GLOBAL AIDS RESPONSE PROGRESS
TRINIDAD AND TOBAGO
COUNTRY PROGRESS REPORT
JANUARY 2010-
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COUNTRY PROGRESS REPORT

TRINIDAD AND TOBAGO

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I. Status at a glance

a. Inclusiveness of stakeholders

The National AIDS Co-ordinating Committee (NACC) came to an end in March 2011. With no staff dedicated towards compilation of the country progress report, the Office of the Prime Minister (OPM) led the preparation of the 2011-2012 UNAIDS Country Report and prepared the initial drafts of the country report and the NCPI Part A in consultation with other HIV/AIDS Co-ordinators in government agencies. Data collection and analysis were supported by the Office of the Prime Minister, the Ministry of Health, government ministries, the Central Statistical Office, civil society organizations and UNAIDS. A draft was disseminated for comments and consultation to government representatives, co-ordination committees and civil society. Modifications and enhancements were made to the document based on the feedback received and this final document was compiled.

b. Status of the epidemic

With a population of approximately 1.3million in 2010, Trinidad and Tobago is categorized as having a generalized and concentrated epidemic. HIV prevalence is estimated to be greater than 1% and exceeds 5% in the most at risk populations. The primary mode of transmission is through heterosexual contact. The estimated number of people living with HIV/AIDS at the end of 2010 was 22,787 producing an HIV prevalence rate of about 1.5% at the end of 2010. These prevalence figures only represent the public health sector and some key private labs which comply with reporting to the Trinidad Public Health Laboratory could be an under-estimate of the true level of HIV prevalence. Data from public health sector show that there was a decline in the number of new HIV positive cases from 1450 in 2008 to 1384 in 2009 and 1148 in 2010. For 2010 there were 205 HIV positive cases reported among pregnant women resulting in a seroprevalence rate of approximately 1.6% among this sub-population. There were 70 AIDS

related deaths in 2010. The most at risk populations were identified as: men who have sex with men, sex workers, substance users and youth.

c. Policy and programmatic response

Trinidad and Tobago's response to HIV and AIDS embraces all levels of government, civil society, the academic and research community, the public health sector, persons living with HIV/AIDS and those at risk and affected by HIV/AIDS. The response to HIV/AIDS is guided during this reporting period by the one year Transitional Strategic Plan 2010-2011 as an extension to the 2004-2008 plan which was extended by one year in 2010. The principal goals are to reduce the incidence of HIV infections and mitigate the negative impact of HIV and AIDS on persons infected and affected by the epidemic.

Several policies were formulated in 2010 including the Prevention of Mother to Child Transmission Policy, the Post Exposure Prophylaxis Policy and the Health Sector Workplace Policy. The reporting period saw strengthening of programme areas, expansion of prevention services and improvements including Voluntary Testing and Counselling, the Prevention of Mother to Child Transmission, and treatment adherence. Prevention efforts were substantially scaled up in 2010 through increased access and geographic coverage to VCT services. The number of sites providing HIV testing and counseling services increased from 28 in 2009 to 31 in 2010. There was a steady increase in the number of persons tested at same day sites from 2007 to 2010 with 39,032 persons being tested in 2010.

Uptake of PMTCT based on annual programme reports showed a decline as 91% of new clinic attendees in 2010 consented for HIV testing and counseling compared with 97% in the period 2007-2009 and a rebound to 95.1% in 2011. HIV prevalence among pregnant increased from 1.2% in 2009 to 1.6% in 2010. One note of progress was that in 2010, 85.9% of first clinic attendees adhered to all components of antiretroviral prophylaxis (83.2% in 2011) and that in 2010 all HIV exposed infants received post-partum prophylaxis.

Vulnerable populations such as youth were targeted during the reporting period with specific campaigns aimed at increasing HIV testing, promoting knowledge and awareness of HIV through initiatives such as the Barber Shop initiative, 'edulimes', youth linkers.

The year 2010 witnessed an increase in the proportion of patients on antiretroviral therapy of 13% from 2009 to 2010. Diagnostic capacity was strengthened as viral load service was transferred from a regional agency to a major national hospital in 2010. A community based home care project was successfully launched in 2010 in one county with 17 community health care workers being trained and 15 clients

accepted into the pilot project. Adult in hospital treatment expanded in Tobago to the Tobago Regional Health Authority in 2010.

Civil society organizations including faith based organizations continued to play a critical role in advocacy for PLWH and at risk groups, reducing stigma and discrimination and promoting HIV/AIDS awareness.

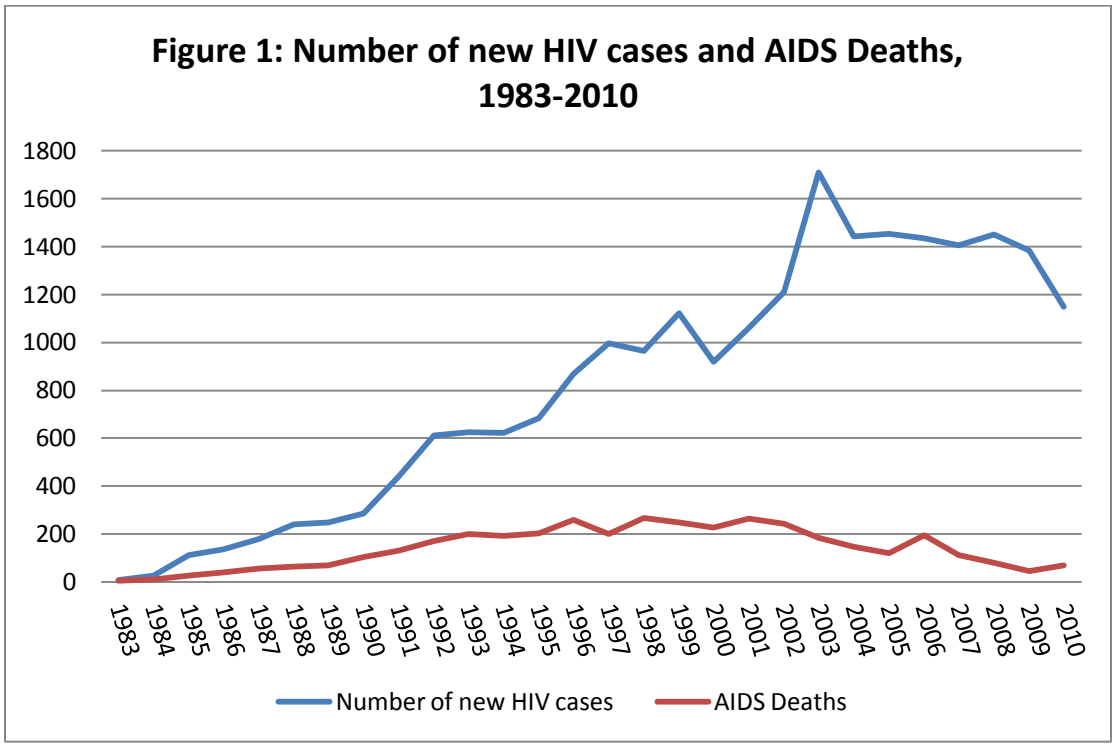
d. Core Indicators for Monitoring 2011 Political Declaration on HIV

Target/indicator	2010	2011	Source
Target 1: Halve sexual transmission of HIV by 2015			
1.1 Percentage of young women and men15-24 years who correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission		63.2	2011 MICS Survey preliminary results
1.2 Percentage of young women and men 15-24 years who have had sexual intercourse before the age of 15		4.1	
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months		0.36	
1.4 Percentage of adults aged 15-49 who have had more than one sexual partner in the past 12 months and who report the use of condoms during their last intercourse		33.3	
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results		44.6	
1.6 Percentage of young people aged 15-24 who are living with HIV	1.3		MOH/HIV/AIDS Co-ordinating Unit Alternate methodology used see appenddix1
1.7 Percentage of sex workers reached with HIV prevention programmes	Data for these indicators are not available. Protocols for behavioural surveillance of these groups have been approved and two national surveys are earmarked for 2012/2013		
1.8 Percentage of sex workers reporting the use of a condom with their most recent client			
1.9 Percentage of sex workers who received an HIV test in the past 12 months and know their results			
1.10 Percentage of sex workers living with HIV			
1.11 Percentage of men who have sex with men reached with HIV prevention programmes			
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	95% (2007)		Data for 2007 TRAC-M Survey of MSM in Trinidad
1.13 Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	Data not available for reporting period.		
1.14 Percentage of men who have sex with men who are living with HIV			

Target/indicator	2010	2011	Source
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015			
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	National data for these indicators are not available. Trinidad and Tobago is by and large not an injecting society. There have been few cases of injecting which have been linked to deportees returned from abroad. **Source: National Drug Abuse and Prevention Programme**		
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse			
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected			
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results			
2.5 Percentage of people who inject drugs who are living with HIV			
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to –child transmission	81.3	81.9	MOH
3.2 Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	37.7	40.3	MOH
3.3 Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months. Mother-to child transmission of HIV (modeled)	16.3	14.9	MOH
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	75.0	73.1	MOH
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	84.9	83.4	MOH
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015			
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	60.5		MOH
Target 6:Reach a significant level of annual global expenditure (US$22-24Billion) in low and middle income countries			
6.1 Domestic and international AIDS spending by categories and financing sources			
Target 7:Critical enablers and synergies with development sectors			
7.1 National commitments and policy instruments	See ANNEX 1		
7.2 Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	0.18	0.20	Crime and Problem analysis Branch/Central Statistical Office
7.3 Current school attendance among orphans aged 10-14 years	Not available		
7.4 Proportion of the poorest households who received external economic support in the past 3 months	Not available		

II. Overview of the AIDS epidemic

With an estimated prevalence rate of 1.5% , Trinidad and Tobago is described as having a generalized epidemic. The principal mode of transmission is heterosexual contact. According to data reported from the MOH, the number of new infections peaked in 2003 with 1709 cases. Thereafter a downward trend was observed which has been steady since 2008. With the increased access to treatment, the number of persons living with the disease has been increasing steadily. To date 22,787 cumulative HIV positive cases were reported in 2010. See Figure 1.



Data Source: Ministry of Health, National Surveillance Unit. HIV/AIDS Morbidity and Mortality Report 2010. (provisional)

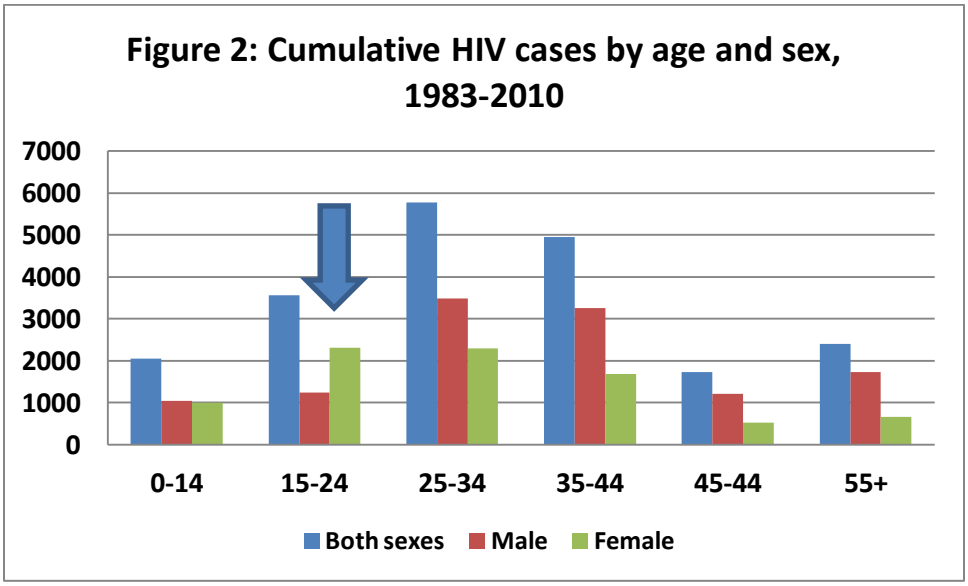
For the entire period 1983-2010, the majority of cases were observed among the productive ages 25-44 years (52.5%). The young adult population accounted for 16.6%. The feminization of the epidemic among young adult age group is evident from Figure 2.

Table 1: Age distribution of cumulative HIV cases 1983-2010

Age group	Percent distribution
0-14	11.4
15-24	16.6
25-34	29.8
35-44	22.7
45-54	8.0
55+	11.1
Not Stated	0.5

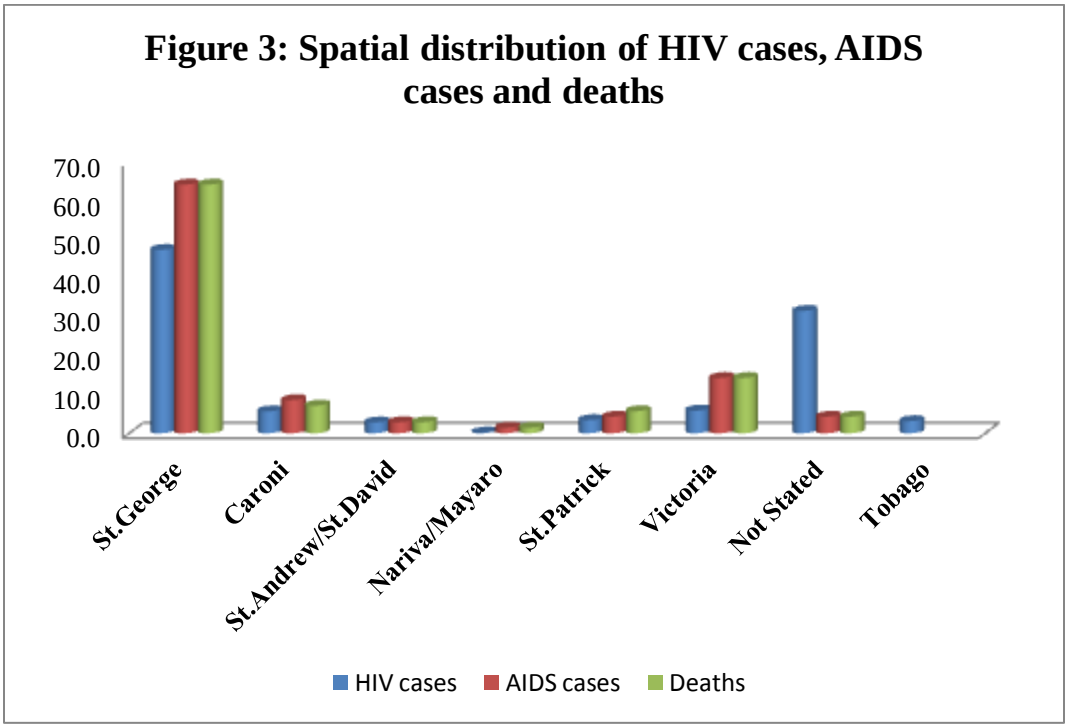
Data Source: National Surveillance Unit, Ministry of Health, Trinidad and Tobago. HIV/AIDS Morbidity and Mortality Report 2010.

In each age group except the young adult ages 15-24, the male/female ratio exceeded 100 indicating excess males HIV cases over females in each age group. The factors affecting this feminization of HIV among youth include age-mixing with older partners, concurrent partnerships, transactional sex, lack of ability to negotiate condom use with partners, lack of empowerment and higher poverty levels among young women. Additionally more females than males access testing, but a greater proportion of males test positive and are hypothesized to be diagnosed late when they present late on account of illness. In 2010 there were 70 AIDS related deaths.



Data Source: National Surveillance Unit, Ministry of Health, Trinidad and Tobago. HIV/AIDS Morbidity and Mortality Report 2010.

Spatial distribution of HIV/AIDS Incidence and Prevalence shows that in 2010 the highest number of HIV and AIDS cases were observed in County St. George which includes the nation's capital. There were also rapid access to testing in the North West Regional Health Authority which includes county St. George West and Central.



Data Source: National Surveillance Unit, Ministry of Health, Trinidad and Tobago. HIV/AIDS Morbidity and Mortality Report 2010.

III. National response to the AIDS epidemic

The national response to the AIDS epidemic is guided by the goals articulated in the National Strategic Plan for 2011-2016 which are to reduce the incidence of new infections and to mitigate the impact of HIV/AIDS on persons infected and affected in Trinidad and Tobago.

a. Programme implementation: prevention VCT

The government of Trinidad and Tobago remains committed to stemming the tide of HIV/AIDS. Pursuant to this goal the 2011-2016 National Strategic Plan (NSP) was formulated as the NSP 2004-2010 came to an end. The NSP 2011-2016 was circulated to government agencies, civil society, the public health sector,

persons living with HIV/AIDS and at risk of HIV/AIDS. The draft National Strategic Plan is evidence-based with input from civil societies and the national research community and will be finalized in 2012.

The NACC came to an end in 2011 but general oversight for HIV/AIDS response continued to be a pressing issue on the national agenda and was provided by the Office of the Prime Minister. The end of the NACC (National AIDS Co-ordinating Committee) has contributed towards the delays in the implementation of the NSP and has resulted in depletion of experienced staff available for required national monitoring and evaluation. During the two year reporting period the response to HIV/AIDS was largely spearheaded by the National HIV/AIDS Co-ordinating Unit of the Ministry of Health and the Tobago HIV/AIDS Co-ordinating Committee.

Despite several challenges, expansion in prevention in terms of voluntary counseling and testing continued through outreach sessions, rapid testing, antenatal testing and events campaigns such as the Caribbean HIV/AIDS Testing Day 2010, County Screening Week and World AIDS Day in Trinidad 2010 and 2011. Trends in the number of persons accessing HIV testing in different settings are depicted in Table 2 below. The number of sites offering same day testing increased from 1 in 2005 to 31 in 2010 while there were three additional mobile testing sites established in 2010.

Table 2- Trends in number of persons accessing HIV Testing and Counseling Services, 2007-2011

Modality of Testing	Number Tested					
	2004	2007	2008	2009	2010	2011
Outreach sessions			1696	650	857	1784
HIV same visit sites		4726	8595	11190	13900	17451
Queen's Park Counseling Centre and Clinic (Rapid Tests)	4423	6689	1651	4204	5574	6055
Laboratory Testing						10644
Events Campaigns				1325	5957	6277
PMTCT(No. first tested)	11001	14732	15625	12325	12744	13010
Total	15424	26147	27567	29694	39032	55221

Source: Ministry of Health HIV/AIDS Co-ordinating Unit Report 2011

The 2011 data table includes HIV testing that occurred in the hospital laboratories. Although the data from that source are not complete, it can be seen that Hospital Laboratory testing contributes significantly to the number of tests performed. Inclusive of the available data from the hospital labs the total number tested increased to 55,221 with a total of 1095 positive cases being identified. Invariably, the majority of HIV+ve cases were identified at the hospital labs and this contributed to the relatively high prevalence of 6.1% when compared with HIV testing in other settings. This confirms the hypothesis not proven before that the majority of HIV positive cases in public sector are due to hospital lab testing. This has implications for regulations for private sector lab reporting.

The health setting demonstrating the second highest seropositivity (but decreasing from 2007 to present) is the QPCC (Queens Park Counseling Centre) which does HIV testing as well as care management of STI clients. Screening at the HIV Same Visit testing sites accounted for seropositivity of about 1%. This level of testing takes place mainly at primary care health facilities, NGO and Tertiary education health care settings. Additionally HIV testing during event campaigns such as Caribbean Testing Day and World AIDS Day accounted for seropositivity of <1%. These events may be hosted in mixed settings such as Public primary health care facilities, NGO as well as Open spaces. PMTCT and testing through Outreach sessions accounted for <1% respectively. In Tobago, the Tobago Health Promotion Clinic continued to be the major site for HIV testing in the island. Other health centres such as in Canaan were earmarked to begin testing in 2011.

An analysis of individuals being tested shows the gender bias in terms of the proportion of women being tested for HIV as compared with the proportion of men. For example during World AIDS Day event, of the 3888 persons accessing HIV testing and counseling, 2460 females compared to 1428 males availed of testing. Of these persons screened 23 were HIV positive, comprising14 males and 9 females. This highlights the need to address men's reluctance to come forward for HIV testing.

In 2011, MOH trained civil society personnel to conduct Rapid HIV testing and counseling strengthening the capacity of this sector to engage in more effective HIV/AIDS prevention. Training of trainers to build Regional Health Authority capacity to have HIV Rapid Test Trainers was also conducted in 2011 with roll out of training earmarked for 2012.

Prevention of Mother to Child Transmission

Prevention of mother to child transmission is an integral part of the national strategy to prevent and control the spread of HIV. In Trinidad and Tobago the PMTCT is universally available at all health institutions in the public sector. During the reporting period the focus continued to be on expansion and strengthening of the PMTCT Programme. In 2010, there were 13,997 new attendees of which 12,744 were tested for HIV. Among those tested, the seroprevalence rate was 1.6%. Of this 85 represented new cases with a positivity rate of 0.7%.

Most at risk Populations and other Vulnerable Populations

Protocols for behavioural surveillance of MARPs such as MSM and CSW were developed and finalized in 2011. National surveys are scheduled to be implemented in 2012/2013. One of the groups considered to be vulnerable in Trinidad and Tobago is youth. The Ministry of Health Youth arm- Rapport continued to implement several initiatives to reach youth in 2010-2011 including Youth Linkers, and Rap Programme. A new initiative which saw success was the Barbershop Initiative which was launched during Carnival 2010 and which involved conducting edulime sessions with patrons and owners of barber shops in some areas. These sessions were conducted by RAPPORT peer educators who distributed condoms, and educational material to these sites. Additionally 8302 condoms were distributed to several RAPPORT sites during the period January to September 2010. The capacity of Rapport Staff was strengthened through training in HIV and TB, working with most-at-risk groups, provider initiated testing and counseling, advanced counseling in HIV and AIDS.

The target of current draft NSP 2011-2016, is that by 2016, 80% of MSM would report using a condom at last anal sex with male partner. There is however a paucity of qualitative and quantitative data on MARPs in Trinidad and Tobago. In a study of most at risk populations commissioned by the NACC and conducted by a CSO in 2009, it was reported that while most MSM agreed that protection should be used all the time they felt that this was not always possible. Of the 10 MSM interviewed in the study, five used condoms at all times, 3 did not and 2 did not respond (Source: Research on Risk factors of key populations for contracting HIV and other STIs in Trinidad, RED Initiatives, 2009). While this study may not be representative of all MSM, they point to the need to improve behavioural change among some MSM in terms of consistent condom use.

This study also investigated knowledge, attitudes and behaviours among commercial sex workers, drug users, homeless people and youth attending tertiary institutions. In these five key populations over 80% knew that either proper use of condoms or abstinence were the best means of protection against HIV. These groups were aware of private and government services however some groups in particularly CSW and MSM tended to avoid using them because of stigma and discrimination. More outreach and confidential services were called for by respondents in this study.

HIV prevention and awareness among prisoners was promoted through a poster competition to promote awareness about HIV, stigma and discrimination. IEC materials were also disseminated among among this at risk population.

Role of Civil Society

During the reporting period civil society organizations continued to be instrumental in the fight against HIV/AIDS. CSOs have provided much needed advocacy for PLWH, developed educational programmes for the general public targeting youth, patients, caregivers, families and friends of PLWH, promoted universal access to HIV prevention, treatment, care and support. Key input and support for MSM and commercial sex workers have been provided by organizations targeting these groups. CSOs have also provided critical services in condom social marketing. One CSO worked with commercial sex workers and provided services such as drop in centres, training of peer educators, recruiting sex workers to help brand condoms and targeted behavior change campaigns to encourage clients of sex workers to take an active role in protecting themselves, their partners and their families, by reducing the number of sexual partners and using condoms correctly and consistently. This CSO estimated that in 2010 its services and products helped to avert 42 HIV and TB DALYS (disability adjusted life years) and 99 Reproductive Health DALYS.

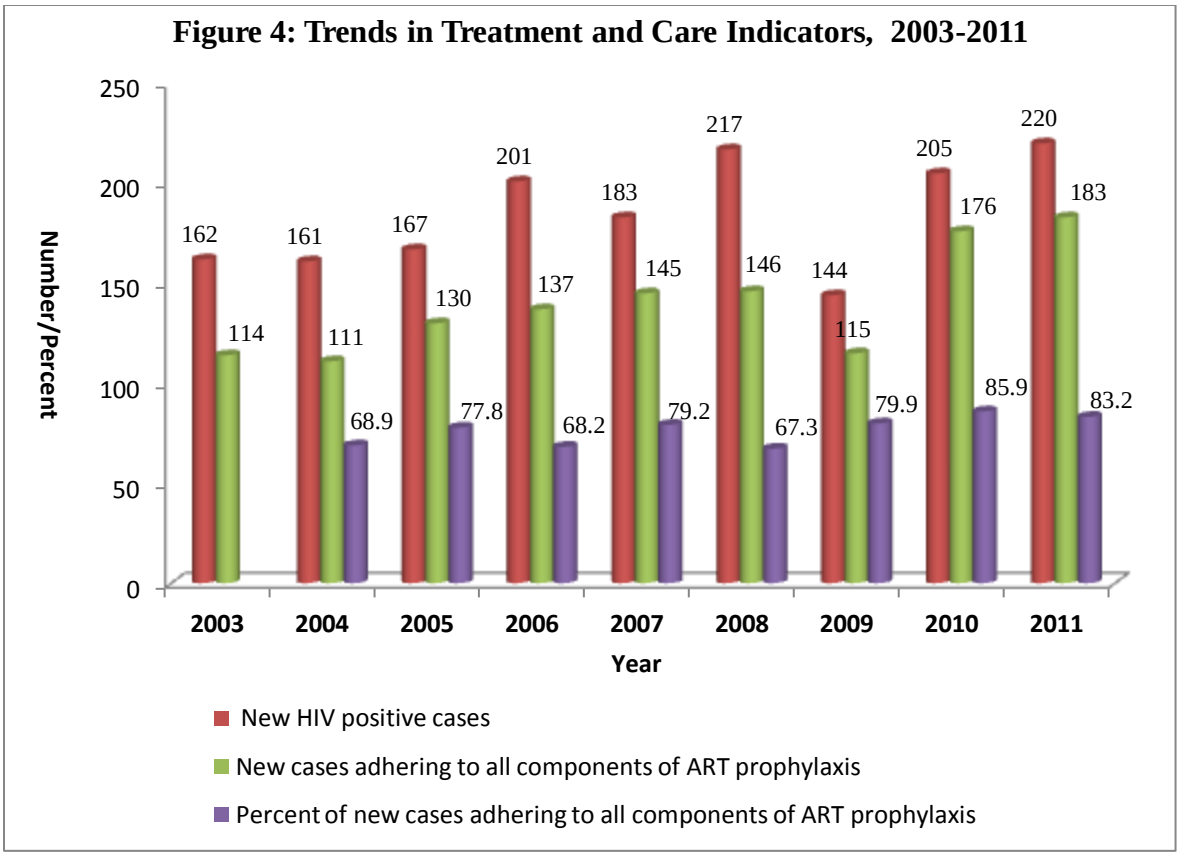
Policy environment

During 2010 major policies were finalized and approved: the Prevention of Mother to Child Transmission Policy, the Post Exposure Prophylaxis Policy and the Health Sector HIV Workplace Policy. The PMTCT was initiated to address and capitalize on evidence showing that transmission of HIV from an infected mother to her child can be reduced by 51%-66% with the introduction of antiretroviral medication during pregnancy. The Post Exposure Prophylaxis Policy is concerned with issues of occupational and non-

occupational exposure to HIV infection. The Health Sector HIV Workplace Policy is based on the national Workplace Policy and is aimed at reducing the spread of HIV and manage its impact on the health workforce including the care and support of health care workers living with HIV. The National Workplace Policy on HIV/AIDS was rolled out in 2010 by the Ministry of Labour, Small and Microenterprises Development and is designed to bring equity and fairness into the workplace for workers living with HIV/AIDS. The national workplace policy is founded on International Labour Organization standards and provides guidelines and principles inter alia that protect the worker from discrimination and harassment; encourage longevity, wellness and well-being; offer education and awareness of workplace exposure and prevention; ensure testing does not affect job security, advancement and promotion; advise on confidentiality issues; foster culturally sensitive dialogue and gender appropriate responses and offer care, resources and support to families.

Treatment, care and support

One of the overarching goals of the National Strategic Plan is to mitigate the negative impact of the HIV and AIDS on persons infected and affected in Trinidad and Tobago. Currently there are seven treatment sites with one in each regional health authority. The Cyril Ross Nursery continues to be the largest pediatric institution. In 2010-2011 national capacity was improved as laboratory surveillance of all CD4 and viral load equipment and of all HIV rapid tests was implemented. In 2010-2011 seven sites were providing care. Programme monitoring showed that 6452 HIV/AIDS patients were in treatment and care by the end of December 2011. Programme strengthening resulted in an increase in ARV coverage. From 2008 to 2010 there have been increases in the percentage of new cases adhering to all aspect of ART prophylaxis among pregnant women as observed in Figure 4.



Source: Ministry of Health HIV/AIDS Co-ordinating Unit Report 2011

It is estimated that in 2010, 6270 persons 15 years and over would be in need of ART. This figure is projected to increase to 7880 in 2015. Mothers needing PMTCT is estimated to be 184 in 2015 while 176 children will need ART in 2010 and 243 in 2015.

Treatment and care further expanded in 2010 with the successful implementation of the community based home care project in one county in St. George West. Training was provided for 17 community health care workers and 15 clients were accepted into the pilot. There were no HIV cases in the pilot and the pilot never progressed to a programme. Capacity to provide enhanced care, treatment and support was further strengthened in 2010-2011 as training sessions locally and abroad were undertaken in ART, palliative care, counseling and testing, policy analysis, systems strengthening.

Knowledge and behavior change, 2006 and 2011

The Multiple Indicator Cluster Survey (MICS) is a nationally representative survey which captures information on the situation of women and children and is used to monitor goals and targets emanating from recent international agreements such as the Millennium Declaration. The 2006 and 2011 MICS were only conducted among women and hence do not include men. The impact of several prevention interventions can be gauged from behavioural change and attitudinal indicators as evidenced from the 2006 and 2011 MICS. For example, there were moderate changes in knowledge of HIV prevention from 2006 and 2011 as evidenced in the Table 3. HIV testing improved moderately. There is clearly need for greater condom use especially in high risk sex situations. Only about one third of women with concurrent partners in the last 12 months used a condom at their last sex.

Table 3: Knowledge of HIV prevention and behaviour indicators among women, 2006 and 2011.

Knowledge of HIV prevention indicators	2006	2011	Source
Percentage of women 15-49 who know HIV can be prevented by having one faithful uninfected partner	90.8	92.4	2006 Final MICS Report and 2011 MICS Survey provisional results
Percentage of women 15-49 who know transmission can be prevented by using a condom every time	83.8	86.5	
Percentage of women 15-49 who know transmission can be prevented by abstaining	89.5	92.4	
Percentage of women 15-49 who knows a health looking person can be infected	96.2	97.3	
Percentage of women who know HIV can be transmitted during pregnancy	87.9	82.9	
Percentage of women who know HIV can be transmitted at delivery	67.1	69.8	
Percentage of women who know HIV can be transmitted through breast milk	68.3	73.2	
Percent of young women 15-24 years who ever had sex	46.9	53.1	
Percent of women 15-49 who have ever been tested for HIV	41.3	57.4	
Percent of women 15-49 who have had more than one sexual partner in the past 12 months and who report use of condoms during their last intercourse.		33.3	

In terms of less discriminatory attitudes towards persons living with HIV/AIDS among women aged 15-49 years old indicators showed mixed findings. A higher proportion of women would buy fresh vegetables from someone with HIV however a higher proportion would want the HIV positive status of a family member to remain secret. The high levels of HIV testing in the survey of women is also supported by expanded accessing of testing of women and men in the general population. Over 90% of the women who had been tested in the last 12 months, received their results. However one caveat is that persons receiving negative test results in the last year could have become infected since that time.

Table 4: Attitudes towards persons living with HIV/AIDS, 2006 and 2011

Attitude towards persons living with HIV/AIDS indicators	**2006**	**2011**	**Source**
Percentage of women 15-49 who would not care for family member who was sick with AIDS	5.2	5.7	2006 Final MICS Report and 2011 MICS Survey provisional results
Percentage of women 15-49 who would want family member HIV status to be kept a secret	37.5	42.7	
Percentage of women 15-49 who would not buy fresh vegetables from a person with HIV/AIDS	37.3	24.1	

IV. Best practices

During the reporting period there has been significant improvements in treatment prophylaxis and zero transmission of cases in 2010 (though not sustained) reflecting improvements in service delivery, coordination and record keeping for surveillance, monitoring and evaluation of cases. For 2010 there was improved national reporting for one county which represents a new best practice. In the absence of a PMTCT Coordinator, the County Surveillance Nurse has been able to successfully integrate the surveillance of the PMTCT programme into the county surveillance for other health activities while the District Health Managers have integrated the service delivery of the PMTCT programme with the Maternal and Child Health programme. As the current cohort of PMTCT Co-ordinators is under attrition, there is immense scope for this best practice to be replicated in other counties.

Another best practice was the establishment of the national HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC) which has the role of implementing the national HIV workplace policy. The objectives of the HASC are achieved through working with enterprises and workers in various sectors including pharmaceuticals, tourism, trade union, transportation, and tertiary education sector and engaging the private and informal sectors. The development of a National HIV/AIDS Advocacy and Sustainability Centre is viewed as a best practice because it is nation specific, appropriate and depicted government's commitment to addressing the epidemic, is in keeping with country needs, resources and superstructure. However it is recommended that countries clearly recognize that in order for such an organization to be successful the following should be considered:

i. HASC-like organizations although coming out of a government policy should be carefully thought out with regards to the restrictions this organization may encounter by nature of its placement in Government Ministries. e.g bureaucratic processes, restrictive policies and procedures. These include and are not limited to sharing of and the prioritizing of funds allotted to the host Ministry and autonomy to make decisions free from political agendas.
ii. The staffing of similar centers or units should be carefully thought out with specific reference to the required skills set and competences of staff
iii. A clear mandate and plan for sustainability is necessary (i.e. what the organization plans to achieve, how it is going to achieve it, identification of key partners, allocation for capacity building and support for and dissemination of research and research findings.)
iv. The Centre or Unit along with the policy needs to be strategically marketed similarly to the way in which Health and Safety Organizations have been established, as it is enshrined as a *go to* organization for assistance and guidance.

Perhaps the most important need and recommendation at the National level is the passing of the necessary legislation in support of a National Policy of this nature. Many of the organizational workplace HIV and AIDS policies developed in the private sector were initiatives of an external body. In the case of Trinidad and Tobago, the Centre was born out of the ILO/USDOL Workplace Education Programme which resulted in a number of companies developing workplace policies. Bearing this in mind, countries should not be afraid to utilize international assistance as a means to get the project off the ground. However, they must be mindful to build their own capacity in the process so as to facilitate continuity. Once this capacity is established, the center would be able to extend its services and develop programmes, at the same standard with a goal to produce similar if not better results, thereby engaging more private sector organizations and the production of successful organizational policies.

V. Major challenges and remedial actions

The end of the NACC in March 2011 and with it the departure of management and technical staff proved to be a major challenge during the reporting period. However in order to reduce the impact of this closure, the national response was spearheaded by the Ministry of Health and the Tobago HIV/AIDS Co-ordinating Committee. The government is working to establish an interim co-ordinating agency until the autonomous statutory body is established. The draft NSP should be finalized in 2012. There is also need for enhanced social and economic support for persons living with HIV/AIDS. Other major challenges include the need to strengthen the capacity of civil society to assist in high impact interventions especially of MARPs. The Ministry of Health and other partners have provided training for civil society organizations in STI and HIV testing, stigma and discrimination. With the closure of the NACC one of the principal challenges to civil society groups has been the decrease in support and funding for programmes in prevention, care, advocacy and testing. The work of civil society with MARPs cannot be overemphasized. The draft national strategic plan 2011-2016 recognizes the critical role of civil society in the response to HIV in this country and makes provision for supporting the work of civil society. There is also need for further research on the size, HIV prevalence, knowledge, attitudes and behavior risk factors of MARPs in order to facilitate evidence based information products, services and interventions for these groups.

VI. Support from the country's development partners

Development partners continued to play a major role in the multi-sectoral response to HIV. During the reporting period the government received financial, technical and other support from a number of partners. These include: the President's Emergency Programme for AIDS Relief (PEPFAR), the World Bank, UNAIDS, UNDP, Pan Caribbean Partnership (PANCAP), Clinton Foundation, PAHO/WHO. Development partners assisted in strengthening pharmacy and lab capacity, inventory management, integration of TB and HIV, initiative to eliminate mother to child transmission of congenital syphilis, enhanced monitoring and evaluation and surveillance through early warning indicators and IT based surveillance systems and workshops for civil society and most at risk populations and outcome evaluations. A health systems evaluation was also conducted with the assistance of PAHO. The country also benefitted from a further extension of a World Bank loan until 2010.

VII. Monitoring and evaluation environment

Prior to its closure the NACC did not establish an M&E unit and a national system for monitoring and evaluation is not yet in place. However a unit for monitoring and evaluation and surveillance is expected to be part of the interim HIV co-ordinating agency which is expected to be established in 2012. Despite the non- existence of a national M&E system, this function was implemented through the Ministry of Health and with the assistance of governmental and civil society organizations.