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Special Report

Development of Trinidad and Tobago's first National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence

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SUMMARY This Special Report aims to outline the development process of the first National Clinical and Policy guidelines on Intimate Partner Violence and Sexual Violence in Trinidad and Tobago and to support the implementation of quality standards for survivors. The study used an implementation science approach to identify key evidence-based practice recommendations from guidance documents on health care for women who are subjected to violence and from relevant national legislation, policy, and practices. The process engaged stakeholders in discussions on the appropriateness, implementation, and use of these recommendations in the context of local health care delivery. Multidisciplinary teams of frontline health workers were consulted in groups in each of the five Regional Health Authorities. Interviews were held with senior government stakeholders responsible for health policy and with representatives of four civil society agencies. Participants provided recommendations to integrate quality standards into routine practice. These were incorporated into the guidelines, which include human rights principles and pathways of care for identifying violence, providing psychosocial and clinical care, safety planning, referrals, care during emergencies, and prevention of intimate partner violence and sexual violence. The guidelines were approved by the Ministry of Health of Trinidad and Tobago on 15 August 2022. Training of trainers has been undertaken to support implementation.

Keywords Violence against women; implementation science; clinical guidelines; intimate partner violence; sexual offenses; Caribbean region.

Violence against women (VAW) is a major public health threat and an ongoing human rights concern (1). Violence by a husband or male intimate partner (physical, sexual, or psychological), known as intimate partner violence (IPV), is the most widespread form of VAW globally. Sexual violence (SV) by perpetrators other than a current or former husband or partner, referred to as non-partner sexual violence, is another common form of VAW (2). In the Region of the Americas, the Pan American Health Organization/World Health Organization (PAHO/WHO) estimates that one in three (34%) women have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence or both at least once in their lifetime (2). Population-based surveys conducted from 2016 through 2018 in several English-speaking Caribbean nations (i.e., Jamaica, Grenada, Guyana, Suriname, and Trinidad and Tobago) showed that an average of 46% of women

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have experienced at least one form of violence in their lifetime, and nearly 30% of ever-partnered women reported lifetime physical or sexual abuse at the hands of their intimate partner (3). During the COVID-19 pandemic, risks of VAW increased worldwide (4), including in the Caribbean region. VAW is a major cause of morbidity and mortality. VAW has significant short-, medium- and long-term effects on the health and well-being of women, children, and families arising from risks such as injuries, mental ill-health, sexually transmitted infections, gastrointestinal and neurological disorders, and reduced functional capacities (2, 5, 6).

In Trinidad and Tobago, the National Women's Health Survey indicated that nearly one in three (30.2%) of ever-partnered women experienced lifetime physical or sexual abuse and 35.4% experienced lifetime emotional abuse from intimate partners. Around one in five (19.0%) of the survey participants had experienced non-partner sexual abuse in their lifetime (comprising forced intercourse, attempted intercourse, or unwanted sexual touching) (7). The survey and accompanying qualitative study (8) identified socioeconomic risk factors associated with having experienced IPV or SV, including low educational attainment, economic insecurity, living in a rural area, and being unmarried and living with a current partner. Both survivors and perpetrators were likely to have experienced violence as a child, pointing to intergenerational transmission (9, 10). In Trinidad and Tobago, as in other countries in the Caribbean, norms supportive of violence have been identified, with rigid gender roles supported by perpetrators' peers (7, 8, 11, 12). Violent behaviors by men are supported by:

> …the prevailing culture [which] tolerates physical punishment of women and children, accepts violence as a means to settle interpersonal disputes or perpetuates the notion that men *own* women. (8)

These attitudes undermine access to health care for survivors; they erode the social support for survivors and lead them to internalize blame and to feel ashamed of having been subjected to violence (7, 8, 11, 13).

In Trinidad and Tobago, the Ministry of Health (MOH) provides leadership for the health sector, and is responsible for setting the national health agenda, developing legislation, policy and planning, regulation, financing, and other functions at the national level. At the subnational level, five Regional Health Authorities (RHAs) were created as statutory bodies that are responsible for delivery of public health care services. In addition, the MOH provides oversight and control of the administration of 17 units comprising vertical services, health programs, and technical support services, including those for sexually transmitted infections, public health laboratory services, population health, education, disaster preparedness, and more. The MOH, its RHAs, and the vertical health programs and services all play a critical role in providing comprehensive care and support to women affected by violence; they act as an entry point to appropriate support and referral to other resources (1). The Trinidad and Tobago National Women's Health Survey (2018) showed that survivors of IPV and SV are more likely to tell a health care provider than any other service provider about the violence they experience (7). However, social attitudes shared by some health care workers and lack of specific training on caring for IPV and SV survivors may reduce access to care. Support may be further limited by the absence of clear referral systems between health and other services, which compounds the lack of available facilities such as shelters for domestic violence survivors (7, 8, 13, 14).

Addressing VAW is a national priority for the Government of Trinidad and Tobago. Development of the first National Clinical and Policy Guidelines on IPV and SV was regarded as a critical public health response to tackling unacceptable levels of VAW, particularly during public health emergencies such as the COVID-19 pandemic. Addressing VAW is also central to achieving Sustainable Development Goal 5, "Achieve gender equality and empower women and girls," and Goal 16, "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable, and inclusive institutions at all levels" (15).

The objective of this study was to outline the development process of the National Clinical and Policy Guidelines on IPV and SV in Trinidad and Tobago. This process was designed to facilitate the adoption of evidence-based practice into routine clinical care and to support the implementation of quality standards for survivors of IPV and SV. These guidelines are also expected to lead to a strengthening of the health system response and improvements in the capacity of health care providers to deliver high-quality care and support to women affected by violence.

METHODS

Implementation science approach

When new clinical recommendations are being developed, care must be taken to ensure that they are feasible, actionable, operational, and acceptable for key stakeholders in the contexts in which they will be applied (16). The process of developing the National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence: Trinidad and Tobago (hereafter, the Guidelines) started with identifying recommendations from existing global evidence-based good practice guidance. Then we used an implementation science approach to optimize their eventual uptake. Implementation science consists of two main processes: (1) identify uptake barriers and facilitators for evidence-based clinical innovations across multiple levels of context; and (2) develop and apply implementation strategies that overcome these barriers and enhance the facilitators to increase uptake of the innovations (17)

The need for an implementation science approach is based on the observation that establishing the effectiveness of an innovation does not guarantee its uptake into routine usage. Contextual factors, not treatment effectiveness, may play a dominating role in whether and how quickly an innovation will become widely used (17). This methodology has been used to develop clinical practice guidelines and was shown to have prospects for making clinical guidelines more implementable (16).

Three main steps in the development process

The first step involved a comprehensive review of global evidence-based clinical and policy guidelines from PAHO/WHO and other United Nations (UN) agencies on the delivery of care for women subjected to IPV and SV (1, 4, 14, 18-23). Trinidad

and Tobago's legislation, policies, practices, data relevant to gender-based violence, and efforts to strengthen the capacity of health care providers were also reviewed (7, 24-32). We evaluated possible ways to align the global guidance with the local policy and practice context.

Evidence-based recommendations were summarized and subsequently included in a consultative process. Instruments to engage stakeholders in discussions sought information on current IPV and SV health care and presented key evidence-based recommendations, inviting their feedback on the appropriateness, implementation, and use in the context of local care delivery. Key domains discussed, in accordance with WHO guidance on IPV and SV care, were how the health system should respond to:

- Immediate emotional/psychological health needs
- Immediate physical health needs
- Ongoing safety needs
- Ongoing support and mental health needs (14)

The second step was to establish and implement collaborative mechanisms and consultative processes with key stakeholders. Operational colleagues need to be full partners because implementation research aims to assess and actively intervene in the structures in which they are the experts (17). Plans were shared and consultative processes approved by the Chief Medical Officer, who appointed a Committee of MOH Representatives to work on strengthening the health sector response to VAW. This multidisciplinary committee composed of government officials, health practitioners, and policy and technical advisors met every 2 months and helped orient the work. This consultative process involved the collection, from November 2020 to March 2021, of primary information through interviews, group consultations, and feedback from health care practitioners across the health, social services, nongovernmental organizations, and civil society sectors. Frontline health workers from multiple disciplines and levels of seniority from each of the five RHAs were invited to participate in consultations in groups of about 7 persons. Individual follow-up discussions were held with some of these staff members. The purpose was to gather information on the performance of the health system, identify possible barriers to the adoption of practice guidelines, and make recommendations to improve the implementation and scale-up of quality standards for providing health care to women affected by violence. One-on-one interviews were conducted with six senior stakeholders from the MOH; Office of the Prime Minister, Gender Affairs; National HIV/AIDS Coordinating Committee; and with four nongovernmental organization and civil society members on the appropriateness and recommended content of evidence-based guidelines in the national context.

The third step involved incorporating the feedback and recommendations from consultations with stakeholders (including health care providers) to produce a first draft of the Guidelines. Feedback was sought from the MOH Committee, MOH Senior Executive Team members, other government, and civil society agencies, PAHO/WHO, and other UN technical advisors, leading to several iterations to ensure consistency with national policy and evidence-based guidance. The Directorate of Women's Health of the MOH and PAHO/WHO worked closely together on revisions and submission for government approval. The steps in the guideline development process are outlined in Figure 1.

The project to develop the Guidelines was supported by the UN European Union Spotlight Initiative to eliminate violence against women and girls. The development of the Guidelines was an activity to strengthen the health sector response, managed by PAHO/WHO, under Pillar 4: Quality Essential Services of the Spotlight Initiative.

RESULTS

Participants highlighted barriers and gaps in the response to IPV and SV and were engaged in discussions on locally appropriate strategies to address these challenges with solutions that were consistent with quality standards and national policy. Areas of concern they highlighted included:

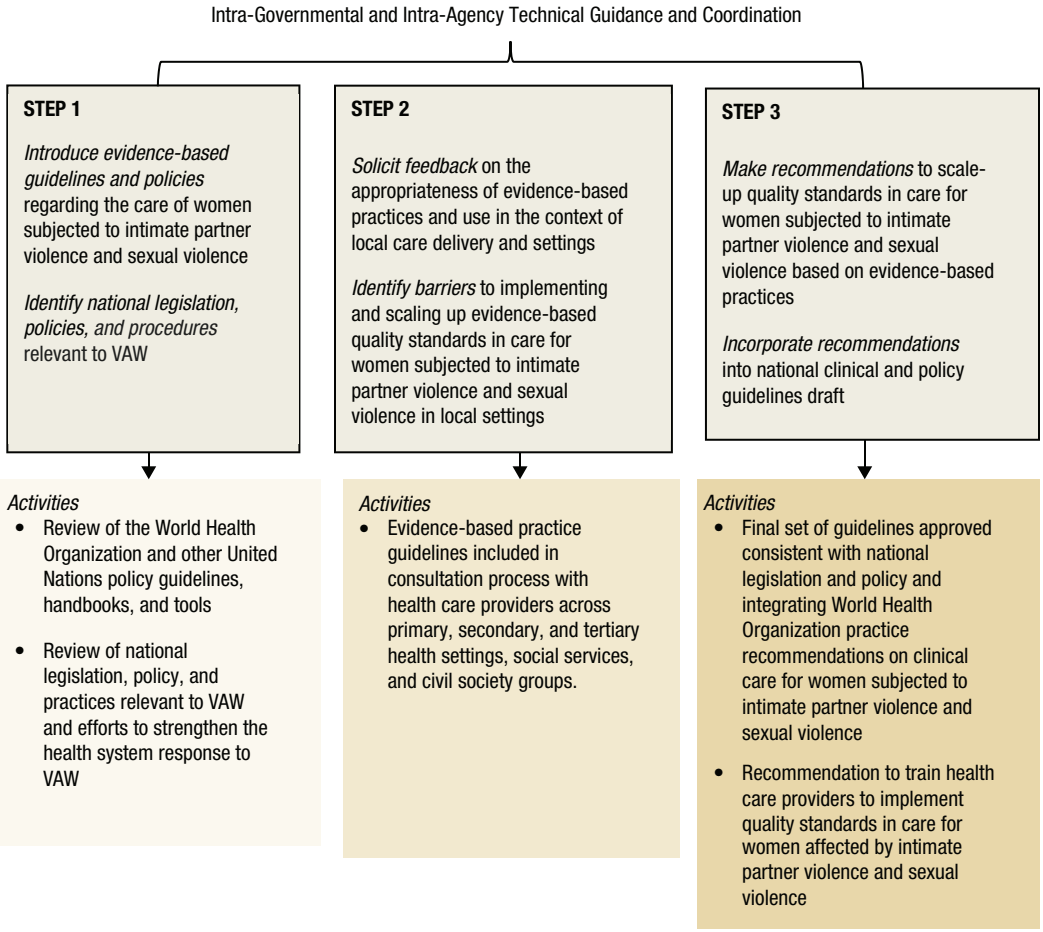
- Lack of guidance on how to support identification of and disclosure by patients who have been subjected to violence
- Need for guidance on immediate- to long-term psychosocial support to be provided to survivors
- Need to integrate care for survivors of IPV and SV into existing health services.
- Weak referral pathways and feedback mechanisms between the health system and police and social services cannot meet survivors' complex needs
- Lack of standardized documentation procedures to monitor quality of care and facilitate referrals
- Need for guidance on effective IPV and SV prevention strategies for the health system
- Strategies to ensure access to care in the context of emergencies, such as the COVID-19 pandemic

Recommendations were incorporated to strengthen identification of and facilitate disclosure by women and girls subjected to violence, provide them with appropriate clinical care and psychosocial support and connect them to other services across health, police, social services, and civil society sectors. A clinical record form was included in the Guidelines to allow health care providers to document, for each patient who discloses IPV or SV, their characteristics, details of the violent event, health care received, and referrals provided.

IPV and SV place women at an increased risk of HIV, both through direct risk of infection and by creating an environment in which women are unable to adequately protect themselves from HIV. Recommendations were incorporated to ask women about IPV in the context of HIV testing and counselling and when administering post-exposure prophylaxis after sexual assault as per Standard Operations Procedures in Trinidad and Tobago (33).

The Guidelines also include a section with recommendations for the health sector to strengthen prevention of IPV and SV that supplements the guidance already included in the National Sexual and Reproductive Health Policy (25). Health care providers are encouraged to become involved in awareness-raising with their patients and advocacy through their networks, stressing the rights of survivors, and working to address underlying gender norms and other social and economic determinants of health (primary prevention). Secondary prevention through early identification of survivors is facilitated by guidance on clinical inquiry, supporting disclosure, and following the

FIGURE 1. Summary of Process to Develop Guidelines to Address Violence Against Women (VAW) in Trinidad and Tobago



Source: Prepared by the authors from the study results.

recommended pathway of care. Guidance on tertiary prevention to mitigate the impacts of violence is also provided, such as establishing long-term options for psychosocial support, employment, and other areas.

In response to the heightened risks of VAW and barriers to access to services in emergencies, guidance developed by the international Interagency Steering Committee of Humanitarian Agencies was also incorporated into the Guidelines. They included recommendations for the implementation of Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies (23) and a Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (22), both of which highlight the need for multisectoral collaboration.

The final version of the Guidelines (34) was approved by the MOH on 15 August 2022. The Guidelines are consistent with national legislation and policy and are integrated with the WHO practice recommendations on clinical care for women subjected to IPV and SV. Using a rights-based approach, the Guidelines reinforce the principles of women-centered care for survivors, gender equality, and high-quality care. The guidelines also incorporate recommendations from stakeholder discussions to address barriers to implementation, support the scale-up and coordination of services, and build the capacity of health care providers through training to implement quality care standards for survivors of IPV and SV. Implementation recommendations to strengthen institutional capacity at the national level were incorporated into the Guidelines as well.

DISCUSSION

Despite the existence of laws on domestic and sexual violence, VAW continues to be pervasive and persistent challenge in countries across the Caribbean. The culture of silence and stigma about the topic presents a barrier for survivors, often deterring access to appropriate services to help mitigate the effects of violence and its health impact. Trinidad and Tobago's first National Clinical and Policy Guidelines on IPV and SV (34) were approved, conveying the commitment of the Government of Trinidad and Tobago to address VAW. The Guidelines are a critical step to ensure access to survivor-centered and comprehensive care, minimizing barriers, especially during times

of public health emergencies, and providing life-saving services. Moreover, early identification of at-risk groups in health services offers a unique opportunity for intervention before violence escalates, thus helping to prevent violence.

The number and variety of persons who participated in the Guidelines development processes described in this report was restricted by the fact that the health sector was prioritizing the response to the COVID-19 pandemic at the time. That professionals and agencies across disciplines and levels collaborated in this endeavor is testament to the perceived importance of addressing IPV and SV in Trinidad and Tobago and bodes well for the development of similar guidelines in resource-constrained settings. The identification of evidence-based practices for the care of women subjected to IPV and SV was facilitated by a dedicated and coordinated team of stakeholders across health, social service, and civil society sectors. The process drew on the expertise and experience of multidisciplinary teams to ensure the appropriateness of the content, prioritizing a survivor-centered approach to ensure that the rights, needs, and preferences of survivors were taken into consideration. Technical guidance and feedback were provided by senior stakeholders from the MOH; the Office of the Prime Minister's Gender Affairs; and the National HIV/AIDS Program. This collaboration ensured that the recommendations were aligned with national legislation, policies, and procedures.

To improve the survivor's experience and address barriers to implementation of Guideline recommendations, the input of civil society groups was also considered. Key recommendations included building the capacity of health care providers through training to strengthen their ability to identify survivors, provide immediate care, and develop safety plans and linkages to appropriate services for survivors of IPV and SV. The development and use of local and national crisis support directories for survivors were also recommended.

The implementation science approach described in this report may be the first critical step in a process of implementation—the development of guidelines rigorously tailored to be appropriate, feasible, actionable, operational, and acceptable in the local setting. Further steps that have been taken include joint MOH/RHA/PAHO training workshops for staff in each RHA, with 419 persons trained in caring for women subjected to violence (13), of which 123 (approximately 25 per RHA) participated in Guidelines train-the-trainer workshops that used findings from the consultative process to steer the content.

The clinical record form included in the Guidelines has been made available in electronic format for data entry and analysis using an existing platform, the Perinatal Information System (SIP), which has been used to monitor women's health care in Trinidad and Tobago since 2018. RHAs have been provided with training and information technology equipment to use the form. Indicators to monitor and evaluate quality of care provided to survivors of IPV and SV presenting to health services have been included for automatic calculation in the SIP IPV and SV interface. Examples include the number of cases of IPV and SV that have been provided with firstline support, the timeliness of provision of HIV prophylaxis to SV survivors, and the number of survivors referred to other sectors.

The Guidelines also include a section with recommendations for the MOH and RHAs to facilitate implementation of IPV and SV care delivery and prevention, including governance, coordination, and resource development mechanisms and procedures. Further use of implementation science is suggested to operationalize these recommendations in specific settings such as in individual RHAs, hospitals, and clinics. Implementation trials can be conducted of specific bundles of implementation innovations for increasing uptake of the Guidelines in each setting (17). Examples of issues that may be considered include phasing of staff training, managerial support, provision of toolkits and checklists, procurement of medical supplies, and communications with other service providers (35). It is especially important to support the implementation processes considering the systemic barriers that exist in the Trinidad and Tobago setting. A few examples are that staff in the health sector are already performing multiple functions; turnover of staff is high; there are few spaces in health facilities where patient privacy can be assured; and there is a lack of awareness among some stakeholders and the public regarding the rights of and care pathways available for survivors.

CONCLUSIONS

Implementation science advances the understanding of methods and strategies to promote the systematic uptake and adoption of evidence-based practices and programs across diverse settings, including health care (16, 17, 35). Using implementation science to inform the guideline development process provided much-needed direction to translate evidence-based practices into routine clinical care for women subjected to IPV and SV. This practical approach is applicable to other countries that are aiming to develop similar guidelines using PAHO/WHO and other UN-based quality standards in caring for women subjected to violence. In our development process, using an implementation science approach facilitated meaningful engagement and consensus-building among national stakeholders that allowed us to adapt evidence-based practices for the local context. The process strengthened institutional capacity and has likely made these Guidelines more implementable.

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Disclaimer. Authors hold sole responsibility for the views expressed in the manuscript, which may not necessarily reflect the opinion or policy of the *RPSP/PAJPH* and/or the Pan American Health Organization (PAHO).

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Elaboración de las primeras directrices políticas y clínicas nacionales sobre violencia de pareja y violencia sexual de Trinidad y Tobago

RESUMEN El objetivo de este informe especial es describir el proceso de elaboración de las primeras directrices políticas y clínicas nacionales sobre violencia de pareja y violencia sexual en Trinidad y Tabago, así como brindar apoyo para la aplicación de normas de calidad dirigidas a las personas supervivientes. El estudio utilizó un enfoque de ciencia de implementación para hallar recomendaciones prácticas clave basadas en la evidencia a partir de documentos de orientación sobre atención de salud para mujeres víctimas de violencia, así como de las leyes, políticas y prácticas nacionales pertinentes. El proceso involucró a las partes interesadas en las deliberaciones sobre la idoneidad, la puesta en práctica y el uso de estas recomendaciones en el contexto de la prestación de servicios de salud locales. Se realizaron consultas grupales a equipos multidisciplinarios de trabajadores de salud de primera línea de cada una de las cinco autoridades regionales de salud. Se mantuvieron entrevistas con funcionarios gubernamentales con cargos de responsabilidad en materia de políticas de salud y con representantes de cuatro organizaciones de la sociedad civil. Los participantes proporcionaron recomendaciones para integrar las normas de calidad en la práctica habitual. Estas recomendaciones se incorporaron a las directrices, que incluyen principios de derechos humanos y protocolos asistenciales para detectar la violencia, prestación de atención psicosocial y clínica, diseño de planes de seguridad, derivación de los casos, atención durante emergencias y prevención de la violencia de pareja y la violencia sexual. Las directrices fueron aprobadas por el Ministerio de Salud de Trinidad y Tabago el 15 de agosto del 2022. Se ha llevado a cabo la capacitación de formadores a fin de brindar apoyo para su puesta en práctica.

Palabras clave Violencia contra la mujer; ciencia de implementación; guía de practica clinica; violencia de pareja; delitos sexuales; Región del Caribe.

Elaboração das primeiras diretrizes clínicas e orientações sobre políticas de âmbito nacional para violência por parceiro íntimo e violência sexual de Trinidad e Tobago

RESUMO O objetivo deste relatório especial é resumir o processo de elaboração das primeiras diretrizes clínicas e orientações sobre políticas de âmbito nacional para violência por parceiro íntimo e violência sexual de Trinidad e Tobago, bem como apoiar a implementação de padrões de qualidade para sobreviventes. O estudo utilizou uma abordagem científica de implementação para identificar as principais recomendações de práticas baseadas em evidências, derivadas de documentos de orientação sobre atenção à saúde para mulheres vítimas de violência e de leis, políticas e práticas nacionais pertinentes. O processo envolveu as partes interessadas em discussões sobre adequação, implementação e uso dessas recomendações no contexto da prestação de serviços de saúde em nível local. Em cada uma das cinco autoridades regionais de saúde, equipes multidisciplinares de profissionais de saúde na linha de frente foram consultadas em grupo. Foram entrevistadas partes interessadas da alta administração do governo que eram responsáveis pela política de saúde e representantes de quatro organizações da sociedade civil. Os participantes fizeram recomendações para integrar padrões de qualidade à prática de rotina. Tais recomendações foram incorporadas às diretrizes, que incluem princípios de direitos humanos e percursos assistenciais para identificação de violência, oferta de atenção psicossocial e clínica, planejamento da segurança, encaminhamentos, cuidados durante emergências e prevenção de violência por parceiro íntimo e violência sexual. As diretrizes foram aprovadas pelo Ministério da Saúde de Trinidad e Tobago em 15 de agosto de 2022. Realizou-se capacitação de instrutores para apoiar a implementação.

Palavras-chave Violência contra a mulher; ciência da implementação; guia de prática clinica; violência por parceiro íntimo; delitos sexualis; Região do Caribe.