SSPA

4th REPORT OF THE

JOINT SELECT COMMITTEE ON

SOCIAL SERVICES AND PUBLIC ADMINISTRATION

ON AN

INQUIRY INTO THE PREVALENCE OF SEXUALLY TRANSMITTED DISEASES (STDS) AMONGST SCHOOL STUDENTS AND INTO THE GENERAL SERVICES ADMINISTERED TO TREAT STDS IN TRINIDAD AND TOBAGO.

THIRD SESSION (2017/2018) 11TH PARLIAMENT

OF THE REPUBLIC OF TRINIDAD AND TOBAGO

FOURTH REPORT

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Date Laid: HoR: ______________________ Senate: ____________________

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The Joint Select Committee on Social Services and Public Administration

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THE COMMITTEE

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Mr. Esmond Forde, MP
VICE-CHAIRMAN

Mrs. Glenda Jennings-Smith, MP
MEMBER

Brig. Gen. (Ret.) Ancil Antoine, MP
MEMBER

Mrs. Christine Newallo-Hosein, MP
MEMBER

Mr. Rohan Sinanan
MEMBER

Ms. Khadijah Ameen
MEMBER

Committee Mandate and Establishment

1.1.1 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.

1.1.2 Motions related to this purpose were passed in the House of Representatives and Senate on November 13th, and 17th, 2015, respectively, and thereby established, inter alia, the ***Joint Select Committee on Social Services and Public Administration.***

1.1.3 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 Committee

1.1.4 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

1.1.5 The Committee comprises the following members:

1. Dr. Dhanayshar Mahabir — Chairman
2. Mr. Esmond Forde, MP — Member
3. Mrs. Glenda Jennings-Smith, MP — Member
4. Brig. Gen. (Ret.) Ancil Antoine, MP — Member
5. Mrs. Christine Newallo-Hosein, MP — Member
6. Mr. Rohan Sinanan — Member
7. Ms. Khadijah Ameen — Member
8. (Vacant)

Secretariat Support

1.1.6 The following officers were assigned to assist the Committee:

1. Mr. Julien Ogilvie - Secretary
2. Ms. Kimberly Mitchell - Assistant Secretary
3. Ms. Ashaki Alexis - Graduate Research Assistant

TABLE OF CONTENTS

Committee Mandate and Establishment v

Powers of the Committee vi

Membership vi

Secretariat Support vi

TABLE OF CONTENTS vii

ABBREVIATIONS 10

LIST OF TABLES 12

TABLE OF APPENDICES 12

EXECUTIVE SUMMARY 13

SUMMARY OF RECOMMENDATIONS 15

INTRODUCTION 17

Background 17

STDS and HIV/AIDS in Trinidad and Tobago 17

Secondary School Students, Youth, and STDs 19

Conduct of the Inquiry 21

KEY ISSUES, FINDINGS, AND RECOMMENDATIONS 22

OBJECTIVE 1: To determine the prevalence of Sexually Transmitted Diseases (STDs) including HIV/AIDS amongst secondary school students 22

Sexual activities amongst school students 22

Global School-based Student Health Surveys (GSHS) 23

Adolescents/youths, HIV/AIDS, and STDs 25

Primary school students infected with HIV/AIDS 26

STD cases brought before MoE 26

Record of school students who are HIV positive and the treatment undertaken 27

Teenage pregnancy and Data on the mother-to-child transmission of STDs among teenagers 27

FINDINGS AND RECOMMENDATIONS 27

Findings 27

Recommendations 28

OBJECTIVE 2: To assess strategies the line Ministries is implementing to reduce the rate of infection amongst this cohort 29

The Role of the Ministry of Education (MoE) 29
Policy interventions of the MoE 33
The Role of Ministry of Health (MoH) 34
Measures in place to protect students infected with HIV/AIDS from victimization and discrimination within the school environment 35
Collaboration between the MoH and Teachers 36
FINDINGS AND RECOMMENDATIONS 36
Findings 36
Recommendations 37

OBJECTIVE 3: To evaluate the quality/standard of health care services and facilities provided to treat STDs and the associated cost 38

Universal treatment of HIV/AIDS in Trinidad and Tobago 38
Standards observed by MoH 38
Health Care Services 39
Health care facilities to detect and treat HIV/AIDS and STIs 39
Reporting mechanism between the MoH and each facility 40
Persons who have been tested at public health care facilities for STDs 41
Person that have tested positive for one or more STD 41
Current state of health care facilities 41
Training of staff 42
Infrastructural and equipment needs of each facility 43
Average wait time for STDs test results 43
Full implementation of the quality management process for HIV rapid testing 44
Availability of antiretroviral drugs 44
Cost of treating STDs 44
FINDINGS AND RECOMMENDATIONS 45
Findings 45
Recommendations 46

Appendix I 50

Appendix II **61**

Appendix III **105**

ABBREVIATIONS

AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
CDC	CENTRE FOR DISEASE CONTROL AND PREVENTION
CRC	CONVENTION ON THE RIGHTS OF THE CHILD
DHSS	DEPARTMENT OF HEALTH AND SOCIAL SERVICES
GARPR	GLOBAL AIDS RESPONSE PROGRESS REPORT
HFLE	HEALTH AND FAMILY LIFE EDUCATION CURRICULUM
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HRSA	HUMAN RESOURCE SERVICES ASSOCIATION
ITECH	INTERNATIONAL TRAINING AND EDUCATION CENTRE FOR HEALTH
MOH	MINISTRY OF HEALTH
NCRHA	NORTH CENTRAL REGIONAL HEALTH AUTHORITY
NFS	NATIONAL FAMILY SERVICES
NGO	NON-GOVERNMENTAL ORGANISATION
PEPFAR	UNITED STATES' PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF
QPCC	QUEENS PARK CONSELLING CENTRE
SSH	SEXUALITY AND SEXUAL HEALTH STRAND
SSSD	STUDENT SUPPORT SERVICES DIVISION
SSSU	STUDENT SUPPORT SERVICES UNIT
STD	SEXUALLY TRANSMITTED DISEASE
STI	SEXUALLY TRANSMITTED INFECTIONS
SWRHA	SOUTH-WEST REGIONAL HEALTH AUTHORITY

THA	TOBAGO HOUSE OF ASSEMBLY
UNFPA	UNITED NATIONS POPULATION FUND

LIST OF TABLES

TABLE	PAGE NUMBER
Table 1: Cumulative HIV, AIDS Cases and Deaths 1983 – September 2009	18
Table 2: Cumulative New HIV Positive Cases by Age group and Gender for 2008	18
Table 3: Incidences of Reports Infectious Syphilis and Gonorrhoea by Age (10-19 Years) and Gender, 2009-2010	20-21
Table 4: New HIV Positive Cases by Age Group (10-19 Years) and Sex, 2011	21
Table 5: Demographic characteristics of the GSHS sample in Trinidad and Tobago, 2011	24
Table 6: Combined table showing Unprotected Sex, Teenage Pregnancy 2014-2016.	25
Table 7: Sex and age group of primary school students infected with HIV/AIDS	26
Table 8: Violations and their consequences for offences that directly and/or indirectly refers/lead to sexual misconduct	32
Table 9: Vacancies at the Queen's Park Counselling Centre and Clinic (QPCC&C) and other specialized STD facilities/clinics.	42
Table 10: Average wait time for various STDs test results	43-44
Table 11: Annual cost of procuring the relevant drugs for the treatment of HIV/AIDS	45
Table 12: The annual cost of procuring drugs for QPCC&C	45

TABLE OF APPENDICES

APPENDICES	PAGE NUMBER
Appendix I: Minutes of the Eleventh Meeting of the Committee	51-61
Appendix II: Verbatim Notes of the eleventh meeting of the Committee	62- 105
Appendix III: Violations and their consequences for offenses that directly and/or indirectly refers/leads to the sexual misconduct of teachers	106-107

EXECUTIVE SUMMARY

2.1.1 At its ninth meeting held on Wednesday November 16, 2016, the Committee resolved to inquire into the prevalence of Sexually Transmitted Diseases (STDs) amongst school students and into the general services administered to treat STDs in Trinidad and Tobago.

As such, the Committee agreed on the following inquiry objectives:

1. **To determine the prevalence of Sexually Transmitted Diseases (STDs) including HIV/AIDS amongst secondary school students;**
2. **To assess strategies the line Ministries are implementing to reduce the rate of infection amongst this cohort; and**
3. **To evaluate the quality/standard of health care services and facilities provided/available to treat STDs and the associated costs.**

2.1.2 The Committee acquired both oral and written evidence based on the objectives listed above. Oral evidence was received during a public hearing held with various stakeholders on Wednesday February 15, 2017. Some of the significant issues highlighted during the hearing were:

a. The inadequacy of the Ministry of Education's Health and Family Life curriculum to enable students to effectively deal with matters concerning STDs;

b. The lack of training programmes to better equip teachers to deal with inappropriate sexual behaviour among the student population and the existence of students infected with Sexually Transmitted Diseases (STDs);

c. The need for additional educators who specialize in Health and Family Life Education (HFLE);

d. Challenges encountered by the Ministry in delivering the sex education syllabus in denominational schools;

e. Resistance from parents as it concerns the participation of students in the Health and Family Life Education Programme (HFLE);

f. The lack of support and resources extended to Principals tasked with the responsibility of *loco parentis* in instances where students are in need of urgent medical treatment;

g. The need for collaboration between the Ministry of Education's School Support System and the MoH with reference to the provision of support services to schools and teachers in dealing with Sexually Transmitted Diseases (STDs);

h. The need for greater collaboration between the Ministry of Health and the Ministry of Education in strengthening the current Health and Family Life Education Programme (HFLE) and other programmes/initiatives targeted to curb irresponsible/inappropriate sexual behaviour among school students;

i. The current ratio of Guidance Officers to students at the Secondary School Level;

j. The increasing use of social media by school students as a platform to display sexual behaviour;

k. The delay in the completion of the 2016 Global School-Based Student Health Survey Report;

l. Reports of students engaging in sexual activities with adults;

m. Students at the primary school level who are HIV positive;

n. The need for a Polymerase Chain Reaction (PCR) machine in treatment facilities. This machine is required to diagnose Chlamydia trachomatis infections. It can also be employed to diagnose conditions such as HPV and Gonorrhoea with more accuracy; and

o. The current rate of mother-to-child transmission of HIV/AIDS.

2.1.3 Based on these findings and other matters which arose during the inquiry, the Committee has offered recommendations which we believe will address the issues highlighted. A summary of these recommendations follows this Executive Summary.

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

SUMMARY OF RECOMMENDATIONS

RECOMMENDATIONS FOR IMPLEMENTATION IN THE SHORT-TERM

(To be implemented within 3 to 6 months of the presentation of the report)

I. That the Minister of Health in his response to this report provide the Parliament with a status update on the publication of findings of the Global School Health Survey (GSHS) that was conducted April 2016;

II. That an appropriate forum be established to facilitate dialogue between Denominational Board, the MoE, MoH Trinidad and Tobago Parent Teacher Association, TTUTA and other relevant stakeholders;

III. That social media be utilized as a communication platform for the promotion of abstinence, safer sex and furthermore, boost awareness of the various health risks associated with unprotected sex;

IV. That there should be a national plan of action for the implementation of strategic objectives of the MoH and related stakeholders as it relates to the testing, diagnosis and treatment of STDs;

V. That the Ministry of Health proceed with alacrity to formulate a Draft Proposal for a policy framework to guide the testing and treatment protocols for STDs in the private health care sector;

VI. That MoH undertake consultations with Private Hospitals and Health care providers with a view to obtaining their feedback on a proposed framework for the implementation of the quality management programme to support HIV rapid testing and Clinical Quality improvement processes;

VII. That the Ministry determine the order of priority for the filling of vacant positions at the various testing and treatment facilities;

VIII. That a copy of the Ministry's Manpower Audit be appended to its Ministerial Response to this report;

IX. That the Ministry of Health, in its response to this report articulate its policy position on the disbursement of free antiretroviral drugs at public health facilities to non-nationals;

X. That the Ministry of Health collaborate with the Ministry of the Attorney General to assess the feasibility of enacting legislative provisions to criminalise the deliberate transmission of HIV/AIDS by one person to another.

RECOMMENDATIONS FOR IMPLEMENTATION IN THE LONG-TERM

(To be implemented within 12 months to 2 years of the presentation of the report)

I. The implementation of a National School Health Policy and establishment of an Adolescent Health Service;

II. That a continuous education approach be adopted in respect of Teachers who deliver HFLE;

III. That the MoH should explore the feasibility of outsourcing the necessary testing to private health care institutions.

INTRODUCTION

Background

STDS and HIV/AIDS in Trinidad and Tobago

3.1.1 Almost twenty-seven years have elapsed since the first case of AIDS was diagnosed in Trinidad in 1983. By the end of the third quarter of 2009, the number of new HIV positive cases reported had reached 202,551[1], and the number of AIDS cases and AIDS related deaths had climbed to 6,208 and 3,845 respectively. In 2007 there were 114 deaths attributed to AIDS while the number recorded in 2008 was 81. **The most recent modeling of the available surveillance data for Trinidad and Tobago indicates a steady, though small increase in the HIV prevalence rates from 1.2% at the end of 2006 to 1.5% in 2009.** This small increase can be attributable to the expansion of treatment services more specifically, the **free provision of anti-retroviral (ARV)** which was initiated in 2002.[2]

3.1.2 The Committee noted with concern the lack of statistical data on the rate of HIV/AIDS infections in Trinidad and Tobago within the past 8 years. As such, the data referenced in this section is relatively dated but provides some indication of the trends which persisted during the period 2002-2008. Up until 2007, new HIV cases among males outstripped new HIV cases among females. At the end of 2006, the male to female ratio for new HIV positive cases stood at 51:49, but at the end of 2008 females accounted for 694 or 48.53% of new HIV positive cases, while males accounted for 609 or 42.59%. The majority of new HIV positive cases among females occurred in the 20-24 age group while the largest number of new HIV positive cases among males were found in the 45-49 age group. Table 1 shows the Cumulative HIV, AIDS Cases and Deaths for the period 1983 to September 2009. Table 2 below provides data on New HIV positive cases by age and sex for 2008 [3]

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[1] Ministry of Health, the Republic of Trinidad and Tobago, National Surveillance Unit; this figure covers the period 1983 to September 2009 and only include testing in the public sector.

[2] 'UNGASS COUNTRY PROGRESS REPORT Trinidad and Tobago 2008-2009". Accessed on January 12, 2017. http://www.health.gov.tt/downloads/DownloadItem.aspx?id=256

[3]"UNGASS COUNTRY PROGRESS REPORT Trinidad and Tobago 2008-2009". Accessed on 12, 2016. http://www.health.gov.tt/downloads/DownloadItem.aspx?id=256

Table 1

Cumulative HIV, AIDS Cases and Deaths 1983 – September 2009

	2007	2008	2009	Cumulative Total 1983 – September 2009
New HIV Positive	1,404	1,448	859	20,255
AIDS	161	93	85	6,208
Deaths	114	81	37	3,845

Table 2

Cumulative New HIV Positive Cases by Age group and Gender for 2008

AGE	MALE	FEMALE	UNKNOWN	TOTAL
< 1	0	2	2	4
1-4	3	1	1	5
5-9	1	4	0	5
10-14	1	3	0	4
15-19	10	51	2	63
20-24	57	143	15	215
25-29	74	134	8	216
30-34	72	104	9	185
35-39	78	60	5	143
40-44	70	47	2	119
45-49	82	32	2	116
50-54	43	25	3	71
55-59	26	17	2	45
60+	35	14	0	49
Not Stated	57	57	76	190

3.1.3 According to the 2014 Trinidad and Tobago Global AIDS Response Progress Report (GARPR), from 2011 to 2012, there was an increase in newly diagnosed HIV cases from 33 to 47, and an increase in AIDS related deaths from 42 to 55.

3.1.4 Recent studies conducted illustrated that the majority of new HIV positive cases among females occurred in the 20-24 age group while the largest number of new HIV positive cases among males were found in the 45-49 age group. **UNAIDS has estimated that at the end of 2015, there were 10,000 to 11,000 persons living with HIV in Trinidad and Tobago.**[4]

Secondary School Students, Youth, and STDs

3.1.5 According to the Trinidad and Tobago 2011 Population and Housing Census[5], out of the total population, **351,622 persons are under 18** (334,305 in Trinidad, and 11,586 in Tobago). Studies piloted among adolescents have shown high rates of sexual activity, early onset of sexual intercourse, multiple partnering, and reluctance to access and use condoms. A 2007 **GLOBAL SCHOOL-BASED STUDENT HEALTH SURVEY**[6] conducted by the Ministry of Health, gathered a wealth of data on the sexual behaviors amongst adolescents aged 11 to 18 years in Trinidad and Tobago. The findings of the survey suggest that *inter alia*:

i. 26.0% of the total student's population have had sexual intercourse during their life. Male students (32.0%) are significantly more likely than female students (20.2%) to have had sexual intercourse;

ii. Overall, 13.2% of students had sexual intercourse for the first time before age 13. Male students (19.9 %) are significantly more likely than female students (6.3 %) to have sexual intercourse for the first time before age 13;

iii. Overall, 17.6% of students had sexual intercourse with multiple partners (i.e., two or more) during their life. Male students (23.9%) are significantly more likely than female students (11.4%) to have had multiple partners;

iv. Overall, 37.3% of students would most likely get a condom or rubbers from a pharmacy, clinic, or hospital if they wanted one;

[4] Edwards, Nikoli. "TACKLING HIV/AIDS IN T&T". Trinidad and Tobago Guardian, December 3, 2016. (Accessed on October 12, 2016) http://www.guardian.co.tt/commentary/2016-12-03/tackling-hivaids-tt

[5] Trinidad and Tobago 2011 Population and Housing Census Demographic Report. Accessed on October, 12, 2016. https://guardian.co.tt/sites/default/files/story/2011_DemographicReport.pdf

[6] "GLOBAL SCHOOL-BASED STUDENT HEALTH SURVEY (GSHS) 2007 Trinidad and Tobago Report." Accessed on October, 12, 2016. http://www.who.int/chp/gshs/2007_GSHS_Trinidad_and_Tobago_Report.pdf

v. Associated with these behaviors are increased risk for HIV, sexually-transmitted infections and unplanned teenage pregnancy.

3.1.6 In a 2013 national youth symposium, themed "***Youth as agents of change***"[7] *in the national response to HIV and AIDS in T&T*, held at Capital Plaza, Port-of-Spain, it was recorded that approximately 1.3 per cent of youths 15 to 21 (years), which is approximately 3,500 youths in T&T are living with HIV/AIDS. The tables below outline statistics of **reported cases** of certain STDs among the 10-14 and 15-19 age groups.

Table 3

Incidences of Reports Infectious Syphilis and Gonorrhea
By Age (10-19 Years) and Gender, 2009-2010[8]

Year	10-14 years	15-19 years
MALE		
Infectious Syphilis		
2009	0	1
2010	0	0
All Syphilis		
2009	0	1
2010	0	0
Gonorrhea		
2009	0	51
2010	0	53
FEMALE		
Infectious Syphilis		
2009	1	4
2010	1	7
All Syphilis		
2009	1	4

[7] "3,500 T&T young people living with HIV/Aids". Trinidad and Tobago Guardian, May 3, 2013. (Assessed on October 12, 2016). http://www.guardian.co.tt/news/2013-05-02/minister-3500-tt-young-people-living-hivaids
[8] "MINISTRY OF HEALTH STATISTICAL REPORT 2009 2009 2011 MINISTRY OF HEALTH STATISTICAL REPORT 2009-2011" Assessed on October 12, 2016. http://www.health.gov.tt/downloads/DownloadItem.aspx?id=376

2010	1	7
Gonorrhea		
2009	2	26
2010	1	8

Table 4

New HIV Positive Cases by Age Group (10-19 Years) and Sex, 2011

Age/ Years	Male	Female	Unknown	TOTAL
10-14 years	0	1	1	2
15-19 years	8	36	2	47

Conduct of the Inquiry

3.2.1 Prior to the commencement of the public hearings, the Committee issued invitations to the public and specific stakeholders to present written submissions based on the objectives of the inquiry:

1. **To determine the prevalence of Sexually Transmitted Diseases (STDs) including HIV/AIDS amongst secondary school students;**
2. **To assess strategies the line Ministries are implementing to reduce the rate of infection amongst this cohort; and**
3. **To evaluate the quality/standard of health care services and facilities provided/available to treat STDs and the associated costs.**

3.2.2 The Committee held a public hearing with various stakeholders on Wednesday 15 February, 2017 with representatives of the Ministry of Health (MoH) and the Ministry of Education (MoE).

3.2.3 The **Minutes of the Meetings** during which the public hearing was held is attached as **Appendix I** and the **Verbatim Notes** as **Appendix II.**

KEY ISSUES, FINDINGS, AND RECOMMENDATIONS

OBJECTIVE 1: To determine the prevalence of Sexually Transmitted Diseases (STDs) including HIV/AIDS amongst secondary school students

Sexual activities amongst school students

4.1.1 Data available on the number of school students who are engaged in unprotected sex is **based on self-reports or cases** brought to the attention of Student Support Service Division (SSSD) personnel and may under-represent the total number of students engaging in sexual intercourse.

4.1.2 The number of students who engaged in unprotected sex was collated by SSSD using statistics for the period 2014-2016 based on student disclosures as well as data on teenage pregnancies. For that three year period, **there were 191 cases of unprotected sex comprising 31 cases in 2014, 65 cases in 2015 and 95 cases in 2016**.

4.1.3 Of the 110 students engaging in unprotected sex in secondary schools, thirty-six (36) were males ranging from 13-18 years and twenty-seven (27) were females ranging from 13 to 18 years. Although child sexual abuse may have included unprotected sex this was not disaggregated in the data and therefore does not include the 524 reported cases of child sex abuse for the period 2014-2016.

4.1.4 In addition, it was reported to the Committee that the following data on sexual activity among young persons were recorded by the Queen's Park Counselling Centre (QPCC) in respect of the15 to 19 age group:

- In 2015 2,255;
- In 2014, 2,503; and
- In 2013, 2,492.

Global School-based Student Health Surveys (GSHS)

4.1.5 The **Global school-based student health survey (GSHS)** is a collaborative surveillance project designed to help countries measure and assess the behavioral risk factors and protective factors in 10 key areas among young people aged 13 to 17 years. This survey is conducted by the World Health Organization, Pan American Health Organization and the Centre for Disease Control (CDC, Atlanta). Since 2003, Ministries of Health and Education around the world have been using the GSHS to periodically monitor the prevalence of important health risk behaviors and protective factors among students.

4.1.6 In Trinidad and Tobago, the lead Ministry in the administering of the GSHS is the MoH. The MoH would, in turn, obtain the necessary approvals from the Ministry of Education. The first survey was conducted from 19-30 April 2007. The subsequent surveys were conducted in April 2011 and April 2016.

4.1.7 Survey procedures were designed to protect student privacy by allowing for anonymous and voluntary participation. Students completed the self-administered questionnaire during one classroom period and recorded their responses directly on a computer-readable answer sheet. Approximately, 53 survey administrators were specially trained to conduct the GSHS.

How is the GSHS conducted?

4.1.8 The Committee was informed that schools must first be registered with the Ministry of Education of Trinidad and Tobago to be considered for participation in the survey. The Trinidad and Tobago (2011) GSHS was a school-based survey of students in Forms 1-4. A two-stage cluster sample design was used to produce data representative of all students in Forms 1-4 in Trinidad and Tobago. At the first stage, schools were selected with probability proportional to enrollment size.

4.1.9 At the second stage, classes were randomly selected and all students in selected classes were eligible to participate. The student response rate was 93%. A total of 2,811 students participated in the Trinidad and Tobago GSHS. Students self-reported their responses to each question on a computer readable answer sheet. The second stage of sampling consisted of

randomly selecting intact classrooms (using a random start) from each school to participate. All students in the sampled classrooms were eligible to participate in the GSHS.

4.1.10 In **Table 5** below shows the Demographics of the students participating in the study.

Table 5

Demographic characteristics of the GSHS sample in Trinidad and Tobago, 2011

	Sex		**Age**			***Forms***			
	Males	**Females**	**12 or younger**	**13-15**	**16 or older**	1	2	3	4
2011	49.9%	50.8%	21.6%	68.3%	10.1%	23.8%	24.1%	26.3%	25.5%

4.1.11 It was brought to the attention of the Committee that a similar (GSHS) study was undertaken in April 2016. However, data are is still being collated at this time by these organizations.

Findings of the GSHS

4.1.12 The key findings of the 2011 study in relation to sexually transmitted disease revealed that 27.1% of the respondents engaged in sexual intercourse. Of these respondents, 55.5% admitted to using a condom the last time they had sexual intercourse (56% were boys and 54% were girls). Comparison of data from the 2011 study with the 2007 study revealed:

- No significant increase in the percentage of students reporting ever having had sexual intercourse during the period;
- That the number of students who had sexual intercourse for the first time before age **13** decreased by 5%;
- A decline by 5% of the number of students who had sexual intercourse with two or more people during their life;

- A 7% increase in condom use by students who had sexual intercourse in 2011 compared with 59.1% in 2007; and

- A 3% increase in students using methods of birth control with their partner most of the time from 22.4 % in 2007 to 25.6% in 2011.

4.1.13 **Comparison of the data between 2007 and 2011 indicate that there is a positive decline in the early onset of sexual intercourse among students**. On the occasions that students are engaging in sexual activity there has been an increase in condom use and birth control methods demonstrating the positive impact of education and awareness on students.

<u>Table 6</u>

Combined table showing Unprotected Sex, Teenage Pregnancy 2014-2016.

Year	Unprotected Sex	Unprotected sex resulting in Teenage Pregnancy *
2014	12	19
2015	35	30
2016	63	32
Total	110	81

<u>Adolescents/youths, HIV/AIDS, and STDs</u>

4.1.14 According to MoH, data sourced from existing admissions at the various public health institutions indicated the following:

- Adult Prevalence Rate (15-49 years) for HIV is 1.2 (2015);

- Number of new HIV infections among male youth 15-24 years is 58 (2015); and
- Number of new HIV infections among female youth 15-24 years is 59 (2015).

4.1.15 It was revealed to the Committee by QPCC that for the period 2012 to 2015, **38 persons from the 15 to 19 age group tested positive for HIV, and 85 for syphilis.**

4.1.16 Furthermore, with reference to students who are infected with one or more STIs/STDs, the Committee was advised by the Ministry of Education that there is only one case of STI/STD brought to the attention of the Student Support Services Division (SSSD) in 2016. However, generally this information is not disclosed to SSSD and MoE does not have access to confidential sexual health status of students provided to doctors/medical institutions.

Primary school students infected with HIV/AIDS

4.1.17 In 2016 the number of cases that have been brought to the attention of the MOE is 5 at the primary level.

Table 7
Sex and age group of primary school students infected with HIV/AIDS

Primary School	
2016	2 (m) 8 years, 11 years
	3 (f) 7 years, 9 years, 10years

STD cases brought before MoE

4.1.18 It was revealed to the Committee that there was just one case that was brought to the MoE's attention as it concerns STDs.

4.1.19 It was further indicated that if matters of this nature are brought to the attention of any officer attached to the SSSD, the officer is required to make a report. **Confidentiality is strictly applied by SSSD when dealing with such matters.**

Record of school students who are HIV positive and the treatment undertaken

4.1.20 In 2016 five (5) cases were brought to the attention of the SSSD. These students received support from the MoE and in addition, social workers engaged the students and their relatives. The Committee was advised that the students would remain within the school system until health factors warrant their removal. This approach is in keeping with the MoE's philosophy of inclusive education.

4.1.21 MoH collects surveillance data from anyone who tests positive for HIV. It should be noted that the data only indicates the age of the infected person. However, for the underage population, the MoH would attempt to determine if the infection was as a result of mother-to-child transmission or a unique infection. Any child who has tested positive and appears at a prevention site will be transferred to a treatment site and put on antiretroviral therapy.

Teenage pregnancy and Data on the mother-to-child transmission of STDs among teenagers

4.1.22 The mother-to-child transmission of STDs among teenagers rate in this country is less than 2 percent, which is in keeping with the WHO's standard to be achieved in the Americas.

4.1.23 Furthermore, during the period 2011 to 2013, there were 13 cases of HIV positive pregnant women within the 15 to 19 age group. However, the MoE has a policy that allows all pregnant students and the fathers (where applicable) to continue their formal education. Support is provided to the students during the term of pregnancy to ensure that the students can return to school.

FINDINGS AND RECOMMENDATIONS

Findings

4.1.24 Based on the preceding evidence/information, the Committee concluded as follows:

i. It appears that the Global School-based Student Health Surveys (GSHS) is the only empirical study conducted in Trinidad and Tobago which aims to capture and analyze data on the prevalence of unprotected sex and STDs amongst the juvenile and adolescent cohorts.

ii. There is a significant level of underreporting and unsubstantiated information regarding students infected with a Sexually Transmitted Diseases (STDs) including HIV/AIDS. However, this is justifiable and largely attributable to the need to attend to such matters/cases in a confidential manner. The unwarranted disclosure of the "STD status" of a teenage student would adversely impact his/her psycho-social wellbeing;

iii. Based on a comparison of the data between 2007 and 2011, it could be suggested that there is a positive decline in the early onset of sexual intercourse among students

iv. There appears to be a delay in the publication of Global School-based Student Health Surveys (GSHS) that were conducted in April 2016.

v. It appears that there exists a need for more teachers or and school administrators to be trained in programmes to better equip them to deal appropriately with sexual behavior among the student population and with students/peers who are infected with Sexually Transmitted Diseases (STDs).

Recommendations

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

A. That the Minister of Health in his response to this report provide the Parliament with a status update on the publication of findings of the Global School Health Survey (GSHS) that was conducted April 2016.

B. That there be greater collaboration between the Ministry of Education and Ministry of Health to better equip teachers to effectively deal with sexual behavior among the student population and with students and co-workers who are infected with Sexually Transmitted Diseases (STDs); and

C. **That social media be utilized as a communication platform for the promotion of abstinence, safer sex and furthermore, boost awareness of the various health risks associated with unprotected sex.**

OBJECTIVE 2: To assess strategies the line Ministries is implementing to reduce the rate of infection amongst this cohort

The Role of the Ministry of Education (MoE)

4.2.1 With reference to the reduction of the rate of infection of STDs, the Ministry has focused on the implementation of a number of preventative strategies to reduce the rate of infection of STDs among the student population.

Student Support Services Division (SSSD)

4.2.2 Student Support Services Division was created or established on January 29, 2004. The Division was established through the unification of the former Central Guidance and Special Education Units and a School Social Work component at the primary school level.

4.2.3 At both the primary and secondary levels, **classroom guidance sessions and whole school information sessions** routinely provide information and skill development as follows:

Classroom Guidance Sessions

- Building Respect;
- Increasing awareness of students;
- Values and making choices in line with one's values;
- Building Social and Emotional Intelligence;
- Risks associated with the inappropriate use of Social Media;
- Inappropriate Sexual Behavior;
- Increasing awareness of ways to be safe during Carnival; and
- Forging healthy friendships and peer relationships.

4.2.4 The inclusion of the option for abstinence as an alternative message for students is operationalized in programmes such as "Crossroads" and in all sessions on human sexuality.

It allows students to embrace the fact that they do not need to follow the societal trends to engage in sexual activity.

Parental Support

4.2.5 School Social Workers provide targeted intervention- Selected groups of students displaying inappropriate sexual behaviors receive information on:

- STDs and HIV;
- Understanding Adolescence;
- Puberty;
- Appropriate uses of the Social Media and how to deal with inappropriate sexual behaviors;
- Relationships;
- Social and Emotional Intelligence; and
- Decision making/Choices.

4.2.6 **Parenting in Education Workshops** are held to assist parents in understanding, guiding and supporting their children during this developmental phase.

4.2.7 **Learning Enhancement Centers (LECs): -** Students on extended suspension who were found engaging in risky sexual behavior are referred to the LEC **for** information and skill building in self-awareness, decision making, understanding sexuality and the dimensions of the human person. Programmes are tailored to address the needs of students.

4.2.8 Monitoring and Evaluation of the above programmes remains a critical aspect of the functioning of the MOE to ensure **targets** are met and the appropriate interventions are delivered. Pre and post surveys, oral responses of participants and feedback concerning behavior change as observed by SSSD staff, teachers and parents are conducted to ascertain increased levels of awareness and positive behavior change.

Curriculum Development and implementation

Sex education

4.2.9 The MOE frames its sex education content on the Health and Family Life Education (HFLE) Programme. The content of HFLE is organized around four (4) themes, built on the foundation of the CARICOM Regional Curriculum HFLE Framework which guides the philosophy and outlines the regional standards of the HFLE curriculum. Core outcomes have been adapted and developed for each of the following four (4) themes:

1. Self and Interpersonal Relationships;
2. Sexuality and Sexual Health;
3. Eating and Fitness; and
4. Managing the Environment.

Implementation of HFLE at Secondary and Primary Schools

4.2.10 HFLE is taught at the Secondary schools for at least two (2) periods per week or teaching cycle using the revised 2014-HFLE Curriculum for secondary schools Forms 1 -3. The HFLE secondary school programme consists of the four (4) themes and a number of selected topics organized within a basic structural framework.

4.2.11 At the Primary schools, the skills, values, and attitudes as articulated in the reprinted 2006 HFLE Curriculum Guide Primary Infants to Standard Five are infused into other subject areas using an integrated thematic approach.

Sexuality and Sexual Health Education module

4.2.12 The Committee was informed that the Sexuality and Sexual Health Education component of the HFLE programme goal is to ensure that:

a) students gain the knowledge necessary to clarify societal beliefs and so become comfortable with their own sexuality.

b) students understand and accept themselves as unique sexual beings with specific needs and become aware of changes and challenges as they go through life;

c) students shall acquire the positive life skills necessary for maintaining reproductive health; and

d) provides students with the skills to deal with the changes associated with puberty, apply life-skills to promote healthy, responsible sexual behaviours and to manage expressions of sexuality in a responsible manner.

National School Code of conduct that addresses the matter of sexual activity within schools

4.2.13 The National School Code of Conduct provides guidelines for responsibilities, standards, and consequences for inappropriate sexual behavior of students including sexual misconduct. It is a responsive approach to incidence of sexual misconduct.

4.2.14 As outlined by the Code the following are violations and their consequences for offenses that directly and/or indirectly refers/lead to sexual misconduct.

Table 8

Violations and their consequences for offenses that directly and/or indirectly refers/lead to sexual misconduct

OFFENCE	OCCURRENCE	MINIMUM	MAXIMUM
Sexual Misconduct	First	Parental Involvement	Suspension
	Repeated	Suspension	Law Enforcement Expulsion
Technology Misuse	First	Informal Talk	Suspension
	Repeated	Parental Involvement	Suspension
Unexcused Absence	First	Informal talk	Parental Involvement
	Repeated	Parental Involvement	Suspension

4.2.15 However, MoE follows the provisions of the law under the Sexual Offences Act and the Children's Act. Moreover, MoE also issued Circular Memoranda on September 2nd, 2008 (No. 76) and 3rd June 2014 (No. 25). The Ministry is also guided by Circular Memoranda issued by the Director Personnel Administration of the 28th April 2011.

4.2.16 With reference to the **violations and their consequences for offenses that directly and/or indirectly refers/leads to the sexual misconduct of teachers** please refer to **Appendix III**.

Policy interventions of the MoE

4.2.17 It was indicated to the Committee that the underlying background to any policy intervention of the MoE stems from the Education Act Chapter 39:01 which states that all children have a right to access education between the ages of 5-16 years.

4.2.18 The *Education White paper (1993-2003)* shaped the policy interventions in the creation of SSSD to ensure that the psycho-social issues impacting children were addressed by the inclusion of a Social Work department and strengthening of the diagnostic prescriptive services for special students. The MoE policy interventions are further guided by the *Dakar Framework of Education (2000)* which recognized that every child has a right to education as outlined by the Convention of the Rights of the Child (1989).

4.2.19 Furthermore, MoE also follows the *World Bank Working Paper No. 137 (2008) - Strengthening in the education sector Response to HIV&AIDS in the Caribbean*. The World Bank guidelines accelerated the education sector component of this country's HIV & AIDS response. As a consequence to this report, the MoE developed its Education /Sector Policy on HIV and AIDS (2010) which states that the "MoE shall actively use education as a strategy for the prevention and reduction of HIV infection among its population through peer education and through its HFLE national curriculum".

4.2.20 The World Bank (2008) stated that "education is an effective social vaccine against HIV&AIDS and that the Education for All (EFA) initiative should ensure that all children are included in school." The World Bank also stated that experience indicates that the **education**

sector warrants special priority in a multi-sectoral response to HIV&AIDS because of its long term and inter-generational implications for the development of society.

4.2.21 Against this background the MOE Education Sector Policy on HIV&AIDS (2010) "aims to promote an awareness among the student and employee population of the MOE about the causes, modes of transmission, consequences, means of prevention and control of HIV and AIDS through comprehensive, needs oriented, gender sensitive, nationwide educational programmes".

The Role of Ministry of Health (MoH)

Strategies to reduce the rate of infection of STD

4.2.22 The Committee was informed that MoH has implemented specific strategies to reduce the rate of infection of STDs among the student population. This includes the use of Health Education and Health Promotion which is ongoing at schools for students at an early age to ensure an enabling environment equipped with the knowledge, attitudes, skills, and values to allow for a more effective decision in the face of peer and other social pressure. Some other programmes include:

a) An **HIV/STI Awareness Session Programme** by NPTA/QPCC&C collaboration (National Parent Teacher Association) with an aim to create awareness of the STI/HIV/AIDS prevention message across the student population;

b) **Reinforce abstinence** messages and strongly encourage students to delay sexual initiation;

c) The HIV and AIDS programme has also had youth consultations to develop a curriculum for clinical care and support for adolescents living with and directly affected by HIV and AIDS;

d) **RAPPORT outreach programme** aims to educate and empower the 12-29 year population on issues related to HIV and Sexual Reproductive Health. These objectives are achieved through a holistic approach to young people's development, namely, an emphasis on healthy lifestyles including a focus on facilitating the development of knowledge and skills related to negotiating safe sex practices and information related

to HIV/AIDS and other STIs. RAPPORT is currently present in NCRHA and SWRHA.; and

e) The MOH also offers free treatment to any adolescent infected with an STD or HIV once consented care is assessed.

Studies or research that informed the policy interventions of MoH

4.2.23 The Ministry reported that the key research studies which inform its policy initiatives include:

1. Assessment of Sexual and Reproductive Health Services in Trinidad and Tobago-Phase 1: Population Programme Unit (2010);
2. Evaluation of the National Health System Response to HIV and STI in Trinidad and Tobago (2011);
3. Final Report on Assessment of Male Specific Sexual and Reproductive Health Services Provided in the Health Sector (2012);
4. The regional study conducted by the University of the West Indies, Health Economics Unit noted some of the socio-cultural drivers of adolescent pregnancy in the Caribbean which include early sexual initiation; misplaced notions of masculinity and femininity; sexual abuse; and religion and child marriage (UWI, 2013);
5. World Bank Report of 2003 that postulated that no other region in the world has an earlier age of sexual initiation than the Caribbean Region (UWI, 2013);
6. Global School Based Health Survey (PAHO, CDC, and MOH 2011); and
7. Caribbean Integrated Strategic Framework on Adolescent pregnancy adopted by CARICOM in 2015.

Measures in place to protect students infected with HIV/AIDS from victimization and discrimination within the school environment

4.2.24 It was indicated to the Committee that the absolute priority of the Ministry of Education is to protect student confidentiality by SSSD personnel. This information is not shared with teachers or other personnel on compound. **Only a Principal is entrusted with this**

information, since by virtue of the Education Act, Chapter 39:01 the Principal is charged with the and responsibility for safety of students.

4.2.25 The Committee was further informed that regular sensitization of Principals and teachers to the essential practice of respect for the confidential nature of students' personal affairs, more so the need to protect the student from the double pain of stigmatization of infection with HIV/AIDS is practiced within schools.

4.2.26 SSSD- Guidance and School Social Work personnel work to create and protect an environment in the schools, where students and parents can access counseling and appropriate referral services. In addition, Parent Information Sessions are conducted to develop parent skills in listening and empathy.

Collaboration between the MoH and Teachers

4.2.27 The Committee was informed that there is collaboration with teachers through the MoH's Public Education Committee, which was established in 2016. Moreover, the Committee has a sub-committee called the Sexual and Reproductive Health Committee, of which the Director of Health Education is the Chair.

4.2.28 It was further revealed that this Committee comprise representatives of the MoE and NGOs and they collaborate on getting the syllabus aligned and structured to deal with issues related to health.

FINDINGS AND RECOMMENDATIONS

Findings

4.2.29 In this regard the Committee has made the following findings:

i. The Staff complement of the SSSD currently stands at six hundred (600) (on paper) and at the secondary school level the ratio of guidance officer to school is 1:1

ii. Some educators are not properly equipped to deliver the HFLE Programme. Furthermore, there is a need for additional educators who specialized in Health and Family Life Education (HFLE); and

iii. The protection of the identity of students who are infected with an STD is a priority for the MoE and it appears that the Ministry has been successful in preventing any breaches of this protocol.

iv. The MoE appears to have a relatively sound framework for the infusion of sex education and life skills into learning experience of students. This framework is guided by internationally recognized studies including the World Bank Working Paper No. 137. Similarly, it was observed that the intervention of the MoH in this area (HIV/AIDS) are guided by a series of studies and credible references.

v. The Committee was pleased to learn that the MoE has included interventions which aim to provide parental support in relation to "vulnerable" or "High risk" students. This holistic approach is commendable.

vi. Delivering the sex education syllabus in denominational schools has been a challenged for the MoE. Due to certain religious doctrines and ideologies, this component of the school curriculum has received some resistance from parents as it concerns the participation of students in the Health and Family Life Education (HFLE).

Recommendations

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

A. We recommend that a continuous education approach be adopted in respect of Teachers who deliver HFLE. This approach would ensure that existing and new teachers are equipped with the most current knowledge and skills associated with family life education. To circumvent financial constraints, the MoE and MoH can seek

to incorporate online resources into teacher training and or seek technical assistance from International organizations such as the Pan American Health Organization.

B. The implementation of a National School Health Policy and establishment of an Adolescent Health Service;

C. In light of the reservations expressed by some denominational schools and parents with reference to participation of students in the Health and Family Life Education (HFLE); the Committee recommends that an appropriate forum be established to facilitate dialogue on such issues between Denominational Board, the MoE, MoH Trinidad and Tobago Parent Teacher Association, TTUTA and other relevant stakeholder with a view to determining appropriate ways of teaching the Health and Family Life Education (HFLE) Programme in these schools

OBJECTIVE 3: To evaluate the quality/standard of health care services and facilities provided to treat STDs and the associated cost

Universal treatment of HIV/AIDS in Trinidad and Tobago

4.3.1 The Committee was informed that clients who tested positive for HIV and present themselves to the MoH are provided care free of charge. Furthermore, if any social issues coincide with the person's infection the client would then be referred to social services for additional assistance. In addition, drugs are also available for the paediatric population.

4.3.2 The Committee was further informed that there have been instances where care was provided to foreign nationals who displayed symptoms associated with AIDS. However, the Deputy Director of the MoH's HIV/AIDS Unit suggested that foreign national acquiring treatment for HIV/AIDS represented a very small proportion of the Ministry's clients.

Standards observed by MoH

4.3.3 MoH has an HIV Testing and Counselling Policy available to persons who have been trained by the MoH. Moreover, the Ministry has also engaged the private sector as it relates to the communication of the contents of the policy. Furthermore, the Ministry also conducted

orientations regarding the *rapid algorithm*. Further policy and regulatory development is required to allow the Ministry oversight of private sector institutions.

Health Care Services

4.3.4 It was brought to the attention of the Committee that a recent sustainability review of the HIV programme has identified the **Quality management processes of the programme to be an area of vulnerability**. Currently, the quality management processes are being implemented to support HIV rapid testing.

4.3.5 Furthermore, Clinical Quality improvement processes are also currently being implemented with support from by Human Resource Services Association (HRSA) and *International Training and Education Center for Health (I-TECH)* as a (US) President's Emergency Plan for AIDS Relief (PREFAR) activity at two of the largest HIV treatment sites in Trinidad. Also, an HIV / STI strengthening programme by CDC will be implemented during this 2017 fiscal period.

4.3.6 A Gap Analysis has been performed in laboratories and the necessary activities for quality improvement have commenced.

4.3.7 Furthermore, QPCC&C in partnership with HACU and a CDC PAHO team supported the validation of the national Syphilis algorithm for quality assurance in testing. QPCC & C & all diagnostic public sites for HIV were part of the external quality assurance testing.

Health care facilities to detect and treat HIV/AIDS and STIs

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

4.3.8 The Queen's Park Counselling Centre and Clinic (QPCC&C), is mandated to be the special centre for the management of clients who are infected with any of the various Sexually Transmitted Infections (STIs).

4.3.9 The protocols and guidelines instituted enable staff to educate persons on preventative strategies, while obtaining relevant information – social, sexual and cultural beliefs, to be better able to respond to the specific needs of the clientele. As such, **QPCC&C's two main clinics are located in Port of Spain and San Fernando**, with **nine (9) related Field Clinics**

throughout the country for ease of accessibility. QPCC&C prevention methods include Contact Tracing Partner Tests and integrated screening practices, which are also available at QPCC&C.

The main clinics of QPCC&C

4.3.10 Currently, the main clinics of QPCC&C are located at the following centres:

- Port of Spain General Hospital;
- San Fernando General Hospital;
- Weekly field clinics located at Rio Claro; Chaguanas, Pt. Fortin; Arima, Princes Town; Siparia; Couva and Sangre Grande; and
- In Tobago, STD services are provided at Scarborough General Hospital.

HIV clinical treatment sites

4.3.11 HIV clinical treatment sites include:

- The Medical Research Foundation of Trinidad and Tobago;
- Ward 2 clinic at San Fernando General Hospital;
- Sangre Grande Hospital;
- Scarborough General Hospital;
- Tobago Health Promotion Clinic;
- Cyril Ross Children Home, and
- EWMSC Clinic Paediatrics only.

Reporting mechanism between the MoH and each facility

4.3.12 It was indicated to the Committee that QPCC&C is a vertical programme and reports to the Medical Director, Health Programmes and Technical Support Services, Ministry of Health. Monthly and quarterly reports are sent the HIV and AIDS Coordinating Unit, Ministry of Health.

Persons who have been tested at public health care facilities for STDs

4.3.13 It was indicated to the Committee that:

- For the period 2012-2015, approximately 254, 521 persons have been **tested** at QPCC&C for STDs; and
- For the period; 2010-2015, approximately 357,868 persons have been **tested** for HIV/AIDS.

4.3.14 Furthermore, it was indicated to the Committee that Syphilis and HIV/AIDS have the highest testing rate at QPCC&C and at other testing facilities.

Person that have tested positive for one or more STD

4.3.15 It was indicated to the Committee that during the period, 2012-2015, 11,771 persons have tested positive for one or more STD in QPCC&C. Furthermore, during the period 2012-2015, **four thousand and four (4004) persons have been diagnosed with HIV.**

Current state of health care facilities

4.3.16 With respect to the Queen's Park Counselling Centre and Clinic (QPCC&C) and other specialized STD facilities/clinics, it was indicated that:

- It has been a challenge maintaining the knowledge base of the organization and this has affected the level of coordination and services provided. There are several vacancy positions for District Health Visitors, contract tracers, social workers and psychologists required to address the most vulnerable persons; and
- Post graduate training is limited and its expansion can allow for the provision of a greater scope of services being delivered in a highly professional manner.

4.3.17 The table below outlines the vacant post at the Queen's Park Counselling Centre and Clinic (QPCC&C) and other specialized STD facilities/clinics as at February 2017.

Table 9

Vacancies at the Queen's Park Counselling Centre and Clinic (QPCC&C) and other specialized STD facilities/clinics.

Categories of Staff	Type of staff	Establishment	Actual Bodies	Vacancies
Doctors	SMO	1	1	
	Registrars	2	2	
	House Officers	4	5	
Nurses	CHV	2	1	1
	DHV	6	2	4
	Community Nurses	18	3 + 10 RN	5
	Nursing Assistants	10	7	3
	Medical Orderly	7	2	5
MSW	Medical Social Workers	1	3	
Pharmacist	Pharmacist	1	1 (PT)	
Field Interviewer	Field Interviewer II Field Interviewer 1			
Clerks	Clerks	22 (IV-1; II-3)	20 (IV-1; II-3)	2
Lab Technicians	Lab Technicians	1	3	2
Statistician	Statistician	1	0	1
Epidemiologist	Epidemiologist	Nil	0	0
Drivers		2	4	0

Training of staff

4.3.18 It was indicated to the Committee that the type of training being offered includes:

- Stigma and discrimination training;
- Provider in testing and counselling;
- HIV rapid test; and
- Orientation with protocols.

4.3.19 It was further indicated that the staff is encouraged to keep themselves updated with the prevailing best practice guidelines through online continued medical education.

Infrastructural and equipment needs of each facility

4.3.20 A Polymerase Chain Reaction (PCR) machine is required at QPCC&C as there are no methods of diagnosing Chlamydia trachomatis infection or screening patients with sexually transmitted infections and antenatal women. The PCR machine can also be employed to diagnose the conditions like Human Papilloma Virus (HPV), Gonorrhoea, with much more accuracy. Chlamydia or HPV cannot be diagnosed through Genital swab microscopy and culture method.

4.3.21 Other supporting equipment and accessories that are required include:

- Refrigerators;
- Electronic blood pressure and pulse monitors;
- Suction apparatus;
- Microscopes;
- Mechanical rotator;
- Centrifuges;
- Biosafety cabinets;
- Freezer for storage of samples;
- Autoclave;
- Overhead showers and eye-wash stations;
- Safety equipment and First Aid kits; and
- Computers and ergonomic furniture.

Average wait time for STDs test results

4.3.22 Table below shows the average wait time for various STDs test results.

Table 10

Average wait time for various STDs test results

Type of test	Average wait time
Genital Swab	1 hour
Genital Culture	1 week
HIV Rapid test	15-30 minutes

Serological Test for Syphilis	1 month

Full implementation of the quality management process for HIV rapid testing

4.3.23 MoH has an existing quality management process for rapid testing where there is standardized training for all persons who do the testing for HIV. Kits that have been tested in the laboratory are utilized.

4.3.24 Furthermore, there is an external quality monitoring system where all testing sites would be sent samples that have already been tested, for these sites to re-evaluate the tests. Once the tests receive the required results, they are sent back to the lab and the sites would receive a score based on the tabulated results. This system began in 2012 and two rounds of testing was completed, however it stopped for one year, but has been re-introduced. The Centre for Disease Control and Prevention (CDC) is currently providing support to strengthen the system within the 2016 to 2017 period.

Availability of antiretroviral drugs

4.3.25 The Committee was informed that the MoH has a continuous supply of antiretroviral medication available at specific HIV treatment sites in addition to the Cyril Ross nursery.

4.3.26 Additionally, some treatment centres have an on-site pharmacy so that patients do not have to go to another pharmacy to acquire medication. In instances where this facility is not available on site, the MoH would provide a confidential service so that patients can access the required medication.

Cost of treating STDs

4.3.27 The Committee was informed that funds allocated to the treatment of STDs **over the last (5) years have been a total of TT$ 39,490,685.18**. Furthermore, in **2016 TT$ 7,344,519.73** was allocated for the treatment of STDs.

4.3.28 With reference to the annual cost of procuring the relevant drugs for the treatment of STDs and HIV/AIDS, tables 11 and 12 illustrates the annual cost for 2015 and 2016.

Table 11

Annual cost of procuring the relevant drugs for the treatment of HIV/AIDS

Year	Cost
2015	$3.9mn
2016	$4.3Mn

Table 12

Annual cost of procuring drugs for QPCC&C

Year	Cost
2015	$778,000
2016	$736,000

FINDINGS AND RECOMMENDATIONS

Findings

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

i. The current facilities available to the public (at no cost) are reasonably well distributed to allow access to the various population catchments. Furthermore, there has been an expansion of treatment services, more specifically, the free provision and continuous supply of antiretroviral (ARV) medication available at specific HIV treatment sites;

ii. The extension of same day testing at multiple sites throughout Trinidad and Tobago;

iii. It appears that in special circumstances even foreign nationals can access treatment for STDs;

iv. The quality management process to support HIV rapid testing and Clinical Quality improvement processes is not being fully implemented. The existing regulatory or policy framework does not give the Ministry of Health jurisdiction over the testing protocols and algorithms observed by private health care providers/institutions;

v. It appears that the Ministry of Health is benefiting from the resources and or technical expertise of international organisations/programmes such as International Training and Education Centre for Health (I-TECH) and President's Emergency Plan For AIDS Relief as it concerns the advancement of this country's regime for the treatment of STDs

vi. The management of STDs requires confidentiality with respect to location and the rooms in the clinic. Currently, a make-shift clinic is being used at the POSGH and major refurbishment works are required at QPCC&C and the POSGH locations;

vii. There are a number of vacant positions within the various testing and treatment facilities which must be filled;

viii. Furthermore, there is a need to construct a National Public Health Lab to full-time diagnostic services. Since the closure of the CFDD's Public Health Lab services, it has caused several delays and deficiencies in the diagnostic services; and

ix. The public health care system is currently without a Polymerase Chain Reaction (PCR) machine which is required to diagnose Chlamydia trachomatis and (HPV) infections. The Committee acknowledges that having the machine is critical to the strengthening of the STI and HIV programmes nationally.

Recommendations

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

A. There should be a national plan of action for the implementation of strategic objectives of the MoH and related stakeholders (such as the MoSDFS and the MoE) as it relates to the testing, diagnosis and treatment of STDs. These objectives should be assigned specific timeframes for Implementation.

B. That the Ministry of Health collaborate with the Ministry of the Attorney General to assess the feasibility of enacting legislative provisions to criminalise the deliberate transmission of HIV/AIDS by one person to another.

C. That the Ministry of Health proceed with alacrity to formulate a Draft Proposal for a policy framework to guide the testing and treatment protocols for STDs in the private health care sector. This Committee suggests that this policy framework be completed within three months of the presentation of this report.

D. Subject to the completion of (B) above, the MoH must undertake consultations with Private Hospitals and Health care providers with a view to obtaining their feedback on a proposed framework for the implementation of the quality management programme to support HIV rapid testing and Clinical Quality improvement processes. This committee further recommends that the consultations and a finalized policy framework be completed by March 2018.

E. That subject to the findings of the Ministry of Health's Manpower Audit, the Ministry determine the order of priority for the filling of vacant positions at the various testing and treatment facilities.

F. That a copy of the Ministry's Manpower Audit be appended to its Ministerial Response to this report. If still in progress, the Ministry must submit the report to this Committee within 7 days of its completion.

G. That the Ministry of Health, in its response to this report articulate its policy position on the disbursement of free antiretroviral drugs at public health facilities to non-nationals.

H. Should Polymerase Chain Reaction (PCR) machines be available in the private health care sector, the MoH should explore the feasibility of outsourcing the necessary testing to private health care institutions. Members of the public can be asked to pay a subsidized fee.

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

Dr. Dhanayshar Mahabir
Chairman

Mr. Esmond Forde, MP
Vice-Chairman

Mrs. Glenda Jennings-Smith, MP
Member

Brig. Gen. (Ret.) Ancil Antoine, MP
Member

Mrs. Christine Newallo-Hosein, MP
Member

Ms. Khadijah Ameen
Member

Mr. Rohan Sinanan
Member

October 12, 2017

APPENDICES

Appendix I

Minutes of Proceedings

MINUTES OF THE ELEVENTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT APPOINTED TO INQUIRE INTO AND REPORT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS MEETING ROOM (EAST), LEVEL 6, AND THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON

WEDNESDAY FEBRUARY 15, 2017

PRESENT

Members

Dr. Dhanayshar Mahabir	Chairman
Mr. Esmond Forde, MP	Vice-Chairman
Brig. Gen. (Ret.) Ancil Antoine, MP	Member
Mrs. Christine Newallo-Hosein, MP	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Ashaki Alexis	Research Assistant

ABSENT

Mrs. Glenda Jennings-Smith, MP	Member
Mr. Rohan Sinanan	Member (Excused)
Ms. Khadijah Ameen	Member (Excused)

Resumption

5.1.1 The meeting resumed at 11:27 a.m.

PUBLIC HEARING WITH OFFICIALS OF THE MINISTRY OF EDUCATION (MoE) AND THE MINISTRY OF HEALTH (MoH) RE: An Inquiry into the prevalence of Sexually Transmitted Diseases (STDs) amongst school students and into the general services administered to treat STDs in Trinidad and Tobago

5.1.2 The Chairman reminded those concerned of the objectives of the inquiry.

5.1.3 Detailed below are the issues/concerns raised and the responses which were proffered during the hearing with the officials of the Ministry of Education (MoE) and the Ministry of Health (MoH):

i. Sex Education as part of the secondary school curriculum

a. Within the core curriculum, there is the Health and Family Life Education (HFLE) programme which consists of one (1) module which addresses the issue of sexuality and sexual health education.

b. At the secondary school level, the HFLE programme is implemented throughout Forms 1 to 3 and is a stand-alone "subject". At the primary school level, HFLE is infused within the curriculum and age-appropriate strategies are utilized. The MoH recommended that two (2) periods per week be allocated to the HFLE programme at the secondary school level.

c. Primary school students are taught about 'good' touches versus 'bad' touches and alerted of the issues which they should report. Condom use is not addressed at the primary school level. At the secondary school level, the issues are addressed in a more in-depth manner and abstinence is promoted. Secondary school students are also taught about appropriate behaviors and the methods for the prevention of STDs.

d. It was also divulged that specific interventions are made through the Student Support Services Division (SSSD) to address some of the issues. Some subject areas such as Biology and Social Studies also address issues related to STDs, its causes and prevention methods.

e. The Chief Education Officer (CEO) revealed that the Ministry had challenges where persons at the school level did not feel they were properly equipped to deliver the programme. Additionally, some of the denominational schools indicated that they would modify the programme by infusing the relevant religious teachings.

f. The CEO was unable to confirm and assure that each student would be aware of the different STDs, how they are contracted and how they can be prevented. He did, however indicate that once the HFLE programme is implemented the way it is supposed to, then all areas should be covered.

g. It was indicated that in the execution phase of the HFLE programme, the MoE had to undertake discussions with different groups such as the NPTA and the denominational boards. The programme received support from these agencies and from the boards with the proviso that they can adapt the programme to their particular belief systems.

h. The MoE has encountered a challenge as it concerns resource persons to deliver the HFLE programme. HFLE is not a subject so teachers are not recruited to teach the subject. Instead, the MoE relies on teachers within the Social Studies stream, Deans and Student Support Services to deliver the programme.

i. The CEO agreed that the teachers who deliver HFLE should be trained by officials of the MoH. He also revealed that the MoE had to change the title of the component of the HFLE from sex education to sexual health.

j. The MoH was involved in finalizing the HFLE programme and schools engage MoH personnel on an ongoing basis to provide support in the implementation of the programme.

ii. MoH Training Programmes for teachers

a. The Chief Medical Officer (CMO) stated that there is collaboration with teachers through the MoH's Public Education Committee, which was established in 2016. The Committee has a sub-committee called the Sexual and Reproductive Health Committee, of which the Director of Health Education is the Chair.

b. He revealed that the committee comprised members of the MoE and NGOs and they collaborate on getting the syllabus aligned and structured to deal with issues related to health.

c. The MoH does not currently have programmes or sessions specifically for teachers. However, the Ministry indicated that trained doctors were sent to schools a few years ago to educate children and teachers on STDs. The initiative however, was met with resistance from the schools, teachers and parents.

d. The Specialist Medical Officer, QPCC clarified that parents felt such an intervention provided too much information for their children and served as a means of encouragement to engage in inappropriate behavior.

iii. Availability of condoms to secondary school students

With respect to the practice of the distribution of condoms in schools, the Specialist Medical Officer, QPCC shared that a field interviewer from the QPCC tried to distribute condoms to school students but was met with resistance.

iv. Statistics on the sexual activity of young persons in Trinidad and Tobago

a. The Specialist Medical Officer, QPCC reported the following statistics as it concerns sexual activity among young persons"

- in 2015 the 15 to 19 age group stood at 2,255;
- in 2014, 2,503; and
- in 2013, 2,492.

a. It was revealed that for the period 2012 to 2015, 38 persons from the 15 to 19 age group tested positive for HIV, and 85 for syphilis.

b. According to the Specialist Medical Officer, QPCC, the statistics revealed that a significant number of young persons are sexually active. She was unable to confirm whether these persons where enrolled in school since this information is not verified when they visit testing/treatment centres.

c. The Director, Medical Research Foundation of Trinidad and Tobago (MRFTT) also stated that the clinics do not see any persons coming through the school guidance system since they are usually accompanied by an older person, relative or friend.

d. It was also revealed that some young persons visit treatment centres alone. In such instances, the doctors cannot turn them away. The Director, MRFTT highlighted the issue of Emancipated Minors and discussed the concept of *Gillick Competence.*

v. Feasibility of a Parental Responsibility Act

The CEO stated that he believed a Parental Responsibility Act would add value to the education system since one of the major challenges confronting the MoE is that of parental support.

vi. STD cases brought before the MoE

a. The CEO revealed that there was just one case that was brought to the MoE's attention as it concerns STDs. He revealed that if matters of this nature are brought to the attention of any officer attached to the SSSD, the officer is required to make a report.

b. He reiterated that confidentiality is strictly applied by SSSD when dealing with such matters.

vii. Challenges faced by the MoE

The CEO underscored that the MoE's core business is that of teaching and learning, however due to the existence of a multiplicity of societal issues, the MoE finds itself dealing with a wide range of issues rather than focusing on its true mandate. He revealed that staff complement of the SSSD stood at six hundred (600) on paper.

viii. Issue of confidentiality as it concerns students with STDs within the school system

a. Students may turn to the HFLE Teacher for assistance. The teacher will then refer the student to the Student Support Services Division where the MoE's multidisciplinary approach will be utilized to address the student's needs. The student will then be medically examined and treated.

b. As it concerns the medical examination of students, one of the Guidance Officers II indicated that the Education Act outlines that the principal of any school can act in *loco parentis* in the absence of the parent. Once it is

recognized that a student is at risk of physical abuse or requires medical attention, the principal can act and inform the parent.

c. The MoE utilizes a two (2) pronged approach whereby the police is informed of any cases and the parent is informed via phone if necessary and Ministry officials will provide the necessary support and intervention required.

ix. Use of Guidance Officers to provide assistance to students with STDs

a. The CEO indicated that Guidance Officers do provide students with assistance as it concerns STDs. He stated that an increased ratio of Guidance Officers to students was required. At the secondary school level the ratio stands at one guidance officer to one school, and in schools where there may be additional issues, there may be two Guidance Officers assigned.

b. It was divulged that part of the process involves the creation of a case file where confidentiality is maintained. The CEO stated that the case files may move with the Guidance Officers across schools and with the students.

x. Whether schools have the necessary resources to deal with STDs

a. The CEO indicated that there will always be challenges with physical resources however, as it concerns equipping principals to deal with STDs among the student population, the MoE has identified a number of dimensions for an effective school and is in the process of implementing them.

b. The MoE continues to work with the Teaching Service Commission to ensure the complement of Deans and Heads of Department, as well as with the SSSD and the curriculum.

xi. Dedicated facilities for the detection of STDs

There are dedicated facilities to treat STIs and the Queen's Park Counselling Centre and Clinic (QPCC) is one such facility. There is also one in the north, one in the south and a number of peripheral clinics located throughout the country.

xii. Sex Education and Sex Education Tutors

a. The CEO contended that it would not be efficient to have one person deal with sex education alone. He suggested that it may be more appropriate to create a specialized post for HFLE. The office holder will also be responsible for delivery of the curriculum in areas such as physical fitness, dieting and healthy lifestyles.

b. The Specialist Medical Officer, QPCC stated that sex education is a sensitive matter since STDs are attached to stigma and discrimination. She advanced that there should be a threshold for the teaching of sex education. In this regard, the Specialist Medical Officer, QPCC called for collaboration among the stakeholders.

c. The Permanent Secretary, MoH submitted that the Ministry has a health education programme called *RapPort* which covers topics such as managing sexuality, gender roles, role modelling, self-esteem, puberty, STDs and sexual reproductive health and safe-sex practices. The programme was designed as a peer-based activity based on the HFLE curriculum which in turn was developed by members from health promotions, the QPCC and the MoE.

d. RapPort is present in the NCRHA and SWRHA.

e. RapPort actively visits schools around the country and utilize evaluation forms after presentations. It was also indicated that a Facebook page is being developed with input from the youth for use on social media as an educational tool.

f. One thousand five hundred and twenty-seven persons (1,527) have benefited from the healthy lifestyle component delivered via the Civilian Conservation Corp. (CCC). The MoH has also executed a 'like yourself' campaign' in which two thousand four hundred and forty (2,440) students participated from the North-West region. Another one thousand and thirty-nine (1,039) students participated in another campaign and around the 'World TV Day' and six hundred (600) in the World AIDS Day campaign in 2016.

g. The MoE gave the assurance that from the information provided under the HFLE and the Guidance Counselling programmes, a female Form I student would have an understanding of matters concerning puberty, understanding sexuality and managing sexual relations

xiii. Data on the number of students who have STDs

Based on her experience, the Specialist Medical Officer, QPCC posited that the majority of the sexual partners of the young persons tended to be older adults. Some of them may have been abused or raped.

xiv. Record of school students who are HIV positive and the treatment undertaken

a. In 2016 five (5) cases were brought to the attention of the SSSD. The students received support from the MoE and social workers engaged the students and their relatives. The students will also remain within the normal school system until health factors warrant their removal. This approach is in keeping with the MoE's philosophy of inclusive education.

b. The MoH collects surveillance data from anyone who tests positive for HIV. The data only indicates the age of the infected person. For the underage population, the MoH would attempt to determine if the infection was as a result of mother to child transmission or a unique infection. Any child who has

tested positive and appears at a prevention site will be transferred to a treatment site and put on antiretroviral therapy.

c. One of the MoE's Guidance Officers II revealed that the Ministry has had a situation where an HIV positive student developed AIDS. The Committee was advised that the child contracted HIV when she was nine years old as a result of incest.

xv. Universal treatment of HIV/AIDS

a. Clients who tested positive for HIV and present themselves to the Ministry of Health are provided care free of charge. If any shortcomings are identified by a social worker or doctor, the client would then be referred to social services for additional assistance. Drugs are also available for the pediatric population.

b. There have been instances where care was provided to foreign nationals who displayed symptoms associated with AIDS. However, the Deputy Director, HIV/AIDS Unit, suggested that foreign national acquiring treatment for HIV/AIDS represented a very small proportion of the Ministry's clients.

xvi. Availability of antiretroviral drugs

a. The Deputy Director, HIV/AIDS Unit indicated that the MoH has a continuous supply of antiretroviral medication available at specific HIV treatment sites in addition to the Cyril Ross nursery.

b. Some treatment centres have an on-site pharmacy so that patients do not have to go to another pharmacy to acquire medication. In instances where this facility is not available on-site, the MoH would provide a confidential service so that patients can access the required medication.

xvii. Projected timeframe for the full implementation of the quality management process for HIV rapid testing

a. The MoH has an existing quality management process for rapid testing where there is standardized training for all persons who do the testing for HIV. Kits that have been tested in the laboratory are utilized. There is also an external quality monitoring system where all testing sites would be sent samples that have already been tested, for these sites to perform the tests. Once the tests receive the required results, they are sent back to the lab and the sites would receive a score based on the tabulated results.

b. It was revealed that this system began in 2012 and there were two rounds. It however, stopped for one year, but has been re-introduced. The CDC is currently providing support to strengthen the system within the 2016 to 2017 period.

xviii. Publication of information on standards to be observed

a. The MoH has an HIV Testing and Counselling Policy available to persons who have been trained by the MoH. The Ministry has also engaged the private sector as it relates to the communication of the contents of the policy. The Ministry also conducted orientations regarding the rapid test algorithm. There is another policy that must be implemented which will allow the Ministry oversight of private sector institutions.

b. It was divulged that some private laboratories after producing positive HIV tests, would send the sample to the MoH's lab for additional testing.

xix. Compliance Officers and Health Inspectors

The Deputy Director, HIV/AIDS Unit stated that this part of the monitoring has not been implemented as it concerned the rapid testing and site visits. She admitted that this area needed to be strengthened and implemented.

xx. Probability of false positive testing

a. A false positive results can occur in particular conditions which is why the MoH ensures there is follow-up. Once a person has been tested as positive, the MoH's policy is to retest at the treatment sites before a person can engage in treatment.

b. The rapid test algorithm is very sensitive and provides 95 percent accuracy which is why results verifications are undertaken to ensure that the client is undoubtedly positive.

xxi. Importance of the polymerase chain reaction machine

a. The Deputy Director, HIV/AIDS Unit revealed that the polymerase chain reaction machine has the ability to diagnose or provide clinical monitoring for HIV and provides a different level of monitoring for the management of HPV infections for persons who have abnormal pap smears. The machine is also the gold standard for the diagnosis of gonorrhea and chlamydia.

b. Trinidad and Tobago currently does not have this capacity and so there are certain illnesses that cannot be detected. For instance, the Chlamydia detection rate would be negligible since there is no access to the machine. She stressed the importance of having the machine since it is critical to the strengthening of the STI and HIV programmes nationally.

xxii. School Code of Conduct and the procedure for managing cases involving students engaged in sexual misconduct published on social media

a. Once the events are brought to the MoE's attention, efforts are made to identify the school and all the students involved, not just the perpetrators but the third and fourth parties as well. The students would then be engaged based on the guidelines outlined in the school code of conduct.

b. Prior to the school code of conduct, individual schools would have developed a discipline matrix which would have identified specific offences and the penalties for each. However, with the establishment of the school code of conduct, schools have the option to adapt the guidelines and develop their own discipline matrix.

c. The maximum penalty for sexual misconduct by a student is suspension and referral to a Learning Enhancement Centres (LECs). The code of conduct has a sliding scale so that for minor offences, students may be cautioned and parents summoned.

xxiii. Positive use of social media

a. The MoE has a draft ICT policy which addresses the use of social media in a positive manner. The CEO divulged that the Ministry received assistance from UNFPA with the HFLE but there is also an 'application' that the Ministry is being asked to launch in schools, which provides information on sex and sexual education. A team at the MoE is currently working with UNFPA with a view to modifying the application since it does not cater to the 13 to 24 age group.

xxiv. Teenage pregnancy and Data on the mother-to-child transmission of STDs among teenagers

a. The transmission rate in this country is less than 2 percent, which is in keeping with the WHO's standard to be achieved in the Americas.

b. During the period 2011 to 2013, there were 13 cases of HIV positive pregnant women within the 15 to 19 age group.

c. The MoE has a policy that allows all pregnant students and the fathers (where applicable) to continue their formal education. Support is provided to the students during the term of pregnancy to ensure that the students can return to school.

xxv. Cases of 'backstreet' abortions

There have been cases of 'backstreet' abortions which resulted in intrauterine infections and infertility. The persons were referred to obstetrics and gynecology clinics.

xxvi. Recommendations/Solutions proffered during the public hearing:

a. that the number of Guidance Counselors assigned to schools be increased;

b. that Sex Education Tutors be assigned to all secondary schools;

c. that there be greater collaboration between the Ministry of Health and the Ministry of Education in strengthening the current Health and Family Life Education Programme (HFLE) and other programmes/ initiatives targeted to

curb inappropriate sexual behavior and STD infections amongst school students; and

d. That social media be utilized as a communication platform to promote abstinence and boost awareness of the various risks associated with unprotected sex.

ADJOURNMENT

5.1.4 The meeting was adjourned at 1:02 p.m.

I certify that these Minutes are true and correct.

Chairman

Secretary

Appendix II

Verbatim Notes of Public Hearing

VERBATIM NOTES OF THE ELEVENTH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD (IN PUBLIC) IN THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR , OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, FEBRUARY 15, 2017.

PRESENT

Dr. Dhanayshar Mahabir	Chairman
Mr. Esmond Forde	Vice-Chairman
Brig. Gen. (Ret.) Ancil Antoine	Member
Mrs. Christine Newallo-Hosein	Member
Mr. Julien Ogilvie	Secretary
Miss Khisha Peterkin	Assistant Secretary

ABSENT

Mr. Rohan Sinanan	Member [*Excused*]
Miss Khadijah Ameen	Member [*Excused*]
Mrs. Glenda Jennings-Smith	Member

11.27 a.m.: *Meeting resumed.*

MINISTRY OF HEALTH OFFICIALS

Mr. Richard Madray	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Aruna Divakaruni	Specialist Medical Officer, QPCC
Dr. Ayanna Sebro	Deputy Director, HIV/AIDS Unit
Dr. Jeffery Edwards	Director, Medical Research Foundation of Trinidad and Tobago

MINISTRY OF EDUCATION OFFICIALS

Mrs. Angela Sinaswee-Gervais	Permanent Secretary (Ag.)
Mr. Harrilal Seecharan	Chief Education Officer
Ms. Darlene Smith	Guidance Officer II
Ms. Amanda Pedro	Guidance Officer II
Ms. Kesha Pierre	School Social Worker

Mr. Chairman: Good morning and welcome back to all our viewers and listeners on the various media which carry the proceedings of Parliament. We are ready to resume the second half of our public hearing. We did not anticipate that the first half was going to generate so much interest. We thought the first half on geriatric care facilities and the regulation of those homes was going to be pretty straightforward, but it has turned out to be a little more complex, so it took a bit more time than the Committee had anticipated.

We are going to start very soon with respect to the second half of our enquiry this morning. This enquiry is really our first public hearing pursuant to our enquiry into the prevalence of sexually transmitted diseases, STDs, amongst students and into the general services administered to treat STDs in Trinidad and Tobago. So our first priority really is to look at the incidence of STDs amongst our school-aged population and then, of course, to look at the general services for STDs in general in Trinidad and Tobago.

There are three objectives of this enquiry. The first, as mentioned, to determine the prevalence of STDs, including HIV/AIDS amongst school students and, two, to assess the strategies of the line Ministry in reducing the rate of infection amongst this cohort and, three, to evaluate the quality of health care services and facilities available generally to treat STDs and their associated costs. I would like to express on behalf of the Committee the gratitude of the Committee to the Ministry

of Education and to the Ministry of Health for the submissions that they sent to the Committee.

I would now like to ask from the Ministry of Education and the Ministry of Health the representatives to make their opening remarks. May I ask Mrs. Angela Sinaswee-Gervais to make some opening remarks? We will introduce ourselves subsequently.

Mrs. Sinaswee-Gervais: Good morning Chair, good morning members of the Committee. Representing Ministry of Education in this important issue, I have with us our technical team who would really get into the discussions on this issue.

I would like to start off though by saying that the Ministry of Education has developed policies to treat with these issues. We have collated a School Support Services Division which will ensure that these psychosocial issues impacting children are addressed. We have also social workers, guidance officers, psychologists, et cetera in that division and they are responsible for strengthening the diagnostic and prescriptive services for special students.

Our policies are guided by the Education Act as well as the World Bank Working Paper of 2008, and we are looking at strengthening in the education sector a response to HIV and AIDS in the Caribbean. So because of that bigger, broader issue we have brought it down to what we can do in Trinidad and Tobago to treat with the issue.

In our education sector policy on HIV/AIDS we have stated that the Ministry of Education shall actively use education as a strategy for the prevention and reduction of HIV infection among its population, through peer education and through its Health and Family Life Education national curriculum. We are working on it. As I said, later on we would get into the fact that we have a two-pronged approach to addressing STDs and HIV, where our guidance and counselling officers would utilize a preventative universal approach, as well as providing customized

short-term programmes for students displaying inappropriate sexual conduct, by intensifying awareness of managing their human sexuality and skill building in goal setting, decision-making and managing peer pressure.

Mr. Chairman: Thank you very much. The rest of your submission will come out in the enquiry, but I do wish to allow Mr. Madray to make his opening remarks on this particular subject.

Mr. Madray: Thank you, Chairman and members of the Committee, once again. My team and I commit to responding as fully as possible to your enquiry. My Ministry has an ongoing programme for the management and control of HIV, and this subject area is very critical as we are all aware to the future of our nation. So I look forward to your questions.

Mr. Chairman: Thank you very much, Mr. Madray. The Chair can also ask the first question, and the first question to the Ministry of Education is as follows: Do you have as part of our curriculum, sex education among secondary school students in Trinidad and Tobago?

Mrs. Sinaswee-Gervais: I will ask for one of the members of the team who would go into that detail please.

Mr. Seecharan: Good morning, Chair and members of the Committee. There are two approaches that I use within the Ministry. Within the curriculum—and here I am referring to the core curriculum—we have a Health and Family Life Education programme, and one of the modules within that deals with sexuality and sexual health education.

At the secondary level, that is implemented between Forms 1 to 3, so it is a separate stand-alone. At the primary school it is infused and age-appropriate strategies are used. So for example at the primary school we are looking at things like good touch/bad touch and alerting students to issues that they may report, whereas at the secondary school it may go into more depth. While abstinence is

promoted as part of that, other areas in terms of appropriate behaviours and also methods for prevention of sexually transmitted disease are also incorporated.

Mr. Chairman: My second intervention—can you give the Committee and by extension the country, the assurance that by the time a student reaches Form 3 in secondary school, he or she is quite aware of the range of STDs which exists, how they are contracted, how they could be prevented and what really are the major causes of the transmissions of these diseases?

Mr. Seecharan: Just now, I omitted to indicate that in addition to that core curriculum on health and family life, there are also specific interventions done through Student Support Services to address some of these areas. But also, in addition to that, within some of the subject areas, social studies and biology, for example, some of these issues relating to STDs, causes and prevention, are addressed.

I will also indicate that for example with the roll-out of the Health and Family Life Education with which we are revisiting currently and strengthening our implementation, we have had some challenges in terms of persons at the school level feeling that they may not have been equipped to deliver it. In addition to that, we have had discussions with some of the denominational schools and they have indicated that, for example the Roman Catholic schools, they would want to have their approach infused, so that there is some flexibility on the side of the denominational schools in terms of adapting to their approach or what they would like to see being done.

Mr. Chairman: The question I posed was this: by the time a student reaches Form 3, let us say he or she is 14, is this student, based upon how the Ministry conducts its affairs in conjunction with the Ministry of Health, is this student well aware of how syphilis is transmitted? Could you from the Ministry of Education give me that assurance in all schools? Regardless of denomination or religious beliefs, are they

aware of gonorrhoea and syphilis and how it is transmitted?

Mr. Seecharan: You are asking me to go down to the school level, but if the programme is rolled out as intended then those areas should be covered. As to tell you every child, I mean, I would probably be going out on a limb.

Mr. Chairman: Again, I want to pose it to the Ministry of Health, do you collaborate? This is a very sensitive area of education. It is not the typical math, physics and chemistry; it deals with private matters. Do you in the Ministry of Health with respect to the relevant department have a programme where you can train teachers on how to deliver this information in a manner which will be absorbed and internalized by the 14- and 15-year-olds in Trinidad and Tobago? The question again, collaboration. Do you have a programme? The people in that department know best how these diseases are transmitted. Do you train teachers or can you train teachers for that problem?

Dr. Parasram: The collaboration is there through the Public Education Committee of the Ministry of Health which was established recently, last year, and it has a subcommittee of the Public Education Committee called the Sexual and Reproductive Health Committee, of which the Director of Health Education, Ministry of Health is the Chair. Members of the Ministry of Education as well as the necessary NGOs are part of that team, and we collaborate in that way in terms of getting the syllabus aligned and structured in a way so it deals with the issues related to health.

Mr. Chairman: But you do not currently have sessions where medical doctors, people specializing in this type of problem would have a couple-hours session with teachers across the country to say, "We the medical doctors are telling about all these problems and I want you to take the information and transmit it to the students". You currently do not have that programme?

Dr. Parasram: Can I just pass you over to Dr. Aruna.

Dr. Divakaruni: Good morning, Chair. Actually right now we do not have that arrangement; that is the truth. But a few years back we honestly tried. We sent our trained doctors to schools to teach children, even to teach teachers and other staff members about STDs. I myself attended quite a few schools to teach them and to educate them to include an awareness of STDs in children, but we really faced a lot of resistance from the schools and teachers and even from parents of children. So that is the reason it kind of died down.

Mr. Chairman: You faced resistance on the education on STDs? What kind of resistance? Please indicate. This is education! Please indicate, doctor, what resistance you faced, because this is something maybe we could help solve at the Parliament level.

Dr. Divakaruni: Many of the parents of children felt that we are educating them too much, rather than this is giving them good part of this education that is spoiling their children. That is how most of the parents felt. A kind of like, this is too much for them; this is indirectly encouraging them to go and have—

Mr. Chairman: Very interesting and very disturbing. Now to the Ministry of Education. Ministry of Education, what is the current policy of the Ministry of Education with respect to scientific sex education in the school system of Trinidad and Tobago?

Mr. Seecharan: Chair, the health and family life education is part of our core curriculum. We have had issues. In fact, when we started rolling out the HFLE programme in earnest, part of that issue raised required us to have discussions with different groups including denominational boards, NPTA. What I can tell you is that since then we have support. In fact, the NPTA has been a part of the review, and have had input in terms of what the HFLE programme involved. We have had sessions with the denominational boards and in principle they have agreed, of course with the proviso that they would be allowed to adapt it to their own belief system.

So I think that some of that resistance has broken down and is being broken down as we go forward.

The challenge that we have right now is in terms of not so much the resistance, but in delivering the curriculum we have subject persons who are qualified and they teach a subject. HFLE is not a subject that we recruit teachers for, so we depend on teachers within the social studies area, deans, and with support from student services to deliver the programme. But the policy of the Ministry is that we—

Mr. Chairman: So do you think coming out of the issue, given the resistance raised by the doctor, that there can be and should be, again, a close collaboration between the teachers of social studies who have a job and responsibility for family life education, to be trained by officials of the Ministry of Health so that the teachers who are then going to transmit the information to students understand what they have to do to transmit the scientific education? Because STDs are scientific; it is virus and it is bacteria. I really am amazed that there is resistance because this is science. This is biology, this is viral infections, bacterial infections, and it is what you would learn in biology in any event, so I am a little bit nonplussed that in the school system in Trinidad and Tobago in 2017 I can hear that there is resistance from parents or church bodies that they do not want young children learning about syphilis. So I think immediately we need to address that issue forthwith.

Mr. Seecharan: Absolutely, Chair. Let me also say that again in the discussions we had in terms of finalizing—in fact we had to change the component from sex education to sexual health. So that was, I guess, public opinion in terms of what we were doing. So that the Ministry of Health was involved in terms of finalizing the Health and Family Life Education programme, and we have on an ongoing basis where schools would engage MOH personnel in terms of supporting the implementation in the schools. So that is ongoing, but as you suggested the increasing collaboration, we would support that.

But let me also say that we have also looked at what is happening, for example, in Jamaica—we were invited through UNFPA, because their programme is well established and in train. In fact we have trained a number of teachers within the system to act as trainers and who we are using and will use to roll out and strengthen the programme.

Mr. Chairman: I will ask MP Esmond Forde and then, of course, MP Christine Newallo-Hosein and, third, Ancil Antoine MP will come in. The Chair has a lot of questions to pose, but I will have to ask them.

Mr. Forde: Good morning to you all. You mentioned that sex education is taught at Forms 1 to 3 in the secondary schools, and you then mentioned that it comes under social studies.

Mr. Seecharan: We have a separate curriculum at the secondary school, but because there is a component within that and we do not have designated teachers, based on curricula alone at the secondary school, we utilize teachers who may have as part of their mandate those areas. So it could be the social studies teachers, it could be the deans. Some of it would be done by—we have a guidance officer. Some of it would be done by the biology teacher. So we utilize the teachers in the school to deliver the programme.

Mr. Forde: So is it a standard practice in all schools, Forms 1 to Form 3, that they will be getting this sex education programme on a regular basis as part of the school curriculum?

Mr. Seecharan: Yes. We recommended two periods per week where different components—so each secondary school should have students being exposed to it within one to two periods, or in some cases where we have started looking at doing things a little bit differently. So where there might be schools, based on information available at the school it could be increased or adjusted accordingly.

Mr. Forde: And with this there is a booklet, there is standard information to follow?

Mr. Seecharan: There is a curriculum to follow.

Mr. Forde: On the enquiry that was completed by our JSC, the last survey was done in 2011, and some of the statistics of sexual behaviours: In one instance, the percentage of students who ever had sexual intercourse, 27 per cent; then, among students whoever had sexual intercourse, the percentage who had sexual intercourse for the first time before age 14 is 62 per cent; and then in the last category, which is 55 per cent, among students who ever had sexual intercourse, the percentage who used a condom the last time they had sexual intercourse. That is 2011. You all have convened a survey in April2016, what is the status of that report? Anyone can shed light on that?

Mr. Seecharan: The line Ministry is the Ministry of Health. The Ministry of Education would facilitate that. I do not know if the Ministry of Health can say when the data would be available.

Mr. Chairman: Ministry of Health, the Committee considers that data to be very critical, because we would like to see what the trend is; is there an increase, is there a decrease? One would assume that with the availability of information on the Net and so on, children perhaps would know about these things a little bit better, but one does not know. You see, if it shows that there is an increase in the incidence of these diseases, then it means that the information out there is not filtering and being internalized by the students. And you do need the specialists in the field from the Ministry of Health to transmit the following information.

But on that score, just before you answer MP Forde's question, with respect to condom availability, is it easily available to secondary school children or is it that it is difficult to obtain? Information on the purchasing of condoms at all?

Dr. Divakaruni: Difficult to obtain. I do not have any information about purchasing of condoms. Actually a field interviewer, one of the specialty of our QPCC, they wanted to distribute condoms to school students. They tried and again

resistance.

Mr. Chairman: So there is a resistance with respect to the distribution of condoms, and you say there is a resistance towards education people on the use of condoms as well?

Dr. Divakaruni: Yes.

Mr. Chairman: So it seems as though there is resistance on measures that will prevent the transmission of these diseases.

Before we go on to MP Forde, we are dealing with sexual activity among our teenaged population. From the Ministry of Health's perspective, I know you perhaps do not have the current data, but in terms of the cohort is it that our young people are as sexually active as their international counterparts? Are they more so, are they less so or are we on par with what is happening in the rest of the world?

Dr. Divakaruni: I have some data to share with you, Sir: 2015, attendance of under19, 15 to 19 is our children, 2,255; whereas 2014, 2,503; 2013, 2,492. It is showing a significant number of them, youngsters, they are school-going children, but I do not have data to say like they are schoolchildren because they hide their IDs, they do not come in school uniform. Understand, that is my assumption, most of them are schoolchildren. We even had repeated meetings with our staff members before I come to this meeting. They said they are sure they are schoolchildren, but they do not have any evidence to say that.

Mr. Forde: And coming back to that report, any timeline as to when that report could be ready, the report that you all convened in April 2016?

Dr. Parasram: It was approved by PAHO and it is due to start in March of 2017. That is the information that I have. The last one was 2011 and it is due to start in March. It really should be every four years, but it is due to start in March.

Mr. Forde: I heard the Chairman going along the line of the idea of condom availability and so on, but out of this social study syllabus that we have under the

sexual education, is abstinence a part of this syllabus?

Mr. Seecharan: One of the options that would be discussed as part of the whole programme.

Mr. Forde: But what level of strength is placed in that idea of abstinence? Now, I know probably through the denominational schools, probably the Catholic board, probably the Presbyterians and so, they may be strongly going out at it, but from the governmental point of view, the ones where the Government of Trinidad and Tobago, and the Ministry of Education has the total responsibility, how strong is abstinence put forward with regard to these individuals? Do we bring in Christians, do we bring in believers, pastors and so in order to assist with these things anywhere along the line?—religious individuals.

Ms. Smith: Religious education is taught even in government schools, separate from the denominational schools, so that message would go out at various levels. However, through Student Support Services Division we do incorporate abstinence as part of our discourse and our own curriculum on sexual health and practices that we speak to the students about. Our discussions would span from primary school right up to secondary school, because we recognize it is a social issue that must be addressed, and we do include it in our curriculum as part of decision making, health care, respect for self, respect for others. So it is a multifaceted approach that we do utilize within our delivery, and abstinence is part of it. We have a crossroads programme that we use with the students, so that it is included in the overall message.

Mrs. Newallo-Hosein: I just want to ask a question based on what my colleague just indicated, and it is addressed to you Mr. Seecharan. A member spoke about sex education being taught in the schools and you indicated that there is a recommendation—a recommendation—to the schools and, therefore I did not get it as though it was mandatory. I did not get it as being forceful. Is it therefore that it may not be enforced—and I term it as you did, sexual health education—is in fact,

taught in the schools?

Mr. Seecharan: The HFLE curriculum where sexuality and sexual health education is one component, is part of the core curriculum and therefore it is a requirement. As I said, we have had some resistance in the past in terms of implementing it, and we have taken a decision—in fact, we have done training and all of that—to ensure that it is done in all schools. We are still in the process where there are some schools where it may not have been implemented the way we intend, and therefore we are working towards strengthening that aspect of it.

11.55 a.m.

Mrs. Newallo-Hosein: I know that throughout the discussions and the only time that we heard about the teachers, the counsellors, the board, et cetera, and only when Dr. Aruna had spoken about the resistance from parents: do you think that a parental responsibility Act can, in fact, if implemented, if enforced can alleviate some of the problems that are currently being experienced in the schools?

Mr. Seecharan: Absolutely. I think one of the real challenges that we face within the education system, and in the majority of instances the parents that we need to see are the ones who are, for many reasons, are the ones who we do not, and that will certainly help.

Chair, if you will permit me just to make a point? It relates to condom use and availability. But I think and if you look that the data that we submitted in terms of number of cases which would have been brought to the Ministry in terms of STDs, you would notice, I think, there was just one. And I do not know if the legislation may be working counter to us in terms of now, because if you go to an officer from the Student Support Services Division, there is a requirement for reporting. There is stigma attached, so the confidentiality issue might be lost, and maybe that is one of the reasons students may not be, particularly in this area, reporting on incidents and who may really need help. So that we may have students who are in need of

help where we can provide support, but may not be seeking that help because they are afraid of, they themselves getting into problem, because of the legislation and where there is a mandatory requirement for reporting.

Mrs. Newallo-Hosein: And according to the report that we received from you, according to the sex and age group of students in primary schools who have been infected with HIV/AIDS, you have for 2016, two students, male, eight years and 11 years and three females seven years, nine years and 10 years. But I have not heard of what the implementation and the process is for the primary schools, I have been hearing a lot about the secondary school. What is it you are doing for the primary schools in terms of what is happening?

Mr. Seecharan: The HFLE programme at the primary school is done on an age-appropriate level so that we do not go into condom use and all of that at the primary school. What we do is we look at situations at primary schools may encounter within that programme. So as I said, it might be teaching students from as earlier as in Infant 1 about good touch, bad touch. So it is done and infused within the curriculum where we saw, within the particular subject areas, some of these concepts could be infused. It is done there.

But let me just add because this is one of the discussions we have been having in the Ministry. We have been having some discussions, we have not made a decision yet whether infusing it within the curriculum, we may be losing some of the things that we want to teach and whether there is the need for pulling it back out and doing it as a separate. But we have not made that decision, but it something that we are looking at.

Mrs. Newallo-Hosein: I thought that good touch, bad touch should be taught at home, honestly speaking.

Mr. Seecharan: Well, Chair, through you, I was telling my colleagues this morning that, given some of the societal issues that we are facing, the school system where

our core business is teaching and learning, we end up spending so much energy dealing with other social issues that it is bringing, it is creating a lot of challenges for us, so that we have to deal with, I mean, our Student Support Services Division, on paper, is about 600. How much more do we add when some of those resources might have been challenged (channelled??) in dealing with some of the literacy and numeracy we have to treat with?

Mr. Chairman: Thank you very much. And before the Ministry of Health comes in, again, I feel compelled to intervene. Because my colleague indicated that there, I mean, do you teach abstinence? And I am sure the majority of students in school, and we are not yet dealing with the second part of the enquiry with respect to the facilities available for individuals living with these STDs, but I am sure the majority of students do, in fact, engage in abstaining from intimate activities. However, we do know that students have STDs. So they did not take in, or imbibe the lessons on abstinence. We do know how much we do not know, but we do know that they do. We do know that the students are sexually active and they do contract a range of diseases. We do know that teenagers get pregnant as a consequence of being sexually active.

The question I want to pose to both the Ministry of Health and to the Ministry of Education is this: a student who is sexually active, despite all the lessons on abstinence and who has contracted a disease, has to be treated. The question is: how is that person treated in the school system so that confidentiality is maintained. Is it that that has to be picked up by a Social Studies teacher who would refer the student to the nearest health centre and the nearest health centre will then be alerted? And this is a student so, please, be sensitive. What is the modality with respect to a student who has contracted any one of the STDs to get treatment confidentially? Any response from the health or education department?

Ms. Smith: Mr. Chairman, I am happy to hear you speak about confidentiality

because that is paramount in all our delivery and in the intervention that we will do with a student who is diagnosed will termed to be having an STD.

If it is the Social Studies teacher may be flagging via the HFLE programme and having a discussion with the class, the child may come to the teacher. That teacher will then refer the student to the Student Support Services Division. Right? And we will then utilize our multidisciplinary approach in addressing that child's needs in terms of ensuring that the child is first medically examined and treated, because that is always paramount. The health of the child will always be the paramount focus for us. Right?

Mr. Chairman: So looking for solution now. You see, we did meet with the Ministry of Education with respect to school bullying and violence and it was revealed that not many schools have the guidance officers, those people who are trained to handle students who are having interpersonal issues, bullying issues and so on.

Do you think that having the guidance officer in the school who is trained in child psychology, who is sensitive, who is understanding, who is approachable is perhaps the best person to whom the teacher could refer the child who perhaps has an STD, and who will then take the child to the necessary medical facilities to ensure that strict confidentiality is maintained from the time the child meets the guidance officer. I am just looking at a process that is easy for the child to follow and for confidentiality to be protected. Do you think that there is merit in that suggestion?

Mr. Seecharan: Chair, actually that system is already in place. I think at the last sitting what we attempted to convey is that increased ratios would assist in terms of us dealing with issues. But currently at the secondary level there is really a ratio of one guidance officer to one school. So there is literally a resident guidance officer at the school. In some schools where we have additional issues there might even be two. Certainly if we can increase numbers, because it is a combination depending

on the issue of guidance, social work and special ed. and we also have the team, the multidisciplinary team where issues might be referred to. But certainly having the guidance officer in the school, who is trained, was the first step.

In fact, Ms. Smith did not mention, but part of that process involves creating a case file where confidentiality, so that that information is not shared. And in fact, it has created some problems because of confidentiality, even the data flow coming forward to tell us cases might have been challenged because those are kept with the officer and moves with the child. If there are issues, not necessarily STDs, but it moves with the officers across schools.

So there is that system in place already. Certainly increasing numbers will help. And I think, you are right, the officer and that system is what is currently, yes, we may need to improve and increase the efficiency of what we do. But I agree with you.

Mr. Chairman: Mrs. Newallo-Hosein. Yes.

Mrs. Newallo-Hosein: Ms. Smith, you spoke about if a child came to the teacher or a guidance counsellor and remember it is a child and therefore, for you to have any child medically examined you must have the parent's approval and guidance. And how do you, or is there something in place to circumvent that if there is resistance from the parent?

Ms. Smith: Okay. Thank you. In my original response I was stopped by Chairman, so I did not get an opportunity to add and continue.

The Education Acts states that the principal of any school acts in loco parentis in the absence of the parent. So that once you recognize that a child is at risk of physical abuse or anything that is untoward that would require medical attention, the principal can seek that medical attention and inform the parent, perhaps meet me at the hospital, meet me at the health centre, and it becomes even more critical if the offending parent is the actual perpetrator of the incest, the abuse or whatever the

case may be. So that it is always a two-pronged approach. We inform the police, the parent via phone if necessary and we do the necessary support and intervention that will be required in the best interest of that child.

Mr. Chairman: And that raises another question. In loco parentis, it arose again when we were looking at school violence and bullying and we looked at the Education Act and that came out forcefully, that in a school the principal is in charge of the security of every single individual, not the Ministry of Education, not the police. The Act is very clear. Are we giving principals in this country the resources to act in loco parentis to overcome the kind of resistance that the doctor has raised with respect to treatment, health education, sex education and the transmission of disease? To the Ministry of Education: do principals have the resources to act in loco parentis?

Mr. Seecharan: Chair, I want to be a little bit careful in terms of how I respond to this. If we are looking at physical resources, there is always going to be resource challenges which, of course, the Ministry is working towards. We depend on releases to—if disclosed, and I am sure if you ask principals they will always tell you, "I can do with more". But in terms of equipping principals to deal with this and many other issues, we have in the Ministry have been working and looking at some at some of the—at schools and performance of other issues and we have identified leadership and management as a core concern of ours. We recognize in many instances when things fall through, often it originates because of leadership and management in the school. And I am not just talking about the principal, because each school is required to have a management team.

We have in the Ministry embarked on, we have done the research, we have looked at effective schools and we have identified a number of dimensions that effective schools look at, they focus on. And we are currently in the process of rolling that out. We have started that some time, but is really supporting that to

ensure that systems and processes that are required to ensure schools operate in the most efficient way, are in place.

We are continuing to work with the Teaching Service Commission because some of these issues arise out of staffing issues. So, we continue to work with the Teaching Service Commission in terms of, for example, complement of deans and heads of departments. So that, in addition to that, as I said, we continue to work with curriculum and Student Support Services.

In fact, one of the things we have been doing within the Ministry is changing the mode or the model in which we operation where, for example, a student whether it is STDs or some other issue, often that person might have interfaced with the guidance officer. We recognize that that presenting case might be accompanied by special ed. or the need for the social worker to be involved. There may be curriculum issues that need to be addressed.

So that in terms of our support to schools we are, in fact, trying to get all the units and divisions within the Ministry to work together. So, we are looking at teams. So that Student Support Services' curriculum supervision working together to support that school-based management process. So, are we in an ideal place? No. But I think we are trying to address some of these issues in very systematic way.

Mr. Chairman: Can you give the Committee the assurance that a child in our school system who thinks he or she has contracted an STD can in fact make an overture to the guidance counsellor and indicate to the guidance counsellor, "I am afraid to tell my parents. There will be mayhem if that happens." Can it be confidential? And that the principal of the school hearing the plight of the child, can see to it together with the guidance officer that the child gets the necessary medical treatment so that the child is attended to and the transmission of this disease is controlled. Is that process in effect currently in the school system?

Mr. Seecharan: Yes Chair, I am assured by my colleagues from the Student

Support Services Division. In fact, the programme rolled out by Student Support Services, the PS spoke about a two-pronged, really. It is a proactive and a responsive approach. And what I can assure you is that, on the responsive side, once an incident or a matter is brought to Student Support Services Division, we respond immediately. That response sometimes may, in fact, mitigate—so, we may have something planned on the preventative side, a programme that we are doing in schools. An incident happens and the priority is, in fact, given to responding to these cases.

Mr. Chairman: Very well thank you. Okay. Yes. You have been silent. You can speak.

Dr. Edwards: Generally an STI usually presents as something acute. So usually it is a discharge, an ulcer or a lump or a bump. And in the clinics we do not see people coming through the school guidance system. Usually they come with an elder person or a relative or a friend. All right? And they usually come to the clinic, they usually come, according to Dr. Aruna, not in school clothes. Very rarely I think we see them coming through the school system. So they use an alternative system to come to us to treat STIs. And in terms of—sometimes they come alone.

Mr. Chairman: Right. I need clarification. Is it that they rely on an older person who is aware of the facilities which are available? Because when you are in school, you are not really aware of all the health facilities out there. It has to be that someone knows where to take them and the trust that person.

Dr. Edwards: Right. So they will talk to a friend or a relative of somebody and they will bring them to the clinic.

Mr. Chairman: Okay.

Dr. Edwards: Sometimes they come alone, eh. We cannot turn them away. So a 16-year-old with an STI, remember doctors, we cannot do harm. So there is something called an emancipated minor. There is something called the Gillick

Competency. This was a case in the UK where a parent took the local health authority to court because the doctors wanted to give treatment and contraceptives to under 16-year-olds, and she lost the case. So the competency case is that, if a student is mature enough and understands the circumstances, you can go ahead and treat them.

Mr. Chairman: Yeah. Okay. But one follow-up question: is it that these facilities are dedicated or is it that the detection of STDs can be done at any health centre in Trinidad and Tobago?

Dr. Edwards: No. These facilities are dedicated to treat STIs. The Queen's Park Counselling Centre and Clinic is dedicated. So there is one in north and one in south and a number of peripheral clinics throughout the country.

Mr. Chairman: So someone in Toco will have to make a trek to Port of Spain. He cannot—

Dr. Edwards: Or San Fernando.

Mr. Chairman: But he or she cannot go to the Sangre Grande Health Centre and expect to get that sort of treatment?

Dr. Edwards: They can go, but they may not get the best treatment and they will actually be referred to the QPCC.

Mr. Chairman: Very well. Yes. So, I was just looking at the widespread availability, given the fact that the population is dispersed and these centres are centralized. Okay.

Dr. Edwards: But QPCC has peripheral clinics. So in Rio Claro, you know, Point Fortin, there are a number of clinics where the staff goes around to.

Mr. Chairman: Okay. And they roving. We got the submission that they are roving. So that someone goes to, say, a health centre in his vicinity, can he or she get the information that he should come back on this day, there will be a specialist, not necessarily an STD specialist, but "nudge nudge, wink wink" we know there is

a specialist who will look at you and that information is available to the attendees.

Dr. Divakaruni: Yes. It is.

Mr. Chairman: Very well. Thank you very much.

Mr. Forde: Ministry of Education. Again, amidst all the challenges, right, that the Ministry may be facing, sex education tutor, could there be a justification to have one in every school, in order to be looking at it from a protective point of view as we look into the future, based on some of the statistics even though it may be from 2011? Could there be a justification in order to be proactive in our approach with regard to sexual education having a greater emphasis in the schools as we continue along?

Mr. Seecharan: Chair, from where I sit I do not know that having one person to deal with sex education by itself would be the most efficient way to utilize that resource. I think if we were to get, let us say, one additional person, that person being a part of the student support, because we deal with a whole—sex education is one aspect of what we do in the schools. I think, maybe through Student Support Services or alternatively if we are looking at creating a position for health and family life education which deals with sex education, but also deals with a number of other areas, healthy lifestyles, physical fitness, dieting, et cetera, that might be the more appropriate approach to use.

Mr. Forde: Now I understand you clearly, but, you know, the more I go into the documentation that, you know, that you all would have presented in both education and health and the information provided by our parliamentary staff. Again, I am just looking from the point of view of looking into the future, in that, you know, we do not then wait when we reach the wall and then deciding, well look, "ay", we need to get over the wall. Right? You know what I mean? But it is something that I think, again, as you say in terms of when you all are having your brainstorming, it is something that you can probably look at. But again, it is all about justification and

as I said, a sex education tutor alone may not be justifiable, but when you look at it in the context of and, again, the emphasis in the syllabus is that is must be emphasized.

You know, it is not that, you know, you go to school today and you say look, "steups", you know, I "aint going to the class today". It is an important class to come to because again, the doctor, you know, from Ministry of Health will not have to come in now with all the instances of, you know, the scenarios, the teachers, the parents do not want the students to be educated along those lines. And you know, it is difficult to understand that a parent not wanting their child to be part of an educational process to—we are not saying they are getting the whole gamut of it, but they are getting the information which will assist them as they get older, you know. So it is from that point of view I am looking at the whole process.

Dr. Divakaruni: I would like to say something about this. You see, sex education is a sensitive matter. STDs are attached to stigma and discrimination. So there should be some limit and they have to draw a line up to what extent they can teach sex education. In this issue I feel the Ministry of Health, doctors from STD clinics and nurses and health workers of STD clinics collaborate with the Ministry of Health education. They can come with better curriculum, so that they know where to draw a line, because it can go up to any extent. And like this is a very tender age of children. They can take it in a negative way. They, like their parents, may have fear of this, their fears might be sometimes correct. If you go too extensive into sex education sometimes it might have a negative effect on their tender minds. So where to draw a line, up to what to teach and emphasis on STDs so that that promotes abstinence in people, because it will create a kind of caring nature for children. I mean, they care for themselves who are not supposed to do this. If I do this I might end up with some disease.

Mr. Forde: And last point, Mr. Chairman. And this is where the professional

approach will become important rather than an individual just taking up the syllabus.

Dr. Divakaruni: Yeah. Yeah.

Mr. Forde: Like I am a teacher and I am taking up the syllabus and I am just going in to teach sexual education. The professional approach with someone who is qualified along those lines will take into consideration what the doctor has just said.

Mr. Chairman: And before you go, this is becoming a little more interesting than I thought it was going to be to me. Because we are dealing, as the doctor said, with children who are tender, but they are becoming adults. They are in that very critical stage. Do we have in the school system within the programme of education a module which will teach girls before the menstrual cycle starts, do we have a programme in the primary school to teach the 10-, 11- and 12-year-old girls everything about the menstrual cycle? Do we have a programme to teach boys before they reach puberty, everything about puberty in a scientific, structured manner so that we are transmitting information, biological information, or scientific information?

Because if we have such a programme, it appears to me a logical extension to speak about the menstrual cycle, then sexuality, then pregnancy, ovulation and then STDs. So I see and a range, very clinical, very scientific and something in which you can write an essay on to let me know that you understand. Is such a programme in existence in the school? And then out of that we get our medical doctors being trained from the school system and our people who are producing medicines and so on. I would imagine that that is a wonderful start to a medical career; understanding puberty. So do we have it?

Mr. Madray: If I may?

Mr. Chairman: The PS.

Mr. Madray: I know the Ministry of Education will respond, but we just wanted to mention that we do have a programme of health education and one of the components of this is sexuality which covers topics like managing sexuality,

HIV/AIDS and safe-sex practices. So to talk a little bit more on that subject and very briefly, I will just ask our director of our HIV/AIDS unit in the absence of our director of health education who is in the observer section to just give a few details of it.

Mr. Chairman: Please. Yes. The floor is yours. Yes.

Dr. Sebro: Okay. Good morning, Chair, and members. We have a programme in the Ministry of Health called RapPort which is designed as a peer-based activity that is based on the HLFE curriculum that was developed from members from health promotions, the HIV/AIDS clinic, the Queen's Park Counselling Clinic and also members from the Ministry of Education.

So while the Ministry of Education does one part, the Ministry of Health also does a peer-to-peer activity that looks at gender roles, role modelling, self-esteem, the issue of puberty, the issue of sexual transmitted diseases, recognizing that sexual reproductive health is a very comprehensive activity where you have to empower the child around who they are as a person, their own gender, their own responsibilities as a person and the issues of self-esteem and abstinence is also a part of that curriculum.

Mr. Chairman: And how many students in Trinidad and Tobago actually benefit from this programme?

Dr. Sebro: So, between 2015 and 2016, we have data from the north-west RapPort programme. We have RapPort in north-west, in the North Central Regional Health Authority and also in south-west. So, I would say we have different components of the programme. We had a 1,527 people benefiting from the healthy lifestyle component which was from the Civilian Conservation Corp, CCC. There is also something called a "like yourself" campaign. We had about 2,440 students in the north-west region. We also had a 1,039 students that were part of a different campaign and around the World TV Day activity, and another 600 for World AIDS

Day last year.

Mr. Chairman: Okay. Thank you very much. Brigadier, did you want to ask? Yes. Thank you very much.

Ms. Smith: Okay. Education we wanted to answer in terms of our teaching of the curriculum.

Mr. Chairman: Very well.

Ms. Smith: As our CEO indicated, under the HFLE we do also address changes associated with puberty, understanding sexuality and managing sexual relations. Under the guidance curriculum, because we have a national guidance curriculum, which I indicated earlier, which spans from primary school through secondary school. We also include those areas and in terms of changes associated with puberty, risks associated with inappropriate use of social media, inappropriate sexual behaviours and forging healthy friendships and peer relationships which all help to address that critical issue that you asked about.

Mr. Chairman: All right. And a practical question: can I get the assurance that given the education, the curriculum on say puberty that a Form 1 girl who is perhaps aged 13 will be able to explain cogently and clearly everything—

Ms. Smith: Yes. We can.

Mr. Chairman:—with respect to the menstrual cycle.

Ms. Smith: I can give that assurance simply because it is mandatory and it exists in all Form 1 schools throughout the country that that awareness and puberty awareness lecture is given in Form 1 in all schools.

Mr. Chairman: And that a girl knows exactly how she can get pregnant.

Ms. Smith: Yes.

Mr. Chairman: She knows about ovulation and she knows about unprotected sex and everything in Form 1.

Ms. Smith: Yes.

Mr. Chairman: Thank you very much.

12.25 p.m.

Mrs. Newallo-Hosein: To the Ministry of Health, you spoke about RapPort and I just want to know—I know you indicated how many students in fact attended, but really, how do you measure the success of these interventions? And while you are thinking about that answer, I want to ask Dr. Aruna and Dr. Edwards, you indicated that a number of persons would come to the health centres or to the facilities to be tested, and you spoke about the difficulty in gathering data because they come in plain clothes and not in uniform. But surely, can the data not be collected or collated on the mere fact that when you come into the facility, you must give your date of birth or is it that you do not have to give your date of birth? So it is just two questions I would like answered.

Dr. Edwards: When they come into the clinic, we usually ask them to give the date of birth so, I mean, we know that they are school-aged children but in terms of what school they go, they might not disclose that to us.

Mrs. Newallo-Hosein: No, we may not need the name of the school obviously, but the data being collected in terms of how many young persons, the students, may in fact have contracted STDs.

Dr. Edwards: Yeah and we have that data. Dr. Aruna has some of that data.

Dr. Divakaruni: I have data: 15 to 19 years age group, they are like totally 199 people contracted gonorrhoea.

Mrs. Newallo-Hosein: What year?

Dr. Divakaruni: For the period 2012 to 2015. This is not one year. Okay, right, and 38 people got HIV positive results, 15 to 19 age group. Again, that is 2012, 2013, 2014 and 2015. Total number of syphilis, 85 people got syphilis in that age group, 15 to 19.

Mr. Chairman: With respect to the treatment of syphilis, I was of the view that

that was a disease of the past but now I am hearing that gonorrhoea and syphilis are still with us. Is this that penicillin is still the basic treatment and that will solve the problem?

Dr. Divakaruni: Yes.

Mr. Chairman: Do you collect information on the partners of these individuals as well? So you ask questions on who are the partners. And are you finding that the partners are older partners than to the teenage children in general or are they the same age? What is the trend?

Dr. Divakaruni: I do not have like concrete information in my hand to prove but still I have an idea because I am there since past 20 years. These children, most of the times, adult partners.

Mr. Chairman: Older partners.

Dr. Divakaruni: Sorry, older partners.

Mr. Chairman: Yes, okay.

Dr. Divakaruni: And most of the times, they are abused by a stepfather or somebody like brother or cousin or something like that which they consent, not that all the time is rape.

Brig. Gen. Antoine: Good day to the panel. In going through the statistics sent forth by Ministry of Health and I am now getting new statistics from you, the data seems to be 2009 and they gave the figure of 4,004 people with HIV. I am dealing with HIV now. But does the Ministry of Education, Ministry of Health, have the number of school students who have been tested positive for HIV positive within Trinidad and Tobago and what kind of follow-up is done in terms of treatment, but also in terms of ascertaining who they contracted it from in terms of whether it is an adult again. Do we have the statistics in terms of the number of school students with HIV and how they are being treated or being dealt with?

Mr. Madray: I will ask Dr. Sebro to respond to that question if she can.

Dr. Sebro: Okay. I would say that the Ministry of Health collects surveillance data from everyone who tests positive for HIV. The data comes to us. It does not have any information to say if somebody is in school or not, it will just indicate the age of the person that is infected. We would collect information on the mode of transition for anybody who is less than—well, for everyone really.

For the underage population, we would look to see if they are coming through from a prevention to a mother-to-child transmission, as well as we will look to see if it is their own unique infection. But for me to break that out for you right now, I do not have data in my hand. But we do not have it specifically to say this is a school, this is a patient who has been diagnosed in school. Any child who tests positive and presents at a prevention site will then be referred to a treatment site and started an antiretroviral therapy.

Brig. Gen. Antoine: Does the Ministry of Education have any data on the school population with HIV?

Mr. Seecharan: For 2016, we have five cases which were brought to us which the Student Support Services Division, they are treating with using their protocols but outside of that, we do not know.

Mrs. Newallo-Hosein: Just to ask a couple of questions. Do these students have access to proper medication, health care and are the drugs available for their care?

Mr. Chairman: And who would pay for it? That is the point. They are children.

Mrs. Newallo-Hosein: Right. And are the partners treated and of course, who pays for it?

Ms. Smith: The five that we monitor and work with, we know that they are supported by us. Our social workers work along with the student and the families to ensure that the proper care is given and to this date, I can say that all systems seem in place for those five students that we monitor at this time.

Mrs. Newallo-Hosein: Ministry of Health, do you have the allocations in your Draft

Estimates of Expenditure, Development Programme for the current fiscal year to attend to any of these shortcomings that we are discussing here?

Mr. Madray: I will ask Dr. Sebro to discuss how it is managed.

Dr. Sebro: All clients who test HIV positive and present to the Ministry of Health, care is provided free of charge. If there are any shortcomings that are determined by a social worker or the doctor, the patient is then referred to the social services for additional assistance, but there is no fee that the Ministry of Health will charge and drugs are available for the paediatric population.

Mr. Chairman: Okay, and with respect to the availability of these antiretroviral drugs, are they available at the drugstores, do they have to go to the health centres? Where do they get them? And do you have a continuous supply of that?

Dr. Sebro: We have a continuous supply of antiretroviral medication and the medication is available at the Ministry of—at specific sites within the Ministry of Health, the treatment sites. The medication is accessible at all our HIV treatment sites in addition to at Cyril Ross nursery.

Mr. Chairman: And is it dispensed in a discreet manner? Because there is still stigma on HIV, unfortunately it still persists. So is it that someone who is HIV positive can go and request his medication and there is strict privacy involved, that there is no embarrassment or any loss of status as a consequence?

Dr. Sebro: The medication is distributed—there are some sites that have their own pharmacy within the site so that the patients do not have to go to another pharmacy, but where that is not done, the Ministry of Health, we provide a confidential service so that patients can get access to their antiretroviral medication.

Mr. Forde: In terms of the five students for 2016 that were diagnosed within the school system, would they continue to be in the normal school system or then would we move them out to, like, based on their age to like Cyril Ross or any other facility as the case may be?

Ms. Smith: No, they will remain in the system unless their health factors should warrant that they need to be removed but we believe in a philosophy of inclusive education and they are treated similar to every other child.

Mr. Forde: And again, the confidentiality will still remain so that students would not know as the case may be.

Ms. Smith: Correct.

Mr. Chairman: And a follow-up, very interesting. Have you had in the Ministry of Education any student for whom HIV mutated into full-blown AIDS?

Ms. Smith: Yes, we have. I have actually worked with one. She is now an adult and she would have contracted it via incest and she was nine years old, but yes.

Mr. Chairman: And she is still surviving—

Ms. Smith: She is still alive.

Mr. Forde: To the Ministry of Health, what is the projected time frame for the full implementation of the quality management process for HIV rapid testing based on the document that you all would have submitted to us on page 2? Right, which was basically the topic: to evaluate the quality and standard of health care services and facilities provided to treat STDs and their associated costs.

Dr. Sebro: I would start by saying that the Ministry of Health has an existing quality assurance process for rapid testing whereby we have standardized training for everyone who is testing for HIV, we use kits that we have tested in the laboratory sector and we have implemented an external quality monitoring system whereby all testing sites are sent samples that we know the answers to, and they will perform tests on it and they return those tests to the lab and the lab will then score those sites.

That system was started in 2012 and we had two rounds of testing and we stopped for one year but we have implemented that again. At this point in time, CDC is supporting the strengthening of that system within the 2016 to 2017 period, so the rapid testing quality assurance programme, the strengthening of it, should be

completed by the end of 2017.

Mr. Forde: Okay, 2017. And then with regard to the Ministry of Health, does the Ministry of Health publish information on standards to be observed by the private/public hospitals, clinics, offering testing facilities for HIV/AIDS and other STDs?

Dr. Sebro: If we publish—can you repeat the question?

Mr. Forde: Publish information on standards to be observed. Right, as you do your testing within the private and public, you know, certain standards that have to be adhered to as you do your testing and so on.

Dr. Sebro: The Ministry of Health has an HIV testing and counselling policy which is available to anyone who is—once somebody is trained by the Ministry of Health, we would share that policy with them. There are private sites that we have engaged in terms of this policy of the Ministry of Health but there is a policy that we have to implement to be able to extend this oversight in some of the private institutions. But the Ministry of Health has engaged the private sector in orientation to the standards of the Ministry of Health in terms of our quality assured rapid testing algorithm for the field. Some of the stronger private laboratories, when they test somebody HIV positive would normally send a sample to the lab as well for additional testing.

Mr. Forde: Right, and in terms of compliance officers or health inspectors, they would be able to verify that the private hospitals and other institutions are operating above board and maintaining the standards?

Dr. Sebro: So that part of the monitoring has not yet been implemented in terms of the rapid testing, in terms of the site visits, that part is the part that we need to strengthen and implement.

Mr. Forde: Right, and what is the probability? Based on your answer, is there a probability of an individual now going to be tested and negative—the person going in negative and probably coming out with a positive response that could have

probably happened at the institution. That is possible?

Dr. Sebro: If somebody goes in to—?

Mr. Forde: Goes in to do a test and the person is negative and they come out with a positive result of being tested at the facility, what is the probability of that happening?

Dr. Sebro: So a false positive then?

Mr. Forde: Yes.

Dr. Sebro: The person is actually negative and they are false positive. You can get false positive tests in particular conditions which is why there is that follow-up. So, for example, there are certain conditions where people might be pregnant where you might get that. So once somebody tests positive, there is a policy of the Ministry of Health for retesting at all our treatment sites before anybody is engaged in treatment. So there is that second level of verification in terms of what happens with the rapid test.

But the rapid test algorithm that we have is very, very sensitive, it is about 95 per cent, and because of the quality system that we have, there is that follow-up. Once the testing is done in a Ministry of Health quality assured site, there is that follow-up of the client to ensure that the client is actually positive and confirm the diagnosis before treatment is initiated.

Mr. Forde: Thank you.

Mr. Chairman: I will ask MP Newallo-Hosein to come in.

Mrs. Newallo-Hosein: You had indicated earlier, Dr. Sebro, that the drugs were free, I just wanted to confirm. Is it also free to foreign nationals?

Dr. Sebro: That is an interesting question. The issue with some of the—we have had instances where we have had to provide care to foreign nationals who have presented on our shores with full-blown AIDS because they presented extensively ill. It is a very, very small proportion of the patients who currently access treatment.

12.40p.m.

And we make attempts to try and find out what the next steps are, because there are some clients who have really presented in hospital with—where we have no choice. We cannot do any harm. There is also the issue where we have concerns about the spread of the disease in our own population and so we have had to treat, for example, if a foreign national is in a relationship with a national, we would have to provide treatment.

Mrs. Newallo-Hosein: You had indicated, Ministry of Health that you had identified in your submission to us, major infrastructural and equipment needs of each health care facility. I believe one of the machines that you had indicated would have been the polymerase chain reaction machine? Can you explain to the Committee how important this piece of equipment is in operating in a facility such as QPCCNC?

Dr. Sebro: Can you repeat the last part of the question?

Mrs. Newallo-Hosein: Can you explain to the Committee how important this piece of equipment is?

Dr. Sebro: That particular machine has the ability to diagnose or to provide clinical monitoring for HIV. It gives a different level of monitoring for the management of HPV infections for people who have abnormal pap smears and it is the gold standard for the diagnosis of gonorrhoea and chlamydia.

The country, currently does not have that capacity. And so there are certain illnesses that we cannot detect. So, for example, our chlamydia detection rate would be negligible because we do not have access to that. It is a screening test. We would be able to provide screening to pregnant women. We would be able to provide a second level of management to people who present with abnormal pap smears, in terms of the typing of the HPV that people present with. It is critical to the strengthening of the STI and HIV programmes for us nationally.

Brig. Gen. Antoine: To the Ministry of Education, in your response to the Committee dealing with the National School Code on the conduct of students, in terms of sexual misconduct, in your response I have seen you speak about complaints to the police, complaints to the principal and complaints to the teacher. But I have been privy to a number of explicit videos on social media, involving school children and sexual misconduct. Have you been addressing these issues, because social media is now a part of life? What is the procedure, in terms of dealing with explicit videos that come across social media that is open to the entire population?

Mr. Seecharan: With respect to students involved with events that would have been seen on social media, once one of those come to our attention we make every effort to identify, first of all the school because in most cases there might be a uniform or something involved. Once we identify the school, we go in and the same process that we follow for students who may not be on social media is then implemented. In fact, every instance that would have been brought to our attention, we have dealt with in the same procedure.

Mr. Chairman: Okay. Could you just hold that? Is there, from the angle of the Ministry, and I want to relate this to the doctors in the Ministry of Health, for the positive use of social media? We have seen the negative use of social media where social media highlights the real negative aspects in behaviour. But have you considered using social media positively, and if so how?

Mr. Seecharan: Currently we have a draft ICT policy and some of those things are being addressed. But let me just go beyond that. I indicated earlier we have gotten some assistance through UNFPA, in terms of dealing with the health and family life education. One of the things, there is an app right now, they have been asking us to launch in schools, which provides information on sex and sexual health education, and a team from the Ministry is actually working along with them, in terms of—because the population the app caters for went out for 13 to 24. So there may be the

need for some adjustments to fit within the school population.

Mr. Chairman: Okay. So you are going to be using it. And now specifically to the medical doctors from the Ministry of Health. Earlier on in the proceeding Dr. Edwards, you indicated that the patients you see school age have come into the clinic when they are at an advanced stage of infection. In the field of medicine, I know that early detection is like 99 per cent of the cure. Do you all think that there is value in using social media, to actually have YouTube clips on what is syphilis, the early symptoms of gonorrhoea, syphilis, chlamydia and those things to look for, which can then be used in the schools? Does such information currently exist? Are you thinking about using that to reach to the students to explain to them what the early symptoms are for some of these diseases?

Dr. Edwards: Those are available on YouTube. In the US and UK, they tend to use social media for partner notification. So somebody has an STI, gonorrhoea or something, they could inform their partner by a social media oops, I think I came in contact with gonorrhoea, so you should probably go and get tested. It is used quite a bit in the US and UK for partner notification. But those things are available on YouTube.

Mr. Chairman: Are teachers in the Social Studies curriculum aware of these online resources which they use to assist them in training students on STDs, exposing them, and so on. Are they aware, to the best of your knowledge?

Dr. Edwards: I am not too sure the teachers would know about it. It is available and the students know about it.

Mr. Chairman: But certainly if it is known by the Ministry of Health, I would imagine that programmes like the RapPort programme, will then disseminate that information. Does the RapPort programme actually visit schools?

Dr. Sebro: So, RapPort is part of the, what Ministry of Education was referring to, RapPort actively visits schools around the country and they do have evaluation forms

they use after they do their programmes with the youth, as well as Ministry of Health, within the ambit of the section of reproductive health sub-committee of the Public Education Committee that Dr. Parasram spoke of before would use a Facebook page. A Facebook page is being developed and that Facebook page, I am advised, has been vetted and there has been input from the youth for use, so that we can use social media then, to help educate the youth.

Mr. Chairman: Basically, you have assured the Committee that the information is available on sites such as YouTube on some of these STDs, and that teachers will be able to access them and the Ministry of Education simply has to notify the teachers as to these particular online resources, which I would imagine would have had to be screened by the Ministry for use in the teaching of the STDs. Is that now used in the school system to the Ministry of Education, social media positively?

Ms. Smith: Yes, Mr. Chairman, we do utilize.

Mr. Chairman: Okay, very well. Thank you very much, Brigadier Ancil Antoine again and then we come back.

Brig. Gen. Antoine: Just a follow-up. These videos on social media, there are third and fourth parties involved. Does the Ministry of Education just deal with the perpetrators, those involved in the sexual misconduct, but also go after the third and fourth parties who are obviously videotaping these activities and putting it on social media?

Mr. Seecharan: Yes. Whenever there is a video on social media we look, we identify everybody who is involved, those who are doing the filming, those who are bystanders, and we follow our guidelines, in terms of school code of conduct and we treat with them. So everybody involved. It is not just—I mean, the guideline applies to all incidents of indiscipline, including sexual misconduct. It is the same process used.

Mr. Chairman: Okay, thank you.

Mr. Forde: Ministry of Education, you all talk about the National School Code of Conduct with specific relation to sexual offences, are these offences the offences identified within the school population that students are aware of what are the penalties or what are the disciplinary consequences as a result of a particular misconduct? Are these identified to students prior or they are only known when a student is involved in a misconduct?

12.55 p.m.

Mr. Seecharan: Let me just back up and give a little history. Prior to the School Code of Conduct, individual schools would have developed what we call a discipline matrix which would have identified specific offences and the penalty for those. The School Code of Conduct was developed and what has happened is that schools have the option of actually using the School Code of Conduct as is, or they may adapt the guidelines provided there and develop their own discipline matrix. So the discipline matrix that schools may have or the School Code of Conduct which follows the same guidelines are utilized.

In terms of specificity, offences and depending on the nature, for sexual misconduct students may get the maximum penalty which may be suspension, referral to Learning Enhancement Centres but, generally, the School Code of Conduct proposes a sliding scale. So that for minor offences it may be caution, calling in the parents. So it is a sliding scale and it is not okay. If you disrespect someone, automatically you will be sent to the Learning Enhancement Centre which is out of school suspension for an extended period where you get a programme of intervention.

Mr. Forde: A follow-up question. Could the prior publicity promotion of these penalties for misconduct be used as a deterrent in schools for students to not be involved?

Mr. Seecharan: The Ministry of Education has what we call discipline or

promoting discipline plan in place where sexual misconduct is one facet of it. Schools, as part of that, are required to develop their discipline matrix and share that with, in fact, guidelines for behaviour, the discipline matrix and the penalty. I will be honest with you Chair, that is part of what we are actually—I have met with Principals just as recent as last week, because what happens is that as the Ministry highlights it—from time to time, we would send circulars reminding Principals to do it, and then a school goes into a mode where they do not have incidents happening and there is a gap and something comes up. So that we have these incidents sometimes highlighted in social media now where the impression is created, but there is the need for us to continue in the Ministry to enforce that process. And I agree with you, once students are aware of the consequences for different offences, it is re-enforced and supported by everyone within the school. It is less likely that, you know, some of these incidents will take place.

Mr. Forde: And I appreciate that, you know, you are thinking along the same lines. You know, the idea of a deterrent. So once they know the consequences, we anticipate that, you know, we would have less of it. Thanks.

Mr. Chairman: Thank you very much. Christine Newallo, last question from you, MP.

Mrs. Newallo-Hosein: Thank you. Ministry of Health, noting that there is a high level of teenage pregnancies, do you have any data on say within the last three years on the mother-to-child transmission of STDs among teenagers? And also for both Ministry of Education and the Ministry of Health, do you see a correlation between the increased violence in sexual activities in schools and STDs and, perhaps, a deliberate attempt to spread the disease?

Dr. Sebro: Morning again. The Ministry of Health's mother-to-child transmission rate for HIV is less than 2 per cent, which is in keeping with the WHO standard that is to be achieved by the Americas.

For specific information for teenage pregnancy, for the 15 to 19 population, we note that we have had 13. This is between 2011 and 2013, we had 13 cases of HIV-positive pregnant women between the ages of 15 and 19; in 2012, we had 12 and in 2013 we had eight. That is the most up-to-date information that I have at this time, but in terms of if those children transmitted to their infants, I do not have the specific information to say that they have transmitted or not.

Mr. Chairman: Thank you very much. We are close to one o'clock which is our termination point. I would like before I invite closely remarks to raise two issues which are related to the topic under enquiry and, that is, we know that despite programmes of abstinence, there is a level of sexual activity amongst our school-age population and that sexual activity can result in the transmission of STDs, but sexual activity can also result in pregnancy. What I would like to enquire of the medical doctors and of the Ministry of Education—to the medical doctors: since abortion is illegal in Trinidad and Tobago, have you seen cases where there were attempted abortions, what we call backstreet abortions with real negative effects in your practise?

To the Ministry of Education, when a student becomes pregnant and she is still in school: are there any programmes in place to provide assistance to the girl so she could continue her education and, at the same time, there is care for the child? First to the Ministry of Health: have you seen instances where there were illegal abortions and you had to then remedy the situation? Then to the Ministry of Education, a pregnancy went to term but the girl is still in school.

Dr. Divakaruni: I saw a few cases like that, went for the illegal abortion. They landed up with intrauterine infections and we referred them to gynaecology clinics, I mean obstetrics and gynaecology. I saw a few cases, they came after a few years after the abortion and they landed up infertile because of the tubal closure. These two things I have observed.

Mr. Chairman: So there is this instance from your medical practise where there are illegal abortions being practised in Trinidad and Tobago? Very well.

And now to the Ministry of Education with respect to a baby that has come to term and the girl now has to continue her education. What do you do?

Ms. Smith: Okay. The Ministry of Education has a policy whereby all teenage mothers or even fathers are allowed to continue with their formal education. We support the students right through to ensure that they are able to return to school and give support around the social work areas in terms of ensuring the infant is okay, that the financial needs are met for the baby and to ensure that the baby is even supported in terms of care while the mother returns to school, but at the end of the day that child is tracked and worked with right through until upon graduation.

Mr. Chairman: Okay. And it may be that the girl may just have to stay to repeat a year that she has lost.

Ms. Smith: Correct.

Mr. Chairman: Very well. That is certainly heartening to hear and it is disheartening to hear that there are still illegal abortions in Trinidad and Tobago that has to be remedied by the health professionals.

We are very close to our cut-off time and so this has been a very, very fruitful, productive and informative session. We have not touched on the second half of our enquiry, which is really with respect to the Ministry of Health, the facilities which are available to the general population for the treatment of all STDs. We will have to look into another enquiry, of course, with the leave of the Committee, on that critically important subject, but we did cover the very important one of the school-age population where we would like to minimize the risk so that they could continue their education.

At this point, I would like to invite closing comments from the two Permanent Secretaries: Mrs. Angela Sinaswee-Gervais and Mr. Richard Madray. I would ask

Mrs. Angela Sinaswee-Gervais to offer her brief closing remarks on behalf of the Ministry of Education.

Mrs. Sinaswee-Gervais: Thank you, Chair. On behalf of the Ministry of Education, I would like to say thank you for giving us the opportunity to share what we have been doing in the Ministry of Education with our students in this particular area. We will continue to work with the Ministry of Health to improve on the systems so that we will be able to do a better job with our students who may be in this situation. Thank you very much again.

Mr. Chairman: Thank you very much, Mrs. Sinaswee-Gervais. Mr. Richard Madray, for the second time, we would ask you to offer some closing remarks to the Committee.

Mr. Madray: On behalf of the Ministry of Health and my team here, thank you for the opportunity today to respond to your questions and we continue to work to improve the quality of our service.

Mr. Chairman: Thank you very much and on behalf of Committee members, I must say this has been a very informative session. The report would, of course, include recommendations and conclusions which we would forward both to the Ministry of Education and to the Ministry of Health so that the problems under review could become lessened over time. I thank you for taking the time off from your schedules to be here to educate us and the general public and to influence public policy. I wish to thank members of the team, the Committee, for taking the time to investigate the issues so that our scrutiny could really be a productive one.

I wish to thank the media as usual for being here covering the proceedings and to all the faithful viewers on the most popular channel on the media, the Parliament Channel, I would like to say thank you and look forward again to another hearing from the Joint Select Committee on Social Services. Thank you. Have a very good afternoon and productive day.

1.02 p.m.: *Meeting adjourned.*

Appendix III

Violations and their consequences for offenses that directly and/or indirectly refers/leads to the sexual misconduct of teachers

Violations and their consequences for offenses that directly and/or indirectly refers/leads to the sexual misconduct of teachers

If the allegations are against a teacher then, in accordance with the **Teaching Service Commission Policy Guidelines for Handling Discipline in Schools Part 2 Section 2.3.1; (Issued by the DPA)**

1. The principal must report **forthwith** (that is, within the same school day) to the Permanent Secretary following the established channels of communication.

2. The Permanent Secretary, immediately upon receipt, informs the Teaching Service Commission.

3. The Commission within 24 hours of being informed, and in keeping with **Regulation 88 (1) of The Public Service Commission Regulations as adopted by the Teaching Service Commission,** issues a notification to the Permanent Secretary informing that the teacher should cease to report for duty.

4. The Permanent Secretary within 24 hours of receipt of notification from the Teaching Service Commission informs the teacher via the established channels of communication.

5. The Permanent Secretary, under **Regulation 90 of the Public Service Commission Regulations as adopted by The Teaching Service Commission** appoints an investigating officer to investigate and report on the issue.

6. The Teaching Service Commission considers over the report and communicates its' decision to the Permanent Secretary.