our platforms.

The public is advised that the Committee's Sixth Report on an Examination of the State of Technical and Vocational Programmes and their Contribution to Achieving the Development Goals of Trinidad and Tobago, was presented in the Senate on the 20th of October, 2023, and in the House of Representatives on the 01st of November, 2023. The report can also be viewed and or downloaded on the Parliament's website *www.ttparliament.org*. We thank you and all the stakeholders, and committee members, and the staff of the Parliament for their procedural and logistical support, and to the viewing and listening audience, thank you all. Our meeting is now adjourned.

12.35 p.m.: *Meeting adjourned*.

Appendix IV – Verbatim Notes of 20th Meeting

VERBATIM NOTES OF THE TWENTY-FIRST VIRTUAL MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION HELD (IN PUBLIC) IN THE ARNOLD THOMASOS WEST MEETING ROOM, SECOND FLOOR, CABILDO PARLIAMENTARY COMPLEX, OFFICE OF THE PARLIAMENT, ST. VINCENT STREET, PORT OF SPAIN ON WEDNESDAY, MARCH 20, 2024, AT 10:15 A.M.

PRESENT

Dr. Paul Richards	Chairman
Mr. Roger Monroe	Vice-Chairman
Mr. David Nakhid	Member
Ms. Vandana Mohit	Member
Ms. Pennelope Beckles	Member
Mr. Esmond Forde	Member
Mr. Julien Ogilvie	Secretary
Mr. Brian Lucio	Assistant Secretary

ABSENT

Mr. Avinash Singh	Member [*Excused*]
Mr. Rohan Sinanan	Member [*Excused*]

DIABETES ASSOCIATION OF TRINIDAD AND TOBAGO

Dr. Andrew Dhanoo	President
Ms. Shoha Dookeran	1st Vice President

TRINIDAD & TOBAGO CANCER SOCIETY

Dr. Asante Le Blanc	Chairwoman, Trinidad and Tobago Cancer Society

TRINIDAD & TOBAGO HEART FOUNDATION

Mr. Amit Maharaj	Manager

Mr. Chairman: Good morning, everyone, and welcome to the viewing and listening audience to this the Twenty-First Meeting of the Joint Select Committee on Social Services and Public Administration. This is the Committee's second public hearing with stakeholders pursuant to its enquiry into Trinidad and Tobago's response to the prevalence of non-communicable diseases, with specific focus on diabetes, cardiological diseases and cancer.

Members of the public are invited to submit their comments on the Parliament's social media platforms, including the YouTube channel, *ParlView,* or via Facebook and Twitter. At this point, I would like to welcome our stakeholders who are with us today, and the stakeholders include: the Diabetes Association of Trinidad and Tobago, the Trinidad and Tobago Heart Foundation, and the Trinidad &Tobago Cancer Society. At this point, I would like to invite members of this Committee to introduce themselves, starting with member Beckles.

[*Introductions mad*e]

Mr. Chairman: We would be joined in the process by member Esmonde Forde, and members Rohan Sinanan and Avinash Singh are both unable to be with us today. I am the Committee's Chairman, Paul Richards. At this time, I would like to invite members of the Diabetes Association to introduce themselves.

[*Introductions mad*e]

Mr. Chairman: Thank you. Dr. Le Blanc of the Cancer Society. [*Chairman confers with Secretariat*] Oh, she will join us in process. And, of course, Mr. Amit Maharaj of the T&T Heart Foundation, good morning.

[*Introductions made*]

Mr. Chairman: Thank you. I am the Committee's Chairman, Paul Richards. We are concerned with three objectives in this enquiry:

1. To examine the efforts of the state to counteract the effects of specific non-communicable diseases, NCD's, within the population, including diabetes, heart disease and cancer.
2. To examine the efforts of civil society to counteract the effects of non-communicable diseases or specific non-communicable diseases within the population including, diabetes, heart disease and cancer; and
3. To determine the main policy changes actions and interventions that are necessary to effectively respond to the increase in non-communicable diseases in Trinidad and Tobago.

At this time, I would like to invite Dr. Dhanoo, as President of the Diabetes Association, to start with brief introductory statements. Dr. Dhanoo, go ahead, please.

Dr. Dhanoo: Thanks, Chairman, and thank you, again, to the Committee for inviting us and allowing us to take part in these consultation sessions. Diabetes in Trinidad and Tobago has now grown to proportions where we have about 15 per cent of our population living with diabetes. Now, these are estimates because the last time a national study was done was in 2011. So these estimates, done by the International Diabetes Federation, would have been what we are relying on.

We have, of course, seen the increase in the prevalence of diabetes and, of course, the impact of diabetes, and not just diabetes in older people as we would have thought previously, but we are now seeing type 2 diabetes more and more in younger people. Of course, we do have type 1 diabetes in our young children and we have been working with them from quite some time on this, and working with

them to manage their disease. But with type 2 diabetes and the increasing prevalence of type 2 diabetes; the increasing the prevalence of the risk factors which lead to type 2 diabetes; and, of course, the increasing number of consequences which include amputations, which include renal disease and loss of eyesight, we are seeing this more and more.

And we are not attributing this to the fact that it may be sometimes difficult to get the treatments on time, more so people are hesitant to seeking treatment when they are supposed to, so there are so many factors at play here when it comes to leading to these issues. And we have been doing work over the past 35 years at the Diabetes Association, working quite closely with the Ministry of Health, I must state. There is so much more to be done, but I do want to commend the Ministry of Health for working with us at the Association and, of course, commend all of our members and volunteers who have done this work over the past 35 years.

Mr. Chairman: Thank you so much, Dr. Andrew Dhanoo. Can we go to Mr. Amit Maharaj, the Manager of the Trinidad and Tobago Heart Foundation?

Mr. Maharaj: Hi, good morning, everyone again. So the Trinidad and Tobago Heart Foundation is primarily focused on the preventive aspect of cardiovascular disease through education and awareness, and our initiatives include lectures, public health fairs, trying to educate the public in different modes across Trinidad and Tobago. We have also focused on the younger generations, so we have been hosting cumulative school lectures to educate younger children from secondary schools across Trinidad and Tobago on steps to prevent heart disease and stuff like that.

We are not primarily medical, in terms of being integrated into the public health system or anything like that, but we do notice because of our proximity in working within the hospitals and with the Ministry of Health that there have been, for persons who do suffer with cardiovascular diseases, longer than optimal wait

times to get their test done through the hospitals and stuff like that, which has, you know—it is delayed and oftentimes they have to seek private care, and not many of them are able to facilitate that to, you know, maintain their health in terms of cardiovascular related diseases.

Mr. Chairman: Thank you so much. And let us say good morning and we are joined by the Chairwoman of the Trinidad and Tobago Cancer Society. Good morning, Dr. Asante Le Blanc. Could you give us a brief opening statement? Thank you from joining us this morning.

Dr. Le Blanc: Hi, good morning, everybody. Sorry to be late. On behalf of the Trinidad and Tobago Cancer Society, we are pleased to be joining this meeting. We hope it is not the first and last, or the third and last. We really need to address all of the non-communicable diseases—chronic non-communicable disease or NCDs. From the Cancer Society's standpoint, we are seeing more and more inadequacies and inefficiencies in the public sector when it comes to both screening, diagnosis and treatment when it comes to cancer. And we are recognizing also the lack of enforcement of the Tobacco Control Act, and we are pushing strongly for vaping to be included in that because that is overcoming the smoking itself, cigarette smoking, and that in itself has a huge negative impact on all NCDs and especially cancer. So we are hoping that we can bring that to the forefront, that we can actually effect change and really making a difference because the population is indeed being effected by NCDs.

Mr. Chairman: Thank you so much, Dr. Le Blanc. Okay. We will start with the Cancer Society. Can I go to member Beckles to start our line of questioning, please? Member Beckles, go ahead, please.

Ms. Beckles: Okay. Thank you, again, Chairman. And let join with all my colleagues in welcoming everyone for what is a very, very important exercise. So

can I ask—first to the Cancer Society, can you tell us a bit more about the society's affiliation with the American Cancer Society, and what are the benefits of such an affiliation?

Dr. Le Blanc: Sure. So the Trinidad and Tobago Cancer Society became affiliated with the American Cancer Society in 2023, and this was in the purpose of the Global Relay For Life. So the Global Relay For Life is a fundraising event but also part of a campaign that brings awareness worldwide. So it is something that happens all through the world where we have relays and that allows us to bring more awareness to screening, to hope, and to what survivorship is really about. So that is our affiliation with American Cancer Society.

At this time, it is just being a part of the worldwide community for Global Relay For Life, and it helps us to network further with our counterparts in the region and also worldwide to fight cancer. It allows us to share information and have an interchange on what can be done, policywise, in our countries. It allows us to also brainstorm to effect proper change in each country and allows us to support one another to effect change, both national, regionally and internationally when it comes to the fight against cancer.

Ms. Beckles: Thank you very much. Could you—in terms of your submissions, you outlined some of your projects and initiatives over the past five years. So can you indicate whether you conduct screenings as part of your outreach initiatives?

Dr. Le Blanc: Definitely. As the national voice against cancer, the Trinidad and Tobago Cancer Society includes in its services a clinic. The clinic is highly subsidized through the subvention from the Government which allows for high-quality screening services at a very subsidized price to the public. So our screening services include—at our clinic at #69 Dundonald Street, and also we have mobile screening units. So our screening includes on-site mammograms and breast

ultrasounds, clinical breast examinations, Pap smears for cervical cancer, the FIT for colorectal cancer, and the DRE and the PSA for prostate cancer. We do hope to improve more. And then our mobile screening is the clinical breast exam and DRE and PSA for prostate.

Ms. Beckles: Okay. Thank you very much. So thank you. You gave us—indicated about the subvention. So can you give us a value of the Government's subvention over the past three years? Could you indicate whether there is a shortfall, and what is the shortfall between what is requested and what is actually provided by the Government? And could you also indicate what is the estimated total amount received from the private sector and individuals? And you can just give that for the period 2023. Thank you.

Dr. Le Blanc: Sure. We had an issue a couple years back where our subvention was extremely delayed. We used to get 1.5, if I am not mistaken, and then we did not get anything for years, and that was about five/six years ago. So we had to have a negotiation and we forfeited that subvention that was missing for years and then we accepted $750,000 per year. We received that subvention, we had to fight for it but we got it. It is not enough but we manage. We have tried to initiate talks with the Ministry to get that increase because we also have a hospice that we manage as well. We have not had any success where that is concerned. But apart from that—and we understand the position of the Government, we appreciation what we are getting, yes, we would like more, we do much more—we can do much more if we get more, but we also try to make up through private sponsorship with corporate.

Through corporate, we have several main fundraisers, so we have the flagship CIBC for prostate cancer. We usually received from them on average maybe—some years, we got 150; last year, we only got a little short over $100,000. We have Scotiabank Foundation, which is for the breast cancer—for women's breast cancer

screening, both in Trinidad and in Tobago, and we got $250,000 from them. And then we have Republic Bank. Republic Bank, they gave us half a million but it is not only for screening, it is also for the Power to Make a Difference programme, which is where we do our flagship fundraiser which is Bubbles for Life. From there we raised, approximately $300,000 net when we take out all of our expenditure, and that all goes towards screening and operations of the Cancer Society.

Apart from that, we may get grants from people who have died, you know, somebody may donate, they may buy a tree of life, a leaf of life. On our tree of life, we sell leaves, we sell branches online, so we get donations that way. But it is mainly through corporate sponsorship and our fundraising events that we do.

Ms. Beckles: Okay. Thank you very much. Now, in your submission you mentioned that:

> The TTCS is a member of the NCD Alliance formed by the Ministry of Health and there may be room for more collaboration with all the partner organizations to execute more initiatives.

So that was the first part of your submission. So can you provide some further details in your role in the NCD Alliance, and some of the activities that you have participated with in the NCD Alliance since its inception, and can you also tell us what sort of initiatives you would like to see executed through this collaboration, and can you describe some of the opportunities for greater stakeholder collaboration?

Dr. Le Blanc: Yes. So, I mean—I think the panel should know that I am a very frank person, so please excuse me for my frankness at this time. So the Trinidad and Tobago NCD alliance was formed. We were one of core members forming the NCD alliance because we saw a need for more partnership when it came to NCD. However, the NCD alliance is, to me, not able to effect anything because we are not

as cohesive as we should be. That is basically because in the NGO world, we are still all fighting independently to make sure that our independent organizations get to do what they are supposed to do in terms of our mission and our vision.

I would like to see that the lead in the Ministry—the point lead in the NCD department in the Ministry meet with us more frequently and allow for better collaboration. Meetings should not be called today for tomorrow, it needs to be better planned. You need to understand that a lot of us are volunteering, a lot of us have very business schedules and therefore, when we miss the meetings, vital information is not given. I find that there is a lot of talk and no action. So I personally miss some of the meetings because I am tired of talking, I am tired of begging, I think we need to act. This should not be a one-off, "Today is this day and we are going to do this." You need to recognize we need to be more cohesive and we need action, we need better communication with the Ministry, and be serious about it. It is not for a photo op, it is not for recognition, it is not for commission, it is about the nation and the population. And I really find that the NCD Alliance has not been able to speak as a group and act as a group, because we are not given that presence as a group. Therefore, individually, each organization has their different strengths.

So, for example, Andrew with the Diabetes Association, I mean, he has tremendous strength in the Ministry of Health—and I am not bashing Andrew—because diabetes is a low-hanging fruit and therefore, it is given a lot of stuff. Cancer is not so much of a low-hanging fruit when it comes to diagnosis because of the cost of it and therefore, it is a struggle. But you are asking not only about the diagnosis and the treatment, but you are asking about making a change on the lifestyle for the population. And that is not being done, because we are not looking at it realistically. There is a big talk about helping the lifestyle of the people, but when we tell you what you need to do, it affects your economics, it affects your trade, and so it is not

being done.

So we are spinning top in mud. We are not doing what we are supposed to do, so we have to do better. And for the NCD Alliance to work, we have to be given that seat at the table, Dr. Clapperton has to hear us, we have to be more cohesive and we have to truly commit to change. I am very sorry but that is my blatant truth.

Ms. Beckles: And thank you very much. So then, can you provide some recommendations for improving Trinidad and Tobago's response to the NCDs? I know you are—in terms of what you just said, some of it is there, but would you like to give us anything specific?

Dr. Le Blanc: Yes. Number one, we need to have mandatory reporting of the NCDs because that allow us to get the data. We are no longer talking in the general, we are no longer talking, "Oh, this is what WHO says," let us see what is happening in our environment. We need to have mandatory reporting of the NCDs in both public and private sector. Let us start with public. We will go on the private later, but let us start in public. We need to effect the Tobacco Control Act. We need to ensure we include vaping in that because that is a big thing for all NCDs, it is not only for cancer. We need Dr. Clapperton or the point lead for NCDs to give us a seat at the table, as the NCD Alliance, and to meet with us and let us bite the cake piece by piece. We do not want to eat the whole cake. Let us sit it down and get it done. We need—just let us get it done, let us meet, let us have those discussions and let us take piece by piece.

We need a registry to be looked at, we need to have that done. We cannot think that these things cannot be done. There is paperwork after paperwork after paperwork, there are files, there are meetings, there are committees, there is everything, and nothing is effected. So I am asking if we can start with, first, meeting Dr. Clapperton, tell us where we are at, tell us what we need to do and how we can

start. It is step by step, one day at time, sweet Jesus. That is all we are asking for. Yeah? And meet with us, talk to us and let us see how—we know that the real world exists. So I am not asking you to be ideal and cut out everything, and all the sugars out of the world and—no, but let us do something. Let us show that we are doing something. And we have to do it from the top, from policy. If we do not effect the policy, we cannot have the change we need.

Ms. Beckles: Thank you very much. So, Chair, I will—[*Inaudible*]

Mr. Chairman: Thank you so much, member Beckles. And thank you, Dr. Le Blanc, and do not apologize for being frank. That is what we are here—we are truly here to get the information we need. We are not here for only polite conversation for presentation sake, we want the information from you, the stakeholders on the ground, of what your experiences are. That is the only way we can get the data to make the recommendations that need to be made.

Just before I move to member Mohit, if you could just elaborate a bit on what aspects of the Tobacco Control Act you think are not being effectively operationalized or applied, one. And two, in terms of data collection, do you, the society, effect any data collection, and what type of data collection would you like to see from the public and the private health care sector, in terms of what they are getting from the feedback from the public and the incidences of cancers? Because we quote global statistics, we quote regional statistics, we quote national statistics, but very often the national statistics we quote are a year old or two years old, which does not deal with the problem—

Member: Five years old.

Mr. Chairman: Five years old, there you go, which does not deal with the problem. And you cannot track the progress of the issue, particularly as it relates to cancer in Trinidad and Tobago.

Dr. Le Blanc: So with the Tobacco Control Act, what we are seeing is that—well, obviously, well, tobacco is still there and we have the suitcase trade of tobacco. But our main issue right know is can we—because when we look at it, we can see where vaping should have been there but because of a change of word, the ENDS or the electronic cigarettes are not included, and we need to address this because vaping has become a huge epidemic in Trinidad and Tobago. When we are allowing advertising of vaping to our teens as something to do and a way to quit smoking, when it is really a way to hook them onto smoking and other drug use, and when we are allowing ads on TV, on radio, on social media, we have a problem, especially if our World Health Organization is saying, "Vaping is bad," how on earth are we not making a change? How on earth? What are we waiting for? Why do we always have to follow fashion? So that is—[*Inaudible*]

Mr. Chairman: So are you saying the present format of the legislation does not accommodate vaping, and vaping is being advertised as contrary to smoking, because smoking has been banned from being advertised, so there is—

Dr. Le Blanc: Exactly.

Mr. Chairman:—a lacuna there that needs to be fixed?

Dr. Le Blanc: Exactly. Because the same tobacco industry is manipulating it and therefore, they are saying, "Oh, do no smoke, vape." Come on now. I mean, it is being touted as something safe and fashionable, and it is wrong, and we have the data to prove it. If you look back when WITCO came out to announce their AGM last year, how good they did but they had a fall in sales because you all gave heavy tax on tobacco, but do not worry because they were coming into the vaping industry and all the data we gave was wrong, I retaliated. I spoke out and I said you are wrong, but nobody followed on that. They are wrong, and it is plain and it is simple, we have to nip this in the bud.

Mr. Chairman: Thank you. And just before I go to member Nakhid and member Mohit, and the issue of data collection and the—

Dr. Le Blanc: Yes.

Mr. Chairman:—and the accuracy and the timeliness of it.

Dr. Le Blanc: Right. So we are presently starting data collection on our own site. We are going do it through our EMR because we noticed that—we were depending on the registry before, and then the death registry went defunct, and then it started again with IARC. But what happens is, it is a population-based registry, so the data that comes there does not identify if, for example, patient A smoked, ate badly, got cancer and died. It just says these people had cancer and this amount of people died. So you cannot make a correlation. So we are trying to work on data collection from our end in the Cancer Society to then extrapolate.

When it comes to the inefficiencies or the disappointment of registration in the public sector with treatment with cancer, as soon as we get the word through our surviving network, or through our networking with other groups, we bring it to attention of the Ministry and the powers that be. Dr. Mike hears from all hours of the day because of what is happening, and it is really frustrating.

Mr. Chairman: Thank you. Member Nakhid and then member Mohit, you can go ahead, please.

Mr. Nakhid: Okay. Thank you, Chair. Dr. Le Blanc, I would just like to get some substance to a couple things that you indicated before. You said that that you get $70,000 after negotiations with the Government and you do get some corporate sponsorship. Correct? What—indicate to us what are your overall operating costs for the year? What are your costs for the year that you would need?

Dr. Le Blanc: Monthly, our costs are approximately $300,000 per month, with salaries for our staff and everything else, and looking after our imaging and all of

that, because we have a contractor that does our imaging for our mammograms and our ultrasounds.

Mr. Nakhid: $300,000?

Dr. Le Blanc: Roughly.

Mr. Nakhid: Roughly for the year, $3,600,000?

Dr. Le Blanc: Yes.

Mr. Nakhid: Right. And you get—so does the corporate sponsorship, does that contribute to the shortfall? No?

Dr. Le Blanc: No, we work our tailbone off and our contractor for imaging gives us a very huge "bligh". So we are in huge debt to him because of that. So we are really working hard to breakdown that debt, but I am telling you, the word "non-profit" really fits us, there is not a single dime, so we just work hard. And we are doing this and we are not going to stop because of that, we have to continue working. So this is really for you to see the goodness of the professionals that we have there that we have a relationship with. They understand it and so we do have to just keep working with them, and they work with us. But we do not—by no means are we looking at you smiling at the end of year saying, "Well, we do not owe anybody." We have huge debt; huge debt.

Mr. Nakhid: Well then, the question needs to be asked. Given that—and I hate to put you on the spot but given that shortfall—although you look like you do not mind being on the spot. Given that shortfall, are people actually dying because of that lack of budgetary allocation? Do people die?

Dr. Le Blanc: No, because we continue to commit to screening. So we do not just sit back, we continue fighting to get more money. So we continue fighting for fundraising for our screening programmes, so we do not say no to a single person. So if they call me and this patient is in need and we need a pro bono, we do the pro

bono. We do not allow—from our end, we do not have that shortfall because we do screening, education and palliative care. We do not do treatment, yeah? But we are there for the population and also advocacy, at this point in time, so we do not allow that. But if we had more money, we could do much more. But at the same time, you cannot give up, and it takes two hands to clap.

So we understand and we work with corporate, we work with the public and right now, for example, we are looking to have a collaboration with the cricketing world. You understand? Because I went out to Miami, I did a 5K for sarcoma, and recognized that the sporting world was sponsoring because that is a part of the CSR. So I reached out to the cricketing world and I said, "Why are you all not doing this?" Right? Because they are affected too, they lose family members too. So we are in talks with that. So we do not sit back. Every day in my bathroom, wherever I am, I am thinking of how we can fix this.

So we are trying to fix it because at the end of the day, we see where we are filling the gaps for the public sector. We help you all with your screening campaigns and we do not look for any—we go to Tobago, Tobago just started. They wanted to say how they were the only ones doing the screening, when we were doing the screening for them, and I said, "Absolutely not, you are not going to take credit," and it is not about credit, it is about understanding the collaboration so you can say, "The Cancer Society collaborates." We are there to help you. We are there to help you however we can and we are not going to stop.

Mr. Nakhid: Thank you very much.

Mr. Chairman: Thank you, Member Nakhid. Member Mohit, go ahead, please.

Ms. Mohit: Thank you, Mr. Chairman. just a few questions on access to screenings. As it relates to your submission—and we thank you for your submission—your submission would have stated that:

Based patient feedback, there are frequent reports of equipment failure and therefore, these failures delay the access to timely screening services.

So I have two questions as it relate to this in terms of the health facilities and in terms of equipment itself. So if you can provide some examples of the public health facilities where your membership has encountered dysfunctional equipment on a regular basis, and if you can provide to the Committee examples of some of the equipment that have been reported to be frequently dysfunctional at the public health care facility.

Dr. Le Blanc: Oh, clearly, all of them. Every single regional health authority. So we are talking Grande, Sando, Tobago, Port of Spain, North West and North Central, all of them. And the equipment that is being cited is the mammogram, and also there is a huge delay in colonoscopies, yeah? So that is a huge delay.

10.45 a.m.

Ms. Mohit: And how has this affected your membership?

Dr. Le Blanc: It affects them greatly, because they cannot get the service that they have paid their health surcharge for. Sometimes they are even misinformed that they do not have to do certain things; that they do not have to do it, and that is ridiculous. So, it affects them, because then when we educate, every Tuesday morning I am there educating. Every time we are educating on social media: get your screening done, get your screening done. And then they reach out to us and say well we tried. I have patients who are waiting years, years for mammogram, years for a colonoscopy. It is not right. We need to do better. We know what the mandate is. ~~w~~We . ~~K~~know what the guidelines are. We need to do better.

Ms. Mohit: And have you had any collaboration, in terms of the Ministry of Health, these ~~E~~RHAs, ~~and~~ regional health authorities, as it relates to these equipment

challenges for your membership or anybody else, to have something done so you know these issues can be dealt with as soon as possible, in terms of these testing?

Dr. Le Blanc: We were approached once, by~~ut~~ NWRHA. If I am not this mistaken it was last year, we started the talks. We said this is what the price would be and it was not a heavy price. We gave them the subsidized price because they are government and we are there to help, and we never heard from them. So, the thing is that there is always—you might have a reach out, but something stops it. The bureaucracy is immense.

Ms. Mohit: Additionally, your submission indicated that access to cancer treatment drug~~s~~ shortages has always been reported by your membership. And we have heard it too in recent times. If you can provide for us some examples of the treatment drugs that are frequently unavailable and whether your association would have raised the issue of the shortage with the Ministry of Health officials.

Dr. Le Blanc: Yes, sorry I have a patient I just need my staff to take out. Hold on, please, one second.

So, what happens is when we listen to the membership and do the drug names, we do not have the exact drug names, but there is always a shortage of breast cancer drugs for example, prostate cancer drugs as well. And so, what happens is—and when I speak to the oncologists in St. James, for example, what they are complaining to me about is that while we have approved the newer drugs for treatment, and they are ~~on~~ formulary, they are still not available. So then we are giving antiquated drugs, if at all, to the patients. And so, this is a big problem, because when they go private they get the drug that is approved and they have to pay for it privately to save their life, or they have to die.

Ms. Mohit: Any reasoning for why it is not available?

Dr. Le Blanc: You are asking me? [*Laughter*]

Ms. Mohit: Well, I am asking you because I am not sure if any reasoning was ~~ere~~ given to you. Any proper reasoning?

Dr. Le Blanc: Well, there is never proper reasoning, but it is lack of funds; that is what we heard, that there is a huge owing on the part of the Government and so the drugs are not being brought in.

And the thing, I have been approached, for example, by a drug company and they said to me: "We are willing to talk to the Government. We have drugs. We are willing to give drugs for free." I hear those words, but yet it is not happening in the public sector. So they are asking me to be the ambassador to get those drugs for free, but I cannot get a meeting, you understand. Because I need to understand what that entails; why is that not happening? If we are being approached and we are being given that opportunity, why not explore it? I am not saying take it, because we have to be cautious when you are affiliated with a drug company. You cannot be affiliated with a drug company. But let us see what is being offered, because it is being offered in other countries and being accepted in other countries. So, therefore, let us see what is happening and explore it. But that is the problem. You are not getting proper communication and if you do not have communication, you cannot resolve it.

Ms. Mohit: Based on what you are saying, Chairman, what I am hearing here is, it is not really availability, it is funding. So the drugs may be available, but funding is not available to acquire the drugs, which is a bigger challenge even.

So, I want to go to tobacco use because you spent a lot of time explaining about the Tobacco Control Act and including vaping. I want to ask you, your submission would have noted education plays a key role in creating the awareness of the harmful effects of smoking and vaping.

From your end, what representation has the Cancer Society made to the Ministry of Health and other related state agencies? Not just the Ministry of Health,

because I know you would have mentioned some of your, please, some of your conversations already. You have the Ministry of Education, because you are speaking to young people and advertising, other state agencies as well concerning the dangers posed by vaping.

Dr. Le Blanc: So, you want to know who else we have reached out to?

Ms. Mohit: Of course.

Dr. Le Blanc: Right. So, we have—through the Ministry of Health and the Ministry of Education, gone into schools and we have done a campaign with Republic Bank and also with Scotiab Bank, with two major campaigns "Can't Fool Me" and "No Smoking, No Vaping". In terms of a continuous campaign, both ministries we have not had support from them, so we do these initiatives on our own privately with those corporate sponsors. We do need that it is there consistently in the face of the young people and it is not only high school level, but it is also primary school level. Because we cannot take it for granted. You know, people say ""oh they are young."" Children are walking out the uterus with their iPad in their hand. So, we need to understand the level of their intelligence. Their brain is there and they are going to fall for those manipulative effects from primary school level. So, we have reached out to the ministries, but they not respond. It is a lot of lack of response. And I do not know why, and it is always about low-hanging fruit. But we have to hit where it needs to be hit. We cannot just look for low-hanging fruit. We have to do what is necessary to really put your money where your mouth is. Do what you have to do, because if not we are going down a slippery slope and it is not just cancer. It is everything.

You are having 30-something-year-olds dying of heart attacks, because between the smoking, the vaping, the energy drinks and everything else, there is no proper lifestyle. So, we have to do something. We are losing the younger members of our population, not only the older sector, and this is the NCDs. And then with the

pandemic, it was even worse. That was an added layer, because we have ~~to~~ sequelae from the pandemic. So this is a big problem. And if we do not start to make changes, we are not going to do any better. We are not going to achieve any single sustainability goal, nothing. Everybody would go to meetings, CARICOM would go to meetings, approve everything and nothing being done. Nothing being done and it needs to be effective.

Ms. Mohit: Thank you, Chairman.

Mr. Chairman: Thank you, member Mohit. Breathe Dr. Le Blanc. I want to ask a question before I go to member Nakhid and then member Monroe for the remainder of our questions related to the Cancer Society. This may be considered by some a controversial question. I am not alien to controversy, for some reason.

Have you, anecdotally or empirically, information that you have seen since, one, the decriminalization of marijuana for private use? Because my small knowledge of marijuana; I am not a smoker, I cannot ~~under~~stand smoke; indicates that people sometimes smoke cannabis with cigarettes and on its own; and two, the liquid THC that is sometimes incorporated into vaping, sometimes develops an addiction and a preference for cannabis. Is that also empirically or anecdotally contributing to cancer in Trinidad and Tobago?

Dr. Le Blanc: Yes, definitely. So, if anybody knows my background, I am a herbalist, but by no means do I subscribe to continuous use of marijuana. I want that to be known. So, the thing is that the decriminalization of marijuana has allowed the public to obviously feel free to use it more. We all know that they used to use it, but now they use it more.

Now, what we have tried to educate is the fact that you are smoking marijuana, the heat going down can also cause cancer. It is not only the marijuana; it is the heat. What we also need to remember is that when you use an electronic cigarette—

because they say: okay, do not use the cigarette, use the electronic device, because that is cleaner. But it gives much more heat through the generator that it~~s~~ has. But not only that, it has other chemicals in there that will then cause popcorn lung and also inadvertently cause cancer. So, it is not like weed is going to help you, because you are not smoking the fresh weed. And smoking on its own, that heat going down that respiratory tract, is going to change the epithelia, the lining of the respiratory tract.

I do not know if any of you all remember long ago you used to play barefoot, and eventually your foot get hard? Because your body has to protect itself. So, it changes the type of cells to protect itself. And with that change, you can be at risk for a cancer to develop. So smoking marijuana in any form, because of the heat, it will inadvertently put you at risk for cancer and other NCDs.

Mr. Chairman: Thank you. What we are going to do is just let ~~them,~~ member Nakhid and Monroe complete two quick questions and then we come to the Diabetes Association. We thank you for your patience, but we are kind of going through a logical process here. Alright? So, member Nakhid and Monroe, your quick questions and then we go to the Diabetes Association and then the Heart Foundation.

Mr. Nakhid:–Ms. Le Blanc, your organization, TTCS, was instrumental, as you stated, in creating the AntiTobacco Bill of 2009. But you said it can help in reducing tobacco usage throughout the country. Can you elaborate on that comment and what specific elements of this previous Bill should be introduced?

Dr. Le Blanc:-Right. So what happened with the Tobacco Control Act is that we were very good at getting it passed and we got that done and it was amazing under Dr. George Laquis, who is our Chairman Emeritus. What happened was the Tobacco Control Unit could not effect the Act properly from the Ministry of Health perspective. So, now, starting maybe two years ago we had talks, because we have

talks all the time with the Tobacco Control Unit and they said they are going to try and effect it. So, if you remember last year when all the supermarkets were up in arms, because we went down to the one dispenser only in the supermarket? So that was the first step in the right direction; not to mention the one with no smoking indoors and all of that. That was, okay. But effecting that aspect of the one cigarette dispenser, that was amazing.

But we have more to do. We need to clamp down on the suitcase trade. We need to clamp down on the importation. We need to up that tax more. Because if we want to effect proper change in lifestyle, we have to do better. And that is what the Act is about; and then include vaping. We have to adjust that Act to make sure it is very specific in words because it is a very grey area, and it needs the exact words. Because these lawyers can find that the word is not there. And when they find the word is not there, then they say well we can bring it in and we can start making this. [*Inaudible*]. WITCO announced: "I am going to go into vaping because you clamped me down with tobacco so now I am going to vape." We have to make a change.

Mr. Nakhid: Chairman, she answered subsequent questions. So you could go to—

Mr. Chairman: Thank you. Member Monroe, go ahead please. Thank you for waiting.

Mr. Monroe: Thank you very, Chairman. Thank you again. Ms. Le Blanc, I thank you very much for your fruitful responses thus far. I would like to know, based on multisectoral collaboration, it was mentioned that one of the main challenges was the lack of public and private sector, in relation to the prevention of successful multisectoral action in control of NCDs. Could you just quickly elaborate for us, these challenges and what you think would remedy them in the shortest possible time please?

Dr. Le Blanc: Sure. I have to come back to the word communication, and adequate communication and we need timely communication. So, the point lead in the Ministry of Health has to communicate to us properly in a timely manner, include us ~~it~~ in the conversation, so that the campaign is not an empty campaign. Let the campaign be worth something. Let us continue it. Let it be sustainable and effective. We need better communication to have better effective cooperation.

The NGOs are here to help. Yes, we are NGOs and we will do our work, but you can hear us if you unify and unite with us. We are the grassroots and, therefore, we can help you but listen to us and communicate with us. We know what politics is about. We know the bureaucracy will exist, but at some point, I mean, we need to wake up, we need to wake up. Because while we are letting things happen policy-wise—I am very sorry to say this, but all the higher ups, all those who have money, they try to do better in their lifestyle. But what happens to the poor man? What happens to them? We have to make a change. We have to try and do better. We just cannot. The tobacco industry, you are not making tobacco, use the damn land and make agriculture. Let us try to live off our land. Cut our importation Bill. We talk a talk, but we do not walk the walk. My ancestry dictates that I continue to remind us as CARICOM, that we can feed our population, but we have to commit to it. We have to commit to it. That is our only way. We need to communicate better. We need to really effect change and put your heart in it. Do not just talk the talk, put your heart in it and get it done.

Mr. Monroe: Thank you very much for that response. Also, I would have seen here mentioned before, consultation with stakeholder groups are needed against the fight of NCDs in Trinidad. Can ~~Y~~you elaborate on the stakeholder groups that you are speaking of here and the type of consultation required to really better this present situation? Thanks.

Dr. Le Blanc: Yes, so the NCD Alliance, the Healthy Caribbean Coalition, the Cancer Society, you saw the individual NGOs, that is why we formed the NCD Alliance so that our voices could be heard unified as well. We have the Healthy Caribbean Coalition. But it is just not heard. You know what they mean? CARICOM hears one thing, CARICOM says one thing, but the Member States do not listen. And you hear very, very dare I say, sloppy, wishy-washy excuses for why we are not doing what CARICOM says we should do. You understand?

So, yes we have to really just talk. They need to talk. Our point lead in ministry needs to hit with the NCD Alliance and the Cancer Society has ~~ve~~ a seat diabetes yes; the diabetes has ~~ve~~ a seat, yes. Dr. Capildeo, who is an oncologist, a very great oncologist in our country, he said to me the other day: "~~"~~We need a cancer point lead in the ministry". I do not want to be singled out, because we are all NCDs, but it is like we do not get the right attention. Each NCD cannot get the attention, because it is only low-hanging fruits and to make you look good. That is what they are doing, and it cannot be that. We have to effect proper change. You have funding, use it not only for low-hanging fruits. Let us hit the hard hitters, ~~as~~ the high hitters, ~~as~~ we have to do it.

Mr. Chairman: Thank you member Monroe and thank you Dr. Le Blanc. We are hoping you can stay around with us for possible questions later on. But thank you for your passion and your conviction. I can hear the passion for this in your voice. I know some people may take it as dramatic, but I take it as passion, honesty and candour~~id~~ and I appreciate that very much.

We are going to go to the Diabetes Association. Thank you Dr. Dhanoo and Ms. Dookeran for your patience, and we can~~ould~~ start with member Nakhid in the line of questioning. Member Nakhid go ahead please.

Mr. Nakhid:–Thank you Chair. Dr. Dhanoo, and my apologies to Dr. Le Blanc, if she left ready. I kept calling her Ms. Le Blanc, I was not aware and I am very sorry. Dr. Dhanoo, you stated that your membership is 30 per cent men, what strategies are you implementing to get an increase in that men membership? You know men do not like to admit to having any kind of sickness or disease. It is our, I call it, ego affliction. What are the strategies you have implemented for your association to get more men to become members of your association?

Dr. Dhanoo: Thanks for that question, member Nakhid. I do not think it is exclusive to~~f~~ our organization. If you go to any single health centre in Trinidad and Tobago, you see most of them are wome~~a~~n. It does not mean that the NCDs affect women more, as you say, because of machismo or because of other factors. Men do not tend to seek healthcare until it is too late or until it is very late. That is one of the reasons men do not live as long as women.

In the organization, it is the same thing. I am sure for Asante's organization, and I am sure for the Heart Foundation as well, it is almost the same; that women tend to take more proactive measures. Now, we have been doing quite a lot with men, in that we are trying to encourage them through the things that they like to do; through sporting activities; community groups that we have. We do have about 20 branches throughout the organization. Quite frankly, we have been struggling to get more men to participate. But what we found is that when we get the women to participate, even though the men may not show up, the wome~~a~~n would go home and give the men advice. The women would go home and make sure the men are in line. And that is what has been happening, but I think it is really a cultural thing. It is something that we cannot really do much to shift that culture, but I think that cultural thing, we need to work on it as a society, as a whole--of--government and whole--of-

society approach towards this. Because it is not just the Diabetes Association that has~~ve~~ this problem.

Mr. Nakhid: Well then, if you are talking about it is cultural approach and our culture tends to be very much inclined towards party and events and one-off affairs, then have you targeted these kind of things, as Dr. Le Blanc was talking about; she looked at the cricket, I think she said sports and all that? Have you done that? Have you gone into these kinds of events to see if you can increase membership that way?

Dr. Dhanoo: I do not think we ~~w~~could go into a party with the Diabetes Association.

Mr. Nakhid: Why not?

Dr. Dhanoo: Well, first of all, we do have events that are targeted more to men. For example, when we do have a 5K, for example, more men would tend to participate than women, and we do have screening activities specifically geared towards men. So, at some times for the year we would try to target men more for diabetic eye screening foot screening, and so on. But again, there is so much to be done. Working with men exclusively has not been at the top of our agenda right now.

Mr. Nakhid: Just one more question as a segue, the Ministry of Health, they are having these kind of one-off events. You see them from time to time, walk, run~~ing around~~, and all of that. Has the Diabetes Association attempted to partner with the Government on that? Are you part of that?

Dr. Dhanoo: We usually are. So, whenever the Ministry of Health has an activity like this, usually under the TT Moves banner, we are either invited or invited to come and have a booth or even part of the planning process. There have been a few TT Moves activities where RHAs have done outreaches, RHAs have done 5Ks and we were part of the planning committee even, at some point in time.

Mr. Nakhid: Well, have you seen any tangible results, because of that?

Dr. Dhanoo: Well, I mean yes, we of course see participation on the day, we see people coming out. But it is very hard to measure tangible results or results like that if there is not a monitoring and evaluation framework established within that event. So, I would say yes, it does encourage awareness. Yes, it does encourage persons to get screened, because at those activities we have seen persons who have never been screened for diabetes or high blood pressure, and so on, before, they have been engaged and realize that they do have these conditions. Of course, we do these types of screening every single day. But beyond that, I do not think it is significant, or rather I do not think it is an appropriate spend for what we want to get out of it, meaning that we could do a lot more with that money. As the Diabetes Association, we can do a lot with that money. It could be put towards a health fair ~~care~~ or that type of event.

Mr. Nakhid: In other words, a health fair is not really a policy that could encourage more participation and membership?

Dr. Dhanoo: Well, not a significant effort. It is not significantly able to do that.

Mr. Nakhid: Alright, let us move on. Your submission identifies projects and initiatives that the Association has held over the past five years. With reference to the activities outlined under the children/–youth activities, state how often these activities are held and what does the Sixth Form ~~I~~internship ~~P~~programme entail?

Dr. Dhanoo: Sure. So, all these activities we do annually. So, we have a schedule of activities, all those listed we do every single year. Of course, for the last few years, we have started new projects. The Sixth Form ~~I~~internship project was actually started three years ago. So this is the third year that we are going to go into it. The reason for this is because ~~of~~ many sixth formers have often reached out to us and they have always wanted to volunteer. Because many of them who want to get into medicine actually need volunteer hours to get into medicine. So, we have decided to create a

structured programme for them, whereby we are teaching them everything they need to know about being in an NGO, being in a health NGO, and we would have taughthought them about research, we would have thought them about fundraising, marketing and development. We gave them—we even partnered with the Ministry of Health. We partnered with other agencies. They went to hospitals. They met the Minister. They went to Guardian Media. They did all sorts of things. They did research, and so on. So, we actually were able to have these sixth formers.

The first year when we put out the ad for it, we had about 150 sixth formers registered. We took 35, because that is how much we can hold. Last year, we had over 600 registered and were only able to take 35. So, this year I know it is going to be even bigger, because there is no other programme like this in the Caribbean, I think, where it is a structured programme for sixth formers for volunteerism. These sixth formers have now formed our youth arm. So now, we have over 100 young people in our youth arm, and these are the people who are there all the time when we dos in any of the activities to volunteer. They are doing research projects, they are doing community outreach. They are doing activities in their schools, and these are the young people who, most of them are actually getting into medicine.

So, for example, last year, seven of our sixth formers got nationals scholarships. Out of the 100 scholarships, seven of our sixth form interns got scholarships. So, theyre are really the cream of the crop when it comes to—and we are teaching these persons about advocacy, about healthcare, about working with people living with diabetes. These are the people who I want to run the organization in 10 years' time. So we are really investing in the future like that.

Mr. Nakhid: And your accredited diabetes educator programme, tell us a little bit about that.

Dr. Dhanoo:–Sure. So, that is a programme from the International Diabetes Federation, which is the Googled umbrella organization for all diabetes associations. This programme is twofold; it is online and it is also in person. So, we would have paid for and trained certified diabetes educators.

Then, from that we developed diabetes educators' education plans. So, we would have developed these plans so that these educators would go into health centres. We made a request of the Ministry of Health, and the Chief Medical Officer granted us approval to go to every single health centre for these diabetes educators to deliver lectures and talk to people living with diabetes. So we have had that permission. We have trained the 35 persons. We are now implementing the rollout where these educators would go to the health centres to teach people about foot care, teach people about taking medication, taking their insulin, how to take insulin, how to test, when to test. These are pieces of information that they do not get from the doctor or the nurse. This is information that you need to kind of figure out for yourself or join the Diabetes Association and come to our meetings and this is what we would teach you. So, we have trained these educators and we are sending them out on the field, sending them out in the health centres to be able to assist and teach people about these things.

Mr. Nakhid:-Your submission talked about competing with other organizations for a limited piece of the pie; the resources that are available. It is quite troubling to hear that. Those resources—are you telling me that there is a piece of pie there and you, and, perhaps, the Cancer Society have to fight for those resources? Is that what it is? Explain.

Dr. Dhanoo:-Asante is saying yes. I do not think Asante and I have had a physical fight before. We may have it verbal sometimes, but we know it is love. But there are limited resources. Asante is right, there are limited resources and we do have limited

resources that we have access to; not just at the Government level, but private sector. Asante gets support from Republic Bank and Scotia. We cannot get from Scotia and Republic Bank because they have given to the Cancer Society already. So, it is like that. Of course, we do have our sponsors. So, we do have Tatil and Tatil Life. We have the Ministry of Health. We have Blue Waters. We have sponsors like that who work with us. But they exclusively work with certain organizations because it aligns better to their mandate, but fighting for resources—

Mr. Nakhid: Stick a pin, Dr. Dhanoo, because I know you are pressed for time. Just give me an idea of what your operating costs are yearly. Can you give me that?

Dr. Dhanoo: So, it is approximately 1.5 million. That is our operating cost. It fluctuates because, of course, most of the cost that we have is for events. So, we have only one paid staff member, actually no, now two paid staff members. We have other staff members from OJT office. So, we have OJTs and most of our members here are volunteers. I am a volunteer as well. Shoba is a volunteer as well. So, we have a huge expanse of volunteers, that is why we are able to do so much with 1.5 million spend. We do not get that from the Government, but we try to raise as much as we can to get the work done.

Mr. Nakhid: What do you get from the Government? Sorry, Chair, last question. What do you get from the Government?

Dr. Dhanoo: Our subvention is 400,000 per year. However, we do also get funds from the TT Moves programme, the health services support programme for activities like our camps, for children with diabetes, camps for overweight children, National Diabetes School Quiz and diabetes symposium. Last year, that support would have been around the area of 500,000 or so, or a bit less than that.

Mr. Nakhid: In addition to the 400,000?

Dr. Dhanoo: Yes, for those activities, yes.

Mr. Nakhid: Thank you, Doctor. Thank you, Chairman.

Mr. Chairman: Thank you, member. Can I direct this question to Ms. Dookeran, who is the First Vice-President of the Association? Two-part question; one, despite the great work of the Diabetes Association and public awareness about diabetes and the Ministry of Health, why do you think there seems to be a lack of response by the public regarding—and at this is men and women, because I have had female and male family members who—they know their family have a history of diabetes, but they do not seem to link diabetes in their family or particular lifestyle habits with the damage that diabetes does to your body silently before it turns critical.

11.15 a.m.

Recently, I have a friend who is in his early 50s, who has a family history of diabetes, and it is only when he got a small cut on his foot playing football, and it did not heal for like three weeks, he went to the doctor and the doctor said, let me test you, and he tested positive for diabetes, and he was on the verge of having the foot amputated, that he changed his lifestyle habit. It seems that only when it gets to that drastic stage that the message about diabetes gets through to men and women in Trinidad and Tobago. I do not know if Ms. Dookeran wants to handle that first and then Dr. Dhanoo.

Ms. Dookeran: Yes. Hello, thank you for the question. One of the things I would say is, there is the fear for people to want the knowledge that they do have problems, and so some of the effects that they have, you would think it is a stigma to tell people that they are diabetic. So, for me, that is one of the problems, and that is the fear of people acknowledging that they are diabetic people. Well, they are diagnosed with diabetes.

Mr. Chairman: Thank you. Dr. Dhanoo.

Dr. Dhanoo: Yes. So, Chairman, there are so many reasons for that. So many reasons for the hesitance people have towards getting tested, or taking action. Shoba did mention the fear that people have, the stigma that is associated, also the treatment. So, for example, you mentioned about the foot, and people do not go to— the reason we have, and we do have quite a lot of amputations we have amputations daily and the Ministry of Health has actually said that most of our hospital beds in Trinidad and Tobago are actually taken up by somebody with some diabetic foot problem. So, diabetic foot problems and foot diseases are a huge issue.

Now, one of the reasons why we know people do not seek care quickly enough, is because they are afraid. They are afraid because the adage is that, if you have a cut on your foot and you are diabetic, you will get your foot cut off. Now, that actually becomes reality because people try all different types of things, herbal medication, and all these bush people are calling themselves doctors, claiming that they could cure everything known to man, and they are going to these people, and only it is too late. They would actually present to the hospital, and then it is too late, the gangrene has set in, half the foot has rotted off, and you have to cut it off to save the person's life.

So, this is one of the reasons why we are having all of these late-stage diabetic complications, because people are not going to seek care early enough. If it is you have that cut, then you can go to the doctor early and you can get it treated. If it is you are losing sensation at the bottom of the foot, and that is one of the programmes we are going to be starting within the next month, which is a diabetic foot screening programme. If you are losing sensation at the bottom of the foot, then you would need to know what to do, how to take care of it, and how to screen it. So, a lot of it is education as well, it is a multifaceted problem. We are trying to deal with some of those processes as well.

Mr. Chairman: Well, I am glad you mentioned—I am sorry to interrupt you. I am glad you mentioned education/public awareness because you have your public awareness programme, the Ministry of Health has its public awareness programme, the other agencies that have public awareness programmes. But the message does not seem to be resonating. So, we have to ask ourselves, is it the message, is it the messenger, is it the format of the message? Because at some stage you have to ascertain if the attempts at public awareness education are resulting in lifestyle changes, and changes in response to making decisions about early intervention, or diagnosis, or early checking that can save your life. I mean, the statement that you made there, to me, should be front and centre, which I never heard before, that a lot of the bed space is taken up by persons who have either a cut that will not heal or is on the verge of being an amputee.

I think there is nothing that could rally someone to change their life more than that, in terms of public awareness. So, are these analyses taking place? And why? Have there been analyses of the effectiveness of these public awareness programmes? As opposed to just keep spending money because you think that your message is getting through, and it is not resonating on the—and it is still having the desired effect.

Dr. Dhanoo: No. And that is a good point because, I mean, we often put out messages, we track what we try to put out. We could only do so much because we do not have the money and the resources to do as much as the Ministry of Health. Now, those messages that are put out may not be targeting all of the right persons and it may not be going out in the right way, or messages are going out, but how much of an effect does a message have?

If it is that you want to screen your foot. Okay, you have a cut, where do you go, what do you do? You are still afraid that you are going to get the foot cut off.

All of these things we need to really address. And then, at the same time right after we give those messages, you have people on television and in the newspapers saying that you can come to them and they will cure your diabetes; you can come to them and we will cure your cancer; or you take my pill and you could you could do this. And these things are being allowed, these things are—and people are spending millions of dollars on these things.

Everywhere, you are seeing these things popping up, and people are calling themselves doctors of this, and that, and they are not, and we are not dealing with it, and so many people I have known have come to us, because they have been going by these quacks for so long, they are not getting any relief because they are—

Mr. Chairman: Put a pause there. I want to dedicate 15 minutes to this later on, because I want to bring Dr. Le Blanc in on it, to deal with this issue because I have raised it already in the Parliament on the floor, about persons who are unqualified, unregistered, and purporting to offer cures that in many cases lead to deaths that are unaccounted for. Let me bring member Mohit in. Member Mohit, go ahead please, thanks for waiting.

Ms. Mohit: Thank you, Mr. Chairman. And let me also take this opportunity to commend both organizations on your ongoing works, it is recognized. In terms of the Diabetes Association, Dr. Dhanoo, what is your organization's take on supporting more stringent government policy interventions? For example, restricting the promotion or advertising of certain items that may be unhealthy for persons to consume, et cetera. What is your position on that?

Dr. Dhanoo: Yes. So, there is a suite of interventions that can be done to—which have been proven to increase the health of a population. These include taxation, these include limiting marketing, these include front-of-package package labelling. The two that I think that are going to work best in Trinidad and Tobago, are front-of-

package labelling, and marketing, limiting marketing. Now, every single newspaper you open, every time you turn on the TV you see a fast food ad no matter what you do, and if we try to out-advertise them, it is not possible. The amount of money that they spend on advertising.

Now, if it is, we limit that, if we limit the ability for persons to advertise or companies to advertise unhealthly foods, especially to children, because you are marketing to children. Marketing to children you are getting them to love your food, they are sponsoring cricket matches and football clubs. So you align with them, they are given scholarships, so you know for the rest of your lives you are indebted to them. And these things need to be stopped, I mean, it is severely hindering the progress that we are trying to make. So, all of this has to happen, we are trying to advocate for this Government policy to at least limit marketing in schools, in school cafeterias. You still go in and you see advertising, you see posters up, on entering the competition and you win the soft drink and you win. So, these types of things need to be implemented.

The other is front-of-package labelling. I know Asante is a supporter, and I know that Amit and they are supporters of front-of-package labelling as well, because we want simple front-of-package labelling. A black octagon at the front of a package that says high in sugar, high in salt, high in fat, to give a person the ability to make an informed decision when they pick up a product. There are so many people who are not able to read the label, they may not have the time to read the label, or they understand the back of the label. So, we want that black octagon at the front of all packages saying: "this product may be high in sugar, salt, and trans-fat, it is up to you if you want to consume it". So, we need that.

Ms. Mohit: Sure. You mentioned youth arm. I believe if I am correct, you just mentioned education. How has your collaboration been with the Ministry of

Education, your youth arm, et cetera, with other agencies, in ensuring that you move a step further based on your recommendations here? Even the Ministry of Health, what is happening with your collaboration with these agencies to ensure that you have some step forward in the right direction, or maybe any type of consultation?

Dr. Dhanoo: So, definitely with the Ministry of Education, we have grown very close in terms of the implementation of projects. So, we have decided to try to get into as many age groups as possible. So, we started with the 6th Form programme, we also have our National Diabetes Primary School Quiz which is Standard 3s. Last year we started a debate for Form 4s**.** We actually think we need to intervene much earlier. There is a project that one of our champions Hema Ramkissoon actually whispered in my ear about, which I really like. It is for toddlers, we need to intervene with toddlers, and that is where the real habit starts. So, we want to work with toddlers and their parents and teach them how to cook, and the snacks they should have. So, those types of interventions we are planning.

Ms. Mohit: But as it relates to policy? In terms of gov—

Dr. Dhanoo: So in terms of policy, we have not worked with the Ministry of Education on policy, in terms of policy for the Ministry of Health, we have of course, advocated for front-of-package labelling. Both Asante and I are a part of the NCD steering committee of the Ministry of Health, and at that level, we are able to champion and are able to give our thoughts on it. Well, of course, it is really just that, our thoughts and opinions. It is really up to them to determine what is next.

Mr. Chairman: Member Mohit, could you just put a pause for our colleague? Member Beckles has to leave us early for another commitment, but she wants to ask a question before we continue. Is that okay?

Ms. Mohit: Sure.

Mr. Chairman: Thank you. Member Beckles, go ahead, please.

Mrs. Beckles: Okay. It is just something I wanted to ask specifically about. It was asked before, and it has to do with children and youth, and how much people understand, because I understand myself about hereditary diabetes, okay. I mean, I am really asking the question because, you know, it is kind of hitting home. How is that information shared, and how can we access it, especially for seeing now that you have, I mean, a seven-year-old with diabetes and having to actually take insulin? I just wanted to relay that. That is my only little quick question I wanted to ask.

Mr. Chairman: Thank you, member Beckles.

Dr. Dhanoo: Thank you, member Beckles. I think a part of your question I did not get, but I think you are asking about hereditary diabetes, and probably leading to type 1 diabetes. So, both type 1 and type 2 are—

Mrs. Beckles: Let me just speak—I do not want to forget. I am asking specifically now about children six years, seven years, eight years? We are seeing it a lot more frequently, and I just wondered in the context of what member Mohit asked a while ago, about the Ministry of Education, because I know personally of children who simply cannot go to school.

I mean, because you know, you have—I mean, it is not easy to go to school, and whether it is a teacher, or even the child themselves at age seven, to have to be able to take insulin. So, I just wanted to get a little feel on that. Thank you.

Dr. Dhanoo: Thanks for that question. And yes. So, particularly the group for children living with diabetes. Now, we do have approximately 200 to 250 children living with type 1 diabetes in Trinidad and Tobago, and this is type, it is an autoimmune disease and it is a very sudden onset and we have children as young as a few months old being diagnosed with this type of diabetes. They have to take insulin for the rest of their lives, as you said.

A few years ago, we would have reengaged the Ministry of Health, and the Ministry of Education, on a policy for children living with diabetes. Now, that policy, I do not know where it is, it has not been acted upon, but some of the things we wanted to implement are for example, teachers do not know how to deal with children with diabetes. They do not know about insulin, children are still being bullied, they have to take insulin in school and children do not know about, you know, they say, "dey taking drugs", or some teachers—we have had issues where the teachers did not want the children to test, or they did not want the children to have something sweet when their blood sugar goes low. We have tried to educate these teachers individually through our branch of the association that deals with these children, the diabetic youth support branch.

We had plans to call out all of these teachers, or at least one teacher from each school to teach them about diabetes and teach them about the things that these teachers need to know, how to deal with a diabetic emergency, so on and so on. We are now linking up with TTUTA and the NPTA and we are hoping that we can implement that programme this year. We want to teach a teacher in every school how to deal with a child with diabetes because we had instances where blood sugars have gone very, very, low and they did not know what to do. And for many, many of these parents, they know with diabetes their lives are totally changed.

11.30 a.m.

They do not have a job anymore because they have to go multiple times a day to test their child. They can never have a full night's sleep as well. So one of the things we have actually started last year, we launched our continuous glucose monitors, which is that patch you put on the arm and get your blood sugars throughout the day, every five minutes. Now, parents who have had it, they no longer need to go to the school all the time. They could be at work and see what is

going on with the child and so on. And these are some of the things we were trying to implement. We need to educate teachers about it, we need to get those resources. CGMs are very, very expensive. I know that the Minister of Health is trying to acquire them for these children and I commend him on that. We are just waiting for them. But we know that is going to help out quite a lot with these children.

Mr. Chairman: Put a pause. We are going to thank Dr. Dhanoo and Ms. Dookeran and ask you to just hang around, as we welcome Mr. Amit Maharaj back to the conversation. He is from the Trinidad and Tobago Heart Foundation, and we thank him for being so patient.

Mr. Maharaj, you have heard a lot of the conversation this morning. From the perspective of the Heart Foundation of Trinidad and Tobago, how much of the conversation can you relate to in terms of your organization, one, in terms of funding, and two, in terms of collaboration with the Ministry of Health in terms of getting messages of healthy lifestyles across?

Mr. Maharaj: Hi, everyone. So there is been a lot of good information coming from both Dr. Asante and Dr. Andrew Dhanoo. From the perspective of the Heart Foundation, from its inauguration in 1998, our main mandate was education and awareness because by the time a person does exhibit signs of heart disease, which usually comes in the form of a heart attack or stroke, it usually is too late and the quality of life depreciates for that person and for their caregivers and everything like that. So our main mandate is preventative mostly, through education and awareness, through health fairs, through lectures, getting information out there. We are also members of the InterAmerican Heart Foundation, the American Heart Association and the World Heart Federation, through which we get a lot of resources of research and everything like that, and we try to disseminate nationwide to the public.

Another branch of our initiatives involves testing through our Know your Numbers campaign and getting persons to actively test their blood sugar, their blood pressure, know their BMI and stats, and everything like that. What we also do, because we are not medical per se, that aspect of heart disease is not directly integrated into our mandate but we do try to assist persons in getting them the resources that they need to get testing and stuff done. So in that aspect, we also have been encountering a lot of persons not getting the testing that they require when they get diagnosed of heart disease.

So stuff like the stress test, the echocardiograms, the ECG, the EKG, a lot of times when they get diagnosed with a heart-related condition through the hospitals, they now come to us and they are not sure what to do, because when they go to book their testing through the public health sector, their test data is like a year/two years and their condition is now. And by the time they get assessed of what the condition is, by that time, it either worsens, or the person is severely ill and it is a snowball effect from the time of diagnosis to the time of when they—

Mr. Chairman: How prevalent is that? Because we have had interfaces with the public too before, and more than one person just—I think it is last week in Chaguanas, a gentleman told us that he had a heart-related condition—I think he had surgery and post-operative—even before he had problems getting an appointment and then post operatively, he got an appointment for over a year for a checkup. So how prevalent is this in terms of reporting coming to you as the Heart Foundation, in terms of, one, the ability to get an appointment; two, the screening and testing at public health care institutions; and three, follow-up treatment?

Mr. Maharaj: So I know that there are a lot of persons who have been registered into the clinics, which, you know, the clinics do—they take their persons and stuff like that, which is not a problem. The wait times to be seen is hours on end really,

because of the load of persons that needs to be seen. So usually what happens is that they go in, they see the doctor, not even—not to the doctor's fault or anything, but the time frame that they get to see doctors is may be five to 10 minutes, and it is not actually the cardiologist, it is their team and stuff like that who prescribe the medications, as you know, per discharge, you know, from when they were in hospital, and it is just a repeat of the drugs and stuff like that to keep them going, you know, to keep their condition stable and stuff like that.

In terms of testing, the test, I have never actually heard someone actually gotten through with a test in a timely manner. It is usually always a year minimum. That is like the best-case scenario. So persons who do need immediate testing to assess their condition usually have to go private if they can, and some can afford it, but many cannot, you know. So it is a very tricky condition of getting the test results back in a certain time frame that the doctors, the cardiologist themselves, when they go back to clinic, can assess them and say, okay, well, this is what is going on and we need to either modify the medication to help you or do extensive testing or schedule surgeries for the persons.

Mr. Chairman: One of the persons who came to share the experiences with us told us that they received—they did not see a cardiologist. I think some other medical health care professional gave them a cocktail of drugs and there was no follow-up to find out how they were responding to the drugs moving forward—that is one, what is your experience with that in terms of your feedback? And two, what is your organization's information on the prognosis of heart-related patients who are not receiving regular post check-ups or long, long appointments in the future, while their conditions may be deteriorating, unless they can go back in an emergency mode because they cannot wait that long and they feel their health waning at some point,

between the time they last visited the hospital, the public health care institution and when the appointment is down the road, in some cases, over a year?

Mr. Maharaj: Right. So usually, that scenario—the first scenario with the repeat of drugs and stuff like that is relatively a norm and it is just that unless we—well, when we go out to our fairs and stuff like that, we also engage with persons who are on medication for cardiovascular-related illnesses and stuff like that, and we try to guide them and tell them, "Are you having side effects from your drugs? Is everything okay?" You know, we try to get that information to them because there is not really a discussion when they go to their clinic visits. It is relatively, okay, "How are you doing? Okay, these are your drugs. Do I repeat? Any major symptoms?" And unless the patients know better to, you know, actively ask the relevant questions to the doctors, which usually is not the case, they tend to just get a script and go back to get a medication, and it is for another six months.

So it is not really a check-up on their vitals and stuff like that, except for like maybe blood pressure and weight that I know of, and then they are re-prescribed the medication, unless they actively say, "Okay, well, this is not working with my system, I am getting this under side effects." So we have to basically coach persons who are on many medications to say, "You have to monitor yourself, you know. You have to—if your body is telling you that this medication is not working for you, when is the next clinic appointment, you need to bring it up with the doctors." Right? So we are that liaison between getting persons to be advocates for themselves, you know, in this system because it is relatively overpopulated and obviously, the quality of time for each person depreciates with each person who, you know, enrolls in the clinic system and things like that. Could you just remind me the second question that you—sorry, I am not hearing—

Mr. Chairman: Sorry, I did not turn on the mike. And what I am going to do in the last 20 minutes is just open the floor to member Mohit, member Nakhid, member Beckles, member Monroe, to any of these stakeholders before us, in terms of our last round of questioning. So, members, you can pose questions to Dr. Le Blanc, to Dr. Dhanoo, or Mr. Maharaj, or Ms. Dookeran on any of the issues we have covered or any new issues you would like covered or questions you would like answered from any of the stakeholders. I will start member Mohit in this round.

Ms. Mohit: Sure. Dr. Dhanoo, in your submission, you spoke of access to medication and it mentioned that:

> Newer drugs which are proven to have a better effect on patients are not on the CDAP formulary, example, Lantus, et cetera.

Are you aware of any reasons as to why these drugs are not available via CDAP?

Dr. Dhanoo: Yeah. Thanks for that question, member Mohit, and it simply comes down to the cost. Obviously, the—if it is that we are providing medication to persons for free, it has to be as economical as possible. Now, Lantus is just for everyone, it is a long-acting insulin and it allows you to control your blood sugar much better because it is a once daily shot. Especially for children with diabetes, it is very, very useful. Lantus has been taken off and replaced, to some extent, with 70/30 or mixed insulin, but it is not, of course, the same thing.

Now, it is much more expensive and that is the reason why it was taken off, firstly. But we are trying to make the case that, especially for children with diabetes, we should get this back for them because it is—what we are seeing here is these children have HbA1c, which is the measure that we use, in excess of 10. Now, HbA1c under 6.5 is normal. In excess of 10 means your blood sugar is on, an average, of like 300-plus throughout the day, and we have children with that, who have diabetes, and it is not well controlled. So we are trying to advocate for getting

Lantus and some of the other analogs onto the formulary for children just to start off, just about 100/200 of them. So we are trying to get that.

Ms. Mohit: Sure. In your submission as well, it spoke to:

> Newer versions of the 70/30 mixed insulins have been reported to not be as effective.

Can you indicate to us whether these drugs are still available via CDAP or whether they should be removed? And, you know, in terms of the Diabetes Association, what would you have done in terms of your recommendations or any consultation as it relates to this particular drug. If you can share that with us.

Dr. Dhanoo: So, of course, when you do have a drug on the formulary, they are just generic forms from different suppliers. The supplier, I believe, last year was changed and there was a Chinese version of the mixed insulin that was being supplied. We have had many anecdotal reports because we have not done a survey or study to support this, but that the dosages that—the number of units that they would normally take—people would normally take have not been effective at controlling blood sugar. So we have brought this to the attention of the Ministry of Health as well, and they are looking into it. But many persons have opted to not use that CDAP-provided medication or insulin and instead decided to purchase their own.

Mr. Chairman: Can I go to member Monroe now? Thank you, member Mohit. Any question member Monroe to any of these stakeholders before us here? We are asking two questions from each of our panelists—our members, please.

Mr. Monroe: Sure, Chairman, thank you. My questions would be directed to Diabetes Association. Chairman, to Diabetes Association, based on submissions before me from you all in dealing with NCDs in Trinidad and Tobago and unsubstantiated non-medical practices, I would like to know, in your experience, can

you elaborate on the main unsubstantiated non-medical claims that have been circulating?

Dr. Dhanoo: Yeah. So there are two levels of this. There is, of course, complementary and alternative medicines, which we are fine with. I mean, this is the bush medicine your grandmother taught you and you grew up with. And Asante is, of course, shaking her head. But using cinnamon and those types of things, that is fine. What we have the issue with is these people who are popping up and they are on radio, they are on television and they are saying they could cure your diabetes, they could cure your cancer, they could cure your heart disease. They use these tests—there are these probes now that they touch your hand, and they put on your ears, and they could tell you all diseases known to man. And these things—I do not know how we are still allowing this to happen.

We are allowing this to be on television, allowing people to say that you could come and you could touch my probe for $300 and you could know if you have cancer, diabetes and at the same time, I have a tablet to give you, a tonic to give you and it is going to work. Now, this is nonsense and we are allowing it to happen. They need to bring legislation to deal with these people because billions and billions of dollars are being spent and people are showing up—

Mr. Chairman: I am glad you are saying that, Dr. Dhanoo. I am very glad you said that because it is—I am going to ask this question of all of you, you first, Mr. Maharaj second, and Dr. Le Blanc third. Do you think the State should be more forceful in dealing with this, either through legislation or some other means? I will start with you, Dr. Dhanoo, and then I will go to Mr. Maharaj and then Dr. Le Blanc.

Dr. Dhanoo: Yes, I think the State needs to be forceful about this. I think legislation needs to be enacted to bring these people, who could make these medical claims, to criminal prosecution, because it really amounts to persons being not treated. It

means that these persons are thinking that they are getting better and they really doing more harm than good, and they only show up into the health system when they cannot do anything about it. These persons are essentially killing these persons. I mean, we need to have this intervention done.

Mr. Chairman: Thank you. Mr. Maharaj—and I have heard it said of hypertension also, in terms of heart disease. What are your thoughts on this?

Mr. Maharaj: I also agree with Dr. Dhanoo, in terms of the misinformation that goes out to the public because money and resources are being diverted from where they should, you know, be invested into, which is proper care for persons with these conditions. And anyone who touts these type of medical claims should have a medical background to, you know, purport what they claim to be and not just providing this hopeful remedy for persons to get better when, in fact, they are just using the person's money, time and precious resources, when they could be rerouted to a specific path to get better, which is through, you know, the Diabetes Association, or the Cancer Society, or medical practices that support their health.

Mr. Chairman: Dr. Le Blanc, there is a medical Act in Trinidad and Tobago which prohibits people who have not received medical training through a recognized institution to call themselves a doctor or to claim to be able to cure diseases. What are your thoughts on this issue?

Dr. Le Blanc: The Medical Board does not seem to be able to enforce this Act. I do not know why. I myself, I am an integrative health care practitioner, so I am a certified medical herbalist. That being said, I always maintain—and if you look at anything I write or speak on, it does not have to be alternative, it has to be complementary. Now, when we call it "bush medicine", I agree, Andrew, yes, it did arrive from bush but the reality is there is a standardized format to herbal treatments

now. And we have to understand and differentiate also the difference between supplement medicine and herbal medicine, and that is it cloudy and grey areas.

So the charlatans that are selling snake oil and claiming that they can cure and cure and cure, they have to be stopped. We see it all the time. We also see supplements being put up for recognition and for approval by the Ministry of Health, for food and drug, and when you approve them as supplements, they then go on TV and say, "We can cure," and that is not right. And we have to have some sort of legislature, and effecting of that legislation, not only having it but effecting it, so that we protect the society because people are looking—are you not looking to be healthy? Are you not looking to live to 90 and 100, and be able to walk and do everything? So when they seeing that angst and that interest in that, they are going to prey on that so, we have to effect it.

People who say that they can cure something, again, they are not doctors, so they cannot cure it. And if you say a herb could—you know what I tell people? Because they come to me they say, "Look, moringa could cure me of cancer." I say, "Now, let me explain something to you. I do traditional Chinese medicine. If the Chinese thought that they could have cured cancer with a herb, why in God's name do we have Chinese oncologists?" You understand?

So you have to break it down to them and you have to meet the patient halfway. I agree that there is a space for complementary medicine but we do have to have some controlled mechanism in terms of that.

Mr. Chairman: It has to be regulated.

Dr. Le Blanc: It has to be.

Mr. Chairman: Member Nakhid, do you have questions for any of our stakeholders, please?

Mr. Nakhid: Thank you, Chair. Yes, I do. To Dr. Dhanoo—this is a question coming from someone who is watching actually on YouTube. They are talking about Ozempic and why it is unavailable? I have to ask the question, why is it unavailable on the local market and studies indicate it treats type 2 diabetes effectively?

Mr. Chairman: But member Nakhid, can Dr. Dhanoo actually answer that question?

Mr. Nakhid: He is a doctor, is he not?

Mr. Chairman: Is that not a question for the Ministry of Health?

Mr. Nakhid: No, but I would imagine, Chair, that he could give us some—at least, a view to—

Mr. Chairman: Oh, he could give us his views. Okay, no problem. That is permissible.

Dr. Dhanoo: So my views on it: so, one, what I do know—because we have been looking at this drug for quite some time. What I do know is there is a global over demand for it and I do know of some distribution agencies—medical distribution agencies in Trinidad and Tobago who have been trying to source it, but the producer is not taking on any new markets because they cannot keep up with the demand. What I can say is there has been a lot of suitcase trading going on with Ozempic and other GLP-1 inhibitors—GLP-1 agonists and so on. But the thing is about these drugs—and I just want to tell the public—it is off-label use for weight loss, may have a lot more side effects than you think it does. And if you are trying to use it for weight loss, to maintain that weight loss, you need to take it for the rest of your life. Once you stop taking it, all of the things that it does, the suppression of appetite and so on, it comes back.

So that is a piece of advice there. It has been used and is very successful at managing type 2 diabetes and we are hoping to have it. Besides Ozempic, there are

other manufacturers who are making similar types of drugs, so we are hoping to have those in Trinidad as well. But be careful of the suitcase traders that are here in Trinidad, giving you and selling you these drugs.

Mr. Nakhid: Okay, I guess that was very edifying for whoever asked that question.

Dr. Dhanoo: Yes.

Mr. Nakhid: My last question to you is about—your submission stated that:

> Inaccessibility, as not all screening tests are performed locally. It is a main challenge identified by your membership.

Can you provide examples of the screening tests that are not performed locally? And explain that to the viewing public when you talk about performed locally?

Dr. Dhanoo: I do think we meant performed locally as in Trinidad but performed at the point of care. So what we are advocating for is point-of-care testing.

Mr. Nakhid: That is what I thought.

Dr. Dhanoo: So point-of-care testing, specifically for HbA1c. So the problem is—the problem we are having in Trinidad is that people—HbA1c test tells you your average blood sugar for the last three months. What are we having now at many of our health centres, you go to see the doctor, you get an appointment to go get your blood drawn probably a month later, then you come back to see the doctor in three months' time or six months' time, and then you get an HbA1c result. So that HbA1c becomes invalid because it is three months previous to that, that you are getting the result. Doctors cannot use that to make any changes in your medication. So what we are advocating for is point-of-care HbA1c testing. You go to the doctor one time, stick your finger and you get your A1c one time. At that point in time, the doctor is able to adjust your medication and know what is going on with the patient.

Now, we have advocated for it. The Minister of Health last year said that they were acquiring HbA1c machines, point of care for every health centre, so we are

waiting for that. We are hoping that materializes this year, but we have not seen that as yet.

Mr. Nakhid: So in lieu—one more question.

Mr. Chairman: No, member Nakhid, I am sorry, we have to end that at noon and you did say one more question.

Mr. Nakhid: Okay, I am sorry. Thank you.

Mr. Chairman: Thank you so much. I am going to ask each of our stakeholders to give us their closing comments. We will start with Mr. Maharaj of the Heart Foundation of Trinidad and Tobago.

Mr. Maharaj: Hi—hello? All right.

Mr. Chairman: Yes, we are hearing you. Go ahead, please.

Mr. Maharaj: Okay, great. Yes. So this forum was very enlightening. A lot of information came out that the Heart Foundation, you know, is in agreement with as well with the Cancer Society and the Diabetes Association. And what we are hoping for is, you know, some more resources to be allocated to public access, in terms of testing, and getting those tests readily available for persons and having their, I guess, quality of care improved in a more individual level, rather than a general onset population of persons at the health centres or the clinics and stuff like that, so that persons would have a better reception of, you know, medical care looking after them going forward, especially those who are unable to reverse their disease or the NCDs.

Mr. Chairman: Thank you. Can we go to Dr. Le Blanc, please?

Dr. Le Blanc: Yes. On behalf of the Trinidad and Tobago Cancer Society, I do thank the members and everybody on the Committee for having this session. I hope it is not the last. But I also hope that the takeaways are used efficiently and effectively, our message is heard, and that we can really make a change based on meetings such as this.

Mr. Chairman: Thank you. And both Dr. Dhanoo and his colleague.

Dr. Dhanoo: Thanks. My colleague, Shobha, had to leave but on behalf of her and, of course, my board, I want to really thank the members of this Joint Select Committee, the Chairperson and, of course, the Cancer Society and Heart Foundation. I really do hope—I want to echo Asante's comment, in that, we really hope that this does bring about some meaningful change in the way that we operate, in the way that we are able to get resources and share resources at that. So I want to thank everyone for that support, and looking forward to what is next from these meetings.

Mr. Chairman: Thank you very much. We would like to thank all of you on behalf of members of the Committee; Dr. Le Blanc, the Chairwoman of the Trinidad and Tobago Cancer Society; Dr. Andrew Dhanoo, President of the Diabetes Association; and Ms. Shobha Dookeran, the First Vice-President; and also Mr. Amit Maharaj, the Manager of the Trinidad and Tobago Heart Foundation. Thank you all for being with us, and your honest and candid contributions here today. But we would like to advise members of the public that our Fourth Town Hall Meeting will be coming up on Thursday, the 25th of April, at 5.00 p.m., at the Arima Community Centre. We invite the entire Arima and environs to come out and give us your views on your interfaces with the public health care system. We have had two before?—three before, and they have been very, very fruitful in terms of getting direct information from you, the members of the public, and what your experiences are with the public health care system, with specific relation to cardiological diseases, diabetes and NCDs in general, and we really appreciate the comments we have received before and hoping to see you in that interface.

And also, I would like to thank the members of the Committee for being here today, including the members who could not make it, for their support and, of course,

the Secretariat to the Parliament for they are always a very, very strong support to this Committee, we appreciate you being with us. And those of you who send questions online and comments online, thank you so much for being a part of our interface today. At this time, we would like to adjourn today's session and wish you a safe and wonderful rest of today. Thank you so much.

11.59 a.m.: *Meeting adjourned.*

Appendix V – Verbatim Notes of 22ND Meeting

VERBATIM NOTES OF THE TWENTY-SECOND MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION HELD (IN PUBLIC) IN THE J. HAMILTON MAURICE MEETING ROOM, GROUND FLOOR, PARLIAMENTARY COMPLEX, CABILDO BUILDING, OFFICE OF THE PARLIAMENT, ST. VINCENT STREET, PORT OF SPAIN ON WEDNESDAY, JUNE 26, 2024, AT 10:45 A.M.

PRESENT

Dr. Paul Richards	Chairman
Mr. David Nakhid	Member
Ms. Vandana Mohit	Member
Mrs. Pennelope Beckles-Robinson	Member
Mr. Brian Lucio	Assistant Secretary
Ms. Lorraine Berahzer	Assistant Secretary
Senior Parliamentary Research Specialist	Ms. Katharina Gokool
Parliamentary Research Specialist	Ms. Rochelle Stafford
Parliamentary Research Specialist	Rea Anne Alexander-Thompson

ABSENT

Mr. Avinash Singh	Member [*Excused*]
Mr. Rohan Sinanan	Member [*Excused*]
Mr. Roger Monroe	Vice-Chairman [*Excused*]
Mr. Esmond Forde	Member [*Excused*]

MINISTRY OF HEALTH

Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer

Dr. Stewart Smith	Senior Health System Advisor
Dr. Marcia Clapperton	Director, Non-Communicable Diseases Unit
Mrs. Anesa Doodnath-Siboo	Principal Pharmacist (Ag.)

NORTH CENTRAL REGIONAL HEALTH AUTHORITY

Mrs. Stacy Thomas-Lewis	Chief Operating Officer (Ag.)
Dr. Abdul Hamid	General Manager - Primary Health Care Services (PD)
Dr. Kimani White	Medical Chief of Staff (Ag.) EWMSC

EASTERN REGIONAL HEALTH AUTHORITY

Mrs. Angelina Rampersad-Pierre	Chief Executive Officer (Ag.)
Dr. Rajiv Bhagaloo	Medical Director
Dr. Jamila Augustine	County Medical Officer of Health

SOUTH-WEST REGIONAL HEALTH AUTHORITY

Dr. Brian Armour	Chief Executive Officer
Mrs. Michelle Murray-La Foucade	General Manager, Policy Planning and Research
Mrs. Rachel Jardine-Burkett	General Manager, Nursing

NORTH WEST REGIONAL HEALTH AUTHORITY

Mr. Anthony Blake	Chief Executive Officer
Dr. Keisha Gangaram	Director of Health
Dr. Kellie Alleyne-Mike	Medical Director, Cancer Centre of Trinidad and Tobago (Oncology)
Dr. Keegan Baggan	General Manager, Primary Care Services

Mr. Chairman: Good morning, everyone. Welcome to the viewing and listening

audience to the Twenty-Second Meeting of the Joint Select Committee on Social Services and Public Administration. This is the Committee's third public hearing with stakeholders pursuant to its enquiry into Trinidad and Tobago's response and responses to the prevalence of non-communicable diseases and other issues concerning the delivery of health care services in the country.

Members of the public are invited to submit their comments and/or questions on the Parliament's social media platforms, including the YouTube channel, *ParlView*, or via Facebook and Twitter. We are happy to have with us stakeholders from the Ministry of Health, including the Ministry of Health itself, the North West Regional Health Authority, the North Central Regional Health Authority, the Eastern Regional Health Authority, and the South-West Regional Health Authority. At this time, I would like to announce that the Tobago Regional Health Authority was invited to attend this meeting. However, the Committee was informed that the authority was unable to participate due to administrative challenges. At this time, I would like to invite members of this Committee to introduce themselves, starting on my right with member Nakhid.

[*Introductions made*]

Mr. Chairman: Thank you all. I am the Committee's Chairman, Paul Richards. I would like to invite the members of the stakeholder groups to introduce themselves and their teams, starting with the Ministry of Health, please.

[*Introductions made*]

Mr. Chairman: Thank you all. We appreciate all your good selves and your teams being here with us. Just to give some context, on November 15, 2023, the Committee met with the management team of the Ministry of Health and the regional health authorities to discuss the State's strategies in combating non-communicable diseases. As you know, non-communicable diseases are among the biggest

challenges facing the world and certainly, Trinidad and Tobago is no exception, with what I believe to be as much as 60 per cent of mortalities being attributed to NCDs in some way or the other.

Following the public hearing, the Committee held five Town Hall Meetings. I would like to already publicly thank those who hosted us in the Parliament building, in San Fernando at City Hall, in central Trinidad, in Arima, and most recently, last week Thursday in Tobago. The first Town Hall meeting was held at the Parliamentary Complex on Wednesday, November 29, 2023; the second at the San Fernando City Corporation on Thursday, January 18, 2024; the third at the Centre Point Mall in Chaguanas on Thursday, March 07, 2024; followed by Arima on Thursday, April 25, 2024; and last week Thursday in Scarborough, Tobago, Thursday, 13 June, 2024. A second public hearing was convened for Wednesday, March 20, 2024, with the Diabetes Association of Trinidad and Tobago, the Trinidad and Tobago Heart Foundation, and the Trinidad and Tobago Cancer Society.

Following the Committee's extensive consultations with the public and members of stakeholder groups, the Committee thought it prudent and important to convene this meeting to allow the Ministry of Health and the CEOs of the regional health authorities and their colleagues the opportunity to respond to some of the major issues and, in some cases, recommendations which were highlighted by members of the public and the various stakeholder organizations. We would like to publicly also thank all the people who came out to those Town Hall Meetings. We really appreciate them coming out and sharing their experiences, good and bad, with us at those exchanges.

At this time, I would like to invite the leads of the teams with us to deliver opening brief remarks, hopefully not extended past two minutes, starting with the PS, Ministry of Health, Mr. Asif Ali.

Mr. Ali: Thank you, Chair, members of the Committee, colleagues of the RHAs, colleagues of the Ministry of Health, and the listening public—

Mr. Chairman: Is the mike on?

Mr. Ali: Thank you. Morning, again, Chair, and member.

Mr. Chairman: It seems to have gone off again. Could we exchange it with another mike? We will just charge the Ministry of Health for it.

Members: [*Laughter*]

Mr. Ali: I guess we will share this one?

Mr. Chairman: Yeah. That is good. Thank you.

Mr. Ali: Okay, fine. The Ministry of Health is the national authority charged with oversight over the national health system and plays a central role in ensuring that the provision of health services conforms to the principles of universal health coverage. As it relates to non-communicable diseases, NCDs, our key strategic priority areas and programme activities are focused on the personal health and wellness of our population, and strengthening our support systems to our clients.

Chair, and members, I take this opportunity to reaffirm the commitment of the Ministry of Health and the RHAs in the provision of health services, and look forward to today's proceedings to allow us to further share information with respect to the programmes and services for the prevention, treatment and care of NCDs. Thank you.

Mr. Chairman: Thank you, Mr. Ali. Can we go next to the Chief Operating Officer of the North Central Regional Health Authority, Mrs. Stacy Thomas-Lewis?

Mrs. Thomas-Lewis: Morning, everyone—[*Inaudible*]

Mr. Chairman: Is the microphone on?

Mrs. Thomas-Lewis: Oh, sorry.

Mr. Chairman: Thank you.

Mrs. Thomas-Lewis: Okay. Sorry. Good morning, Chair, and committee members. My name is Stacy Thomas-Lewis, representing NCRHA this morning with our General Manager, Dr. Abdul Hamid, and our Medical Chief of Staff, Dr. Kimani White. We are here to highlight all our improvements and the activities associated with our battle against the NCDs, with the instructions and guidance under the Ministry of Health. So we trust that all the questions and comments posed to us, we will be able to respond in a positive and productive manner. Thank you.

Mr. Chairman: Thank you. Can we go next to Mrs. Angelina Rampersad-Pierre, the CEO, Eastern Regional Health Authority?

Mrs. Rampersad-Pierre: Thank you, Chair. With me today is Dr. Rajiv Bhagaloo, our Medical Director, representing secondary care services; Dr. Jamila Augustine, our County Medical Officer of Health, representing our primary health care services. The Eastern RHA is very excited to be here this morning to participate in this session. We look forward to answering all the questions posed by the members and Chair, as well as being able to inform the public of the services and our improvements at the Eastern RHA.

Mr. Chairman: Thank you. Next, CEO of South-West Regional Health Authority, Dr. Brian Armour.

Dr. Armour: Good morning, again, Chair and members. The South-West Regional Health Authority is pleased to be here in partnership with our colleague, RHAs and the Ministry of Health, and with the general population at large. Accompanying us as part of the south-west delegation today is our General Manager, Policy, Planning, and Research, Mrs. Michelle Murray-La Foucade, as well as our General Manager, Nursing, Mrs. Rachel Jardine-Burkett. We to look forward to answering all questions in a matter of accountability to the public and we are very conscious that we are all here for the health and well-being of the nation at large. Thank you.

Mr. Chairman: Thank you so much to you all. Just a bit of housekeeping, we remind both committee members and officials to direct their questions—oh, I am sorry. Can we go to Mr. Anthony Blake, please, CEO of the North West Regional Health Authority? My apologies, sorry.

Mr. Blake: No problem, Dr Richards. So morning to you, again, and morning to the members of the Committee. Just like my colleagues here, and the PS, we are proud, at the North West Regional Health Authority, to be here because accountability is important to us and to our colleagues here. With me today, I have Dr. Keisha Gangaram, our Director of Health. I also have Dr. Kellie Alleyne-Mike, Medical Director of the Cancer Centre of Trinidad and Tobago. I also have Dr. Keegan Baggan, our GM, Primary Care Services. Thank you very much.

Mr. Chairman: Thank you all. Certainly, with everyone here, including the CMO, we know we have the prominent stakeholders and figures in the health care system in Trinidad. Of course, Tobago could not be with us for administrative reasons, and we really hope to be able to identify, through you, some of the challenges you are having because our interfaces with the public have been very eye-opening and elucidating to what they are experiencing on a day-to-day basis, in terms of interfacing with the health care system in Trinidad and Tobago.

As you well know, because you are the medical health care professionals, when people are ill, or their families are ill, it is a crisis in their families, and there is a response that they have internally, psychologically and physically. They are under duress under those moments and they go to the public health care system, in particular, to get redress in a particular way. There have been good news and there have been very, very not-so-good news. So we hope to be able to share some of the experiences with you that the public has been able tell us directly.

In terms of just housekeeping, we ask members and officials to direct their

questions through the Chair. Members are kindly asked to activate the microphones on their devices in front of them when you are acknowledged by the Chair and turn them off when you have concluded your contribution, and we will proceed accordingly.

In terms of our interfaces with the public, the issues that have risen fall into some general categories, including delayed appointment times; delayed service times; equipment shortages; access to treatment; access to medication, in some instances, focused on CDAP; and inside of the medical health care system. Also, they have had issues in patient record management and also, last but by no means least, in particular, reference to NCDs, and proactivity, and being proactive, and preventative awareness and education programmes.

It was quite interesting to hear some circumstances where persons went in, in what they considered emergency situations—and I know there is a triage process in the hospitals. But in one case, in particular, a young woman went in with severe breathing difficulties and was forced to wait. In another instance, a gentleman and his wife both had heart conditions, and after the initial intake, were given a year appointment to follow-up and the gentleman's wife passed, unfortunately. These are the kinds of stories that we have heard, in addition to some good news. So I think the public is expecting a lot, in terms of responses and recommendations on how they will be implemented.

I want to start by asking the PS and the CMO a question about the—and there is a difference between clinical proficiency, with the medical professionals, and administration and management. Of course, they work together—you can correct me if I am wrong—to complement an efficiently operating health care system. And in doing some research before coming here, many of the papers I have read indicated that among the biggest challenges facing the health care sectors in North America,

in the UK—in the NHS in the UK and across the world, is the management and administration of health care services across various sectors.

So could the PS and then the CMO indicate if there are challenges in administration and management in the various RHAs in the country, and what those challenges are that you face on a daily basis in delivering health care services to the people of Trinidad and Tobago?

Mr. Ali: Thank you, Chair, maybe I could start. So at the level of the Ministry, we do have the appropriately resourced persons to provide that sort of administrative support, oversight, guidance, and technical guidance also to the RHAs. I would let the respective CEO speak to what exists at their various RHAs.

11.00 a.m.

Dr. Armour: Sure. At the South-West Regional Health Authority, there is an organizational top structure, which starts with the CEO and the executive management team, and then we have technical heads of departments in different spheres. The core business of the industry is medical and nursing, so we do have core clinical executives there and we do have a demarcation into secondary care and primary care services, as well as outreach services.

From a health system's approach, apart from the core services, we do have other spheres of administration: human resources, finance, ICT, corporate communications, particularly quality as well, and risk management services, to name a few. So organizations like us, we are guided by a strategic plan, which in turn is guided from the Ministry of Health's strategic plan and they in turn are guided by the Government's agenda. So with a strategic plan, vision and mission and with your goals and objectives, then we implement and architecture policies and programmes and service delivery models to manage the health care system.

It may sound armchair but those documents and reports are living documents

so we get dynamic feedback from patients, staff, visitors alike, and then we factor that into a monitoring and evaluation framework that then impacts on how we interpret the results and meet the needs of the patients at core. So that is a snapshot as to how the management and administration works it out.

Mr. Chairman: I am glad, Dr. Armour, you mentioned it was an armchair response because I could find that in a book and a document, and that is great. It is wonderful that is the prescribed policy and procedure and strategies but what I want to get from you as to the question, because what we have gotten is a different level of feedback from the public. That may be all well and good as documented, but that is not the feedback we got in terms of if that is operating efficiently because of the delays and the challenges.

So, the question again is, are there challenges and what are those challenges because clearly, when you walk into the hospital, the RHAs, particularly the larger hospitals, you will see scores of people waiting hours; 12 and 10 and 16 hours. So what I want from you is what are the—clearly that cannot be efficient operation. Clearly, there has to be challenges, which are the catalyst for those massive delays in people who are in crisis in many cases. What are the challenges you are experiencing in management and administration that may be causing these kinds of issues? So the overall policy document is great, but when the public is looking on, that is not the experiences in a lot of cases, in many, many cases. They want to hear what—we are giving you the opportunity to tell us what your challenges are.

Dr. Armour: Duly noted Chairman. The system is not perfect, but there is a balance scorecard of successes and challenges. One of the main ways in which we monitor successes and challenges is through management of quality indicators for which we have client feedback system reports. And we measure the things that were mentioned in the public consultations: wait times, delays for surgeries and things

like that. So therefore from that, the challenges when they present to us, then we have to have systems in place to use the resources that we do have, in order to be efficient, to at least ameliorate and at best solve the problems that we do have in the sector. So it is a monitoring and evaluation framework.

Our quality department, from the executive arm to the front-end arm, they look at the impact of the service delivery models and programmes, and based on the feedback that we get, then we do a resource allocation or reallocation approach in order to solve. We work in a resource-constrained context, so we are always asked upon to be as efficient as we can. Everybody would like more resources but the resources, we use it as efficiently as we can at this point.

Mr. Chairman: To make—let me be more direct with my question because that answer kind of frustrated me. I am not saying you are inaccurate, you know. Do you have equipment challenges? Do you have staffing issues? Do you have personnel management HR issues that provide significant challenges in you effectively delivering health care at the North West Regional Health Authority directly?

Mr. Blake: Sure Dr. Richards, I will attempt to qualify some of what you said. Let us start with the health administration first. When we look at health care as my colleague said, yes, you have a lot of clinical professionals but managing an RHA is similar to managing any different ministry. So when you come out of the operating theatre and so on, you have to manage for success, and in some of the ways that Brian would have said.

One of the things we have seen at the North West Regional Health Authority is, a lot of the middle management were not really trained for management. So you may have been a nurse all your life and then graduated now to become a nurse manager, but what is the pathway for that? You may have been a doctor and then

now you become the head of clinical operations and so on, but not being trained for management. One of the things you would have seen, for instance, on our social media, is that we would have partnered, signed an MOU with the University of Trinidad and Tobago to train our clinical professionals in management. We have actually done an entire cohort last year. That cohort would have graduated two months ago and we are starting a new cohort this month, specifically to train clinical professionals in the areas of middle management, realizing that there is not a depth of management knowledge within the clinical professional area.

The next thing we look at is resource allocation. When you look at the type of human resource coming through the RHAs. We always hear about nursing shortages and every RHA here could bear me out. We always have shortages in that specific area and they will tell you that nurses are really the lifeblood of the organization. But you are facing several factors there, you are looking at the pull from the US. You yourself, Dr. Richards, spoke about in your research. You looked at the NHS and so on and you would see the large difficulty they and all, at this point in time having retaining nurses. The same thing is going on in Canada; the same thing is going on in the states. So, you have all these recruitment agencies coming to Trinidad and Tobago now to recruit our very qualified nurses here.

One of the issues are that nationally, the pool of available nurses is not sufficient to give us the level of nurse-to-patient ratio that we would like. What we have done, we have been working with the Ministry of Health and the international desk in the Ministry of Foreign and CARICOM Affairs to also look at recruitment of foreign nurses. We are also looking at our retention strategies for local nurses. We are currently doing a permanency exercise at the North West Regional Health Authority. We also, with the coming of the central block, we have approximately 100 nurses on full-time specialist training now. So we are investing in the training

and education of our nurses, also helping to fix that issue of retention. The next thing you spoke about was equipment. Yes, you have a difficulty with equipment and I will contextualize it.

Port of Spain, for example, has two CT machines now. There was a time we had one CT machine and thankfully, we got another one this year. The one CT machine, based on the need—I am a civil engineer and I could tell you, when you get a piece of equipment in the public service, the manufacturer would say to you "The running hours for this piece of equipment is supposed to run six hours for the day maximum". But because of the patient load on a CT machine, on a dialysis machine, other types of machines, you may find that one piece of machine, example like a CT, being on for 24 hours in the public health care system. So the ability to plan maintenance from the engineering staff, based on the need from the public, is much more difficult because we would have looked at running hours and be able to say "You know what? We will change a CT tube every six months and order a tube every six months." but because of the need in public health, it is much more difficult to predict.

The other thing is, because we do not manufacture these things locally, and because of the challenges with foreign exchange, a lot of the local suppliers are not stocking spare parts in Trinidad. They rather keep their foreign exchange than have spare parts on the shelf, waiting for the RHA to order. So, a lot of times, if you have a breakdown with a piece of equipment, what will happen, the manufacturer rep locally may say to you "It may take four weeks, three weeks" and so on to get the specific part in the country. Remember, none of these dealerships would really stock, other than simple maintenance parts. Once it is, how should I say, a more complex part, it is something that we have to go out of the country for, and it usually takes some time; and obviously, that would cause some downtime with us.

Mr. Chairman: Thank you. Just before I go to my colleague, member Mohit. PS and CMO, could you give us a sense of what the nurse-to-patient-ratio is presently in Trinidad and Tobago, and what best practice internationally is, and how we compare?

Mr. Ali: Chairman, I would let CMO speak to what is the best practice international ratio, but it would vary between RHAs. Obviously, each RHA would have a different—our nurse-to-patient ratio is not the same across the board so that varies by RHA.

Dr. Parasram: Even between RHAs, it varies between types of settings. For example, in an ICU setting, we expect that we have one-to-one or one-to-two ratios for nursing. In a general ward where you have some ambulant patients, you would find that would change over time. So, it does vary, not only within RHAs, but at the individual setting and we can provide that in writing as it relates to the different types of settings to the Committee if that is acceptable.

Mr. Chairman: Are we along—and I understand what you said with the different types of nursing situations or needs. But, given what you know of the RHAs, are there RHAs that are vulnerable because of the nurse-to-patient ratios? And, which RHAs would those be and those that more comparable to international best practices in any of the categories including the ICU nurses or general practice nurses?

Dr. Parasram: I would not say that there is a specific RHA that is vulnerable. I would say there is a specific setting and CEO Blake started the conversation about being a small island developing state and the issue of retention and engagement, even on the first instance of subspecialists in both nursing and medical care is always a challenge for us. So, out of that, we find that for certain specific areas, there is always a challenge for nursing. For example, in terms of retaining ICU-trained nurses, is a difficult area for not only us, for other small island developing states like

us. And it really relates to the packages that we offer, conditions of work and all the others that have gone before, in terms of discussion.

I think, just mooring us back to the NCD epidemic a little further; the waiting times especially in an A&E setting, is related to the large prevalence of NCDs in Trinidad and Tobago. We had significant discussion of the last meeting related to the work that the Ministry is doing to try to move towards prevention. Moving towards prevention is not something that will cure the ills of the system overnight. It is something that takes five to 10 years to be in process. In the meantime, we have to try to do the engagement, as CEO has said, to increase the number of staff that we have at the frontend bearing the challenges. So I would say as you asked in the outset, the challenges that we have is that we continue to have an NCD epidemic, and this is looking at the national level. And our focus in the Ministry is really trying to deal with that at the primary care level, through prevention and hence we have our director of NCD is with us today as well.

We also have the challenge that Trinidad and Tobago continues to try to offer universal access to care as a free system in the public system. Offering free universal access to care in the context of also offering some of this free universal access, bearing in mind we have a non-national policy, which speaks to access of public health diseases, immunization, and acute emergencies for non-nationals as well. You have a growing population that is seeking public health care. Just to contextualize a little bit, the challenges that we are seeing from the policy level: retention, NCD epidemic, and of course, having universal access with a finite purse.

Mr. Chairman: Thank you. Member Mohit.

Mr. Nakhid: Just for my own education, just crystalize it for me based on what has been submitted so far. We have a problem with the nursing ratio; our nurses are—we are short staffed basically. Correct me if I am wrong, that is what I am hearing.

There is a nursing drain, which I know personally from family going abroad and so. Correct?

Dr. Parasram: I would not say there is a general short staff. What we said is in specific areas, there is short staff of certain types of nurses. General nursing for example, and the nurses among us can elaborate a little further and I can speak to my CNO, Chief Nursing Officer, and get figures as to which categories are actually short staffed, so we can submit that to the Committee.

Mr. Nakhid: So just a question Mr. Parasram. Has anything been put in place—

Dr. Parasram: Sure.

Mr. Nakhid:—to cater to that kind of specialization that you are referring to?

Dr. Parasram: What we have done through the Ministry is, through the international corporation desk and bilateral and bilateral arrangements with other countries; as you know there is an existing arrangement that we have with Cuba, longstanding arrangement, for a number of years. So nurses continue to be brought in through that agreement. We are trying to look at other bilateral agreements that can be put in place, Government to Government, to do similar from other territories as well, while we do training, which is an ongoing process for the subspecialties. So, it is training of our local nurses in the interim and while that—before matriculation and before completion, we are trying to buttress that with international support as well.

Mr. Nakhid: And how has that been going? You can give us some indication?

Dr. Parasram: I think without the international support it would be difficult to maintain the services that we have so really, I think that cooperation has been very good towards Trinidad, and we want to see that grow from other territories.

Mr. Chairman: Thank you. Member Mohit.

Ms. Mohit: Thank you very much, Mr. Chairman. Mr. Chairman, I am listening to

the responses and I totally understand what is a correct CEO's answer, but I think what the general public is looking forward to hear from this meeting, is that of what exactly is being done to improve the health care system.

11.15 a.m.

So, Dr. Armour, I listened carefully in terms of your monitoring and evaluation, your resource constraints, et cetera, how you would usually deal with it. But, arising out of these town hall meetings, we would have had specific issues being vented to the Committee that have long wait times. So for instance, what I would like to hear from you today is what exactly the RHAs are doing to deal with patient volumes, given the public outcry.

In terms of your equipment shortages, which you mentioned, we would have had persons saying to us that they are forced to seek private health care due to the issues they face in the public institutions due to shortages of equipment, et cetera. What exactly is being done to address the shortage of equipment? How are you approaching your PS? How are you dealing with draft estimates for the next financial year, et cetera? What exactly is being done as it relates to your patient volume, your shortages of equipment? Yes, your monitoring and evaluation, and your resource constraints explanation, it sounds good. That is normal procedure. But in terms of hearing these issues coming from members of the public at these town hall meetings, it is not by coincidence, it is each and every town hall meeting that we attended, persons had these issues ventilated. So, can you please explain from your various RHAs what exactly is being done as it relates to these delayed appointment times, these shortages of equipment?

Mr. Ali: Chair, if I may, before the CEO starts off, just taking up on member Mohit's question, I am looking at three areas, as you said, possible, or perceived

equipment shortages, delayed appointment times, or wait times for appointments at the clinics. I know it was mentioned also within your A&E Departments—

Mr. Chairman: Treatment times.

Mr. Ali: —treatment times within A&E. So I would let the respective CEOs speak to what are we doing in terms of those three areas, what strategies they have in place to address those things, but just bearing in context what CMO spoke about contextualizing where we are in terms of increase demand, for example, at our clinics, and to a lesser degree at our emergency departments. Because of NCDs, you have more persons coming in. So while as CMO said we treating with health promotion and educating and empowering the public, that will take some time. Those persons who unfortunately have diabetes, have hypertension, that is not helping them so much right now. It will help those persons prevent them from getting NCDs. So we have to treat with the current situation as we go forward.

Dr. Armour: Okay, thanks for the question. Dealing with major equipment shortages. We have major medical equipment and in South-West view they largely function well. We have an aged MRI that has had intermittent challenges with downtime, but we are working with the Ministry of Health through the PSIP and Administrative Systems to attempt to source a new MRI. But, the current MRI is functional. And we also collaborated with North Central Regional Health Authority within the last couple of weeks in order to deal with our outpatient persons who have to get MRI services at North Central while we reserve the warded patients to access our MRI services that are currently functional.

Our CT scans—we have two CT scans. We were down for a CT scan for about four to five months due to the fact that the one in the ED was aged, and as of yesterday we have supplied, installed and commissioned a 120 slide CT scanners the South-West Regional Health Authority, San Fernando department. So, in terms of

what was intervening in the interim is that we had one CT that was managing ED cases, cases coming to the emergency department, as well as the outpatient clinic. But with the commissioning of this new CT scan, we are back up to two CT scans and that also excludes the CT scan services available at the Point Fortin Hospital.

We do have X rays, ultrasounds and other equipment that have a certain redundancy factor as we call it, so if one breaks down, we can rely on another machine in the interim and that is really through our hospital EDs and our district health facilities.

How that translates to wait times, for example, in the Point Fortin Hospital, you can walk in and get X rays same day, you can get ultrasounds same day. In the outpatient clinics in San Fernando General Hospital from the data metrics that I do have, you generally can get the appointments within a couple of weeks to get those tests done. Those are basic tests. MRIs, we do have the relative backlog around eight or nine months but, as I said, we are addressing that working with the North Central Regional Health Authority. In terms of the waiting times, we do monitor very closely—

Mr. Chairman: How does eight to nine month waiting time affect a patient's prognosis?

Dr. Armour: Largely it will not. So, we will have persons who have to have what we call elective procedures where they have disabilities or ailments that can be best corrected with surgery, but it is not life or limb threatening, but it will improve their quality of life. So, the medical and nursing personnel they will collaborate and we will have a prioritized list. I did say that for persons on the ward we are maintaining those who need urgent MRIs, whether it is for urgent surgeries, or urgent procedures that still is done. And we are collaborating with the North Central Regional Health Authority within recent times to address that backlog but out of all the equipment

that is the only one that we face challenges with at this point in time but that will be resolved.

Mr. Chairman: Mrs. Rampersad-Pierre.

Mrs. Rampersad-Pierre: Thank you Chair. So at the Eastern RHA, just to give some context, we cover one third slice of the island. That alone in itself is a challenge because we serve Matelot all the way up in the north, Guayaguayare, Biche and Brothers Road. We are also unique in that we have a lot of tourists coming to our area as well. So that speaks to the patient volume sometimes and the geographical spread that some of our patients have to traverse in order to get services. So that in itself is a challenge and can also be linked to the patient care in terms of them coming down to access. We do have 16 primary health care facilities in the Eastern RHA with an A&E in Toco, Rio Claro and Mayaro. So that allows us to bring some of the secondary care services closer to the population, of course, major secondary healthcare services, they will have to traverse to Sangre Grande for that.

In terms of equipment shortages, at the Eastern RHA, we do not have some of the larger equipment like MRI, for example. That will come on stream and we fully operationalize our new Sangre Grande Hospital. So we would depend on a partnership with our other RHAs to serve the population so, of course, we will be impacted by wait times because our patients are in a pool with the national public, where we partner with our other RHAs. In terms of our equipment management, in terms of what we do—

Mr. Chairman: Just to get a sense.

Mrs. Rampersad-Pierre: Sure.

Mr. Chairman: —when your patients from Eastern RHA are referred to your partner RHAs, who already have delays, how does that impact their time now

because it seems to be that what Dr. Armour said and Mr. Blake said is that they have challenges because they also have volume.

Mrs. Rampersad-Pierre: Yes.

Mr. Chairman: So if you are transferring or referring your patients now, for MRIs on top of that, what happens to their appointments?

Mrs. Rampersad-Pierre: All right. And there is also prioritization from the clinical perspective, so that when the MRIs are referred and the clinicians review, they will know the severity and the urgency of the cases that is coming their way. So yes, it will add to the volume of the other RHAs but clinical prioritization will occur so that clients who are very urgent, example, oncology patients will be seen a lot faster than someone who may be looking at something a little less severe. So it does add to the pool.

Mr. Chairman: What if I told you earlier on this morning, and this is to the general pool before us, that while that may be so in principle and it may be happening, I cannot doubt that I have no evidence to say it does not. Just this morning, I heard about a situation where a gentleman had a very bad headache, went to St. James—and this is not necessary for you but generally—went to St. James, the initial examination saw him seeming to have a brain bleed. So he was referred to Port of Spain and he had to wait 24 hours to get a scan. When he got there, they told him: Well St. James "ain't" tell me nothing. So he went there expecting to have his documentation in place because he was referred by a sister establishment but had to wait 24 hours with a brain bleed and it is only when he called a relative in the system to intervene, he got services 24 hours later. So while in documentation it maybe so, in practice there seems to be gaps in some instances, communication. How do we respond to that? How do we fix that? Is that something that you acknowledge may be happening?

Mrs. Rampersad-Pierre: So we do have a very good partnership with the RHAs. We have our Quality Department who will ensure follow-ups in terms of the referrals. Of course, for inpatient services, it is a lot easier because that person is going down to get it coming back up to the ward. For outpatient services, we monitor through our quality system as well as our ongoing outpatient clinics. So when we know a patient has to come back for clinic, you know, the file is checked and so on and if the MRIs are not in there, we have follow ups with the respective RHAs on it. Right? I am not saying that we may not have hiccups in between, but that is the system that we have in place. And of course, if there are delays and patients reach out to us, we ensure through our Quality Department that we monitor throughout to get the necessary reporting from the MRIs or whatever testing we send outside.

Mr. Chairman: Mrs. Thomas-Lewis.

Mrs. Thomas-Lewis: Good morning Chair, and the Committee again. As it relates to the interaction at our Accidental & Emergency, the NCRHA has clinical ambassadors, clinical liaison officers, and emergency medical technicians. So as soon as a patient presents themselves, they are interacted with either one of those positions and clinical priority is given. We have a 98 per cent uptime as relates to our medical equipment. We undergo rigorous planned preventive maintenance on all our medical equipment.

Over the past five years, we have been able to receive medical equipment ranging from infusion pumps, CT machine, MRI and in addition our brand new hospital, the Arima General Hospital is also poised to hold—it has CT machines, MRI and radiological and sorry, my apologies but gas machines, an ICU with a range of medical equipment. We also have the Couva Hospital that has MRI machine, CT and medical equipment. So we are at a positive stage as it relates to medical equipment.

As it relates to backlogged radiological responses, what we have done—our strategy is that we have taken those that might have been a backlog at the Eric Williams Medical Sciences Complex and we have sent it to Arima General Hospital and Couva so that has brought down our backlog. And, in relation to staffing, what we have done is that we have done continuous audits, quality improvement audits, and we have looked at all our clinical needs and management need and we continued schedule training.

Mr. Chairman: Thank you. Mr. Blake.

Mr. Blake: Thanks again Chair. Let me just start with the waiting times at A&E. So the North West Regional Health Authority has a specific problem with waiting times at A&E, and I want to acknowledge that from the onset, but that problem would have presented itself once the Central Block at Port of Spain General Hospital was condemned and demolished. We went from having over 500, almost 600 beds at the Port of Spain General Hospital to now having just over 100 beds at the hospital. It means that persons coming into A&E being triaged and seen and so on, and that waiting time to go to the ward or to be presented with a bed is always extended because now Port of Spain General Hospital is always filled. There is never an empty bed at Port of Spain General Hospital. So it is almost like you are waiting in A&E for someone to be discharged to get a bed in the hospital.

What have we done since then? Well, obviously we have 540 additional beds that will be commissioned at the end of March next year when the Central Block comes onboard. But to alleviate some of that stress, the Ministry has assisted us by providing funding at the St. James Medical Complex to open a 60 bed unit which we opened during COVID-19, which is used now to refer low acuity patients from Port of Spain to move them from the wards in Port of Spain to St James to free up bed space. So we are going to have some limitations between now and March next

year based on the limited bed space and that will affect the transition and the patient journey from that triage in A&E onto the wards and so on.

In terms of the major medical equipment, I spoke about some of it earlier. But, I want to say we would have commissioned a new radiology suite at the Port of Spain General Hospital last year which includes new CT machine, digital X ray, mammography and so on and that has been working well. The existing Accident and Emergency, we do have a portable X ray and a digital X ray machine there. Just two months ago, we would have commissioned a new MRI at the St. James Medical Complex and that has assisted us greatly.

One of the things that we have done to alleviate critical needs for MRI and emergency needs, we have a referral agreement with at least two of the major providers nationally for MRI. So we have a referral pathway that we send critical MRIs to the private sector too also.

Mr. Chairman: Member Nakhid.

Mr. Nakhid: Good morning again.

Mr. Chairman: Unmute the microphone.

Mr. Nakhid: What measures are in place to prevent doctors, from redirecting patients to their private practice when procedures can be done at public institutions?

Mr. Chairman: I do not know if the PS or the CMO wants to deal with that. That issue came up several times, at almost every town hall meeting, where patients indicated either formally or informally, they were told: "You eh go get it right now here you know but you could check meh down the road."

Mr. Nakhid: At considerable expense to them.

Mr. Ali: Thank you, Chair. So yeah, that we have also gotten that complaint from our clients with respect to doctors that practise, so I know—

Mr. Chairman: What is your official policy on that?

Mr. Ali: It should not be done. The patients are treated at the public system. That is the official policy. It is as simple as that. But let me let the respective CEOs speak to what they have done in their individual RHAs and facilities with respect to that particular practice.

Mr. Nakhid: Just let me interject. So, you are saying this is not official policy that cannot be done. It is not supposed to be done, but it was a widespread complaint. That is what we are saying. It is a widespread complaint.

Mr. Ali: And I acknowledge that Member but it is not the policy of the Ministry nor the RHAs for patients to be referred to the doctor's private practice. That is not the policy.

Mr. Chairman: So can Dr. Armour identify what has been done to minimize or eliminate that? First of all, is it something that you acknowledge is happening at your RHA?

Dr. Armour: Yes. So at the RHA we have attempted a policy approach, it is a conflict of interest and the short answer is no. So, it is a conflict of interest and there is also too, the public/private practice dynamic that would have come come up in previous commissions of enquiry into the health sector that was a point for national discussion.

What we do now in the current reality is that we internally alert staff on a daily basis, what tests are available and not available and we are going one step further, with the Corporate Communications Department to also put up public notices particularly in emergency departments to indicate by exception, this test is not available. The majority of our equipment uptime are up and running so only the instance is not running, we will put that up as a notice so the public is aware moving forward. We also have a system if a test per chance is not available, it is supposed to be escalated by the doctor to the head of the department and then, we have our

Medical Chief of Staff and Director of Health because the Ministry of Health has indicated that we do have the autonomy where required in order to outsource tests in the event it is not done publicly.

Mr. Chairman: I am loathing to interrupt you. Member Nakhid asked: What was being done? Your PS directed the question to the heads of the RHAs. You acknowledge, and I am presuming the other RHA heads acknowledge, that this is a complaint they have had, that patients are being redirected from the public healthcare sectors by doctors and other professionals to private healthcare sectors. So, the question was not about what is available. The question is, now that we have acknowledged it is happening, what is being done to minimize or eliminate it and if you have identified doctors who are engaging in that practice, what happens to them? Because, the PS indicated it is not policy, it is frowned upon. What is being done? Have you identified doctors or other professionals who are engaging in this practice and what has been done?

Dr. Armour: In terms of identifying doctors engaged in the practice, we have to depend—like in any system, the patient has to validate a complaint through the Quality Department and then that has to be investigated. Some patients honestly are afraid or they have a fear of being victimized so they do not put the formal complaint forward. Also, too, we are looking at our own internal security department in order to determine if there can be operations to unmask this phenomenon. So, it is something that is not that simple or easy, because you have to have evidence in order to take consequence management against employees who have found to do this practice. So therefore, that is why what is being done is to ensure that everyone has the same information.

The staff has it; the patient has what tests are available. Because we find a little more unfortunate reality where tests are indeed available but persons are still

telling patients that the tests are not there. Because when you have uptime of equipment and the majority of your tests are available, then that is a different paradigm and therefore, what we are realizing is that despite what is being said tests are indeed being available also too, another finer dynamic is that the tests are done but there may be delays in terms of from the tests being read and report being available. That is what we are also looking at so that if you do a test, rather than the doctor tells the person well, you know, if it did a test and it is not available or that they may not do the test because they believe it will take long for us to get the results, that is what we are also looking at.

So we are setting metrics to state, if you do test A, B, or C, it is going to be ensured that you will get it within two weeks and if you do not get it alert us. Therefore, those are the systems that we are doing to increase the accountability and to reduce that phenomenon. But yes, there is need for a national discussion, as I said, based on previous commissions of enquiry to address this public/private practice conflict of interest.

Mr. Nakhid: In the interest of the public, just let me break it down a little bit for you. I understand all what you said. Let us say we have a brave patient who came forward and made that complaint, identify the doctor, what is the systemic repercussions of that? What kicks into place for us to have some justice for the public?

Dr. Armour: What kicks into place is that that complaint will be taken, it will be investigated and therefore if it is—

Mr. Nakhid: By?

Dr. Armour: —by the Quality Department to do a quality investigative report, plus or minus maybe security as well. Therefore once you have investigative report, with a case to answer, then it goes through our RHA Code of Conduct mechanism,

because you are expected to perform your duties diligently. Therefore, if there are matters within your control that you choose to willfully not perform your duty on in terms of offering the patient the service or informing the patient the service was available. So there can be consequences management through the Code of Conduct, disciplinary tribunals, what have you, as a case may be. If it is anything that is criminal, we refer the matter to the police.

Mr. Nakhid: So give this for the benefit of the public again and for us, how many cases have you prosecuted in this one, given the widespread complaints that we have had on this topic?

Dr. Armour: None.

Mr. Nakhid: None?

Mr. Chairman: Member Nakhid, I think you should direct the question to the CMO and or the PS.

Mr. Nakhid: Oh well, who ever it relates to. Okay Chair. To the CMO?

Mr. Parasram: No.

Mr. Nakhid: None, zero.

Dr. Armour: Yeah, none, zero. But the thing is that even though we have not gotten that level, we know it happens but persons have to come forward and that is the issue. So therefore, the actual registering of the complaints, but your scenario was in the case of if somebody is brave to come forward and write, what would we do? So that is what we will do.

Mr. Nakhid: And you remind me of something you said, they might be afraid. Afraid of whom? Of what institution? What could possibly happen? I do not understand. I did not understand that at all.

Dr. Armour: Well, persons who are ill, they are vulnerable and therefore, they are dependent on the physician to administer the level of care that they need. So

therefore, there would be fears that there would be a compromise of the doctor/patient relationship in that regard. So therefore, persons who come may be discouraged to report.

Mr. Chairman: Dr. Armour says a frightening thing—

Mr. Nakhid: [*Laughter*]

Mr. Chairman:—that you are putting into the public domain about the possibility,

Dr. Armour: I am saying possibly

Mr. Chairman:—that persons who feel they have a quality issue with the level of care they are getting in the public health sector, and I am not saying it is not true, are fearful of victimization. And I guess you are talking from your South-West Regional Health Authority. Can the PS or any other RHA head indicate if they have had any complaints about that issue where doctors are referring—well, let me not say doctors, but professionals are referring patients to private health care institutes. Because it is something, yes, it is a national issue that has come up with commissions time and time again, but for some reason, this country seems not to want to deal with it. And it has come up over and over in our town hall meetings and is a serious issue facing the healthcare sector that I think at some point we have to deal with.

Mr. Ali: Chair, so I will let the CEOs respond, but just want to clarify one thing with South-West. I know member Nakhid would have asked, how many cases have been prosecuted and the answer is zero. I just want to get clarity from Dr. Armour. How many complaints have you received?

Dr. Armour: That I will have to get back to the Committee, but in my memory the answers not within recent time, at least not within my five-year tenure so far, that I have had recorded complaints of such nature.

Mr. Chairman: Member Mohit—but have the other RHA heads received any such complaints?

Mr. Blake: Thanks Dr. Richards. So yes, I have actually received written complaints. The PS would have received a complaint from a member of the public, it was passed to me as CEO. While I would not want to speak about the specific incident, it dealt with surgery at the hospital, and the patient being referred to a private institution and so on. The Ministry would have asked me to investigate same. I would have appointed based on the RHA conduct regulations an investigator and so on, and gone through the due diligence process where that is concern. So yes, it is a phenomenon that we are seeing and have seen.

So it is twofold really. What you want to do is say and emphasize to the clinical team, the physicians and others at the hospital, that this is misconduct. There is no ambiguity where that is concerned; to let them know based on the conduct regulations, this is a conflict of interest and it is misconduct. We have done that in terms of going back to the physicians and having that hard conversation.

In fact, at a meeting, the PS and CMO would have shared that we were at North Central, we would have spoken to a number of the surgeons in particular about this specific issue. The other thing, and I just want to give Brian a little bit of support here, is that we need members of the public to put things in writing, because information is not evidence. While the Quality Department may get some information it becomes my word against your word. If we have something, if we have a submission in writing, there is a process based on the disciplinary Code of Conduct in the RHA because now we have some evidence to investigate.

Mr. Chairman: Speaking of evidence, the other limb to this phenomenon is in addition to the patients or the clients making the reports, what we have also had, anecdotally, is that while doctors or professionals are supposed to be on duty in the public healthcare sector, they "clock in" and they go about their private business. That is also part of the phenomenon. Is that something of concern to you goodly

people, because that one you have more administrative control where evidence is concerned and, more to me, responsibility for. Is that something that has occurred or you are actually pursuing or investigating, or examining or monitoring? Because that is another part of the issue.

Mr. Blake: So I will start again, Dr. Richards and yes, of course, that is something of grave concern to us. And, we spoke a little earlier about persons understanding their role as managers at the executive level and as middle managers. So you find now that persons in the hospital setting must manage those persons under them. Everybody in a hospital is rostered to work a particular duty and so on. In the hospital system, we have something called a "return of personnel," where the finance and HR department will look monthly at a person's attendance and punctuality and that needs not to be a rubber stamping exercise. Department heads must really take control of that and ownership of that. So in the learning and education that we have done with our middle management it is something that we continue to emphasize but it is an issue, it is a problem, and we are working on it.

Mr. Chairman: Member Beckles.

Mrs. Beckles-Robinson: Can I ask a follow-up from member Nakhid's question? I just want to be clear. Is there a disciplinary code that specifically states to the doctors that they cannot offer to a patient their private practice?

Dr. Armour: Through Chair, I will attempt to answer. The short answer is no. Based on collective agreements for doctors' contract, junior doctors are prohibited from engaging in private practice specifically from the hours of 8.00 a.m. to 4.00 p.m. In the RHA Code of Conduct in the law, there is no specific provision that says it is a misconduct to do so and then we also have to put into context that at the senior doctor's level, there is a relative dearth of specialists. So therefore, you do find that

there is a demand both in the public and private health sector for a limited specialty skill sets that only few nationals or few persons employed could provide.

So therefore, for senior doctors in the collective agreement, there is no specific requirement to specifically to provide a full 40-hour workweek based on their specialty skills and that is something way back—

Mr. Nakhid: Excuse Doc, sorry, sorry, sorry. But that is different from the question the member asked. You stated before, we know what is this problem ahead of us. She asks about the disciplinary code; you said there is none.

Dr. Armour: Specifically.

Mr. Nakhid: So then what are you going to investigate if somebody makes a complaint? How are you going to investigate if there is no disciplinary code in place? So what you are doing is useless.

Mr. Ali: Can I?

Mr. Chairman: Yes.

Mr. Ali: Through you Chair.

Mr. Chairman: Yes.

Mr. Ali: So both CEOs would have referred to the RHA Code of Conduct Regulations, so which is similar to what exists in the public service. So it will not and just on member Beckles' question—that would not specify the specific possible infraction, so to speak. It will speak about possible misconduct. What needs to happen is that the RHAs would have written to the respective, as from a policy perspective, some policy guidelines and those are what the doctor or any other professional may be in contravention of.

So, when Brian spoke about the regulations not being specific, it is not and it will not be, it cannot be that prescriptive to list every infraction in the Regulations. It would speak to something, I am just using an example, to bring the service into

disrepute, for example. All right. So it is that broad, but the respective policy guidelines issued by, I guess, the Director of Health and CEO Blake spoke about the management in the respective hospitals and authorities, would speak to these are your obligations as a clinician, as a nurse, as a technician, what have you and if you are in breach of those guidelines and that is where the disciplining process kicks in, in the regulations. I am not sure if I cleared it up.

11.45 p.m.

Mrs. Beckles-Robinson: Can I just ask one more question?

Mr. Ali: Yes.

Mrs. Beckles-Robinson: Okay. Following on member Nakhid, if you, based on your evidence, have not been able to prosecute anyone, have you formed the view that there is an issue—as it relates to patients, you know, having to go to someone's private practice or hospital, okay, have you formed the view that there is a problem, and are you satisfied that the present rules of conduct, the disciplinary code addresses that matter? If you say no to that, are you doing anything?

Mr. Ali: Sure. Thank you. Through you, Chair, so CEO Blake would have mentioned there was one formal report that we got—written report. And I think that matter is still under investigation. So the process is not completed. It is still being investigated, if I am not mistaken. So I do not think we can say that it does not work. It is actually on the way, as we speak. I am not sure, if I may—to ask the other two RHAs if they have—

Mr. Chairman: Yes, please.

Mr. Ali:—any reports of such—

Mr. Chairman: And just before we go to the two RHAs, are medical health care professionals required to disclose to the RHAs or the Ministry of Health if they are engaged in dual roles? Are they required to say, "Well, yes, I am working for the

public health care sector, but I also have a private practice, so I practise elsewhere," are they required to disclose that?

Mr. Ali: I do not think they are, Chair. I am subject to correction. I need to look at what their employment contract with the respective RHA speaks to.

Mr. Chairman: "Mm-hmm".

Mr. Ali: Yes.

Mrs. Rampersad-Pierre: All right. Both phenomena, yes, I have heard of it existing, but it has not really reared its head at the Eastern RHA. Should we be given any reports, of course, the consequent management training and so on that we have in place—just to back up a little bit, our doctors are fully aware that this is forbidden, you are not supposed to do it. We have ran, and continue to run consequent management training so they are aware of, should they bring the authority into disrepute, what can happen in a case like that. At the Eastern RHA, we also ensure that, through our management structure, we always advise and inform the doctors of what—that is forbidden. But it is not something that has really been seen in the Eastern RHA. But should it be seen, we do have systems in place to deal with it.

Mr. Chairman: Mrs. Thomas-Lewis.

Mrs. Thomas-Lewis: Yes, Chair. At this time, I do not have that information available, but what I can share with the Committee is that clinical governance is paramount to our Medical Chief of Staff. As such, all our clinics and operating theater times are held, and this is monitored, both through the office of the MCOS and our DOH. So no clinics are canceled and no theaters are cancelled. We have daily dashboards that we would work with, as well as we work closely with our medical records department, so that before the operating theater and clinics are held, the patient lists are gone through. The day after, we also do a reconciliation of all the theater times and the clinics that were held. So the NCRHA would, after the

clinics, conduct telemedicine check-ups during the clinic and your next clinic date, to ensure the patients are well. This is what is done.

Mr. Chairman: Just before we go to member Nakhid for his final topic in this round, and then member Beckles-Robinson, I have to tell you—and this is my opinion anecdotally—I do not get the sense that this phenomenon of doctors or medical health care professionals potentially comprising the system by this referencing to—referral to their private practices or hospitals is something that is being pursued as vigorously as it should. Based on the feedback that we have gotten in our interfaces with the public—because it seems from what we have gotten—and that is just a snapshot, we are aware. It is a widespread practice that the public is very, very disturbed about.

So my suggestion is that some sort of formal investigation be done to gather some data on this in a really formal and profound manner, to see if it is happening as widespread as it seems to be, based on our feedback, so that more definitive consequences may emerge. Because based on members Beckles-Robinson and Nakhid question, I do not know what the consequences are going to be, even if you investigate it. Because the consequences—bringing the RHA into disrepute, that is a whole legal, long case there, you understand?—with no potential definitive outcomes based on what we have heard. Member Nakhid.

Mr. Ali: Chair, I just wanted to make a comment, if I may. So I accept everything you just said. We will look at a formal investigation. But I want us to just bear in mind what Acting CEO, North Central, just said. That speaks to looking at the process. So while we have a lot of anecdotal mentions of referrals to the private sector, as the CEOs have said, we have very little written complaints coming to us that we can actually investigate. So barring getting those written complaints, which we should love to get and investigate and treat with, we have to do what you just

spoke about, which is to look at the system itself, and that is what Stacy spoke to. Maybe it was not that clear, but that is what is done, and that is what is done at the respective RHAs. Obviously, that is not that easy because it speaks of looking at every clinic, and what is the patient coming for, were they referred for a surgery, what is the wait time, what is happening with that person. That is a lot to go through. It is being done. It is not being done a 100 per cent, as we speak. It is something in progress, but if we have—

Mr. Chairman: I will make what may be a controversial statement before I go to member Nakhid. We may have whistleblower legislation on the books soon. Member Nakhid.

Members: [*Laughter*]

Mr. Nakhid: Yes. Just to remark on what you said, on the ground, the problem with these written submissions for people giving evidence, that is a problem in itself. You do not know the people on the ground. Some of them who are going, especially with NCDs, once you tell them write their complaint, they are gone. They cannot, some of them cannot. What you should have is a system in place, where people can make an oral complaint, and somebody writes it for them and signs it. I mean, there are so many things that can fill those gaps you all are talking about. Okay? Anyway—

Mr. Ali: Through you, Chair, we do have that in place. That is where the quality department comes in, where people come can make complaints there. So that does exist.

Mr. Chairman: Thank you.

Ms. Mohit: Mr. Chair, before we move on, you are saying people can make complaints. You are now saying to persons here in this meeting that, you know, we encourage people to make complaints. You are telling us monitoring and evaluation

takes place, quality control takes place, but members of the public are not aware that they can make these complaints. From our general discussions with persons at these Town Hall Meetings, persons are just simply not aware. They get this referral paper, they want their surgery to deal with the shortcomings of the RHAs. Maybe—I am not sure if it is not being looked at because these private doctors who have their private practices kind of take the, how do you say it?—a horse of the—usually, they take the problem away from you. When they get a referral, they go to the private doctor, get their surgeries done, get their testing done, and they no longer come back to the public health care institutions. So I am not sure if it is because of that, but persons are not aware that they can make complaints.

First, maybe they are not even aware that they can do a complaint in writing. You are saying that persons may be victimized or afraid. And you are telling us, CEOs, respectfully, that we encourage people to put things in writing. On one hand, you are hearing that you can be victimized, and on the other hand, you are hearing, write a complaint. So if you write a complaint, you are not going to be victimized? So these are the questions on, members of the public, their minds. So you have to encourage persons via public awareness. What do you have in place for that?

Mr. Ali: Thank you, member. Through the Chair, so I take that on board, in terms of, are we sensitizing our clients sufficiently? The RHA could to speak to that, as to what is being done on the ground at the respective hospitals. Are the CSRs out there advising patients? But I think, and I said it at the start, that is what this is for also. We take this opportunity at this Committee hearing to share that information, because people listen in. So—

Mr. Chairman: Thank you, and we appreciate that. What we can tell, by this exchange on this particular topic—because every member asked some probing questions about it, because it has come up over and over again, so it maybe some

feedback to you that something needs to be more vigorously pursued. Member Nakhid and then member Beckles-Robinson.

Mr. Nakhid: Another major complaint we had was the access to medication, especially when it deals with the treatment of prostate cancer. Avodart, Flomax, a lot of people said that they could not have access to those. Is there a low supply of those drugs?

Mr. Ali: Chair, if I may, I will let my Principal Pharmacist speak to the issue of pharmaceuticals.

Mr. Chairman: Please.

12.00 noon

Mrs. Doodnath-Siboo: Thank you very much. Thank you, Chair. So with respect to—just to get it, three clear questions, it is challenges with respect to the delivery of CDAP and in terms of measuring the success of the programme, and the assessment in terms of the current iteration. So with respect to the assessment, if I can go in the order—any order. So with respect to the assessment, it started in February of 2003. There would have been assessment within 2003 itself and therefore, because it started with over 65, the assessment, based on the acceptability of the programme itself, at the end of 2003 it was where it was expanded for all, access to all in terms of assessing very quickly.

Fast track to 2024, there would have been further assessments of the programme where we would have included other disease states in terms of—it started with eight disease states that we were treating. It is now 11 disease states. And there would be, again, with the further assessment which is currently underway, we are looking at probably expanding the type of medicines and the amount of medicines; the availability of items on the CDAP listing. The most current one would have been in 2019 with respect to our Hearts Initiative, which is the

management of hypertension in the primary health care setting and the addition of one particular item onto the CDAP programme. So that is in terms of the assessment and the acceptability by the members of the public.

The Ministry did take a review and assessment of the programme in terms of expanding the programme. The measures—the success would be the amount of clients who usually access the programme in terms of how we measure. At this point in time, I can safely say that we do have—to date so far, for this year, approximately 87,000 clients who would have accessed the service for the year 2024 to date.

We have approximately 186,000 clients who would have been registered per se on the CDAP programme. So those are the ways in which we measure the success of the programme in terms of the measurement of the success. Challenges with the delivery of the CDAP, of course from the inception we would have had challenges because it was a first time going into the public-private partnership with respect to having clients access the service and access medicines to treat their particular NCDs. What would have happened, we would have looked at our delivery service in terms of the amount of pharmacies and the reach to the clients who we would like to reach, the members of the public, so we would have increased and encouraged pharmacies to be able to come onto the CDAP programme to be able to provide that service for the members of the public.

Secondly, our delivery to the pharmacies, which will be through a contracted service, we would have looked at mechanisms by which we would increase and improve that service to be able to get medicines out of our central stores to these far-reaching areas and we would have increased the schedules. In addition, the supply in terms of how they would order—normally they would have been given the option of just ordering once a month—what we would have looked at is in terms of the amount of stock-outs that we would have had in the CDAP programme. What

we would have done is increased the times—the amount of times that they can order the medicines, giving them the ability to order supplementals.

So they would have their big order for the month and if there is anything that is running out in a particular pharmacy, they can do a supplemental order. In addition, what we have also done is we have given the CDAP monitors the ability to redirect stock, because we do have visibility of the pharmacies and the stock that they have currently. So where there is any shortfall within the active system, the monitors do have the ability to move stock around, of course, with the necessary paperwork. So those are some of the things that we would have done.

In addition, with respect to clients accessing the service, initially it started where they would go with the CDAP forms to the particular pharmacy that they were registered in only. Now the system is in such a way that you can access it at any pharmacy in Trinidad and Tobago. You do not necessarily have to go back to that particular pharmacy where you were initially registered, save and except the ones for the glucose testing strips because they have to go to the specific pharmacies because it is a consumption data that we use for that.

So that is the only one; other than that, all other medication, the members of the public, once you are registered on the CDAP programme, you can access your medicines at any pharmacy in Trinidad and Tobago. Thank you. I do not know if that would have answered all of your questions.

Ms. Beckles: Well just—I mean, your views, I am grateful. You have given a lot. I mean, the critical thing, I think, for the public is the sustainable issue, so I do not know if anybody can address that point.

Mr. Ali: If I may, Chair, through you, so that is something that, as we said, we are actually looking to undertake a review of CDAP. Mrs. Siboo mentioned what type of drugs, whether we are going to add new drugs for new conditions, look at the

existing drugs, look at the population beneficiary perspective, so it is an assessment we have to do. I do not know if we will be able to comment on that at this point, member.

Mr. Chairman: Well, could you contextualize what sustainability entails? Is it cost, a combination of cost, accessing the drugs? The CMO spoke at the start of our interface about increasing numbers of persons seeking medical care for NCDs, an increase, a continuously increased load or a combination of all those things, which will impact sustainability of this.

Mr. Ali: Thank you, Chair. So short answer, yes. It speaks to cost obviously. It speaks to accessibility. CMO spoke about it. We do have additional health facilities but you also have the pharmacies across the country where it is available. So it is really cost, accessibility. Those are the two main factors you are going to be looking at.

Mr. Chairman: Your colleague spoke to 186,000 people registered, are those 186,000 accessing CDAP drugs or just registered and how often do you update that listing of persons accessing because life means people will pass? And are there checks and balances for persons who are on the list that may have passed on to be taken off the list and the list upgraded regularly so that there is a current understanding of the data that you are working with—the population data pool you are working with? Also added to that, you mentioned 11 diseases, are there particular drugs that are obviously in more demand than others and proving more difficult to access for clients?

Mr. Ali: Sure. So I will let Mrs. Siboo answer those questions, if I may.

Dr. Parasram: So just to discuss the sustainability issue, I know we would have taken a decision a few years ago, the CDAP pharmacies, as we said, it was a private enterprise. So coming on to deliver the goods that were distributed from the

NIPDEC side of it, so there is now a fee of TT $68,000 that has to be paid by the private pharmacies if you want to come onto the programme. So there is that upfront fee that has to be paid which did not exist before. So we are talking about building sustainability into the future.

So there is also a change in the dispensing fee. So for each item under the CDAP—so you have 10 items on your prescription when you go to the pharmacy, there is a dispensing fee. So the pharmacist is being given a fee by the Government for each item prescribed, and that used to be at the outset in the vicinity of $15 when the programme had just started. It was actually reduced to $10 and it now stands at $8 per item.

So looking forward at sustainability, those are two of the financial—well, considerations we took into mind when we made those changes to the schedule. So those would impact sustainability. Barring the full review, those are things that have already been done looking towards sustainability of the programme. So Mrs. Siboo can go into a little more detail.

Mrs. Doodnath-Siboo: Thank you very much. So with respect to the number of clients who would have been registered on the system, yes, that was one of the main contentions. So what we would have done is have a unique identifier so that there would be no duplication and therefore we would be able to safely say that, yes, that is the number of clients registered. However, the number of persons accessing would be a real-time information that we get. So this figure would be a real-time because of the current IT system that pulls that data with that unique identifier. So that iteration was done, I think, about three or four years ago because of the fact that we were getting duplication in the system which would translate into pilfering or—well not really pilfering but hoarding of medicines and stock-out. So it would speak to those particular things.

So we would have adjusted that in terms of the IT system and that is one iteration. So we have a unique identifier that would have been put in place. So it is 87,050 who would have accessed the service to date. With respect to the different disease states and the items, the number of medicines or the particular items, at the inception of CDAP what we would have done, we would have done a survey from the hospital setting to determine what was the most consumed item and the ones that clients would be accessing most, and that is where that particular basket of drugs came in.

Again, it still treats the same 11 disease states but, of course, it will all depend on if you have more chronic disease as opposed to more arthritic types of clients accessing the service. But that being said, it remains the same basket. So from time to time, you will see different pockets, increase or decreases in terms of consumption, but generally it is across the board in terms of an equal amount. Thank you.

Mr. Chairman: What determines—who determines, I guess, or what process determines what specific drugs for specific ailments are chosen? Because we have had feedback also from the public about the side effects—the significant side effects of some of the—what they described as the generic drugs. Now I cannot confirm this but this is the feedback that we got at several of the town hall meetings. Also, has there been an increase in the cost of drugs in the last couple of years that is also impacting sustainability? There is an anecdotal conversation in the public domain about the coalescing of private pharmaceutical companies that the public sector may be competing with to access drugs internationally that may have driven up the cost of drugs. Is that something that you are being faced with also?

Mrs. Doodnath-Siboo: Thank you very much, Chair. So with respect—just to understand, the drugs that are available—the basket of drugs that are available via

the CDAP programme, it would be the same. It is a subset of what we buy for the public health sector. So it goes through the same tender evaluation process so it will just be the same subset. So the complaint or the response with respect to the side effects that they are getting, it is no different from what you would get from the public sector.

I want to state categorically that all of the drugs that the Ministry of Health would procure for the public health sector has to be coming from a WHO-approved lab, and in terms of the registration process, we are very strong-willed with respect to that. So we ensure that the labs and the procurement agency and the procurement requirements are all within the legal requirements of the country.

So that drugs are coming from a WHO-approved lab, so in terms of the side effects, all drugs would usually have side effects. Different people as individuals will have different side effects to it. So it is no different from the set that you would get in the public sector. I am not too sure about the second question. If you could just repeat it. Sorry.

Mr. Chairman: The cost. The potential. Has there been an increase in the cost to the State in recent times that may be significant and notable?

Mrs. Doodnath-Siboo: Okay. Thank you very much. So, as with everything else, the cost of drugs—our evaluation process, there is a criteria, and we would look to make sure that we have the registered product as well as a cost-effective medicine. So there would have been slight increases in cost and the cost would have been as a result of freight, because all of those would be factors that impact the cost of the medicine.

So we would have had freight cost, insurance cost. Those are costs included in the logistical part of the procurement. So there would have been a slight increase, yes, in terms of the cost of medicines that has to be made available via the CDAP

programme.

Mr. Chairman: Thank you. Member Beckles.

Ms. Beckles: Right. Okay. So just following up on the—so how does the Ministry plan to address any shortcomings, that is availability of any particular drug at pharmacies, challenges with the procurement of drugs, of the programme in its current iteration, and are there any plans to improve the system? The other one would be, what are the medium to long-term sustainability goals for the programme? Of course, that is linked to your 186,000 persons on whether based on the allocation, you know. It comes back still to sustainability issues. So any comments.

Dr. Parasram: So as PS suggested, member, there is a review process that has to happen. I would not want to pre-empt a thorough review of the programme before we give an answer to that query. However, if the programme does not exist in terms of that iteration, the drugs have to be delivered to those persons for continuity of care through another mechanism. So that is as much as I could say pre-emptively.

Mr. Ali: If I may, Chair, through you, I think, member, you also asked about the shortage of drugs.

Ms. Beckles: Yes.

Mr. Ali: If I am not mistaken, I do not think we have that as a chronic challenge with CDAP. Anesa? I do not think we do, but Anesa could clarify.

Ms. Beckles: Okay. But do you see any trend, I mean, in any particular drugs because—I mean, any shortage or you are seeing more less that whatever is required it is normally available?

Mr. Ali: Whatever is required is normally available as we speak to CDAP specifically here.

Ms. Beckles: Okay.

Mr. Ali: I mean, in terms of drugs generally, there are obviously global factors at

play, but with regard to CDAP, no.

Ms. Beckles: Okay. Thank you.

Mr. Chairman: Member Mohit.

Ms. Mohit: PS, you just mentioned that you are not aware of any shortages in terms of the CDAP medication which are usually provided for those in need, have you received reports that persons have to journey—someone mentioned earlier that you can go to any pharmacy now and get the medication under CDAP. In these town hall meetings, many persons would have mentioned that they have to journey even outside of their geographical location, everywhere in Trinidad and Tobago to get their required medication. Some of them even mentioned that it is more than six months they have not been able to acquire or get their drugs, their CDAP medication. Have you been receiving reports such as these, and if so, what is being put in place or what measures the Ministry has put in place to deal with such reports and issues faced by those who require these drugs?

Mr. Ali: Sure. Thank you. Through you, Chair, but before I let Mrs. Siboo respond, I just want to clarify one thing, member, in terms of access to CDAP. It is at any private pharmacy that is part of CDAP. Not every private pharmacy is a part of CDAP. That is the choice they make. So not every private pharmacy is on CDAP, and I just want to clarify that one point.

Ms. Mohit: Yes.

Mr. Ali: Sure. Anesa.

Ms. Mohit: We are aware of that, PS, but I am speaking to pharmacies who provide CDAP medication. Even at the RHAs, some of them were mentioning problems to get the medication provided at the RHAs as well.

Mrs. Doodnath-Siboo: Thank you very much. So with respect to the drugs that they are speaking about, I just want to make sure that it is the basket of drugs because

there is a limited basket of 52 items that you get via the CDAP programme. So even if they get a prescription at the hospital, it might be for something that is not on the CDAP programme. So once a complaint comes to the attention to my office, to the office of the CMO, what usually happens, because I can tell you that we do get from time from time, we do get—coming through our corp comm unit we would get complaints once or twice, if this item is not available.

Normally, because NIPDEC runs the CDAP programme, or undertakes the CDAP programme on behalf of the Ministry of Health, it is forwarded directly to the CDAP component—the aspect—the unit of NIPDEC for resolution. I, myself, follow up personally because I will call to find out if the problem would have been resolved, and therefore it usually happens and that is the mechanism we use. So it goes back to NIPDEC. CDAP, they handle it because they have access to every pharmacy. They have visibility of the stock at every pharmacy that is registered under the CDAP programme.

Ms. Mohit: Additionally, some—so you have pharmacies who give to patients CDAP medication but they also have the same medication for sale at their pharmacy. How do you deal with that particular issue which was also an issue mentioned by persons who require CDAP medication, that it is not available under CDAP at these pharmacy but the pharmacies have it available for sale to these very said patients? Have you received those complaints and how are you also dealing with that?

Mr. Chairman: I think you also mentioned that there was hoarding in some instances which may radiate to member Mohit's question, because there may be some, a few unscrupulous people like in any other sector.

Mrs. Doodnath-Siboo: Thank you very much, Chair. So as mentioned with respect to the hoarding, what we would have done is developed the unique identifier. So if you go to, let us say, SuperPharm in Diego Martin and you access your CDAP

medicines, and some for reason you try to go to, let us say, Massy in St. Ann's, the system will now allow you to dispense any further medicines because you would have gotten your full supply. So that is one iteration that happened with the CDAP programme that reduced, in most cases, the hoarding, that particular part of the hoarding. With respect to member Mohit's question, we have to understand that the items, the products that the Ministry or NIPDEC procures on behalf of the Ministry for the public sector are the same items available for the private sector purchase. So therefore, it may be the same item but we try to maintain batches separate and apart so we can identify. The CDAP programme does have monitors that go from time to time.

So if a complaint comes to us with respect to that, the monitors will go, but what I am saying is that, we have to—like CMO would have mentioned, we are reassessing the programme again based on the little complaints that we are getting come to our attention. That is one of the areas that we are looking at in order to—so if we have—and again we are asking the clients, "Please submit your complaints so we can investigate further", and we can bring some sort of resolution or do something with the programme. That would be able to give us a better ability to provide that service to the system. But it is the same basket of drugs that is available in the private sector for sale—

Mr. Chairman: But I think what—sorry to interrupt. What they have done is used the Parliament town hall meetings to proffer those complaints and that is what we are bringing to you now. They may not come directly for several different reasons as outlined before, but they have used these town hall meetings and that is why we are bringing the feedback to you. These are the complaints and the concerns from the public, so asking them to bring it again it is like—

Dr. Parasram: So, Chair, through you and to the member, if we can get the

complaints confidentially at the Ministry, we will certainly pass that over to NIPDEC so it can be investigated expeditiously as well. And we have in the past, once the monitors do the investigation and they find in terms of the pharmacist being errant, there is a mechanism through the Pharmacy Board that can play a role as well.

Mr. Chairman: Thank you. Member Mohit.

Ms. Mohit: Yes. Thank you, Chair. Particularly at the Arima town hall meeting, it was stated that there is a batch of insulin that is about to expire and NIPDEC has not released any notice about the expiration or the recalling of the particular brand. Can you state whether you are aware and can you address this particular issue at this forum for us? And if you can also state for us what is the overall procedure for recalling or removing drugs that are in circulation as such?

Mrs. Doodnath-Siboo: Thank you very much. So I can state clearly, yes, I am aware. It is insulin R and the expiration would have been 30th of June, 2024. We do have stock available, February 2025, that has gone into circulation, however, because of limited resources we would usually ask that the clients would be able to be—given that the medicines for insulin in particular, it is just one month. So let us just say the client came in the end of May, I am saying they would be more than likely given the insulin, because we ask for first expiry, first out. That is the mechanism that we use in terms of the dispensing and distribution. Certain items, like eye drops and insulin, of course, the expectation is if we give you an insulin today and you are supposed to use it within a month, that insulin will be finished before the expiration date.

The monitors as well would also recall or retain the particular batch of expired items. The pharmacists are asked to place it in a separate area. The monitors will come and retrieve it from the pharmacies back to NIPDEC. That communication goes out to the pharmacists; at least the CDAP registered pharmacies at least three

months in advance. So that this procedure will take place and the monitors will have enough time to go to Trinidad and Tobago to get all—to retrieve all of the expired stock, and the pharmacists are asked to submit their requisitions for the new stock, the unexpired stock so that patients will get the stocks that is not expired.

I have had complaints and I have brought it to the attention of NIPDEC. What happened at the time is that the monitors went in immediately. They would have warned the pharmacists. There is a procedure because it is a contract that they sign with NIPDEC on behalf of the Ministry in terms of the provision of the CDAP service to the population. So we do have stock of the insulin at this point in time. The pharmacies that were errant in that sort of behaviour, they were written to, and I know the monitors did go in. The complaints that I would have had from that particular area, the monitors did go into those pharmacies and there is stock available at time point in time with 2025 expiration.

Mr. Chairman: Member Mohit.

Ms. Mohit: What was the quantity in that batch of expired insulin?

Mrs. Doodnath-Siboo: I cannot say at this point no time but I would probably be able to give it to you subsequently, if that is okay.

Ms. Mohit: Yeah.

Mr. Chairman: Thank you. And just to let you know that we understand that one of our other committees are chaired by the hon. Speaker, the PAAC. We will be doing an in-depth enquiry into pharmaceuticals in Trinidad and Tobago. Member Nakhid.

Mr. Nakhid: Following up on that, how does the Ministry safeguard against persons selling or distributing recalled drugs? Did you all hear me?

Members: Yes.

Mr. Nakhid: What are the safeguards in place?

Mrs. Doodnath-Siboo: Thank you very much, Chair. So once there is an item that is to be recalled, a media release goes out from the Ministry of Health to alert the public, and that being said, the public is given the necessary details in terms of where you can call or what you can do in terms of resolving the issue. In terms of safeguarding the sale of recalled items, we have the regulatory unit of the Ministry of Health that undertake inspections on a daily basis. So once those things go out, we usually go out to the pharmacies to try to retrieve or to do what we need to do from a regulatory perspective to ensure that the public is in no harm at this point in time.

Mr. Nakhid: I think we saw a lot in our recent history that some pharmacies had stamped again or put a new stamp on some drugs, and so on. That was a couple of years ago. I mean, how can you safeguard against these things?

Mrs. Doodnath-Siboo: Member thanks. Public education and media coming out from the Ministry in terms of safeguard and what is the correct thing to do, and this is what the Ministry would have attempted on several occasions. Once there is a recall and there is sensitization—I know late last year, we would have sent out two media releases, communication out to the Ministry with respect—sorry—to the public with respect to what you look for on your labels in terms of how you read your product packages and a contact number at the Ministry of Health where the public can call to get to seek further information whether a product is registered or not.

Mr. Chairman: But in terms of your internal processes, because there has been a lot of reference to the quality control division in each of the RHAs, the Minister of Health is on public record as stating that there are pharmacies that have been investigated for selling non-approved drugs and pharmaceuticals. So if that is happening, by extension, what member Nakhid is asking you about may also be

happening. Have there been pharmacies who have been identified as running afoul of this?

Mr. Ali: Chair, if I may, so I was just going to mention that point that we do have within the Ministry inspectors in the Chemistry, Food and Drugs Division that do go out to the respective pharmacies. They look to make sure they are following the regulation and the law. They look at recalled drugs, expired drugs, registered/unregistered drugs. So where we do find breaches, the items are seized and the matter is referred to the TTPS. So if we do have instances where that occurs, that is the process that is followed.

Mr. Chairman: But again, are there pharmacies that have been identified as running afoul of this practice and referred to the TTPS?

Mr. Ali: Chair, yes.

Mr. Chairman: Okay. Thank you. Member Nakhid.

Mr. Nakhid: Has CDAP experienced any major discrepancies regarding the eligibility of patients to receive assistance under the programme or the inaccuracies in the dispensing of drugs by participating pharmacies? If so, please describe the discrepancies and your proposed strategies to counteract them.

Mrs. Doodnath-Siboo: Thank you very much. So the answer to the question is, no. As would have mentioned before, because of what would have been unearthed from the inception of CDAP and the continuous assessment over time, the iteration of the IT system would have allowed for us to be able to manage those particular issues in terms of clients accessing medicines more than once within the same period of time. In terms of issues, in terms of inaccuracies of dispensing—was that the question? I did not—

Mr. Nakhid: Yeah.

Mrs. Doodnath-Siboo: Right. Good. Inaccuracies of dispensing: so the pharmacist

at each pharmacy, based on the Pharmacy Board Act, you must have a pharmacist and the pharmacist is the one responsible. That is the person who signs off the prescription and the issuing, dispensing of the prescription. So that responsibility lies solely with the pharmacist and therefore any inaccuracies, the pharmacist is directly responsible for that.

If for some reason there is something that happens—I am speaking from a pharmacist's perspective at this point in time—normally, if it is picked up from our end in terms of the dispensing end, we contact the client, we contact the doctor. If the client brings—has an issue or if it is picked up by the doctor, the communication comes between the pharmacist, doctor and the client for resolution. But, as far as I am aware, there has been no complaints or inaccuracies, and the iteration of the IT system would have allowed to treat for the multiple dispensing.

Mr. Nakhid: Okay. Is there any process to revise the current CDAP eligibility criteria in terms of diseases and medications covered or are you satisfied—[*Inaudible*]?

Mr. Ali: Chair, if I may, so that is part of—both CMO and I mentioned, member, that we have to do that review of the CDAP and that would be part of the review process.

Mr. Chairman: We have 15 minutes and three sections to get through. Member Beckles.

12.30 p.m.

Mrs. Beckles-Robinson: Yes. So in the interest of time, I am going to—this is patient record and I am going to give you three questions, they are not really difficult, it is all about confidentiality. So how does the Ministry of Health plan to address concerns about patient confidentiality breaches and the loss of patients' medical notes due to negligence? Can each RHA briefly advise on the progress achieved, if

any, in relation to the digitizing of patients' record at public health care institutions? And, the other is, are there standard procedures and protocols across all RHAs which govern the release and/or transfer of patient records to external parties?

Mr. Ali: Thank you. Chair, if I may, I will let the RHAs respond to those questions, please.

Mr. Chairman: In the interest of time if you could keep the answers as concise as possible please? Thank you. We could start with Dr. Armour.

Dr. Armour: The answer is yes, patient confidentiality is paramount, prescribed in policies. So they do have a lot of safeguards in the medical records department with respect to managing confidentiality. Similarly, with review and transfer of records and even patient access records under the FOI Act, that is prescribed with medical records and legal departments. With respect to digitalization of records, we are part of the national effort that is led by the Ministry. At this time we are in the business of converting paper-based records into digital records involving equipment, scanners, personnel and staff, and not only medical records at the core, but also having electronic access to the other aspects of care, particularly lab, radiology, pharmacy and so forth at this time.

Mr. Chairman: Is there a timeline in terms of completion of that digitization process?

Mr. Armour: We work with the Ministry of Health so I would like to refer to the PS, because we are working under the national effort.

Mr. Chairman: Okay, thank you. Mr. Blake.

Mr. Blake: Sure, so I would not go over what Brian said in the interest of time, but as Brian said it is a national effort in terms of digitization. But, just to reiterate that north-west has reached somewhere in terms of our digitization. I would like to say we are very advanced in terms of that effort—

Mr. Chairman: What does that mean? Very advanced is very [*Inaudible*]

Mr. Blake: So I would qualify it member, so what we would have in 2018/2019, we would have started a pilot with New Fields Technology, an international company.

Mr. Chairman: 20 percent, 40 percent, 60 percent?

Mr. Blake: Now I would say—the Ministry actually recently did a survey of all the RHAs and I think in terms of the health information system development we were at about, overall I would say about 60 percent.

Mr. Chairman: Okay. Mrs. Rampersad-Pierre and then Mrs. Thomas-Lewis.

Mrs. Rampersad-Pierre: All right, as Dr. Armour indicated, confidentiality is of paramount importance. The same protocols are observed at the eastern RHA. In terms of the protocol for release of patient records, yes, there is a protocol in place for that and it is adhered to. In terms of digitization, we are also part of the nation thrust. At the eastern RHA we have commenced digitization of patient records specific to our Accident and Emergency as our first phase, and we are "gonna" be guided by the national efforts through the Ministry of Health as we progress further with our digitization efforts.

Mrs. Thompson-Lewis: Chairman, yes, we are very dedicated and focused on our patient confidentiality. Just as Mr. Blake indicated, we just partnered with the North-West Regional Health Authority under New Fields Technology for patient registration and pharmacy module at the Arima General Hospital. In addition, in 2023 we introduced an Eric Williams Medical Sciences Complex Medical Records/Patient Referral Unit. We are proud, this is working wonderfully. So we are basically 100 percent as it relates to digitization utilizing in-house owned system, they are also in the national thrust as well with the Ministry of Health.

Mr. Chairman: This is a joke, eh. You all sound like a wonderfully rehearsed

choir.

Members: Yeah. [*Laughter*]

Mr. Chairman: Well I am not casting any aspersions. The question also, PS, and you can answer in addition to the digitization process—

PS: Thank you, Chair.

Mr. Chairman:—because I know it has been—we have received information, that is an ongoing process not only in the Ministry of Health but in other Ministries. What presently occurs?—because we have got several persons coming forward. In one instance I remember clearly the woman said, in south she was asking for her patient records which she had quite a challenge in getting her own information, which to me should belong to her. What is the policy of using your own information to take to private institutions on your own volition? She got the records of a male in an unrelated ailment and it was a disaster for her to try to get the correct records in her case because—Then when she went back they could not find her records at all, and she has been a patient for a number of years.

Mr. Ali: Thank you, Chair. So I would let CEO Armour speak to that specific issue. But let me just touch on digitization because I know that we all spoke about it. So very briefly, the strategies—and the CEOs had mentioned it—we started with the emergency department, we then roll out to the out-patient clinics and the wards at the respective hospitals, and then we roll out to your health centres. So that is the very broad strategy. As we said, the different RHAs are at different stages of that where the percentage comes in, but that is the overall strategy. And then, ideally, what we are going to get to is the one-patient one-record concept, so if you go to a hospital, say San Fernando General Hospital, and you visit the health centre in Valencia they will both have access to your one record. That is the ultimate end point.

Mr. Chairman: The Minister of Health had, during the heat of the COVID-19 pandemic, spoke to this digital identification card in the health care sector that was going to revolutionize, yada, yada, yada. Can we get an update on that? Is that something the Ministry is still pursuing in terms of the digitization of records in concert with having a unique identifier, perhaps, for each client?

Mr. Ali: All right. So, I think what you may be referring to would have been during the vaccination drive, that vaccination card. So that would have been specific to vaccinations. What we do have, and as I said that is our objective, is the one-patient one-record, and also having a unique identifier for each patient. Now I know that the Ministry of Digital Transformation is also looking at a unique ID for citizens. So whatever they come up with we will be using the same thing, but in the interim, we would have a unique ID for a patient in the health sector. That would then dovetail and fit into the overall digitization strategy from the Ministry of Digital Transformation.

Mr. Chairman: So while the digitalization process is ongoing, and Mr. Blake indicated it is approximately, I guess on average 60 percent across the board, what happens in the situation where a patient is unable to get his or her records, or the records cannot be found? Because I am presuming all these are now paper-based, which in some instances have to go to a department to be digitized. How is it reconciled if a patient loses his or her record, what happens then? And, what may account for that?—because it seems to happen relatively regularly.

Dr. Armour: In terms of the complete loss of record, our data, although it does not happen that frequently. What tends to happen in real-time is that sometimes patients, based on their multiple chronic disease, they may attend multiple clinics, sometimes within a short period of time. So you do have a courier system problem sometimes. If you attend a clinic today and then you attend within two weeks, that same file that

was in the previous clinic to get across to the other clinics—So that is what digitalization is supposed to address. Also too, even with the paper-based system as is, is that we are cognizant of that and therefore those complaints come to us through the quality department and we deal with the patient one on one, and deal with the medical records department. So that is the current reality of the situation at present.

Mr. Chairman: So the Ministry of Health takes the responsibility to sending the file to the next department or next institution?

Dr. Armour: No, the particular specialty clinic, out-patient clinic. So if you have both a heart problem and a kidney problem, and you go to two clinics, because it is one-patient one-record, sometimes if you attend this clinic today, let us say within two weeks you go to another clinic, sometimes you do have challenges like that. That is continually being addressed. It has happened, at least under my tenure, much less frequently, but one complaint is one complaint too many, so we still look at it.

Mr. Chairman: And what is the process on patients getting access to copies of their records for their own use?

Dr. Armour: The short answer is, yes, they are entitled to it under the—If you want your entire core record, under the Freedom of Information Act you can apply for it and therefore you could get it. Otherwise—

Mr. Chairman: So you have to apply for your own medical information under the Freedom of Information Act even though you have an ID that says I am the person who these records pertain to?

Mr. Ali: Chair, if I may—

Mr. Chairman: I am asking because I do not know.

Mr. Ali: No, no, understood. So while Brian mentioned the FOIA request, I mean that is if you have to go that route. But there is a form available at all the RHAs at the medical record department that the patient simply fills out to request their record.

The issue of timeliness in getting in getting the records—

Mr. Chairman: Thank you for that answer, because the alternative identified Dr. Armour it seems to be a bit absurd that I have to go through an FOIA request to get my personal records. Any way, we are just moving around. Member Mohit, education awareness. Thank you for the response, I appreciate it.

Ms. Mohit: Thank you again, Chair. In terms of education and awareness initiatives, if you can just outline for us whether your Ministry has considered implementing, let us say school nurses with a focus on nutrition education in the school curriculum as a preventative measure? Because I know the CMO is very adamant on preventative measures. So if you have any responses as it relates to that as well as the elderly population. We have seen many elderly persons attend these town hall meetings. If you can state for us what measures the Ministry plans to implement regarding travel nurses and mobile health services to ensure accessibility to health care for those unable to travel to clinics or hospitals?

Mr. Ali: Sure. Thank you. Through you, Chair, so I think there are three issues you mentioned there member. One is the issue of the schools and what is happening in schools, I will let the CMO speak to that. The other two issues you mentioned are related in terms of the elderly and community outreach, which really speaks about our district health visitors, and that programme—And then also, as you said, the mobile outreach, which I think I will let the respective CEOs speak pretty briefly to those two initiatives. But I will let CMO answer on the schools first.

Mr. Chairman: Please do because we have literally six minutes, we have to get out of here for another meeting coming up.

Ms. Mohit: Thirty seconds.

Dr. Parasram: I think what you are speaking of, I am just clarifying, travel nurses that you spoke about, I think what we call them in Trinidad that is probably from

another jurisdiction, the terminology that is. So we call them District Health Visitors, so they are based in each health centre. There is a lead, sometimes there is more than one, and traditionally they would go to visit persons at their homes. So, for example, someone is a shut-in, they cannot really access, come out of their home to access care, the nurses actually go to the homes, sometimes with physicians as well from the district health facilities, and they do their blood pressure checks, sugar checks, they carry the medication as well. So that is what I think you are alluding to in terms of—the term "travel nurses" does not exist in our territory, we treat them under the banner of District Health Visitors.

As it relates to the School Health Programme, the Ministry of Education has, as far as I am aware, established a School Health Programme by way of hiring nurses—or in the recent past, meaning at least a few years ago. So, we have been working and the Ministry of Health, through its School Health Visitors Programme, which again is district health visitor-led. So it is led from the primary health care level. It seeks to deal with prevention at the school health level. So, School Health Programme is a number of things. As children come to school you get assessments, for example, in terms of development. So you will find the school health visitor together with a number of persons will go in, they do weight, they do height, they do checks, examinations as well, and then we do school health visits for immunization to do mop-up coverage for those types of things as well.

So, in terms of the prevention aspect of it, we have, in the recent past, gone ahead and established some programmes for school children in terms of the ages of school children. Dr. Clapperton can go into detail as the NCD Director as to what we have been doing to target the adolescents and the children, recognizing that the children are our future and the habits form earlier on will for the rest of their life guide them as to how they should proceed in terms of diet and exercise. Really we

are trying to create a movement for lifestyle change. Our fundamentals to it is very simple, when you are trying to create change at a population level we keep it as simple as possible.

Mr. Chairman: Dr. Clapperton I am going to be very unkind to you and give you two minutes.

Dr. Parasram: Yes, I mean just for her to start I want her to focus on the adolescents and the children, what we have been doing under the parameters of education, increasing water intake, good diets and increasing movements.

Mr. Chairman: Okay. Dr. Clapperton.

Dr. Clapperton: Well, just to add to what CMO would have mentioned, and to bring to the fore in case a lot of persons who may not be aware, that recently, and we will be looking to run this activity again within the Easter vacation across all of the Regional Health Authorities in collaboration with the Ministry of Health, we would have had the NCD Inspector Academies for children ages five to 11. The children had an opportunity during their Easter Vacation to learn healthy lifestyle habits and were given opportunities—Well, it was built on the premise of children being the agents for change and they would have attended these camps for a period of one to two weeks. On completion they would have graduated as, you know, NCDs inspectors, and they had the opportunity to go back home.

They were given sticker-fine booklets to go home and share with their friends and neighbours and even parents in instances where they found them not practicing the healthy lifestyle measures that they would have been taught. They would have been exposed to food and nutrition, you know, opportunities for meal preparation, gardening, and also physical activities like yoga and dance and all of these things. And they have the opportunity to share with, when they go back home, what they would have learnt and to even advise and issue their sticker-fines for persons who

are found in breach—so the adults as well.

Mr. Chairman: Thank you, that is a very good initiative. Congratulations on that, and go and tell mommy I am not eating two starches today. [*Laughter*] All right. Member Beckles. Good luck with that.

Mrs. Beckles-Robinson: Just a quick question: In relation to Dengue, on this whole issue of education, okay, so I can say as the MP for Arima, because I am declaring my interest, I recently discovered someone who has dengue and chickungunya, as well as another one that I cannot really remember, but have you found any—is there an outbreak? I mean, are we educating the population about it? Somebody died from Arima on the matter. I do have a concern so I just wanted to get any feedback.

Dr. Parasram: So yes, we would have been conducting a series of sensitization exercises beginning with the—In early February we started to do sensitizations for the clinicians as well, because having clinicians being able to recognize the symptom and signs and the treatment very early on mitigates against the risk on a background of people presenting with viral illnesses of differential origin. So they need to know what they are dealing with. In terms of the public education, we have been launching since, I think, early April, a source-eradication campaign. So what we are trying to get to the public early is that elimination of the breeding grounds for mosquitos, invector-borne, can eliminate or prevent the outbreaks of dengue.

So in terms of our national numbers, you asked about outbreaks, we had about 147 confirmed cases for the year thus far; that is for this year. As we know dengue is endemic to the Caribbean and to Trinidad and Tobago, and has been so for a number of years. We have been hyper-endemic, meaning, having a large number of cases from the period 2014 and before where we would have had almost 6,000 cases a year in that period. Post 2016 to present, our numbers have remained very low, thankfully so far, but we have seen outbreaks in other parts of the Caribbean region

and Latin America, and we are keeping a very close eye on what is happening in Trinidad.

Certainly, there is an increase in number of cases, I do not know, when we do our, what we call "epidemic curve" it does not go into the alarm, beyond the alarm zone as yet. It is still within the control level but our main thrust is to really get our prevention message out there. So if you reduce your breeding grounds in and around your homes—A Aedes Aegypti only travels about a mile in terms of radius from its breeding spot. So if we can get that control done at the local level, the community level, we can actually eradicate from the source. So that in connection with spraying when required for the adult agents can mitigate against the risk of an epidemic occurring.

Mr. Chairman: Okay, thank you.

Mrs. Beckles-Robinson: Just putting in a quick plug for—

Mr. Chairman: Sure.

Mrs. Beckles-Robinson:—any further education in Arima. I mean I have been sort of begging.

Dr. Parasram: Certainly.

Mrs. Beckles-Robinson: And just to link with what Chair said, because I have a case where somebody went and they waited the whole day at the hospitals, of course they gave up. It ended up that they did have serious, serious—

Dr. Parasram: Sorry.

Mrs. Beckles-Robinson: Yes.

Dr. Parasram: So the education is being led from Insect Vector Control as well in terms of at the local level, and the regional corporations are working with us through local government.

Mr. Chairman: Member Nakhid, quickly, final questions, please.

Mr. Nakhid: Yes. What regulatory framework is being put in place to enforce compliance with the labelling of local or imported foods as far as the high sugar content is concerned, or the bad fat content? Because it is just not fat, I understand there is now bad fat and good fat.

Mr. Ali: Thank you. Member, through the Chair, that is—a discussion that is happening right now at the level of CARICOM in terms of looking at legislation with regard to packaging for food labels. So we are part of that discussion as a country.

Mr. Nakhid: So a discussion is taking place but nothing has been put in—

Mr. Ali: No, that is at the level of CARICOM in terms of discussing legislative changes.

Mr. Nakhid: So as far as the farmers are concerned, are there any incentives or support for farmers, their businesses to transition towards a safer, more sustainable pest-control methods?

Mr. Chairman: He seems confused, so we will put that one on the Ministry of Agriculture, Land and Fisheries. All right. Thank you. I just have a quick question based on education and awareness. One of the issues that came up in many of the town hall meetings was the fact that, and this is in keeping with preventative and proactive health care as Dr. Clapperton indicated. One, people, because of the long wait times are reluctant to, in some cases, resistant to going for regular medical checks, which by the time their systems have started to deteriorate, exacerbated, it is more load on the health care sector.

So the long wait times and the poor feedback can create a cycle of deterioration, one; and two, is there a real public awareness programme, because a lot of the issues that end up clogging up the main hospitals can be remediated in the local health district. But, the public is not aware of where to go for what, so they

just go to the emergency room, when if they go to the local district health centres they can have most, if not a lot of their issues remediated. Would someone care to comment on that and what the Ministry is doing to identify to the public in a real sense where to go for what to make the system more efficient quickly?

Dr. Parasram: So there is a real example that has started many years ago in north-central, so I would ask Dr. Hamid to speak about the walk-the-talk, the walk-the-talk you mentioned there, which actually deals directly with what you are saying. So there are people who are repeat—who return frequent times to an A&E, for example, for diabetes out of control, hypertension out of control, those are flagged, and he can tell you what is done at the primary level both in terms of education and outreach.

Dr. Hamid: All right, so good afternoon everyone. So, basically the North-Central Regional Health in the year from 2016 we had recognized the fact that we have a lot of persons in our communities who are not being reached by the health care system and so on, so what we did was a partnership with the religious organizations throughout our communities. We termed it the Walk-the-talk Programme, and this is where we partnered with the religious organizations to meet them on their level, meet the congregations, do mass screening of the congregations and so on.

We have actually covered maybe about 50-something thousand persons throughout our catchment area, plus almost 500 organizations on a regular basis. We are discovering more religious organizations. Basically, what this does is bring the awareness to the population where they could access services, pick up, screen persons for diseases at their convenience on their levels and so on, and accelerate treatment or so on in terms of persons that we pick up who have deteriorating conditions and so on in the public sector. So we are actually catching a population who may not be health-seeking behaviour as such, which is a big problem we have in Trinidad and Tobago, and we are offering interventions and so on at that stage as

well.

Mr. Chairman: Is there a specific focus on men?—because men are even more reluctant than women to go seek medical health because they feel they are all that.

Dr. Hamid: Right. So basically North-Central Regional Health Authority also was the pioneer of something called the Men's Wellness Initiative, where we started this mass screening exercise at least once a year, maybe about four years ago. Some of these exercises would have gotten thousands. Up to 2,000 men showed up, and as the subsequent ones became more and more and more. So, this is particularly directed towards males and, you know, it is a sort of cascade effect in terms of persons, males, showing much more health-seeking behaviour than usual.

Mr. Chairman: I think it is a strong generalization to say 2,000 men is progress. We have a lot more men to get into the catchment. Quickly—

Dr. Clapperton: It is a start.

Mr. Chairman: Well, 2,000 is a start. Can we just have closing comments? Thank you all.

Ms. Mohit: Quick, I will take you up on that offer in my constituency. I will definitely recommend some religious institutions.

Dr. Hamid: Of course, we look forward to it.

Mr. Chairman: Thank you. Could we have quick closing comments from the chairman and each of the CEOs of each of the regional corporations, please?

Mr. Ali: Sure.

Mr. Chairman: PS, sorry.

Mr. Ali: Thank you, Chairman, members. So again thank you very much for allowing us to share some of what we have been doing, and to also bring forward some of the concerns from the stakeholders you would have interacted with. We have taken notes of it in terms of some of with private practice, the CDAP, looking

at—and I particularly looked at the issue of communication, public education, and sensitization. I think that is something that, while we have been doing it, it is something that we have to look at doing a lot more of and to find ways of doing it. This helps. But definitely at the level of the RHAs and the Ministries is something that we definitely want to look at. So again, thank you, Chair.

Mr. Chairman: Referencing of medical professionals to private institutions is something of grave concern. Dr. Armour.

Dr. Armour: Good day, Chair, and members, thank you all very much for the opportunity to be here and to address the concerns as best as we can as stated through the town hall meetings with the general public. We take all comments seriously on board. I would just like to remind in closing that, at the South-West Regional Health Authority, with our health centres, close to 34 primary care centres, three hospitals, and extended health care centres, and seeing about close to half a million encounters in primary care and about a quarter million in the hospitals, it is a health ecosystem for which we fit into the national efforts. So, while we acknowledge that we do not have the strategies and policies in place, the concerns and the benefit to patient care is a continual process improvement, so we remain committed to that effort working with all stakeholders.

Mr. Chairman: Dr. Armour you have the most interesting speech pattern. Mr. Blake.

Mr. Blake: So, Chair and Committee, I want to say thanks very much from the North-West Regional Authority, and on behalf of my colleagues, I also want to say the session today was very informative and very real as to the concerns that people actually face on the ground. I want to say my team and I have not only come here today, but we have looked online at all the consultations that you all have had and have taken questions that we have seen there, and some of the recommendations and

have started to try to put some of them in place. So thanks again for the opportunity to be here.

Mr. Chairman: And Mrs. Thomas-Lewis.

Mrs. Thomas-Lewis: Chair, and Committee, the NCRHA would like to thank you very much for the opportunity, and to the listening public, the NCRHA with the other regional health authorities, will continue to engage its clients to ensure that every interaction will ensure that individual connection. I would like to thank Dr. Abdul Hamid and Dr. Kimani White for their interaction today.

Mr. Chairman: Thank you, and Mrs. Rampersad-Pierre.

Mrs. Rampersad-Pierre: So on behalf of the Eastern RHA, Chair, members, I wish to thank you all for the opportunity given to us today to be accountable. I have noted all comments, and the Eastern RHA is committed to continuous quality improvement, and let me just take this opportunity to thank Dr. Rajiv Bhagaloo and Dr. Augustine for accompanying me today, and we look forward to continued partnership to ensure that we can serve our communities well.

Mr. Chairman: I would like to thank you all for coming. I know we did not speak to everyone and you brought your entire teams, we apologize for not touching—having everyone contribute, but we did not know where the conversations would go, but we appreciate you all coming here and taking time, which is greatly appreciated. And also to put on the record, that although we focussed on the challenges, we did get some positive feedback in many instances, that we would like to acknowledge and put on the record. So congratulations on your successes, because there are successes, and we hope you continue to build on them. Thank you for being here. And to all stakeholders who participated in today's deliberations and our town hall meetings, and to support our crew, the Committee members and their continued support and participation, the staff of the Office of the Parliament for your procedural

and logistical support, and also to the viewing and listening audience for your comments and your attention. Thank you so much. Our meeting is now adjourned.

12.57 p.m.: *Meeting adjourned*.

Appendix VI – Verbatim Notes of 24TH Meeting

VERBATIM NOTES OF THE TWENTY-FOURTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD (IN PUBLIC) IN THE LINDA BABOOLAL MEETING ROOM, GROUND FLOOR, PARLIAMENTARY COMPLEX, CABILDO BUILDING, OFFICE OF THE PARLIAMENT, ST. VINCENT STREET, PORT OF SPAIN, ON WEDNESDAY, JANUARY 15, 2025, AT 10:15 A.M.

PRESENT

Dr. Paul Richards	Chairman
Mr. Roger Monroe	Vice-Chairman
Mr. Esmond Forde	Member
Ms. Vandana Mohit	Member
Mr. Rohan Sinanan	Member
Mr. Avinash Singh	Member

SECRETARIAT

Mr. Julien Ogilvie	Secretary
Mr. Brian Lucio	Assistant Secretary
Ms. Lorraine Berahzer	Assistant Secretary
Ms. Rochelle Stafford	Parliamentary Research Specialist
Ms. Rea Anne Alexander-Thompson	Parliamentary Research Specialist

ABSENT

Mrs. Pennelope Beckles-Robinson	Member
Mr. David Nakhid	Member

OFFICIALS FROM THE MINISTRY OF HEALTH

Mr. Terrence Deyalsingh	Minister of Health
Dr. Roshan Parasram	Chief Medical Officer
Dr. Brian Armour	Chief Executive Officer SWRHA
Mr. Davlin Thomas	Chief Executive Officer NCRHA
Dr. Maria Clapperton	Director, Non-Communicable Diseases Unit

Mr. Chairman: Good day and welcome to this public enquiry. Welcome to our viewing and listening audience to the Twenty-Fourth Meeting of the Joint Select Committee on Social Services and Public Administration. Happy New Year to everyone. Thank you for being here, and best wishes to everyone. This is the Committee's fourth public hearing with stakeholders, pursuant to its enquiry into

Trinidad and Tobago's response to the prevalence of non-communicable diseases, with specific focus on diabetes, cardiological diseases and cancer, and related aspects of the public health care system.

Members of the public are invited to submit their comments and questions via the Parliament's social media platforms, including YouTube, *ParlView*, or via Facebook and/or Twitter. We thank you all for being with us today, including the hon. Minister of Health, the hon. Terrence Deyalsingh, Minister of Health, and the Ministry of Health's representatives.

At this time, I would like the members of the Committee to introduce themselves, starting with member Sinanan.

[*Introductions made*]

Mr. Chairman: At this time, I would like to invite the hon. Terrence Deyalsingh, the Minister of Health, to introduce himself and his team.

[*Introductions made*]

Mr. Chairman: Thank you all for being here. We really appreciate you being here. It is an opportunity for us to interface to get some information, and for the Ministry to share its plans and policies moving forward for a healthier Trinidad and Tobago. Among the broad issues we are to consider today are:

- Some of the systemic issues and resources and their shortcomings, in some instances, among the RHAs, policies, plans and legislative action of the Government for mitigating the escalation in managing NCDs and challenges presently confronting the Government in that regard;
- The Government's performance in nudging the population toward healthier lifestyle choices, strategic partnerships, and collaborations with the private sector and civil society in combating and managing the prevalence of NCDs; and

- The medium-term and long-term national goals of the Government as it relates to reducing the levels of NCDs among Trinidad and Tobago.

At this time, I would like to invite the hon. Terrence Deyalsingh, the Minister of Health, to make brief opening remarks. Minister.

Mr. Deyalsingh: Thank you very much. Good morning, Mr. Chairman, members of the Joint Select Committee, and members of the viewing public. I take this opportunity, Chairman, to reaffirm the commitment of the Ministry of Health and the RHAs in the provision of health services and its supporting programmes, and, in particular, the prevention, treatment and care and control of non-communicable diseases. It is recognized globally that NCDs disproportionately affect people in low and middle-income countries. That could be encapsulated in the term, the "social determinants of health", where nearly three-quarters of global NCD deaths occur.

Upon assuming office in September 2015, it was recognized there was a need to focus the NCD strategy under upstream prevention needs, and this Government shifted the focus from tertiary and secondary health care to one of prevention at the primary health care level. This includes the decentralization of mental health and the inclusion of mental health as an NCD. Trinidad and Tobago led the way in that determination. Greater emphasis was placed on utilizing a life course approach, inclusive of measures to encourage behaviour change and promote personal health and wellness. This life course approach employs an integrated health services model to satisfy the health care needs of the population by journeying them through their entire life course.

The approach encompasses a myriad of programmes and services from birth to infancy, to early childhood, to adolescence, to adulthood, and to the elderly, thereby securing a healthy sustainable future for our population. Another key focus is empowering individuals, families and communities to take charge of their own

health through self-management and behavioural change. It is envisaged, Mr. Chair and Members, that this integrated primary health care-orientated life course approach will consistently lead to improved health and, by extension, economic outcomes, enhanced health equity, and improved efficiency overall.

Additionally, during the period, 2016 to 2024, there were several initiatives implemented by the Ministry using this life course approach:

- The establishment of a Non-Communicable Diseases Unit at the Ministry of Health, a first.
- The establishment of a national NCD steering committee, a first.
- The implementation and use of graphic warning labels on the packaging of tobacco products.

Pregnancy, infancy to childhood:

- The design and implementation of the gestational diabetes management programme. That simply means gestational diabetes, women who are pregnant, to identify patients with diabetes in pregnancy through universal screening, another first.
- The standardization of criterion protocols and the provision of personal glucose monitors to 3,218 patients, with the overall goal of improving maternal and newborn health outcomes.
- The achievement of attaining baby friendly hospital accreditation, international status at several health facilities, for example, Mount Hope, Sangre Grande, Point Fortin, Scarborough.

Mr. Chairman, as a result of our initiation of breastfeeding at birth, because that is recognized as one of the success factors in preventing childhood obesity, breastfeeding rates have moved from—that is early establishment of breastfeeding—less than 10 per cent in 2015 to between 80 and 95 per cent at all public maternity

units to date.

Early childhood to adolescence:

- The banning of sugar sweetened beverages in schools.
- The promotion of healthy lifestyles at schools and community centres with the supply of exercise equipment to 478 primary schools, 134 secondary schools, 12 special needs schools, and 13 community centres.
- The launch of TT Moves Junior to promote adoption of healthy lifestyle practices amongst our youth via the hosting of Healthy Me Camps.
- The launch of the NCD Inspector Academy targeted at children between the ages of 12 to 17.

Adulthood and elderly:

- The re-energizing of the TT Moves behaviour change campaign, inclusive of the hosting of several TT Moves health and wellness festivals across all five RHAs.
- Signage engaged in the public towards a healthier lifestyle, with key messages encouraging persons to drink more water, eat more fruits and vegetables, and to move more.
- In addition, the procurement and operationalization of six mobile health units, the Men's and Women's Wellness initiatives, which are mainly geared towards screening, diagnoses and management of four major NCDs, including cancer. The activities included counselling and education for key services, not only limited to cancer, but also drug and alcohol use, mental health, sexual reproductive health, diabetes, hypertension, vision and hearing, and HIV/AIDS.
- The introduction and 100 per cent scale-up of the Hearts Initiative. This

is a programme that focuses on reducing the burden of cardiovascular diseases through effective management of hypertension and high blood pressure across all health centres, with over 66,000 persons being enrolled, and 28,237 or 43 per cent of them having achieved control of their hypertension to date; another first for Trinidad and Tobago.

- The standardization and restructuring of our diabetes wellness clinics and its establishment at all RHAs, with supporting guidelines and protocols.
- The establishment of the Diabetic Foot Management Initiative, with the result in reduction of major lower limb amputations by 16 per cent to date. We have never done that before.
- The operationalization of the national lung cancer, early detection and management clinic at Eric Williams Medical Sciences Complex.
- The completion of the second National NCD Risk Factor Survey to collect up-to-date information on and assess the current burden of NCDs and NCD risk factor behaviour within the population.
- The first National NCD Primary Care Training Initiative for all RHAs, which was a series of five workshops per RHA for physicians and nurses in primary health care capacity-building initiatives.
- The launch of the NCD hotline, 800-4NCD, on August 06, 2024, to strengthen linkage to care and promote self-management amongst persons living with NCDs. This service is available toll free, and it is accessible 24/7 and it is supported by a number of physicians. Through these physicians, the pilot project provides medical advice to callers who may be seeking to address queries that they may have regarding their blood sugar readings, HbA1c readings, and cholesterol blood test

results. This service in particular, Mr. Chairman and Members, supports and enables persons towards self-management of their conditions.

- The launch of the Know Your Numbers campaign and the production of a supporting Know Your Numbers booklet, which not only provides health information, but also provides a mechanism for persons to document, monitor and track their blood sugar and blood sugar readings all in one place.
- The establishment of the Clinical Guidelines Review Sub-Committee for the standardization of clinical practice guidelines for major NCDs.

Mr. Chairman, the above-mentioned activities, the Ministry's strategies for addressing the issue of non-communicable diseases, is an integrated—and this is important—primary health care-based approach as opposed to hospitalization. Enhanced equity and improved efficiency at a fraction of the cost previously. Mr. Chairman, as I close, and members of the Committee, we thank you for questions, which you will pose, and we are here to inform and educate the public. Thank you very much.

Mr. Chairman: Thank you very much, Minister Deyalsingh. Your introduction was so comprehensive, you have wiped out my first three questions, but we have 17 more. [*Laughter*] So thank you for that. Minister, you are on record as saying that NCDs, of course, as we know, globally, pose the biggest threat to health in countries across the world and devastate populations for many different reasons, and that we cannot—and I am paraphrasing here—we cannot fund our way out of a health crisis. I think the CMO also indicated that on one of our interfaces that it is not about pouring more money into the system, it is about changing the lifestyle choices and patterns in the society.

I know you would have covered some of the Ministry's policies and strategies in your introduction. But, can you indicate to us, as the Minister of Health, if you think we are close to turning the corner in resonating the issues with the population at large for personal responsibility and the family's responsibility, or is it seeming to be a challenge in changing those lifestyle choices and patterns?

Mr. Deyalsingh: Thank you for the question, Chair. So this NCD epidemic is 100 years in the making. The early literature points to the 1920s and 1930s where physicians in the United States were dropping dead, and that is when the whole issue of cholesterol and plaque came into focus. It is exacerbated by our movement away from an agricultural setting where you were active to urbanization, a movement away from physical labour to desk labour. Look at what we are doing, sitting. It coincides with the Americanization of our diets. It coincides with the adoption of technology where children no longer play but sit in front of a screen. So, yes, it is a global challenge.

What have we done—and this is where Dr. Clapperton will come. I always say, "You cannot manage what you cannot measure." We recently redid our STEPS Survey, which was first done in 2011, and we have some results of the 2024 survey, which will tell us, and Dr. Clapperton could go into more detail, what is the current status of health of the country and what the challenges are in terms of how we eat, alcohol consumption, tobacco consumption, movement, and so on.

There have been some gains, but one of the major success factors is going to be for the population, and I mentioned this, to undertake self-management and recognize that they also have a role to play.

Mr. Chairman: Thank you. Can Dr. Clapperton give us—thank you for that, Minister—a sense of where we are? I know we would have covered some of it in our Town Hall Meetings in terms of levels of cardiovascular disease, levels of the—

if I am not mistaken, the three main types of cancer, prostate, breast and lung cancer, or any other type that is prevalent in society, where we are and how the direction the data is pointing to in terms of our mitigation or management of those, please?

Dr. Clapperton: Good morning again. Chair, through you, so in 2024, the Ministry of Health has recently completed the second iteration of the PAHO/WHO STEP Survey, and the STEP Survey is basically a survey that measures the levels of risk factors for non-communicable diseases within a population. By repeating the STEP Survey, we are also able to make comparisons between the recently completed survey and ones that may have been completed before. As for Trinidad and Tobago, there was one done in 2011. So looking at key NCD risk factors, especially the ones that relate to behaviours inherent within the population, we are able to have an idea as to the current levels of risk factors within the population, and even have an idea to project in terms of the future burden of non-communicable diseases.

So I will just take you through some of the key findings from the recently completed 2024 survey. So this survey was conducted in persons, adults, in the non-institutionalized population in Trinidad and Tobago, from ages 18 to 69. The prevalence of tobacco use, that is the percentage of persons who currently smoke tobacco, we found that to be 21.3 per cent.

There was a higher prevalence among males as opposed to females. The prevalence of alcohol consumption, that is the percentage of those who currently drink alcohol or consumed alcohol within the past 30 days of administering the survey, we found a prevalence of 51.5 per cent; 59.6 per cent in males and 43.4 per cent in females. What we noted here was that in 2011, the prevalence of alcohol consumption was 40.6 per cent. So there was a 10.9 per cent increase between 2011 and 2024.

With respect to consumption patterns, it was observed that even though males consumed more alcohol than females, we noted a significant increase in the

consumption of alcohol among females, and this was found to be an increase of 12.5 per cent.

With respect to dietary practices, we looked at the percentage of persons who consumed the required five servings of fruits and vegetables per day. We found that 93.3 per cent of the population consumed less than five servings of fruits and vegetables per day.

With respect to levels of physical activity, and this was defined by the World Health Organization—for the purpose of this survey we utilized the definition:

A minimum of 150 minutes of moderate-intensity activity per week.

This was further explained to participants with the use of pictures, et cetera, and we found that the median time spent on physical activity per day was 102.9 minutes, which had increased in comparison to the previous survey conducted in 2011.

For the first time in Trinidad and Tobago, and as previously mentioned by the hon. Minister, the Minister of Health took a position in 2018 to include mental health as a non-communicable disease. In this same vein, the 2024 iteration of the STEP Survey included a newly introduced module from PAHO/WHO, which assesses the levels of symptoms for depression among members of the population within the past 12 months. So we included a mental health module.

So with respect to the persons who responded in terms of symptoms for depression within the past 12 months of administering the survey, we found a prevalence of 13.6 per cent, with the larger proportion being among females as opposed to males.

So, to further assess the burden of NCDs within the population, we looked at a combination of five risk factors. So we went through some of these risk factor behaviours previously. So, while I go through the five risk factors that we looked at, you know, I encourage the listening public to assess yourselves and see how many of these five risk factors that you may already exhibit, because this gives us an

indication of the future burden of non-communicable diseases.

These five risk factors that we looked at in terms of combined risks are as follows: current daily smokers; persons who consumed less than five servings of fruits and vegetables per day; low levels of physical activity; being overweight, that is having a BMI of greater than or equal to 25; and having raised blood pressure, that is, having blood pressure readings greater than or equal to 140/90. We found that 1.6 per cent of the population had zero of these risk factors, whereas 38.4 per cent of the population had three or more of these five risk factors.

With respect to raised blood pressure, there was a prevalence of 29.0 per cent of persons with having raised blood pressure. Fasting blood glucose levels, there was a prevalence of 15.8 per cent of persons having a raised blood glucose level, and 39.6 had the prevalence of elevated or raised cholesterol with 39.6 per cent. Additionally, again, to look at the future risk or to project the future burden of cardiovascular disease within the population, and based on the data that we already collected, we were able to do calculations to assess the 10-year cardiovascular disease risk among persons who we surveyed and to do weighted calculations to make this applicable to the population.

So this risk could either be 10 per cent, 10 to 20 per cent, or greater than or equal to 20 per cent. We felt that persons within the age group, 40 to 69, who had a 10-year cardiovascular disease risk of greater than or equal to 20 per cent, that prevalence was 11.8 per cent. So that is the risk of having a cardiac or cardiovascular acute event within the next 10 years.

Mr. Chairman: Can I ask you, Dr. Clapperton, to put a pause there, that is a lot to digest.

Dr. Clapperton: Yes. That is the end of it actually.

Mr. Chairman: We would probably get back to some stats, but if you could supply

the STEP Survey to the Committee, if it is not prohibited, we would appreciate that. I think the Minister is acquiescing.

Mr. Deyalsingh: So there is a final review to take place together with PAHO, once that is done it will become a public document and we will certainly share it.

Mr. Chairman: Thank you so much. Just before I go to member Sinanan, just two quick questions. The sample size for that survey was?

Dr. Clapperton: The calculated sample size was 5,404, and the actual response that we received was a total of 4,052 respondents.

Mr. Chairman: Thank you. Minister, if I could defer to the CMO, one of the startling data points Dr. Clapperton identified to me among the risk factors was that alcohol usage in the sample went up by almost 10 per cent in 13 years. That to me is striking. More than that, 59.6 per cent of men in the sample consumed alcohol in the last 30 days. Dr. Parasram, what impact does it have on the population's health overall, all those who are caught in that demographic in terms of predisposing them to NCDs and, by extension, the strain it puts on the national health care grid?

Dr. Parasram: So looking at that figure in itself in isolation, we cannot utilize that data alone, because we are looking at someone that would have consumed alcohol within the last 30 days. Right? We are not quantifying it in terms of the number of beverages you consume per day, and that sort of thing. So that is done in terms of—Dr. Clapperton has more granular details as to that particular figure, and maybe she could provide that first. So having noted that, generally the trend is a small increase in even the consumption in terms of per day; alcohol being one of the risk factors, as you know, that is linked to a number of NCDs. For example, it has been associated now clearly in the literature for the development of certain types of cancers, for example. Alcohol by itself is a risk factor for certain mental health diseases as well.

So, being an increase in any of the risk factors—and as she showed the combined effect of increasing not one, but multiple risk factors redounds to having a population more at risk of acute events occurring in the near future. So our multipronged approach was really to decrease all the risk factors, not simultaneously, but at least in our public education systematically; try to have targeted interventions to decrease all of them over a period of time, thereby redounding to the decrease risk at the population level. Noting that if we at the Ministry take a whole-of-government, whole-of-society approach, it always comes down to, regardless of how our public education is done to the individual, and making those individual-level decisions, and that is why we need the cooperation of all to get these things inculcated as part of our culture.

That is the difficult part about having an NCD programme and a prevention programme. Because, you could speak about it, you can educate about it, but at the end of the day, when you go home of your houses and you make those decisions, one-on-one, with yourself as to what to eat and what to drink, have we done enough in terms of being able to have the behaviour change aspect of it identified, so that people make those right choices?

Mr. Chairman: Even before the final report is done, has the Ministry been able to do a comparative with our regional counterparts in terms of a way our data points are lining up with the regional counterparts.

Dr. Parasram: So we have international—and Maria could go into details. She just did not want to go into the full report, but she could go into details as to the international benchmarks, as well, of course, if we are looking at individual—she could probably tell us which ones are above normal and below normal in terms of Trinidad as expected by the WHO international guideline. So, I do not know if you want us to go a little more granular at this point and then we could have a discussion.

10.45 a.m.

Mr. Chairman: We have a lot of questions, but we will get to that.

Dr. Parasram: Sure. Yeah.

Mr. Chairman: Member Monroe has a follow-up in terms of alcohol consumption and then member Sinanan. So, in terms of the link between alcohol consumption.

Mr. Monroe: Thank you, Chairman. Given the findings that are linked between alcohol consumption and non-communicable diseases, is the Ministry considering restrictions on advertising the sale of alcoholic beverages?

Mr. Deyalsingh: So that will have to be a policy position. Restricting the advertising of alcohol is not something that the Ministry of Health is considering right now as a policy position. What we have always advised people to do is to make wise choices and it is not only about alcohol, I do not want us to focus on alcohol, it is about a lifestyle change inclusive of alcohol, tobacco, eating better, and moving more. So it is not about banning anything, it is about nudging—I think the Chairman used the word nudging, nudging the population to achieve a healthier lifestyle and to make choices in what you consume and how you move.

Mr. Chairman: Member Sinanan.

Mr. Sinanan: Thank you, Chair. The Minister did indicate in his opening remarks, he answered a significant amount of questions that we would have posed. But just for clarity, in your 2023 annual report, it was stated that Trinidad and Tobago approached the implementation of the 2030 Global Development Agenda, it will begin with the core areas including the maternal mortality containment, HIV/AIDS and the reduction in the incidence of NCDs, you did indicate significant progress. Are you satisfied with the level of progress that you would have made in those areas over the last two years?

Mr. Deyalsingh: So on the question—thanks for the question, member, and through

you, Chair. On the incidence of maternal mortality, we achieved our SDG goals which we were supposed to achieve in 2030, we actually achieved those in 2018. The number of women dying in childbirth has decreased significantly and Trinidad and Tobago is recognized as a global leader in how to do that. So yes, I am happy with that.

You asked about the issue of HIV/AIDS. The UN adopted a standard back in 2015 without going into the complex details to achieve a cascade of what we call 90-90-90 by 2020, that has since by adjusted to 95-95-95 by 2030. What does that mean? It means that to eradicate HIV as a global issue a country must know the number of people living with HIV, 95 per cent of those people living with HIV must know their status, so that is the first 95. We are at 93, so we are just two percentage points off of that. We have made significant process with that. Of that amount of people who know their status—so let us take this room, we have 20 of us here, if 20 of us know our status, then 95 per cent of those must be on what we call ART, antiretroviral therapy, that is drugs. We are currently at 75 per cent, so the second cascade is 75, the first one is 93. And then of those people on antiretroviral therapy, 95 per cent of those must have a level of the virus in your system where it is not easily communicated to another person, you must be what we call virally suppressed, we are currently at 96 per cent.

So the UN has set 95/95/95 by 2030, our current status is 93/75/96, so we have made some significant progress, so that is the answer on those two parameters.

Mr. Chairman: Thank you. Are there any challenges in the availability of antiretroviral therapy?

Mr. Deyalsingh: Absolutely, not.

Mr. Chairman: Member Mohit. Thank you.

Ms. Mohit: Thank you, very much, Mr, Chairman. Good morning again, Minister.

In your opening address which was pretty lengthy, giving us quite a lot of information, I get the point of self-management, I get the point that the Ministry is also educating the public on self-management, but the issue of vaping in terms of policy and legislation, does the Ministry have any plans as it relates to the Tobacco Control Act in terms of amending it to deal with the issue of vaping and how does vaping contribute to cancer? Any statistics or anything like that in Trinidad and Tobago, if you can give us some information on that?

Mr. Deyalsingh: So, I will tell you what I told the Senate in response to this exact same question. The issue of vaping is primarily amongst our teenage population. So with the Executive Secretariat of the Inter-American Drug Abuse Control Commission, the Organization of American States, we conducted a regional training of trainers in the Universal Prevention Curriculum practitioners series prevention in the Caribbean region. The UPC School-Based Prevention Course, we are rolling that out to all the schools. What we have done so far is in 2023 a preventative approach to vaping amongst children and other key populations was adopted. We conducted 12 health education centres at various schools across the country and sensitized approximately 1,200 to 1,500 students about the health risks and dangers and alternatives to e-cigarettes and vaping.

Basically, what we are doing at this stage is collecting the baseline data, we are doing the interventions and actions and that will be the precursor to any legislative change which is being suggested to the Tobacco Control Act. As to the effects of vaping on children, I will defer to the CMO.

Dr. Parasram: I think you asked the particular question in terms of relation to cancer. So in terms of vaping, the medical side effects are emerging because it is a relatively new phenomenon in terms, it is not like tobacco that has been around for quite a long time. So in terms of effects, you are saying the acute effects generally

in terms of the respiratory system and the cardiovascular system are the main concerns at this point. In terms of longer-term effects for longer-lasting use, there has not been any, as far as I am aware, any research with linkages to cancer which, of course, in the past has been strong as it relates to tobacco use, so there is a link to tobacco. So, yeah more or less that is the health effects. But it is a new phenomenon, research is ongoing and it is being—well, basically the health effects are being elaborated as we go and as more and more research comes to us.

Mr. Chairman: And just before member Mohit continues, Minster, just for clarity, so there is no active consideration being given by the Government now in terms of amending the Tobacco Control Act to deal with vaping even while you are collecting the baseline data? Because my understanding in my research on the issue is that the countries that have outlawed vaping, it is because of the propensity of the amount of information that speaks to, one, the adverse health effects, the epithelial cells in the throat are being damaged and making younger people in particular more susceptible to respiratory issues. And two, it serves as a jump-off point from vaping to tobacco use and countries have been proactive in understanding that scientifically, empirically and making moves to amend their laws to deal with that.

Mr. Deyalsingh: So the position of the Ministry of Health at this point in time is to look at the issue of vaping in Trinidad actively, do the preventative work at each level of the schools and as I said, this will form the precursor to inform legislative changes moving forward. So legislative change is something we are looking at, but we do not have a policy position now to say, yes, we are banning vaping. It is something that will come in the future as we look at it.

Mr. Chairman: I hope so. But I just put on the record that it is very disturbing for me to drive down Frederick Street and see children in school uniform with vaping pipes regularly and it is becoming more and more prevalent even walking around

the streets. Member Mohit.

Ms. Mohit: So Minister, based on your response, do you think as of today your Ministry will take a more aggressive approach in at least trying to provide a policy as soon as possible as it relates to vaping?

Mr. Deyalsingh: Yes.

Ms. Mohit: Additionally, Minister, as we look at legislation again, are there any plans as it relates to front-of-package labels, taxation on healthy foods, restriction on advertising, et cetera? Because I think some years ago you would have met with fast food chains and you actually condemned them on the way they were advertising at the World Health Assembly and nothing has really changed, not much has changed. So are there any types of legislative plans as it relates to unhealthy foods?

Mr. Deyalsingh: Yes. So I think I also made the point that people have to make wise choices. When you start to ban things wholesale across the board, it may lead to the reverse effect. If you remember back in the 1920s when the United States banned alcohol it did not decrease the consumption of alcohol, it just drove it underground. We live in an open-market society so we always advise the population a lot of the onus is on you, especially the parents not to overindulge in fast foods. It is not about banning anything we have always advised the population and myself and these are my words, do everything in moderation.

On the issue of front of label packaging, that is a trade matter which the Hon. Paula Gopee-Scoon is leading at the CARICOM level so the Ministry of Health works with the Ministry of Trade and Industry on that.

Ms. Mohit: So Minister, I get the issue of the population but in terms of the fast food chains, you know, they were supposed to, based on your conversations, they were supposed to put healthier options on their menus, what has become of that?

Mr. Deyalsingh: So the last conversation I had with them last year, Maria, if you

remember the date, it had been around October, they had pledged to introduce it and I think they have.

Ms. Mohit: You think they have or you can confirm?

Mr. Deyalsingh: Yes. It is voluntary.

Ms. Mohit: Okay.

Mr. Deyalsingh: It is voluntary. I cannot compel them, but we have to ask parents again, to guide their children in making wise food decisions.

Ms. Mohit: But Minister, we are not speaking ban but legislation can somehow regulate. So that is why I am asking about legislation, not specifically banning anything.

Mr. Deyalsingh: What legislative measures would you recommend?

Ms. Mohit: Well, it will depend on your findings.

Mr. Deyalsingh: Yeah.

Ms. Mohit: So that is why we are asking the question from the committee's end, if you have any planned legislation, just like vaping, in terms of packaging and unhealthy foods.

Mr. Deyalsingh: No. At this point in time and I made that point clear when I spoke at the Assembly, we have no plans to legislate what people eat. We ask people to make wise decisions and Dr. Clapperton could tell you we have done a lot of the work in how to read labels, what is the salt content in French fries, 16 teaspoons of sugar in one soft drink when your average daily intake should be what, six or thereabout. But we have also worked with the soft drink manufacturers and some of them to their credit have voluntarily reduced the amount of sugar in their drinks because of our intervention with them and if you read their labels, you will see how much per cent less sugar in some soft drinks and juices.

Mr. Chairman: Just before we go to member Monroe, following the question from

member Mohit, Minister and team, I understand your position of not wanting to ban, but other jurisdictions have found success because moral suasion does not always work and sometimes it is availability and a lot of it is marketing. And a lot of it means that while we try moral suasion, the NCD epidemic continues putting a burden not only the health care system but on the human resource capacity of the population and I guess that is why member Mohit's advocacy comes into maybe try both at the same time. Moral suasion will work and personal choices should work, but also sometimes you have to legislative, not for the consumption part but from the supply part.

Mr. Deyalsingh: So it is not the Ministry's position at this time to recommend that sort of harsh measure.

Mr. Chairman: Thank you. Member Monroe.

Mr. Monroe: Thank you very much, Chairman. Minister, I just want to follow up on the conversation of vaping and the stuff surrounding cancer. How has the Ministry been able to respond to the increase in cases of cancer thus far?

Mr. Deyalsingh: So let us deal with the issue of cancer as you said. Let Dr. Clapperton start with what are the main cancers and then I will go into what the Ministry has done. So I think that is a good jump-off point. So again coming out of the STEPS survey our cancer registry, Dr. Clapperton can start.

Dr. Clapperton: So again, recently the Ministry of Health conducted an updated review of the data contained within the Elizabeth Quamina Cancer Registry and this report of the 2024 captures data in Trinidad and Tobago on cancers from 2003 to 2020, and the information outlined is as follows: For the period 2003 to 2020, 43, 380 individuals were diagnosed with cancer; 97.9 per cent of those persons were over the age of 25; 49 per cent of those diagnosed were male and 51 per cent were female; 39 per cent of persons were between the ages of 60 to 74 years old; 36.2 per

cent were Afro-Trinidadian and 23.0 per cent were Indo-Trinidadian.

In terms of the top three leading causes of cancer in men would be prostate cancer, followed by colorectal cancer and then cancer of the lung and bronchus. The top three leading causes of cancer in women are breast cancer followed by cancer of the uterus and then colorectal cancer.

Mr. Deyalsingh: Right. So that is a landscape of the cancer burden in Trinidad and Tobago broken up into numbers, demographic between the afro-population, the indo-population. What are we doing now at the Ministry to manage this burden of cancer? The first thing we do is engage in education. We have done significant work in education. Then we do screening so that people will know what their status is. Members may have seen the recent prostate screening test that we did for men which does not mean a digital rectal examination, it is just a blood sample. After we screen for those who need to be linked to care, we link them to care and treatment and then palliation. So it is a whole approach from screening, education, treatment and care.

But over the past ten years we have made the following interventions, we have increased our imaging capacity, so that the diagnosis becomes better, it becomes faster. Advances in radio therapeutics, radiation, the extension of our infrastructural footprint both at St. James and recently opened the Cancer Centre of Trinidad and Tobago, the south branch which Dr. Armour will speak about when I am finished. We made significant strides in our surgical procedures using laparoscopic surgeries more and more which are minimally invasive, less blood loss, less recovery time. The switch to the digital platforms, expansion in blood testing, and key to make sure that we have the people going forward, eight scholarships which were offered last year for the DM in oncology, the Doctor of Medicine in Oncology, eight scholarships and those eight people have started their training this month, and then

increase clinical trial, research collaboration with agencies overseas. So that is what we have done, we have also introduced more brachytherapy, more LINAC training. We are going to have a MRI and CT installed in south in 2025. We had the first MRI installed in St. James last year. So all of these are the efforts for screening, linkage to care and then palliation.

I would like Dr. Armour to say now, what he is doing with his enhanced cancer centre in south which was formally the Augustus Long Hospital.

Dr. Armour: Through you, Chair and members, the Cancer Centre Trinidad and Tobago, South was launched officially on 14th December last year and that is a culmination of a strategy led by the Government where there was an agreement between Heritage Petroleum and the Ministry of Health in order to lease the Augustus Long Hospital, long-term lease, to the South-West Regional Authority for the purposes of re-purposing that building to house cancer services which forms part of the national grid for cancer care now at this point in time. We consider the launch successful at this time.

We have moved the services that were formerly at San Fernando General Hospital, and based on the burden of disease, naturally, it has outgrown the old facility so therefore right now we are at the Cancer Centre and we have moved most of the services and there is the outpatient clinic setting. We are going to finally move across by the end of the month. The infrastructure and equipment such that we could move the chemotherapy services and we also have at the direction of the Ministry with the spectrum of care, have a palliative care unit, a 15-bed palliative care unit and for which together with the support of the Ministry and the population and the staff, the future diagnostics and so forth will be coming in next two years. So therefore, with the ambience of Augustus Long in of itself, plus the staff and services, we will be the south parallel to what already is occurring in the legacy northern facility of St.

James.

Mr. Deyalsingh: Before we move on, Mr. Chair, you had mentioned and Dr. Clapperton had mentioned lung cancer. Our lung cancer treatment facility is centralised and located north-central and I think Mr. Davlin Thomas could give the population through you, Mr. Chair, some good information about that.

Mr. Chairman: Please.

Mr. Thomas: Through you, Chair, thank you, Minister. The North Central Regional Health Authority currently manages a thoracic surgical department that does two tiers of services, one is that we engage directly in some of the outreach that is required so we are at exhibitions, et cetera, including school children, so we do that kind of outreach that the Minster and the Director for NCDs would have mentioned. But more directly, the thoracic surgical department is engaged in lung cancer surgery and diagnosis.

We have just received what we call a body plethysmograph which is one of the high-end pieces of equipment throughout the world so we have recently commissioned our first plethysmograph. What that does is that absolutely, exponentially increases our ability to adequately diagnose and we do have another one coming in, well, it is in the country and it should be commissioned before the end of this month. So in terms of diagnosis and treatment and certainly surgery that department is dedicated to that.

Mr. Chairman: Member Forde and then member Singh.

Mr. Forde: Thank you, Mr. Chairman. Again, throughout the enquiry it was found that there is a gap between men seeking preventative care and screening. In light of the male-centred initiatives put forward by the Ministry:

1. What are the targets set out for male involvement and have these targets been met?

2. Is the Ministry satisfied with the current response to the male-focused initiatives and programmes that have been launched by the Ministries or the RHAs?

3. Are there any plans to expand programmes targeting men?

4. And again, how was the Ministry's RHA able to get men to come out in their vast numbers to the various screening sessions that you all would have hosted throughout.

As you know, Mr. Minister, I attended the one at Mount Hope.

Mr. Deyalsingh: Yes.

Mr. Forde: And I know it was a tremendous success because, you know, we men, tend to not want to come out, you know, to check our health. So just give us a little briefing along those lines, please.

Mr. Deyalsingh: Sure. Through you, Mr. Chair, thank you, member Forde, for the question. So if you take men and women, more woman actively seek out health care, less men do that, that is traditional around the world. Men feel we are invincible, you know, we are macho, we do not get sick. Right. Having said that, one of the major issues facing men as Dr. Clapperton said, is the issue of prostate cancer and lung cancer because more men smoke. So what we have done, Mr. Davlin Thomas just said what we are doing for lung cancer at Eric Williams.

For the prostate screening, last year was the first time in Trinidad and Tobago we launched the finger-prick blood sample for PSA testing. Before for a man to know his status he had to do the digital rectal exam or a PSA test where you take a blood sample, it has to go to a lab, you wait 14 days to get the result. With this screening you get your results within five minutes.

We had set a target of about 20,000 men should know their status within one year. The first screening, I think, we got roughly about 5,000 men. Right now, with the influenza drive I have at the mass vax sites, included in that is also the prostate

screening test, so men can go into any of these sites and get that done. So those were the targets we set. Am I happy with the way the men are now responding? The answer is, yes, because it shows once you make it available and easy the men will come out. Are we going to expand it, yes. And I think Mr. Davlin Thomas could come in now because he pioneered the men's initiative at Mount Hope.

Mr. Thomas: So to date—really what we would have done on the advice of the Minister was to engage in creating a kind of habitable environment that would facilitate the encouragement of males to attend so we engage in entertainment, et cetera. To date, the success rate is that we have, in the four or five that we have had so far 5, 000 men, and that is at a rate of about 1,000 men showing up in one day to have their testing done, that is significant. What we have also done as well is to streamline the care for those anomalies, so we streamline the test results to ensure that once we see these 5,000 persons, if we have some anomalies we identify those persons and have separate clinics for those persons so that we could quickly bring them back to normalcy.

Mr. Deyalsingh: So let me just expand a little bit on that because the targets are important, member Forde. When we did the first round of the new novel PSA testing, we got between 7 or 10 per cent of those men who had elevated PSAs. Now, traditionally they would never know and then when you catch them it is stage two, stage three, stage four so we catch them early and then we link them to care and that is what I said, part of the strategy for cancer is screening, early detection and link to care.

And what Mr. Thomas had done at NCRHA as a direct answer to member Forde, we made the environment such that men will want to come. They do not just come for a medical examination, they have barbering, pedicure, manicure, facial. So it is an environment which is non-threatening, which is relaxing and then they get the

medical advice and the screening done in that type of environment.

11.15 a.m.

Mr. Chairman: A follow-up on that—and may I add my commendations because I saw some of those caravans and they were highly successful. Member Singh—

Mr. Sinanan: Yeah, I just—

Mr. Chairman:—and then member Sinanan, sorry, and then member Singh.

Mr. Sinanan: Yeah, that is okay—[*Inaudible*]

Members: [*Laughter*]

Mr. Sinanan: Okay. I appreciate the answer there and I think that is a big plus, how to encourage people to come and do testing and so on. I just want conformation. When we do this test, you have to have a follow-up, and from time to time, you have to monitor any progress or anything. How is your record-keeping with that? Because when you go to these clinics and so, or even if you may go to an RHA or anywhere, you have to create a file.

In terms of using technology, if I go to this RHA today, and tomorrow, I move my residency and I am now in a different area, can I visit that area and my file is accessible, and, you know, what mechanisms you have in place to ensure that my file is not lost or misplaced? You can actually check with technology now the last time you did this test, you were at this level, this is what is showing up now, and I have that assurance that my file, one, is not misplaced, and I can access it at different agencies in the country.

Mr. Deyalsingh: I think Minister Sinanan lives at the Ministry of Health, because the question he asked is a valid one. Patients over the years have been inconvenienced and bedevilled by the issue of lost files. That situation is untenable. As the health system evolves and changes, we have to adopt technology. And it is disheartening for a patient, when you wait for a clinic appointment and you go, you

cannot find the files. That bothered me.

So, in 2023, we started to lay the groundwork for the adoption of technology, and Minister Sinanan wanted to know, if I move to an area, what happens, how can we judge the progression of your disease. So the adoption of technology, through our health care system is a wide, and deep, and complicated process. At the Ministry, we took the decision to start to adopt technology in four key areas; four key areas that brings a level of commitment from our doctors and nurses, which redounds to the benefit of the patient.

What am I talking about? Minister Sinanan said, if he moves—so if you are living in Diego Martin and your CT result is there, and you go to San Fernando, you do not want that patient to do another CT. That is extra radiation, use of resources. There is something PAC system, basically PACS, Picture Archiving and Communication System. On a PAC system, all the images and reports are stored. For the first time in Trinidad and Tobago, RHAs can see and share your images across a PAC system. We are getting there. Different RHAs are in different things, but at the end of this month, all images—a doctor in San Fernando can see the image you took in Sangre Grande. So you can see the progress of your disease, when you see changes in the CT, changes in the MRI. That is underway. The CEOs will talk about that.

Two, you withdraw blood—so you have a complete blood count, you have all your electrolytes. The lab information system, like the PAC system, is now being integrated. So I could see your blood results wherever you are in Trinidad and Tobago from three months ago. We are now using e-prescriptions. And finally, on the issue of lost files, we have started the process of digitizing our files. What we are doing is something called "scan on demand", and I would like Dr. Armour to talk—because he is the pioneer of this in the South-West Regional Health Authority. So we have millions of files but we cannot digitize all at one time. So we are

digitizing, in the first instance, the most active files, that is, the patients who come to us most frequently.

So just before I go to Dr. Armour, just to give Minister Sinanan the assurance that technology is being used right now, a doctor can see my scan that I did in Arima, if I go to San Fernando. That is the PAC system. He can see my blood work. And the e-prescriptions, he can see what drug I was prescribed in Sangre Grande if I go to San Fernando. So let Dr. Armour—

Mr. Chairman: Just before, Minister—just be before you go to Dr. Armour, I will tell you that in our town hall meetings, this issue of filing, and lost files, and record-keeping came up over and over again, and we were assured that the digitization and access issues, the ICT issues were in an advanced state. Can you give us a sense of how advanced that process of digitization and digital access to patients' files has progressed?

Mr. Deyalsingh: So, as I indicated, there will be millions of files. We have prioritized—and Dr. Armour can tell you. We have prioritized our recent patients. We are not going to digitize a file from a patient who died 20 years ago. We want to get the patient experience down pat. So we are digitizing files because, as I said, and I admitted it, lost files is an inexcusable thing to happen. The issue of digitizing is one that we are actively engaged with, and I think Dr. Armour can come in at this point in time.

Dr. Armour: Through you, Chair—thank you, Minister—yes, from a digitization perceptive, from the use of the staff, there is a lot of inter-connectivity. Just permit me to give just a snapshot chronical of what a patient experience is like in the digital system to explain or for the public to judge the level of advancement.

So at any of our five emergency departments at present, if you go in for any treatment modality, the entire system is paperless. So from the time you enter, all members of

staff, not only nurses and doctors, all the auxiliary staff, they all have access to computers and equipment, and they are able to speak to you, and they are able to enter—to create an electronic record for you.

As the Minister said, if it is thereafter the required blood test is taken, rather than wait for the paper-based result to come, it is more instantaneous. As soon as the results are ready, the doctors and nurses can look on the computer and determined the results, and as the Minister said, you can also determine the past history of results that you took.

The same occurs if you require any radiological imaging test. And this also means on the back end—while the patient's experience is on the front, and I go for a CT scan or an X-ray, and the results are almost immediately available to the doctor, it is available in two ways. There are back-end doctors who do the report and put it on the electronic system, and also, through the doctors and nurses, who can look at the raw film and also make an instant analysis.

As the Minister said, particularly with radiological imaging—because sometimes patients and caregivers, particularly if you come in very ill, they might not know the complete history. Doctors and nurses could not only pull up the test that they ordered for you, they could determine now if there is need to order a test because you have a previous results that is in the system if you did it in another RHA. So that is the sort of emergency department experience that there is overall. And also too, if you are seen in the emergency department and you are not a candidate for admission, as the Minister said, there is also electronic prescription that is generated. You do not have to wait for script, you simply leave where you are in the ED, you go straight to the pharmacy, the pharmacist has your prescription already and they dispense the medication for you. So that is a customer care experience that we have at the five emergency departments and we at the South-West Regional Health Authority

represent the Ministry of Health's direction that also emerging in varying degrees to the other RHAs.

Mr. Chairman: Is that also available at Mr. Davlin's—the North Central Regional Health Authority?

Mr. Thomas: Oh, yes, currently—and in particular for the ancillary and auxiliary services, for example, the lab tests, the X-rays, CTs, and so on, MRIs. We basically can see and report on X-rays, CTs, et cetera, at South-West Regional Health Authority, North West Regional Health Authority—currently—Eastern Regional Health Authority, and basically throughout the North Central.

Mr. Chairman: So it is interconnected?

Mr. Thomas: It is interconnected as we speak. And just to underscore the importance of it, that whilst the physical file that we are now scanning to digitalized is important, when the patient actually shows up at the doctor, the doctor needs to see whether the patient recently had any X-rays, CTs, et cetera. He or she gets to see that in real-time from any RHA that that person would have been at, including the lab test, and more importantly as well, now for us, pharmaceuticals.

Mr. Chairman: What is the process of patients to access these files, one, because patients had said to us in the town hall meetings that some people told them, "Well, you cannot get that file now?"—I guess part of the digitization would fix that—and also, with coupled that, technology and ICT is a double-edged sword. One of the issues patients articulated to us was that they get a diagnosis now and everybody knows their business in half an hour, so confidentiality issues with ICT.

And also, I know Dr. Armour—but it may have been the test case for a cyberattack at South-West Regional Health Authority. Are the protection cyber issues robust enough given the fact that the more digitized you become, it opens vulnerabilities from time to time, where people are actors trying to creative mischief and mayhem?

Mr. Deyalsingh: So before we go to Dr. Armour to talk about the specifics at South-West Regional Health Authority, may I gave, through you, Chair, the Ministry's position on protection of data? We are working with our lead Ministry and our lead Minister, which is Minister Bacchus, the Ministry of Digital Transformation, to get the proper back structure to make sure, as far as humanly possible, our data is secure. So that is what I am doing at the Ministry level but, of course, as you know, no system is a 100 per cent perfect but we are taking more than reasonable steps with Minister Bacchus to protect our data. Dr. Armour.

Dr. Armour: Yes, with respect to the cyber recovery and now cyber reliance based on our incident, and plus working with the other RHAs and the Ministry, essentially, data redundancy, data security, having back-up of data, and, of course, regularly testing our back-ups of data, all of that is in place essentially at this point in time. As the Minister said, working with other Ministries and other expert assessment tools, we continually review that aspect of data security at this time.

One other quick point to mention with respect to the digital thrust—I gave the ED as example, but this also extends as well to our primary care network and in the context of NCDs, the primary care approach where also doctors in primary care can also see images. Also too, we are nearly complete to also generate the e-prescriptions in that environment. So within a smaller health centre, primary care setting, the patient care experience is very similar to what I have described in ED. You can go in, your information can be entered on the electronic record. We have access to lab results that are taken and assessed at the hospitals, that come straight to the health centre—same thing for your imaging—and then when you leave the doctor consultation without a script, you can get it at the pharmacy at the health centre.

We also have something at the South-West Regional Health Authority called "e-referrals". It means to say, if a doctor sees a condition and it is required to be referred

to a hospital, you, as a patient, no longer have to take a referral and go to San Fernando to drop it off. We electronically generate the referral and we send it directly to San Fernando, or the major hospitals, and vice versa. I say "major hospitals" because that includes San Fernando and Point Fortin. So that patients are also experiencing this access to results, care, more real-time services and more comfort for them, so that they could focus on taking care of themselves, rather than trying to navigate the system in a paper-based environment.

Mr. Chairman: Thank you.

Mr. Deyalsingh: Chair, before you proceed, you raised the issue that at town hall meetings, people say that they cannot get their files.

Mr. Chairman: Not people, one or two people.

Mr. Deyalsingh: I just want to put on record that there is no policy to deny any patient and/or his designated next of kin from getting their files. What happens—and I am glad for this opportunity—is that persons who are either not the patient or not the designated next of kin request files, and we cannot give out confidential patient information to any third party. You will be surprised why unconnected third parties wish to see confidential patient information. So there is no policy to deny a patient, if alive, and/or his designated next of kin from accessing files. I will say it again. Very often people who are unconnected for a variety of reasons want access to patient files. I will let Mr. Davlin Thomas come in here.

Mr. Thomas: Oh, yeah. It is ironic though that the very confidentiality posture that we have as an institution will prevent—for example, if you are a patient and a random member of your family comes and asks for your file, we will vehemently say, no, on your behalf. That is our policy. The designated next of kin will have to have, if you are conscious, your authority or your authorization to be able to access; if your conscious.

Mr. Chairman: Thank you. Member Singh.

Mr. Singh: Thank you, Mr. Chairman, and good morning, again, to the hon. Minister and your team. I have a couple questions. One in particular, I wanted to just shift back to the conversation about cancer, but having respect for time, we will seek to ask that question in writing. But just on the outset, Minister, you did say that in the past, you would have taken initiative to ban sugar-sweetened drinks in schools. I just wanted to get from you the response in relation to that decision, having had the opportunity to explore that time that this was done. What were the results of that exercise, and if—because you mentioned, "We cannot know if we cannot measure." So we were able to measure the impact of that activity at schools? In terms of the follow-up to that, the European Union prohibits or severely restricts many food additives that has been, and have been linked to cancer. Some of these items—I mean, Dr. Parasram might be in a position to identify some of these. So, Minister, if you want to just take that first part, and I will move onto the other question.

Mr. Deyalsingh: Thank you. So the issue of lifestyle diseases in children, as indicated before, it is a lifestyle change. It is difficult to measure the impact of any one intervention. So, yes, we banned the sale of sugar beverages in school, but for a healthy child, the parent also has to make sure that when that child goes home from school, that they do not drink the beverage at home. I have no control over that. The parent also has to make sure that when they go out for a treat, that that treat is not eaten every single day. So the chicken and fries is not an everyday thing. What we have to measure is what the overall impact of these changes and again, the STEPS survey may have some data on that.

I know we are looking for quick answers but at the end of day, this NCD epidemic, a large portion of the responsibility lies with the individual, parents especially, in how they expose their children to unhealthy eating habits. I will say it again. I never

said not to eat doubles, not to eat chicken, not to drink soft drinks. What I am saying, do it in moderation. Start to substitute—if you are drinking three soft drinks per day, drink two and one water, and then the following week, drink one and two waters. Kind of wean yourself off of the addictive nature of fast foods and sugar beverages. Dr. Clapperton?

Mr. Singh: Thank you. Dr. Parasram?

Dr. Parasram: I think at the previous joint select we had on NCDs, we had alluded to a follow-up food consumption survey, which will take place. So we have begun the initial phases of planning of that food consumption survey, which is in collaboration with FAO as well, and World Food Programme. Is that right? We hope to rollout that—meaning the rollout being the actual data collection part of it, so it will give us a more in depth look at what we actually consume as a public in a given day. So it is actually is a very detailed tool that will measure what persons—very similar to the STEPS methodology, but we are aiming to do by utilizing some sort of telesurvey, where we can actually utilize phone devices to conduct the survey, rather than the STEPS. In the STEPS case, we utilize CSO's enumerators to go the districts to collect physical data.

So hopefully, by the first quarter of '25 or thereabouts, we will begin our process of collection. Usually, it takes about two to three months to complete that. So let us say by end of fiscal 2025, we should have some preliminary data as to food consumption. But as Dr. Clapperton already said, in terms—there was a little component about consumption of fruits and vegetables in the STEPS survey, which she already gave the data for, which suggest that are not consuming the amount of fruits and vegetables as a population, as we should be doing.

Mr. Singh: Thank you. Chairman, I just want to switch now to—based on the discussion at our town halls meetings, some systematic issues were raised and I just

want to touch on two, with your leave, as it relates to resource shortcomings amongst the RHAs. Some of our town hall meetings suggest that throughout Trinidad and Tobago, it was mentioned to us that staff shortages subsequently contributed to delayed appointment times for person. I want to know, how is the Ministry addressing these staff shortages of skills gaps that may affect the delivery of services at the various RHAs?

Mr. Deyalsingh: I will make an opening statement and then the two CEOs could come in. That is a very important question, member Singh. It must be recognized, we live in a world of scarce resources. The issue you have raised is real but it is a global issue, especially specialized staff, especially staff trained in their particular specialities or what we call "subspecialties". So you have a cardiologist who is a specialist, but then you have paediatric cardiology, which is a subspecialty. There is a global shortage, especially of specialist health care workers.

Having said that, we take every effort to recruit from abroad, as far as humanly possible, these resources, especially at the specialist level and subspecialist level, but we are fighting with every single country in the world to get these specialists. I will now turn over to the two CEOs to say what they are doing operationally.

Mr. Chairman: Minister, just before you turn over to the CEOs. If I could? Could you give us a sense of the particular specialist areas where you have shortages, and what those would be, what specific disciplines those would be?

Mr. Deyalsingh: So the CEO is going—

Mr. Chairman: Thank you.

Mr. Deyalsingh: Well, hold on. Let the CMO come in.

Dr. Parasram: So I think we can probably provide you that as a committee in writing, because we have been compiling a list at the Ministry for many years, which we have used with our partners in other countries for recruitment purposes, so we

can probably share that list in depth.

Up to yesterday, I had a meeting with the Chief of Staff and the CEO at North Central Regional Health Authority related to staffing issues, and as Minister alluded to, the subspecialist characteristics that tend to be the pervading talk of the day. You have an internal medicine specialist, which we have—we have a DM programme in UWI that does that—but when you go to the subspecialist levels like an endocrinologist, for example, you have difficulties with those. It is crossing, cutting across all the countries of CARICOM and the world, generally speaking, but we will provide that in writing before you go over to—[*Inaudible*]

Mr. Chairman: Thank you.

Mr. Deyalsingh: So one solution before we go there. I mentioned that the Ministry give eight scholarships for a DM programme in oncology. So you target key areas, critical areas, and try to focus resources there, and as I said, those eight persons have started training this month. So that is some of the policy decisions we make. So CEOs now.

Mr. Thomas: We found—consistent with what the Minister and the CMO would have raised, those subspecialties, as well as some of the highly technical categories of workers, like the speech therapists and so on that support our behavioural services. So what we have done quite recently is we have recruited someone to actively engage overseas to find persons who are interested in providing services, some of those rare services at the North Central Regional Health Authority. We have had some success so far. We have a listing of some persons who interested neonatologists, transplant surgeons, et cetera.

We have interviewed, we have recruited recently, two speech therapists—those were particularly difficult to find, and there are currently working at the Arima General Hospital at the newly formed behavioural unit; two paediatric behavioural

psychologists in particular—that was as well difficult to find, but we recruited them through that person who we have found on the market. It is a work in progress but in addition to the efforts that are being done by the Ministry, we are engaging simultaneously.

Mr. Chairman: Two-part question based on that response. And yes, I agree, specialists are in short supply around the world, and in some instances, other jurisdiction can offer more, so it is a challenge to get them to this jurisdiction. What are you doing to keep them? Because I have a friend who is highly qualified. She now works at John Hopkins. She is Trinidadian and said she was frustrated to leave the country because, well, she applied and did not get any responses, and she was snapped up in the West Coast of the US. Unfortunately, she had to run from there because of the fires. And two, are there nursing shortages—and I do not know if there is accurate data pointing—but the Nurses Association is consistently complaining about nursing shortages, in particular neonatal nurses which, in their opinion—I do not know if this accurate again—may or may not have contributed to neonatal deaths we saw last year unfortunately. Are there nursing shortages, and are there specialist nursing shortages in the country?

Mr. Thomas: Well, in particular for us—I mean, we are always recruiting nurses. The specialist nurses though are, of course, more difficult to find. So, for example, we do have neonatal nurses within our establishment that we do not have any vacancies, as we speak, of neonatal. We do have trained neonatal nurses. We do have nurses, whether it is in-house training or certified elsewhere.

What we found though is that—and I think it is worth—the standards here, in some instances, are higher. So, for example, when we attempted to recruit some echo techs, to bring them into facilitate us, we were in situations where their training might be three weeks or three months, and our standard is two years. So that is

always an issue for us, that we tend to have higher standards, in terms of qualifications, and training, and duration of training. So once we sift through some of that, it is easy for us to facilitate. But we are currently engaging in the recruitment, particularly for the Arima General Hospital, to facilitate neonatal-trained nurses and we are looking for them throughout, but our establishment within the other hospitals are—[*Inaudible*]

Mr. Chairman: I will go to member Singh and then member Forde.

Mr. Singh: Thank you, Mr. Chairman, and I will just ask one more question and I will wrap up my questioning. Minister, in the past, we have heard about the notion about medical is tourism. Is this something still on your radar, or is it something that we have been exploring? And the second part to that question is, could you give us an indication or idea of a foreign national accessing medical services in Trinidad and Tobago, and walk us through an example, if one exists, where someone can walk into one of our public health facilities, be treated upon and has to pay for the service via our health facilities?

11.45 p.m.

Mr. Deyalsingh: Thank you. So the issue—let us take your second question first, because you have asked a really, really important question—of foreign nationals accessing care, let me say up front, if any of us here go to the United States or Canada and you fall ill, you have to pay for every single thing you get. Let us admit that. What we have done in Trinidad and Tobago by Cabinet decision of June 2018, I was asked by the Cabinet to bring a policy position to treat with this vexing question. Because what you used to have, were people coming here to be treated and taking up a bed that your family member should be lying on.

The policy we have adopted is this: A foreign national, as opposed to other countries where you cannot access any of this, you can access all public health services, for

example, vaccines. You can access emergency care free of charge at any of our A&Es. You can access maternity care. That is the extent of which we ask the taxpayer to fund foreign nationals seeking care here. That is our policy as opposed to other countries, where, if you fall and you go to accident and emergency, you get a bill. You asked if we can charge? No. We have no capacity to take, accept money from anybody, whether it is a local or a national. So I hope that—so like during COVID anybody in Trinidad and Tobago, national or not, could get a COVID vaccine.

Right now I am on a flu vaccination drive, anybody could get a flu vaccination free of charge. Anybody could walk in to an A&E and get emergency treatment. So you can get primary health care treatment to some extent, public health. So I hope—

Mr. Singh: Yes.

Mr. Deyalsingh:—that answers that, right. On the issue of medical tourism, that is not something the Ministry is pursuing right now. What the Ministry is focused on right now is further strengthening our local capacity. That is something, and you are quite right, that is something we should look at in the future once you have satisfied your local demand. So we would look at that sometime in the future. Thank you very much. Those were two really good questions.

Mr. Chairman: I am glad that was the answer. You would have created a maelstrom because you—just before I go to member Forde, I remember CEO Thomas when he came before us before had given us some response times at his particular RHA. But our interventions and our interactions had provided different data points, in terms of people going to the hospitals and I am going to give that some context in a bit, and having to stay 24 hours before getting attention. In some instances, having to sit in corridors or lie on the floor in corridors, which I saw myself at Mount Hope, yes, and you had indicated, I could be wrong, that the general

response time was about eight to 10 hours. Could you give us a sense of what that is and I know you made interventions that a lot of the time the public does not know, "well, they clog up"—I am using the word loosely. They go to the hospitals when their ailments could not be handled at the health centres and you indicated that public information drive could have alleviated some of that load that the hospitals if people understood what they had to go to the hospitals for, which is basically critical care. So, the question is, one, what are the response times for persons walking into the RHAs, the hospitals, for medical care? And two, how much progress has been made in terms of educating the public on what they should actually go to the hospitals for versus what can be remedied at the health care centre and if necessary, refer to the hospital for treatment?

Mr. Thomas: Through you, Chair. So we have taken the bull by the horns in three tiers. We have increased—because I mean, there is a finite number of patients who need to access emergency care. And those patients, and if we relate that directly with the NCD-related patients are basically lifestyle patients. So, on the outer concentric circle, we are engaging in those activities like the wellness club and so on, to encourage lifestyle changes. And using the theoretical transformation model, we are engaging to move persons from recognizing that there are activities that could happen. Usually there is a step called "contemplation" and then there is a step of "engaging in the activity". We have engaged those free activities, for example, and we have started at Eddie Hart where you get yoga, aerobics, et cetera, daily.

Mr. Chairman: I think you misunderstood the question.

Mr. Thomas: No. That is one tier because it is related.

Mr. Chairman: Okay.

Mr. Thomas: So, that we will have, at the end of the day, less patients coming into the system. At the primary care facility, we have bolstered our ability to engage

those patients who need emergency care on the outskirts. So, we have done quite a lot of refurbishment and systemic works at the Chaguanas District Health Facility. We have now opened in Chaguanas, a premium emergency department that has inherent capacity to engage those patients. Prior to that, those patients would go to Eric Williams Medical Sciences Complex.

So, at Chaguanas we have daily, 100 or so patients, that would have been transferred, now staying at the outskirts. We are currently doing the same kind of refurbishment at the Arima District Health Facility and that should be completed at the end of the month, as per the mandate of the Ministry. That will be completed. And so that we will have inherent capacity at that facility to engage in treatment of patients that would have been transferred. So, if you look—so on the outskirts, we are attempting to stop patients from having the need of emergency care.

At the peripheral facilities, we are engaging in enhancing the capacity at our district health facilities to deal with the emergency treatment of patients so that they could keep those patients. The net effect, and we are already feeling it, is the decrease in the numbers that are arriving at the Eric Williams Medical Sciences Complex, because those patients would have been transferred. We also have what we now term our overflow capacity of "boarded" patients. Boarded patients are those patients that would have been seen, because remember we have inherent capacity, an inherent number of beds, within the emergency department itself. So we have an overflow that happens at Couva medical facility. But intrinsic to the department itself, what we have done is we have also hired EMTs as one phase. So, what we have done is that those patients that engaged the department are initially triaged by nurses, et cetera, and supported by emergency medical technicians who do routine checks on these patients.

In addition, we hired a cadre of what we call "liaison house officers", to facilitate

boarded patients. And that is to say that if a patient is identified as a patient that is to be moved to a ward, and again we have inherent infrastructure, we have 500 beds, and usually the numbers are way higher than that. So some patients inherently may have to stay in the emergency department. What we have done is we bolstered our ability to care for those patients in the emergency department. So we hired additional doctors whose only responsibility is to ensure that if you have what we call a "boarded patient" in our department, that they ensure that they get their appropriate medications, that they get their appropriate direct visits, et cetera, that is being currently managed by a senior emergency physician, Dr. Paul, who basically ensures that that is happening.

But, simultaneously we have recruited what we call a "general manager, secondary and tertiary services". And what that person does is monitor on a daily basis, the dashboard of the systems and in particular the relationships between the throughput and/or volume of persons who engaged the wards, who were actively balancing the inputs into the department, the outputs to the wards, the discharges on the wards. And simultaneously, once we start seeing that it is bubbling into a place where the congestion will become difficult for the patient we then start engaging other hospitals. So we transfer to Arima General Hospital, we transfer as well to Couva, we engage in ensuring that we have the right practices occurring on the wards to facilitate this charges. So it is multipronged and multi-tiered and it is, these are activities are engaged in on a daily basis.

Mr. Deyalsingh: Chairman, you raised a very important point that you get this information at town hall meetings. I think it is an extremely important point you have raised, and between the CMO and I, we would like expand on it so when you have these town hall meetings you are now chairing a meeting from a point of information so you could judge what someone is saying. An accident and emergency

department, what we have done and what I insisted we do, we expand our capacity to treat them. I understand the public's angst when you have your relative needing emergency care but the layperson believes, I must come into an A&E and within five minutes get a bed. That is not good medicine.

Sometimes the best place to be for an acute condition is in an accident and emergency department. Because what we have done we have increased and expanded the capacity for acute cases to be treated in an A&E, where you have a multidisciplinary team among you. You can get your CT as a priority, your X-rays are a priority. Once we put you on a ward it means you are stable enough to be there but very often the relative or the patient feels I come to an A&E and within five minutes I go to a ward. That is not good medicine, because we practice, in Trinidad and Tobago, something called the CTAS system in the A&E. And it is important in these town hall meetings that persons conducting these meetings understand how an A&E works.

An A&E is not first come first serve, which is what the relative expects. An A&E is worst come, first served, because you are trying to save lives. So we use something called the CTAS system, which the CMO will go into. It is called the Canadian Triage Acuity System which is geared towards treating the most acute, most serious person first and make sure we save that person's life. CMO.

Dr. Parasram: Thanks very much. So the CTAS system in the simplest form is ranked in five levels. Level one to level five, right. Level one requires usually resuscitation or something like the like. So you must be seen immediately. So if you are level one chances are you either come in by ambulance and you have to be seen immediately. Level two emergent, which is usually, has to be seen within a period of 15 minutes. Level three, which is considered urgent must be seen in less than 30 minutes and that is benchmarked internationally. Level four, less urgent,

which is less than 60 minutes, in terms of time to be seen and level five, which I think is the category where we get most of the complaints, is basically none urgent cases. Usually the wait time which is expected for that is less than 120 minutes. That is to be seen—and as Davlin indicated, the triage is to be left and that is a policy from the Ministry.

So the triage in the past may have been nurse alone led. We have made the policy that that has to be either nurse with doctor assisted or full doctor doing the triage. So the doctors are the one that will do the assessment to determine what category you fall within him and then determine what treatment occurs after. What the Ministry has done as well is, we have put in system of monitoring and evaluation that has standardized looking at the wait times across all the A&Es in the country, all five RHAs and we have developed a tool together with the quality departments of all these RHAs. I think it was earlier on in 2024, late last year, where we are now measuring the wait times based on the CTAS scale to see basically how the performance of the varying A&Es match up to the international benchmark. So that is happening.

Mr. Chairman: Can you give us a sense of the preliminary of the outcome of that?

Dr. Parasram: Yeah. We should be—because it started late last year in terms of standardizing the tool, we have rolled that out to all the RHAs, and we should be getting preliminary data coming back to us in the first quarter of this year as to how they are performing. But I do not know if any of the CEOs want to say from their particular institutions how they have seen their CTAS, well assessment, performing. Brian, I do not know if you want to volunteer any of it.

Dr. Armour: In terms of CTAS assessment—

Dr. Parasram: CTAS assessment and the level of performance with meeting the metrics that was set up by the Ministry.

Dr. Armour: Yeah. Well for the South West Regional Health Authority you generally find the emergency and the urgent level one, level two. Those are like gunshot wounds, motor vehicle accidents, those are seen immediately. Generally patients or relatives complain and it is within the metrics. The level four and level five—I will leave out level three for last, level four and level five, those are patients who tend to walk in, self-referral, more ambulant and more often than not the reality is, they would not be admitted because they do not require ward care and as the Minister said whatever could still be sorted out in the emergency department can happen. You would tend to find complaints. Yes, we may have lengthening, in some cases, beyond the two hours.

So like level five they said, everything should be sorted in two hours. It may be a bit longer because what we find actually is an average is one in three to one in four patients who come to the ED, are in that level. And therefore what we have done within the last 15 to 18 months, patterning in from north central, we have called what we have instituted now, what you would call a "community liaison clinic". What we do is basically like a general practice clinic nestled within the emergency department and we actually utilize our primary care doctors who are in the health centres to rotate into this system.

So what you find happening is that if you come in an ambulance, self-referral, you are not going to be admitted because of the other priorities, it may naturally lengthen. We actually in the ED send you to, now, what we call our community liaison clinic doctors and apart from treating with you there and then, somewhat similar to the liaison house officer concept but in an ambulance setting. We also indicate to you there and then, listen, there is a health centre nearby, this is what the health centre offers, we can do this for you in an outpatient primary care setting to help educate and intervene even in the emergency department busy scenario.

The level three patients in the context of the NCD, those are patients who will eventually get admitted and they have complicated illnesses several times on account on account of chronic disease, a heart attack, an evolving stroke and infections and so forth. A lot of the cases are medical and therefore what happens to those patients as well, generally the KPIs are met but in average and you would be triaged in10 to 15 minutes. To see the doctor, it may take you between two to four hours and then we have to do test and investigations that may take you to another two to four hours. So we are talking six to eight hours as a level three client, complicated illnesses, we eventually are going to admit to, but because they coming so ill we actually have to take that time to stabilize you before admitting to the ward. So therefore, overall, level one, level two KPIs are met, level four, level five KPIs are largely met and can be longer than average, but those patients are not going to die. Level three clients, we aim, the KPIs are largely maintained and based on everything that goes on in the ED we know the level three clients are persons that need to be stabilized. And I would say overall based on the KPIs the Ministry has sent out we largely meet those at this current time.

Mr. Deyalsingh: I just want to re-irritate before we move on because Dr. Armour said it. I understand the layman's angst, I understand it. But very often the best place to be in your first few hours is in the A&E. That is where you get the most immediate treatment and we stabilize you. If it takes a few hours to stabilize you that is good medicine. But very often people expect, "ah come to an A&E and ah must go to ah ward in five minutes." That is not good medicine. Our main concern is to stabilize that acute level one and level two patient, according to the CTAS system. The levels three and four, what we have done, as he said, within the two A&Es now, like in the Chaguanas new A&E, we have level one and two on the ground floor and level three and four upstairs. So that is the model—

Hon. Member: Four and five.

Mr. Deyalsingh: Level four and five, sorry, upstairs. So that is the model we starting to use. To just to recap, very often the best place for the acute patient to be is in the A&E where they have everything around you, all the consultants stabilize you and then we send you to a ward.

Mr. Chairman: I am just going to exercise more effective time management now—

Mr. Deyalsingh: Sure.

Mr. Chairman:—because we are coming to the end. I am going to go to member Sinanan, member Mohit and then member Forde, as we seek to make that deadline.

Mr. Sinanan: Alright, and I will be short with my question. But basically what I have heard from the team at the Ministry of Health is, I mean clearly you all have a plan, you all are working towards it. We understand the health care system, you would always have challenges, because what we operate in Trinidad, basically is a free public health system and there will always be challenges but we can see that you all are at least getting to what is called, basically international benchmark standard, that is what you are gearing for. And you will always have people who may not be satisfied for the satisfied. So you would always have complaints, complaints you cannot really ignore because you have to strive for a first class treatment even though it is considered a free public health system. How do you track and monitor complaints?

Mr. Deyalsingh: So, I have always told people coming from a marketing background that complaints are a gift from God. It is only complaints that drive you to improve. So let me say that upfront. We welcome complaints especially genuine complaints, genuine ones. So at the Ministry of Health on becoming Minister, I started to track complaints. I would give you the global picture and then the CEOs can go in to the microcosm that exist in their RHAs.

In 2015, this as you said, member Sinanan, this free health care system, we were doing 1.5 patient interactions. Now, people confuse that figure, they say, "well we only have 1.3 million people in Trinidad". Patient interaction, because one patient may interact with the system 20 times for the year. We were doing 1.5 million patient interactions. The number of complaints we had was 6,612 out of 1.5 million patient interactions. The resolution rate was 74 per cent. We were able to resolve 74 per cent of that. But, the way the question was phrased from Mr. Sinanan, what was the client's response? The client customer satisfaction rate in 2015 doing 1.5 million patient interactions with 6,612 complaints the satisfaction rate was 53 per cent. Only 53 per cent of them were satisfied with the way the complaint was dealt with.

By 2024, we moved from 1.5 million patient interactions to 2.2 million. We measured it. This system was being interacted by our population 2.2 million times. But look at what went down. The number of complaints went down from 6,612 to 2,095. And the satisfaction rate went up from 53 per cent to 75 per cent. So it means we take complaints seriously. It is a gift, because that drives us to improve. That is how I measure it at the Ministry of Health. So, the CEOs could tell you now, what they do on the ground with complaints and how we treat with them.

Dr. Armour: Through you, Chairman, thank you Minister.

Mr. Chairman: I do not want to do this, but I am going to beg you to be as concise as you can, in the interest of time.

Dr. Armour: Sure. I would say in summary that at the RHAs we work with our quality departments where there is a telephone hotline. In our case it is 87-SWRHA, and persons can come in to either the offices or call through the line and make complaints. All complaints are taken seriously. I would like to emphasize that point and several complaints are very good suggestions for process improvement. So

therefore, we try to speak to complainants, if they come in person or if they call on the phone or if write the Ministry or the RHA we contact them within 24 hours and we investigate. And we actually—while we resolve the customer complaint we also still look on the back end for the process improvement, if it is an issue with staff or services. Our overall satisfaction rate is similar to the national average. It is currently at 75 per cent.

Mr. Thomas: Similarly, at the NCRHA the issue is that we report directly to the Board regarding complaints via the quality committee. We also have what we call a Service Improvement Committee, so that, whilst we collect and analyze and synthesize the complaints that come in, we engage in the activities that would create experiences that exceed the expectations of the clientele. So for example, we now have liaisons and ambassadors at the front of the building when you come in for an appointment, particularly your first appointment, you have people there expecting you, directing you where to go. That is just one of the innovations, but that came out of the Service Improvement Committee.

Mr. Chairman: Thank you. Member Mohit, quickly, then member Munroe and then member Forde.

Ms. Mohit: Yes. Chairman, thank you very much. Mr. Chairman it has to do with the hours of health centres. But firstly I just want to say that I would like to publicly commend the attendees of our town hall meetings. I have just listened to the Minister where he would have indicated that the worst are treated first. But in some instances what we have heard at those town hall meetings was that of patients would have experienced the long waiting periods of 10 to 15 hours, sometimes running into 24 hours. So, whilst I commend these attendees, it was our job to listen at these town hall meetings and you know those attendees what they would have said at those town hall meetings would have triggered a lot of approaches of which I am learning of

today.

We would have met with the RHAs, et cetera, during the last year and what we are hearing today I would say that these were triggered based on the voices of those people who would have attended those meetings. With that being said, Minister I know you mentioned and the CEOs of the RHAs, that you are trying to lessen the loads at the Eric Williams Medical Sciences Centre, et cetera, by having the primary health facilities be utilized more. With that being said there are some primary health care centres, which are opened for limited hours of the day. Do you have any plans to have some of those facilities at least open for a 24-hour period?

Mr. Deyalsingh: Okay, so, first of all I did say, "complaints are a gift from God". So coming out of those town hall meetings, we pay attention to those complaints.

12.15 p.m.

The issue of opening up primary health centres, 2e have to understand there are different levels of health centres. The CMO would explain why some health centres, based on their designation, are open for certain hours.

Dr. Parasram: So basically you have categories of health centres. So the categories would begin with something that we call an outreach health centre, which is basically usually open two or three days a week. In the past, we would have had some of those in far-flung areas where you have a service two or three days a week. One of them in the past would have been Las Lomas; I think that changed in the recent past. Beyond that category, so you go from outreach to the regular health centres, which are open from Monday to Friday 8.00—4.00. These are the regular health centres that persons are accustomed to. It usually provides services for chronic disease generally antenatal care, immunization, and the lot. That is the common health centre that people are aware of.

There is the enhanced health centre, which is what Davlin and Brian alluded to—the

CEOs—and those are usually put in close proximity to an Accident & Emergency Department where they also have a general practice clinic that can see class four and five levels. So they take some load off A&Es and in general they either open the health centre part—so there is a health centre component plus a GP clinic. The health centre component goes from 8.00—4.00. The GP clinic goes from 8.00 usually to 10.00 or to 12.00 at night. The district health facilities are the last component of the health centres, and those usually contain a health centre as well but they also have an adjunct accident and emergency. For example, Chaguanas District Health Facility, that is a district health facility, as well as Couva. Those go—the health centre part again 8.00–4.00 and the A&E part goes 24 hours from Sunday to Sunday. So those are the different categories.

In terms of looking at the landscape and the utilization reports, from those centres we determine if, for example, an outreach centre needs to open two days a week or they need to open three days a week. So based on the utilization reports, based on the proximity of one health centre to the next, for example, if we use the Las Lomas example, you will find that there is a larger health centre in Cunupia, which is not too far flung from there, and there is St. Helena. Again, geographically very close. So hence the reason it may not have to open all five days for the week. But we use that type of data to determine the hours of opening as well as the days of the week that the centres should be open.

Mr. Chairman: Thank you. Member Monroe and then member Forde.

Mr. Monroe: Thank you very much, Chairman. Minister, I know we have a time constraint but quickly I just want to find out two things. What are the reasons for our declining fertility rate, one, and two, in our fight against NCDs, strategic partnership and collaboration with the private sector and civil society are very important. I want to know, and the committee would like to know as well, what is

the additional support needed to support community organizations and NGOs to drive grassroots health promotion initiatives?

Mr. Deyalsingh: Member Monroe, you want to get me in trouble today. Declining facility rates, yes. I am beginning to regret I said that on Christmas Day, but it is a fact. Okay, briefly. For a population to renew itself over the course of a woman who is fertile—15 to 49, I believe—you need to have 2.1 children per person to renew the population. We have been declining over the years. What are the reasons? In the absence of a study in Trinidad and Tobago, I will tell you what the global trends are and we could extrapolate or assume. One of the reasons families had large amounts of children in the old days was because of infant mortality. Many children died before the age of five. So you were having a lot of children because children were dying.

With the advent of immunization children lived. So there was no need for those families to have replacement children. As societies moved from underdeveloped, developing, agricultural to industrialized, you do not need many children to work a farm as in the old days. That is one of the reasons families globally, in the old days had children, cane cutters and so on. With the advent of modern contraception in the 1960s, especially the birth control pill, it meant that women had more control over their reproductive cycle. And then, globally you notice, as countries became more industrialized, and more developed, as more and more women take their rightful place in tertiary education and the workplace, fertility rates tend to decline. That is the global picture, but in the absence of any study in Trinidad and Tobago, I am just putting that global picture there. So I hope that gets me out of trouble.

Mr. Chairman: Well "replacement children" may get you in more trouble.

Mr. Deyalsingh: Yes, I know. [*Laughter*] Yeah, yeah, but that is a fact. When you read the literature, that is a fact. When your children die at age two and three

because of polio, measles, mumps, scarlet fever, but now you have vaccines and children live, right. So that is a fact.

On the issue of NCDs. Yes, we work closely with many NGOs. On the diabetes front, we work very closely with the Diabetes Association of Trinidad and Tobago and they actually get a grant from us. We work with the Trinidad and Tobago Cancer Society, they get a grant from us. We work with—this cervical cancer group, Ayanna S. Dyette Foundation for Cervical Cancer, we work with them and any of the NGOs that we can work with to spread the message and spread the burden. Yes, we are free and willing to work with them. So member Monroe, I hope that answers your two questions briefly.

Mr. Chairman: We will go to member Forde and then I will come back to you. Member Forde go ahead please.

Mr. Forde: Sure, the timing of my particular question at this time Mr. Chairman, but I will still throw it out and the Minister could give us a brief comment or if he desires to send it to the Secretariat in writing. As we know, strategic partnerships and collaborations with the private sector and civil society are paramount and you just mentioned one or two NGOs in your last discussion. What is the current collaborative relationship between the Ministry and civil society groups such as the Cancer Society, Diabetic Association, Heart Foundation, the Pharmaceutical Board? Hon. Minister. How does the Ministry plan to strengthen these collaborative bonds? Has there been any challenges with providing resources to help civil society groups and NGOs to achieve their mandate?

Mr. Deyalsingh: Okay, thank you.

Mr. Forde: I do not know how brief you can tell me.

Mr. Deyalsingh: So I just spoke about the Diabetes Association. I spoke about the Cancer Society. They get grants, they get resources from us. We work with them,

Ayanna Dyette Foundation for Cervical Cancer we work them. We have work with the Autistic Society of Trinidad and Tobago. We work with Horses Helping Humans for autism.

There are 18 NGOs that we currently provide subventions for. We provide subventions also for drug addiction, those people dealing with drug addiction. So there are 18 NGOs. You mentioned the Pharmaceutical Society. They are not an NGO in the true sense of the word that receives a subvention. They are a professional development body for pharmacists but we do work with them. Whenever we need advice and so on, we call on them and we have a very collaborative relationship.

Mr. Forde: No major challenges as such.

Mr. Deyalsingh: No.

Mr. Chairman: Member Mohit.

Ms. Mohit: Thank you Mr. Chairman, quickly. Minister seeing that we have you here, and we are dealing with health facilities and management, and we heard so much today about the Chaguanas District Health Facility. One of the burning issues in the district of Chaguanas and one of the questions raised at the Town Hall Meetings was that of a health facility, a proper new health facility to be constructed in the district of Chaguanas. Do you have any information for us in terms of location and when that will be constructed given the traffic horrors in Chaguanas as well?

Mr. Deyalsingh: Member Mohit, like Minister Sinanan, you seem to be in the Ministry of Health. So, excellent question because you are right. Chaguanas is one of those burgeoning areas. There was an ad in the paper about three weeks ago for proposals to build a new Chaguanas health facility. So that is on the cards and we hope—I think UDeCOTT put out the request and I will have to check with UDeCOTT to see how far we have reached.

Mr. Chairman: If we could end where we started Minister. Before I give you a chance to bring closing comments, we started by focusing on the importance of preventative initiatives. Dr. Clapperton gave us some interesting data points on the survey. I know the Minister has invested a lot of time and effort in TT Moves and the TT Moves Junior programmes. Can you give us a sense of how you are tracking the success of these programmes? Thank you.

Dr. Clapperton: Thank you again Chair. So all of the programmes and initiatives that have been implemented, in their design stages or planning stages, have a monitoring and evaluation component built in. So when they have rolled out, at those stages we may be collecting data or after completion of some of them, we would be reviewing sometimes based on participant feedback and, you know, the amount of persons anticipating as well. So we have been collecting data on several of the programmes that have been implemented.

Mr. Chairman: And just quickly, when the Minister spoke earlier on about changing the trends when Dr. Clapperton gave the data on alcohol consumption and food consumption, we are in going into to—well we are in the Carnival period. We are not going into, we are in the Carnival period. We have this feature called all-inclusives, which promotes free drinks, free alcoholic beverages and other beverages and free food. Culturally, it is one of those paradigms that shift Trinidad and Tobago into high-gear consumption for a three-month period. Well actually no, it is for a four-month period coming out of Christmas into Carnival. How does to Ministry deal with that cultural aspect of trying to change the trend, because that is a whole quarter of a year which can impact the data for the whole year if you look at it.

Mr. Deyalsingh: Yes, thanks. Chairman, that is a very good question to ask. Overindulgence in alcohol at any time of the year is not wise, but we do tend to overdo it in the Carnival season. Every year, through the Ministry of Health, and its

daughter agency NADAPP, we do put out public advisories as to how the population should conduct themselves into what they eat and drink and consume during the Carnival. So NADAPP always does this and 2025 is going to be no different. But coming out of Dr. Clapperton's research with the STEPS survey, we do seem to have a shifting demographic alcohol consumption, especially amongst females, which did not show up in the 2011 survey. This is the benefit of doing these surveys every ten years.

So I want to make an appeal through you, to not only women, but to all persons that, like everything else, moderation is the key. And, you are quite right. This three-month period, we are going to have excessive use of alcohol, but NADAPP is on the ball. Thank you.

Mr. Chairman: We are also exercising a bit more even if it is purely for aesthetic reasons.

Mr. Deyalsingh: Yeah.

Mr. Chairman: Minister in closing would you like to present some closing comments please.

Mr. Deyalsingh: Yes, thank you Chair. Well, first of all, I want to really thank you Chair and members of the Committee for your excellent questions. I think the public is much more informed as to what we are doing at the Ministry of Health and the RHAs. I want to take the opportunity to thank all 22,000 healthcare workers who do their jobs diligently every single day, 24 hours a day, seven days of the week, Christmas, New Year, Eid, Divali; does not matter.

It is a professional cadre we, and I, are proud to lead. I want to thank you once again for the opportunity and I think we have educated the public through your kind intervention Chairman. Thank you.

Mr. Chairman: Thank you so much. We will like to thank you hon. Minister

Terrance Deyalsingh for taking the time to be with us, particularly under the circumstances. We know you were not well recently. We really appreciate you making the extra effort and coming out. Dr. Parasram, ORTT, Chief Medical Officer; Dr. Brian Armour, Chief Executive Officer SWRHA; Mr. Davlin Thomas, CEO of the NCRHA; and Dr. Maria Clapperton, Director, Non-Communicable Diseases Unit.

We would also like to take the time to thank members of the online audience who were streaming live on YouTube, for their questions and comments and insights and invite the Ministry to send any additional information that you think the Committee can use in its final report on this enquiry. We would like to thank also Members of the Committee and, as usual, the Parliament Secretariat for their unstinted support in this endeavour. On behalf of the Committee, I will like the thank you all for viewing and this meeting is hereby adjourned. Thank you so much.

12.30 p.m.: *Meeting adjourned.*

APPENDIX VII

Summary of Policy Updates provided by the

Ministry of Health
1st Session, 13th Parliament

February 02, 2026

Policy Updates from the Ministry of Health

The Ministry of Health outlined several initiatives and policy updates in the ***2026 Social Sector Investment Programme (SSIP),*** detailing how the Ministry intends to address non-communicable diseases (NCDs) in the upcoming fiscal year. The following initiatives, projects, and policy updates are summarized below:

Prevention and Management of Non-Communicable Diseases (NCDs)[67]

With respect to the prevention and management of non-communicable diseases (NCDs), the Ministry outlined three key initiatives[68]:

1. **Comprehensive Assessment:** *This initiative involves an assessment of existing community-based and home-care services to ensure that health care centers are adequately resourced for NCD*

[67] https://www.finance.gov.tt/wp-content/uploads/2025/08/SSIP-2026.pdf

[68] Ministry of Health NCD Policy Updates – JSC Response re: An Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with specific focus on Diabetes, Cardiological Diseases and Cancer)

screening and treatment. The assessment is currently underway and is expected to be completed by the third quarter of 2026.

2. **National Health and Wellness Plan:** *The Ministry plans to collaborate with key educational and research institutions to develop a national plan that positions preventative care as a central pillar of health policy. As part of this effort, the Ministry proposes the launch of a National Behavioural Change Campaign under the theme 'Step into Wellness" in the second quarter of 2026. The campaign will target adults aged 35-55, children aged 5-12 and the general population aged 18-60. Key activities will include community based events, digital engagement, mass media outreach, influencer engagement and strategic partnerships with the Ministry of Education, the Ministry of Sports and Youth Development, the Ministry of Culture and Community Development and the Ministry of Works and Transport.*

3. **WHO Acceleration Plan to Stop Obesity:** *This initiative adopts the World Health Organizations Acceleration Plan to Stop Obesity that outlines incremental steps for a comprehensive and systematic approach to addressing childhood obesity. The plan supports countries in navigating implementation challenges and achieving measurable outcomes. For fiscal 2026, the WHO Acceleration Plan to Stop Obesity Programme aims to increase levels of regular physical activity among youths aged 6-18 years.*

Summary of programmes, projects and initiatives arising from the implementation of the CCS[69]

In collaboration with PAHO, the Ministry of Health will implement the Country Cooperation Strategy (CCS) 2025-2030, which outlines five strategic priorities and twelve focus areas to guide programmes and initiatives over the next two years. These priorities address health system resilience, prevention and control of NCDs and mental health conditions, communicable disease elimination, climate change and health resilience, and digital transformation of the health sector. A two-year work plan aligned with PAHO's planning cycle is currently under development and is expected to be completed by mid-March 2026. PAHO's T&T national and

[69] Ibid

Washington head offices will finalize funding allocations and sources upon approval of the work plan.

Summary of action items to address risks associated with the illegal drug use[70]

The Ministry of Health continues to implement actionable prevention initiatives through the National Alcohol and Drug Abuse Programme (NADAPP) and the Tobacco Control Unit, focusing on drug use and vaping prevention. These activities include educational and capacity-building sessions in primary and secondary schools, as well as training programmes for community policing personnel. Funding for these initiatives is provided through NADAPP's recurrent expenditure allocation and general recurrent expenditure line items supporting the Tobacco Control Unit. Inter-agency collaboration is coordinated through the Drug Information Network of Trinidad and Tobago (DIN-TT), which includes key ministries, national security agencies, the Tobago House of Assembly, and accredited substance abuse treatment and rehabilitation centers.

Targeted Interventions focused on Children to address NCDs[71]

The other related targeted interventions focused on children to address NCDs include:

i. The Nutritional Guidelines for schools that was commissioned in January 9, 2026;
ii. Health promotion in schools via Health Education Division, MOH;
iii. The Healthy Vacation Camps Initiative;
iv. The School Health Screening Programme-Hearing and Vision; and
v. 'U matter', a mental health initiative towards behavioural change among youths to provide safe, confidential and real-time support to adolescents across the country.

[70] Ministry of Health NCD Policy Updates – JSC Response re: An Inquiry into Trinidad and Tobago's Response to the Prevalence of Non-Communicable Diseases (with specific focus on Diabetes, Cardiological Diseases and Cancer)
[71] Ibid

APPENDIX VIII

Minutes of the 2nd Meeting of the Committee held on November 19, 2025

1st Session, 13th Parliament

MINUTES OF THE SECOND MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION,

HELD ON WEDNESDAY NOVEMBER 19, 2025

Linda Baboolal Meeting Room, Ground Floor, Cabildo Building, Parliamentary Complex, St. Vincent Street, Port of Spain

PRESENT

Members of the Committee

Dr. Desirée Murray	Chairman
Mr. Ravi Ratiram	Member
Mr. Symon de Nobriga, MP	Member
Mrs. Melanie Roberts-Radgman	Member

ABSENT/EXCUSED

Ms. Khadijah Ameen, MP	Vice-Chairman
Dr. Michael Dowlath, MP	Member
Mr. Sean Sobers, MP	Member
Mr. David Nakhid	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Lorraine Berahzer	Assistant Secretary
Mr. Brian Lucio	Assistant Secretary
Ms. Rochelle Stafford	Parliamentary Researcher

CALL TO ORDER

1.1 The Chairman called the meeting to order at 9:39 a.m. and welcomed members present.

ANNOUNCEMENTS

2.1 The Chairman advised that the following Members asked to be excused from the day's proceedings.

- Ms. Khadijah Ameen, MP;
- Dr. Michael Dowlath, MP;
- Mr. Sean Sobers, MP;
- Mr. David Nakhid.

CONFIRMATION OF MINUTES OF THE FIRST MEETING HELD ON FRIDAY OCTOBER 03, 2025

3.1 The Minutes were confirmed without amendments on a motion moved by Mr. Symon de Nobriga, MP and seconded by Mrs. Melanie Roberts-Radgman.

MATTERS ARISING FROM THE MINUTES

4.1 The Chairman referred to item 7.4, page 3 and confirmed that Members received the Updated Inquiry Proposal.

4.2 The Chairman advised Members that the Secretariat made certain revisions to the document based on her feedback.

PRE-HEARING DISCUSSIONS RE*: Public Hearing re: An inquiry into the state's response to student underperformance in primary and secondary schools, the adequacy of the Student Support Services Division (SSSD) and its impact on school dropouts at the primary and secondary school levels*

5.1 The Chairman indicated that later in the proceedings, the Committee would convene its first hearing with stakeholders of the Ministry of Education pursuant to ***its inquiry into Student Underperformance and Student Support Services.***

5.2 The Chairman invited members to consider the Issues Papers prepared by the Secretariat.

5.3 The Committee discussed the approach to be taken during the hearing and questions listed in the issues paper were allocated to Members accordingly.

OTHER BUSINESS

Carrying Forward the Draft Report on Non-Communicable Diseases (NCDs)

6.1 The Chairman advised Members that, due to the dissolution of the 12th Parliament on March 18, 2025, the former Committee was unable to submit its Report on an Inquiry into Non-Communicable Diseases (NCDs) to the House and the Senate.

6.2 The **Chairman** suggested that, given the **significant work** done by the previous Committee, a **Special Report** on the key findings and recommendations emanating from the Inquiry can be submitted to the House/ Senate.

6.3 It was agreed that the Secretariat should prepare and circulate a Draft of the Special Report for the consideration and approval of Committee members before the document is laid in the Houses.

Next Meeting/Agenda

7.1 The Chairman reminded members that the Committee's next inquiry would focus on ***the Effectiveness of Sporting Programmes in diverting youth from delinquent and criminal activities.***

7.2 The Committee reviewed and agreed to the Inquiry Objectives as drafted by the Secretariat.

7.3 Members acknowledged that the Committee's next meeting date is **Wednesday, December 17, 2025, at 9:30 a.m.**

7.4 The Secretariat was instructed to issue a ***Call for Public Submissions*** to ensure the views of relevant stakeholders, including NGOs and athletes, are captured.

SUSPENSION

8.1 The Chairman suspended the meeting at 10:05 a.m.

ADJOURNMENT

10.1 The meeting was adjourned accordingly at 12:45 p.m.

I certify that these Minutes are true and correct.

Chairman

Secretary

December 12, 2025