UNGASS COUNTRY PROGRESS REPORT

Trinidad and Tobago

Reporting period: January 2008–December 2009

Submission date: March 31, 2010

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Acknowledgements

The National AIDS Coordinating Committee (NACC) wishes to acknowledge various development partners, stakeholders and individual consultants who took part in developing the Trinidad and Tobago United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report.

Several civil society organizations (CSOs) provided critical inputs in the development of this report.

The NACC would like to acknowledge:

- The United Nations (UN) Joint Team on AIDS (UNJTA) and Office of the Prime Minister (OPM) support through workshops for civil society and most-at-risk populations as well as the stakeholders' meeting during the preparation of the report to validate the data collected, build consensus and agree on the major challenges that constrain the implementation of the National HIV/AIDS Strategic Plan.

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- CSOs including, Non Government Organisations (NGOs), Faith-Based Organizations (FBOs), People Living with HIV (PLHIV) working with most-at-risk population groups are thanked for having taken part in the development of the Trinidad and Tobago 2010 UNGASS report. They helped identify gaps, limitations and constraints, best practices, the support needed from the development partners, major challenges and remedial actions that need to be undertaken in the country to improve the national response to HIV and AIDS. The NACC also wishes to express its gratitude to the many organizations for their continued support for various HIV and AIDS activities in Trinidad and Tobago.
- The following Government ministries:
    - Ministry of Education;
    - Ministry of Sports and Youth Affairs;
    - Ministry of Social Development;
    - Ministry of Health; and

- Ministry of National Security;

are acknowledged for having identified the major challenges met in mainstreaming HIV and AIDS into the public sector.

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- The National AIDS Coordinating Committee would also like to acknowledge the part various consultants played in developing this report.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Clinic
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CSO	Civil Society Organizations
SW	Sex Worker
FBO	Faith Based Organisation
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
KAPB	Knowledge Attitudes Practices and Behaviour
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have Sex with Men
NACC	National AIDS Coordinating Committee
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
NSP	National HIV/AIDS Strategic Plan
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-child Transmission
STI	Sexually Transmitted Infection
THACC	Tobago HIV and AIDS Coordinating Committee
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing

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Status at a glance

Inclusiveness of the stakeholders in the report writing process

In December 2009, the UN Joint Team on AIDS (UNJTA) in Trinidad and Tobago through UNDP, recruited a consultant to support the National AIDS Coordinating Committee (NACC) Secretariat and coordinate the activities and consultancies relating to the preparation of the Trinidad and Tobago report to the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) for the period January 2008 to December 2009.

Report Development Plan and Support

The NACC mobilized resources to collect, compile and validate the relevant data and prepare the reports. The following support was received:

- Data collection and analysis were supported by the NACC and the HIV and AIDS Coordinating Unit of the Ministry of Health (HACU)
- Engagement of civil society organizations (CSOs) and most-at-risk groups was supported by the United Nations Joint Team on AIDS;
- Collection of data on National AIDS spending was supported by the UNAIDS Country Office and the UN Joint Team on AIDS; consultants were appointed to undertake the exercise.
- Report writing, compilation and editing were supported by the OPM; a consultant was hired to undertake the task.

Status of the epidemic

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 20,255[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. Table 1 below provides summary data on new HIV positive cases, new AIDS cases and deaths due to AIDS.

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 and

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

more specifically, the free provision of anti-retrovirals (ARVs) which was initiated in 2002. The period under review also saw the further extension of same day testing at multiple sites throughout Trinidad and Tobago. New infections peaked at 1,709 in 2003, and since then has fluctuated between 1,404 in 2007 to 1,453 in 2005. Up until 2007, new HIV cases among males outstripped new HV 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%. Information on the sex of 127 or 8.88% of the positive cases was not provided. 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. More research is needed to determine whether this reflects the fact that more females are presenting for testing or is indicative of an increase in the incidence of HIV among females. Table 2 below provides data on New HIV positive cases by age and sex for 2008.

Table 1
Cumulative HIV, AIDS Cases and Deaths 1983 – September 2009

	2007	2008	2009[2]	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

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

[2] Figures for 2009 are for the period January 1 to September 30.

All Ages	609	694	127	1430

During 2009, several research studies and assessments were conducted in Trinidad and Tobago which facilitated a better understanding of the social and behaviour challenges and concerns impacting on the HIV epidemic in Trinidad and Tobago. In addition to reviewing the general population, some of the most-at-risk populations particularly men who have sex with men (MSM), transactional sex workers and youth were studied. Historically, information on these groups has been non-existent making it difficult to design appropriate impactful interventions that are specific to these groups.

Policy and Programmatic Response

The Trinidad and Tobago HIV and AIDS National Strategic Plan 2004-2008/10 is evidence based and enjoys broad ownership. Implementation delays primarily as a result of the depletion of management and staff of the National AIDS Coordinating Committee (NACC) Secretariat and delays in the recruitment of replacement staff, combined with limited civil society capacity and the reduction of funding for the NSP by the Government of Trinidad and Tobago warranted an extension of the plan implementation period to September 2010. During the two year period under review, the United Nations Joint Team on HIV and AIDS provided technical support to the NACC in addition to facilitating the inclusion of key stakeholders from civil society. These include people living with HIV and AIDS and the most-at-risk, the government, civil society, the faith-based community, the private sector and development partners.

Two major policies were finalized, approved and disseminated between 2008 and 2009. These are the Trinidad and Tobago Workplace Policy which was developed out of the International Labour Organization's workplace project and in close collaboration with the Ministry of Labour and Small and Micro Enterprise Development with inputs from the full range of stakeholders; and the HIV and AIDS Counselling and Testing Policy.

The programmatic focus has been to expand prevention (particularly testing), care and treatment and target communities and at-risk groups to ensure that HIV and AIDS interventions are effective.

In addition to the resources provided by the Government of Trinidad and Tobago, the European Commission, the World Bank and the United Nations Joint Team on AIDS provided resources to support the implementation of the NSP.

There was an attempt to observe the three ones principle and some progress was made. The main stumbling block has been the finalization and implementation of the monitoring and evaluation framework.

UNGASS INDICATOR DATA

UNGASS Core Indicators	Sub-population	2008				2009				Comments/Explanation
		Source	Numerator	Denominator	%	Source	Numerator	Denominator	%	
1. Domestic and international AIDS spending by categories and financing sources										
2. National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)										See Annex 2.
3. Percentage of donated blood units screened for HIV in a quality assured manner		National Blood Bank	21,500	21,500	100%	National Blood Blank	22,239	22,239	100%	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Males	Facility Based Reporting System	1071			Faculty based Reporting System	1256			
	Females		1083				1372			
	<15									
	15+		2318	4477	51.78%		2639	5198	50.77%	
5. Percentage of HIV-positive women who received anti-	Females 15-49	Ministry of Health PMTCT Reports	146	217	67.3%	Ministry of Health PMTCT Reports	74	135	54.81%	Data obtained from the 2008 Annual Report on the PMTCT Programme

UNGASS Core Indicators	Sub-population	2008				2009				Comments/Explanation
		Source	Numerator	Denominator	%	Source	Numerator	Denominator	%	
retrovirals to reduce the risk of mother-to child transmission										2008
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	TB patients	Ministry of Health TB Yearly Report 2008	36	73	49.31%	Ministry of Health TB Report 2009	6	95	6.32%	
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Female 15-49									Data is not available
	Male 15-49									
8. Percentage of most-at-risk populations that received an HIV test in the last 12 months and who know their results										No new studies were undertaken
9. Percentage of most-at-risk populations reached with HIV prevention programmes										No new studies were undertaken
10. Percentage of orphans and vulnerable children whose households received free basic external support in										A two-year supply of milk is provide to all babies born to HIV positive women.

UNGASS Core Indicators	Sub-population	2008				2009				Comments/Explanation
		Source	Numerator	Denominator	%	Source	Numerator	Denominator	%	
caring for the child										
11. Percentage of schools that provided life skills-based HIV education within the last academic year										Data is not available
12. Current school attendance among orphans and among non-orphans aged 10-14										Data is not available
13. Percentage of young women and men aged 15-24 who are able to correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission										2006 Baseline data provided by the KAPB Study reported on in the previous report, a new study is to be undertaken during the next reporting period.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission										Data is not available
15. Percentage of young										2006 Baseline data

UNGASS Core Indicators	Sub-population	2008				2009				Comments/Explanation
		Source	Numerator	Denominator	%	Source	Numerator	Denominator	%	
women and men aged 15-24 who have had sexual intercourse before the age of 15										provided by the KAPB Study reported on in the previous report, a new study is to be undertaken during the next reporting period.
16. Percentage of young women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months										2006 Baseline data provided by the KAPB Study reported on in the previous report, a new study is to be undertaken during the next reporting period.
17. Percentage of adults who had more than one sexual partner in the past 12 months and who report the use of condom during their last intercourse										2006 Baseline data provided by the KAPB Study reported on in the previous report, a new study is to be undertaken during the next reporting period.
18. Percentage of male and female sex workers reporting the use of a condom with their most recent client										No Study undertaken.
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner										Study undertaken in 2004 no recent study undertaken.
20. Percentage of										Not relevant

UNGASS Core Indicators	Sub-population	2008				2009				Comments/Explanation
		Source	Numerator	Denominator	%	Source	Numerator	Denominator	%	
injecting drug users who reported the use of a condom at last sexual intercourse										
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected										Not relevant
22. Percentage of young women and men aged 15-24 who are HIV infected		Ministry of Health, HACU	73							Unable to disaggregate data for denominator
23. Percentage of most-at-risk populations who are HIV infected										No recent studies have been undertaken
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	15+	Facility Reports	263	364	72.25%	Facility Reports	229	296	77.36%	
	<15		27				26			
25. Percentage of infants born to HIV-infected mothers who are infected.		Annual Report on the PMTCT Programme for 2008	7	98	7.1%					

Overview of the HIV epidemic

Overall prevalence rates are increasing for HIV. 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. Based on a forecasting exercise completed in July 2009 using a CD4 count threshold of less than 200, the prevalence rate is projected to increase to just under2% by 2015[3]. One of the main reasons for this increase in prevalence is the increased survival rate of many PLHIV who have been accessing the free anti-retroviral therapy made available by the Government of Trinidad and Tobago since 2002. Mortality rates are declining and fell from 113 in 2006 to 81 at the end of 2008. At the end of the third quarter of 2009, 37 deaths had been recorded for 2009, compared to 42 for the similar period in 2007.

Rapid testing and voluntary counseling and testing (VCT) are more widely available with same visit/rapid result services being offered at 28 sites, with three sites affiliated to an NGO and one site based at a tertiary level institution. A total of 15,685 tests were conducted at rapid result sites in 2009, with 295 HIV positive cases identified and a positivity rate of 1.9%. Some 140 or 47.5% of the HIV positive cases were male and 155 or 52.5% were female. The national HIV Testing and Counselling Policy was approved in 2009 and has been widely disseminated. A greater proportion of Trinidadians and Tobagonians now know their status but there are still large numbers of persons who do not know their status and among them are persons who indulge in risky behaviours.

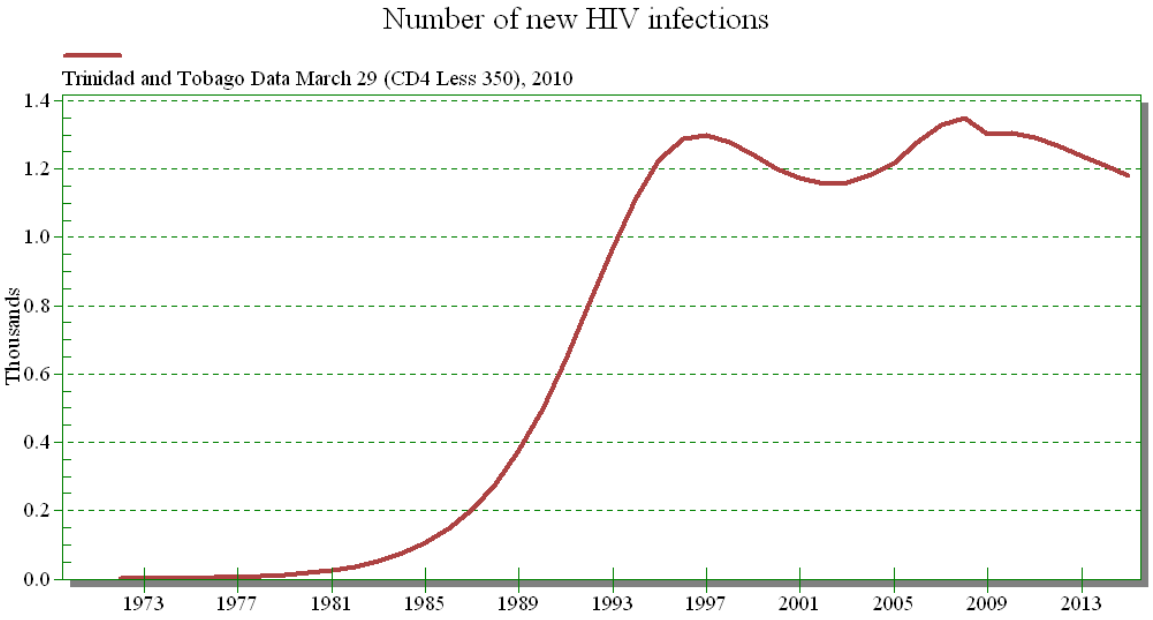
The scale-up of ART is continuing, but treatment services remain centralized at seven locations with the Medical Research Foundation being the main service provider. By the end of 2009, some 3,592 person were on ART. Some 3,425 or 95.35% of those on ART were adults while 167 or 4.65% were children. The number of persons requiring ART is projected to increase to 4,500 by 2015.

There are many challenges to providing care, treatment and support services to HIV positive patients. Many doctors remain reluctant to treat AIDS patients and several persons only present themselves for treatment when they have already developed full-blown AIDS. The major differences in the risk of infection faced by different population groups have been acknowledged and will inform future programmes. Young women between the ages of 20 to 29 are at very high risk. The negative partner in a discordant relationship is at particular risk. High-risk social groups such as sex workers, men who have sex with men have not received sufficient attention in programming, treatment and care. Targeting of these groups should improve as the various stakeholders utilize the assessments and studies conducted in 2009 and other earlier studies to design and roll out customized programmes.

[3] HIV prevalence estimates have been computed by the NACC Secretariat using surveillance data obtained from testing among pregnant women aged 15-49 and the Spectrum Model made available by UNAIDS.

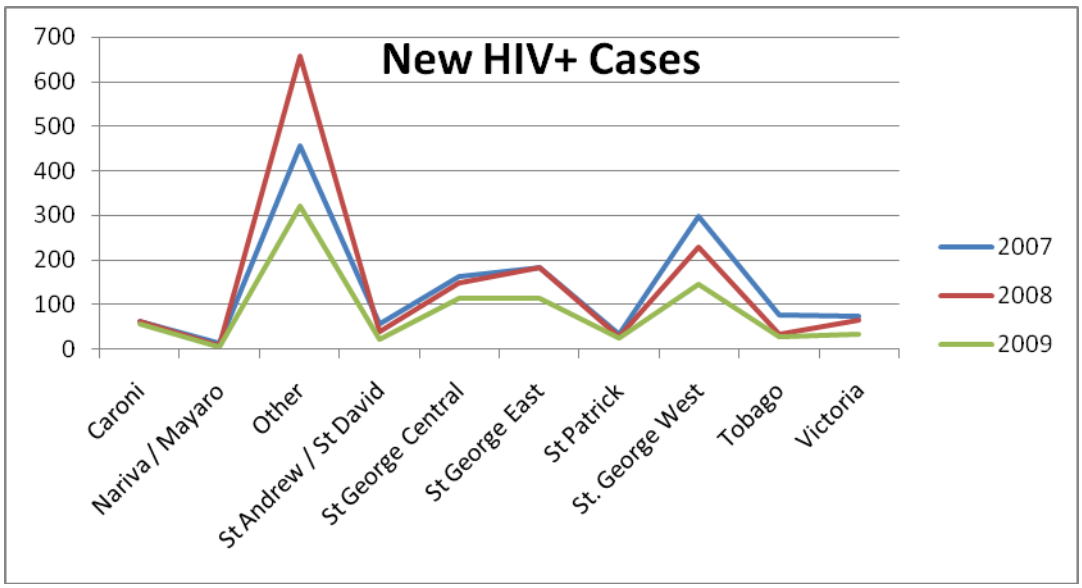
Trends in Prevalence

Projections of new HIV positive cases were calculated using Spectrum which put the number of new cases in 2013 at 1,240. This is lower than the 1,448 new cases reported through the Trinidad Public Health Laboratory in 2008.



HIV and AIDS Morbidity and Mortality

A review of the data on new HIV positive cases by county indicates that many persons who present for testing are not providing information on their place of residence or that the information is not being properly recorded. This has resulted in the majority of new cases being allocated to the other category. On the other hand, the majority of new AIDS cases were reported in St. George West. It must be noted that the county of St. George is the most densely populated county in the country.



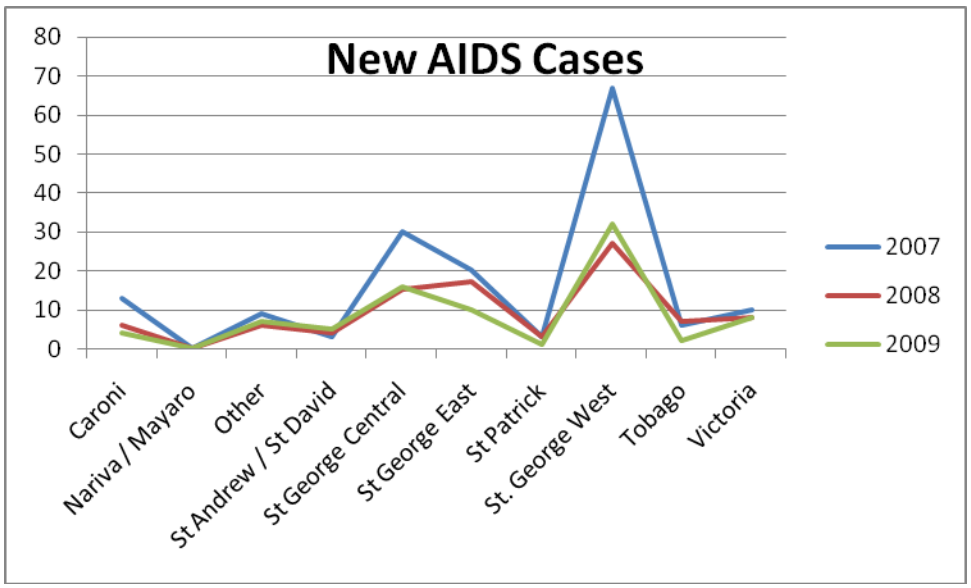


Table 3 below provides data on deaths due to AIDS by geographic location. The highest number of deaths were recorded in St. George West.

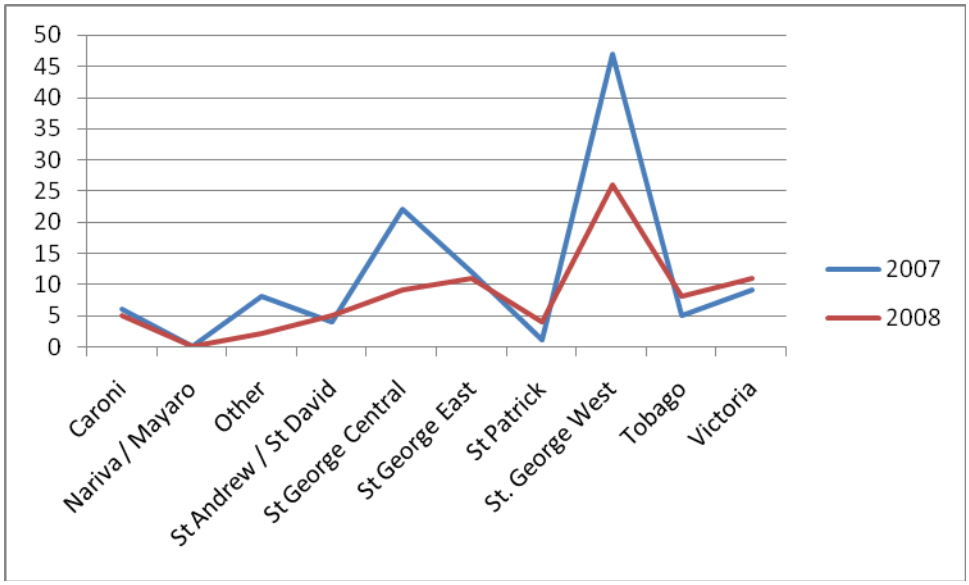
Table 3

AIDS Deaths Reported by County/Health Administrative Districts 2007-2009

County	2007	2008	2009*
St. George West	47	26	15
St. George Central	22	9	9
St. George East	12	11	2
Caroni	6	5	1
St. Andrew/St. David	4	5	3
Nariva/Mayaro	0	0	0
St. Patrick	1	4	0
Victoria	9	11	5
Tobago	5	8	1
Not Stated	8	2	1
All Counties	114	81	37

***Data for January to September 2009.**

AIDS Deaths by Health Administrative District



Tuberculosis (TB) and HIV

Tuberculosis (TB) is one of the most common AIDS co-infections. HIV testing for TB patients is a critical entry point to interventions for both treatment and prevention. There was a substantial increase in the provision of HIV testing between 2005 and 2009, with reported numbers of HIV Positive cases increasing from 26.82% in 2005 to 30% in 2007. A decline to 22.96% in the number of HIV positive cases was observed in 2008 but the percentage of HIV positive cases increased again to 29.32% in 2009. See Table 4 Below.

Table 4

TB/HIV Co-infections 2005-2009

Year	2005	2006	2007	2008	2009
Total Reg. Cases	179	253	260	322	324
Total TB/HIV	48	73	78	73	95
Percentage	26.82%	28.85%	30%	22.96%	29.32%
TB/HIV Deaths	21	22	26	13	22
Percentage	43.75%	30.14%	33.33%	17.81%	23.16%

TB/HIV deaths showed a steady decrease from 43.75% (2005) to 17.81% (2008), increasing slightly to 23.16% (2009). The data suggests that the expanded testing has facilitated earlier detection and treatment of HIV positive TB patients. There appears to be a correlation with the high testing rate achieved and the reduced number of deaths to TB/HIV.

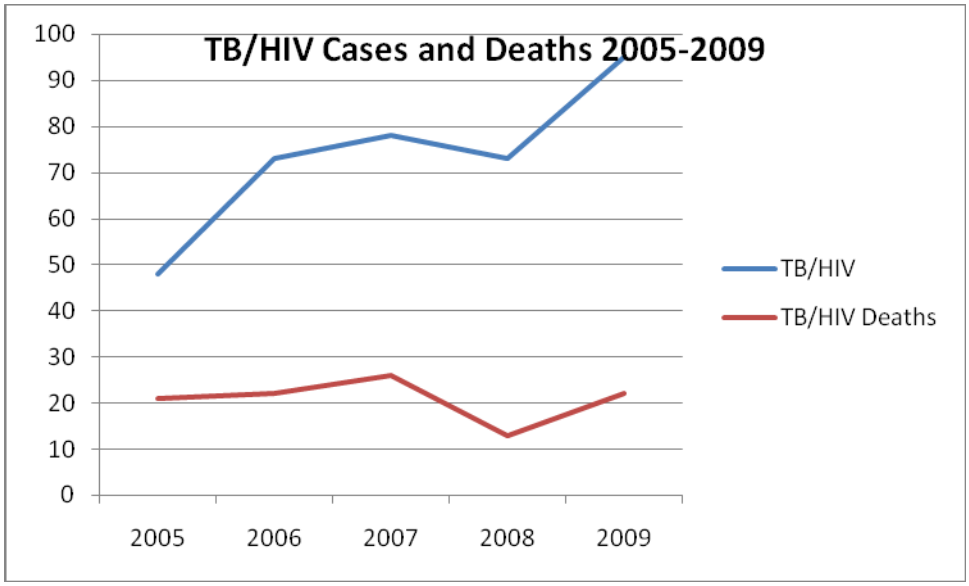
A major reason for promoting HIV testing in TB patients is to facilitate provision of CPT (Co-trimoxazole Preventative Therapy) and ART (Anti Retroviral Therapy) to HIV Positive patients. The benefits of testing can be seen in the high proportion of TB patients testing positive for HIV who were treated with CPT and ART.

There were 322 registered cases of tuberculosis (TB) reported in 2008. Some 318 or 98.76% of persons with TB were tested for HIV and 73 persons or 22.96% of those tested were determined to be HIV positive. Some 76.71% of the TB/HIV positive cases were new cases. Ten persons were treated with co-trimoxazole only, while 36 persons were given anti-retrovirals (ARV) and co-trimoxazole.

For the year 2009, of the 324 registered cases of TB, 306 (94.44%) cases had their HIV status ascertained, and of the 306 cases there were 95 (31.05%) HIV Positive cases.

Of the 95 positive cases 70 (73.68%) were new cases with HIV. Also of the 95 HIV positive cases 13 (13.68%) were given Co-trimoxazole only and 6 (6.32%) were given ARV + Co-trimoxazole. There were 22 (23.16%) TB/HIV deaths.

For the year 2009 there was no registered case of Multi Drug Resistant TB. Of the 324 registered cases there were 34 (10.49%) substance abusers, 9 (2.78%) prisoners/exprisoners, 24 (7.41%) diabetics, 8 (2.47%) homeless and 1 (0.31%) patient with Cancer also with TB.



HIV testing of TB patients is a key component of the HIV treatment and prevention strategy and expanded HIV testing of TB patients since 2005 resulting in reported cases of TB/HIV co-infection increasing from 26.82% (2005) to 30% (2007) in 2007. Though over 98% of TB cases registered in 2008 were tested for HIV, there were only 22.96% were HIV positive.

TB/HIV deaths showed a steady decrease from 43.75% (2005) to 17.81% (2008), an increase in the death rate was observed in 2009. Of the 22 TB/HIV mortality cases in 2009, the age range 45-54 and 25-34 were most affected with 9 (40.91%) and 6 (27.27%) respectively.

Table 5
TB/HIV MORBIDITY BY AGE 2009

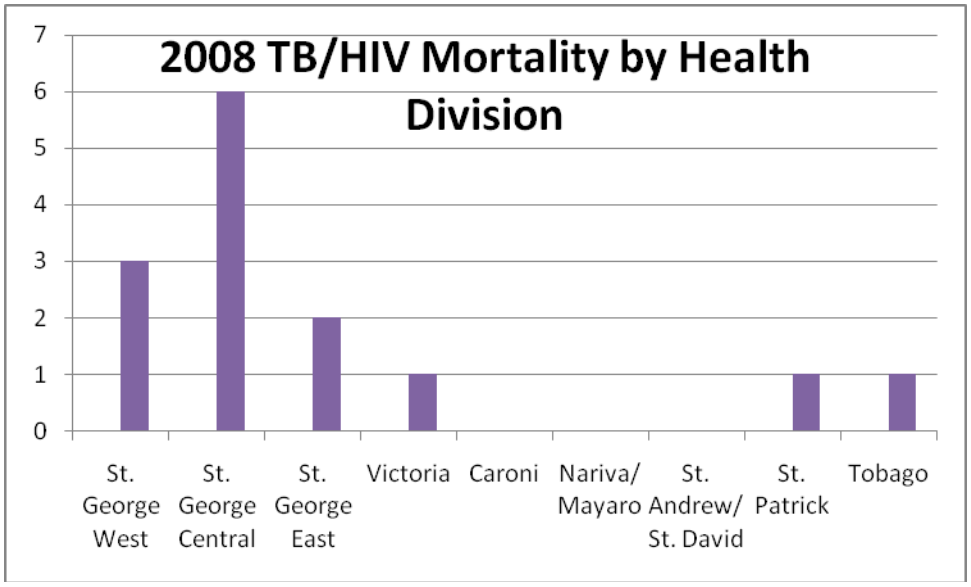
Age	Under 1	1-5	6-14	15-24	25-34	35-44	45-54	55-64	65+	Total
Male	0	0	0	1	14	21	23	5	1	65
Female	0	1	0	6	8	6	6	3	0	30
Total	0	1	0	7	22	27	29	8	1	95
%	0%	1.05%	0%	7.37%	23.16%	28.42%	30.53%	8.42%	1.05%	100%

As was the case with new HIV positive cases reported in 2008, the majority of those with TB who also tested positive for HIV (28.77%) were within the 25-34 age group.

Table 6
TB/HIV MORBIDITY BY GEOGRAPHICAL DISTRIBUTION - 2008

County	St. George West	St. George Central	St. George East	Victoria	Caroni	Nariva/ Mayaro	St. Andrew/ St. David	St. Patrick	Tobago
Male	8	25	4	4	7	0	1	1	2
Female	6	7	4	3	0	0	0	0	1
Total	14	32	8	7	7	0	1	1	3
%	19.18%	43.84%	10.96%	9.59%	9.59%	0%	1.37%	1.37%	4.11%

The incidence of TB/HIV co-infection follows the pattern of HIV/AIDS with the highest number of cases being diagnosed in the County of St. George as can be seen in Table 6 above and the graph below.



HIV prevalence and most-at-risk populations

Previously, Trinidad and Tobago was categorized as a country with a generalized epidemic. This resulted in little or limited attention being given to collecting data on HIV prevalence and behavioural indicators among the most-at-risk groups such as , MSM, homeless people, substance abusers, CSWs and youth. The National HIV and AIDS Strategic Plan (NSP) identifies the most-at-risk groups as: women, youth, children, prisoners, migrants, sex workers, MSM and low income earners and their dependents. The limited data available indicate that the high prevalence in some of these groups may be indicative of both a generalized and concentrated epidemic pattern. The NACC and the THACC have commissioned a few studies and assessments to enable a better understanding of the pattern of the epidemic and which will

inform programming and the new HIV and AIDS strategic plan. A list of the main studies, objectives and area of focus is presented in the table below.

Table 7
NACC and THACC Supported Studies on Most-at-risk Groups

Name of Study	Focus	Objectives	Key Findings
1. Research on Risk Factors of Key Populations for Contracting HIV and other STIs	MSM; Sex Workers; Homeless or socially Displaced populations; Substance Users; Youth	To investigate the sexual behaviour, belief and practices of the identified populations	• The groups investigated were familiar with the prevention messages featuring local celebrities which form part of the NACC's HIV prevention campaign • While the groups had general knowledge about how HIV is transmitted, some still had their own ideas and prevention practices; • The majority of persons interviewed were not practicing safe sex and were indulging in risky behaviour; • Substance users and homeless populations engage in sex work to finance their addiction or in the case of the homeless to earn income • A strong correlation was observed between substance use, economic needs and the consequential adoption of risky sexual behaviours and lifestyles. • Prevention and care programmes will have to address the psycho-social needs of these groups many of whom also fall prey to violence, stigma and

			discrimination and other abuse. • In addition, policies and programmes need to tackle some of the structural and cultural issues.
2. HIV and AIDS Social and Behaviour Mapping in East and Wes Tobago	Cross section of Community Members	To investigate the perceptions and attitudes relating to sex, sexuality and HIV and AIDS	• Main agents of socialization and education about sex and sexuality for men are their peer groups particularly the men who “Lime” on the block; • Young women obtain their information about sex and sexuality from young men, schools and community resources; • Respondents reported widespread sexual activity among the young and early sexual debut; • Religion and established churches were identified as powerful agents within communities and dictators of norms and values. • Many respondents were knowledgeable about transmission and prevention but many also harbored misconceptions • Economic realities and gender vulnerability were strong determinants of risks to HIV. • Male condoms were more widely available as well as cheaper;

			• General feeling that public testing sites did not afford confidentiality and there was greater confidence in private testing sites.
3. HIV and AIDS Baseline Risk and Needs Assessment of MSM, MSM, Sex Workers and MSM Sub-populations in Tobago	MSM	To develop a profile of MSM and conduct a risk and needs assessment relating to HIV transmission and prevention, drug use and sexual behaviour.	• Respondents were weary of and reluctant to be labeled; • Sexual identity and status of those surveyed were varied – straight homosexual, MSM who are dating married or living with female partners, single and willing to connect with whoever; • Knowledge of HIV transmission was relatively poor and though there was awareness about the use of condoms to prevent transmission, condoms were not consistently used
4. Assessment of Tobago's Culture as a Critical Component in HIV Prevention	General influence of culture	To assess the cultural diversity of Tobago, its general characteristics, unique and distinct features with emphasis on the socioeconomic environment, gender relations, childrearing, religious practices and geographic influences, its potential and practical impact on HIV prevention	• Local culture influences responses to health seeking behaviours and health care and thus must be considered in designing appropriate prevention and education programmes.

National response to the HIV and AIDS epidemic

Leadership and Coordination

Situation and Response Analyses were conducted in Tobago in 1999 and in Trinidad in 2001. The findings of these assessments informed the Trinidad and Tobago National HIV/AIDS Strategic Plan 2004-2008 which guides the national response to date. Capacity constraints and overly optimistic implementation schedules have resulted in slow implementation. As a result the period for implementation of the plan has been extended to September 2010.

During the period under review the Secretariat was impacted by changes to its management which left the secretariat without the services of a director for several months at critical stages of its operations. At present the Secretariat is functioning without the services of a Monitoring and Evaluation Officer and a Strategic Planning Officer and this has required existing staff to provide ad hoc support to these areas. Vacant positions also exist in the THACC Secretariat.

Efforts to mainstream HIV and AIDS into the delivery of public sector services have continued and there are currently six HIV and AIDS Coordinators in place at the following ministries:

- Health;
- National Security;
- Sport and Youth Affairs;
- Education;
- Social Development;
- Labour and Small and Micro Enterprise Development;

These positions are currently financed by the respective ministries and these officers continue to play a pivotal role in sensitizing the staff of their respective ministries and advocating for the inclusion of or consideration of HIV and AIDS related issues in various ministry and department policies.

The total national HIV budget for 2009 was TT$39.2 million of which CSO funding totaled TT$1.32 million or 3.38%.

The current NSP 2004–2008/10 identifies the priorities and strategies in responding to the HIV and AIDS epidemic as follows:

Table 8
NSP Priorities and Strategies

Priority Areas	Strategies
Prevention	• Heighten HIV/AIDS education and awareness • Improve the availability and accessibility of condoms. • Extend the responsibility for the prevention of HIV to all sectors of government and civil society. • Introduce behaviour change intervention programmes targeted to young females. • Introduce behaviour change interventions targeted to youths in and out of school. • Support behaviour change programmes targeted to MSM. • Implement a nationwide MTCT programme. • Develop a comprehensive national VCT programme. • Promotion of VCT services. • Ensure the availability of adequate post exposure services. • Increase knowledge and awareness of the symptoms of STIs • Ensure effective syndromic management of STIs. • Provide"youth friendly" sexual and reproductive health services.
Treatment, Care and Support	• Implement a national system for the clinical management and treatment of HIV/AIDS • Improve access to medication, treatment and care for persons with opportunistic infections. • Provide appropriate economic and social support to the PLHIV and to the affected.
Advocacy and Human Rights	• Promote openness and acceptance of PLHIV in the workplace and in the wider community. • Creation of a legal framework that protects the rights of the PLHIV and other groups affected by HIV/AIDS. • Monitor human rights abuses and implement avenues for redress. • Mobilize opinion leaders on HIV/AIDS and related human rights issues.
Surveillance and Research	• Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. • Conduct effective epidemiological research and clinical trials
Programme Management, Coordination and Evaluation	• Develop an appropriate management structure for the national expanded response. • Gain wide support for the NSP. • Mobilize adequate and sustained resources to support implementation of the NSP • Monitor the implementation of policies and programmes as outlined

	in the NSP. • Strengthen the key constituents of NACC. • Strengthen support groups for PLWHIV to better respond to the epidemic and increase the number of these support groups.

Despite several challenges, Trinidad and Tobago has enjoyed considerable progress since the last reporting period with regard to the expansion of testing and counseling services and the expansions of treatment and care service and delivery sites. Overall prevalence rates have increased steadily but this may be attributable to a falling off in the number of deaths due to AIDS related diseases mainly as a result of the availability of free ARVs. Notwithstanding, there is room for improvement particularly with regard to patient follow up. VCT is more widely available and a greater proportion Trinidadians and Tobagonians know their status. The scale-up of ART is occurring slowly and must be accompanied by supervision to ensure that the protocols and standards established, approved and disseminated during the period under review are adhered to.

With regard to adherence to the prescribed treatment regime by children on ARVs, an adherence counselor has been provided for the out-patients of the Cyril Ross Pediatric Treatment site.
Even so, enormous challenges lie ahead.

Trinidad and Tobago operates on the '**Three Ones'** principle agreed by Caribbean Community Countries:
• One national AIDS coordinating authority with a broad-based multi-sectoral mandate
• One AIDS action framework to coordinate the work of all partners
• One national monitoring and evaluation system

One national AIDS coordinating authority
Since 2003 the NACC has operated under of the Office of the Prime Minister. The NACC is comprised of representatives from the public and private sectors, civil society, the PLHIV community, academic institutions and the donor community. The NACC is supported by a secretariat which is located in the Office of the Prime Minister, which focuses on policy formulation, programme management, coordination, finance and monitoring and evaluation. With respect to Tobago, the organisational structure for the expanded response gives recognition to the power conferred on the Tobago House of Assembly (THA). The Tobago HIV/AIDS response operates under the auspicies of the Office of the Chief Secretary Tobago House of Assembly (THA). A Tobago HIV/AIDS Coordinating Committee (THACC) was established in Tobago and its membership includes participation from the public and private sectors, civil society and PLHIV community. THACC is represented on the NACC. As is the case in Trinidad the THACC is supported by a Secretariat.

The NACC and THACC in the case of Tobago coordinates all programmes, policy and interventions in the AIDS sector which are funded by the national government and international donor community and during the period under review coordinated the programmes funded by the World Bank, the European Commission and the UN Joint Team on HIV and AIDS.

In 2008 The THACC disbursed EU funds to community-based organizations (CBOs) for prevention and mitigation interventions as part of the prevention programme in Tobago.

The Civil Society Perspective
On a scale of 0 to 10 with regard to the inclusion of CSOs in AIDS policy, planning and programming (with one being the lowest ranking and 10 the highest) CSOs in Trinidad and Tobago rated their level of inclusion as "2" and "3" respectively. This seems to suggest that CSOs believe overall that they are not well represented in the sector dealing with AIDS and they have not been afforded the opportunity to make a meaningful contribution to political commitment and policy formulation. The responses received from CSO representatives also suggests that those questioned felt that they were excluded from the government's budgetary and planning processes.

One AIDS Action Framework to Coordinate the Work of All Partners

The NSP 2004–2008/10 has its genesis in the situation and response analyses conducted in Trinidad and Tobago in 2001 and 1999 respectively. It is the product of a fairly consultative process. As a result there is a fairly strong sense of ownership among government, civil society, UN agencies, development organizations and the corporate sector. A process of joint review of the current plan will help to further consolidate gains and promote a strong sense of ownership of the next NSP. The institutional arrangements for implementing the NSP 2004–2010 reflect its multi-sectoral nature. No single agency has overall responsibility for implementation. It is therefore critical to have strong coordination mechanisms so that stakeholders can achieve the established targets and objectives. The national coordination of NSP 2004- 2010 is one of NACC's core functions. However a review of the various reports suggests that the NACC has been involved in programme implementation in many areas other than prevention for which it has some implementation responsibility. This suggests that some of the partners do not have the required capacity to deliver the projects and programmes assigned to them and that extensive institutional development and technical support is required so that the NACC remains focused on its coordinating function.

The NSP is founded on four key principles – **Inclusion, Sustainability, Accountability and Respect for Human Rights.**

NSP Organisational Achievements

- Donor agencies committed to national coordination – a good example of this is the UN Joint Team on AIDS joint programme of technical support;
- Collaboration with Regional agencies including the Pan Caribbean Partnership against HIDS, the Caribbean Health Research Council and the Caribbean Coalition of National AIDS Programme Coordinators
- Establishment of the post of HIV and AIDS Coordinator in key government ministries
- Inclusion of civil society and the private sector in service delivery;
- HIV and AIDS linked to poverty reduction and development;

The civil society perspective
For part of the period under review the NACC provided technical support to CBOs through a consultant. UNAIDS also provided support for several capacity building workshops. Notwithstanding, CBO capacity remains weak in many areas. The number of national and

regional fora where the public can share information network and build partnerships declined during the period under review. A National umbrella organization of PLHIV has been created as an advocacy group to ensure that the agreements of the UNGASS Declaration of Commitment on HIV/AIDS are implemented. However, it is underfunded and has limited capacity, which means that their potential has not been realized. The NACC previously utilized the services of a consultant as an officer for civil society engagement and to provide technical support, however this position is currently vacant.

CSOs believe that they are not receiving enough resources to play a significant role in the national response and that this situation was exacerbated in 2009.

There is a Sub-Committee for each of the five priority areas. —Prevention, Treatment Care and Support, Advocacy and Human Rights, Surveillance and Research and Programme Management, Coordination and Evaluation. Sub-Committee membership is drawn from the key implementing agencies in that specific area and from other strategic partners. Subcommittees monitor progress in a general way. Sub Committees help stakeholders to overcome implementation delays and, if necessary, make recommendations for policy action to the NACC.

One national monitoring and evaluation system

NACC is the coordinating authority for Trinidad and Tobago's national HIV and AIDS M&E framework. A review of the M&E Framework was conducted by the World Bank in 2008 but most of the recommendations have not been implemented and the position of M&E Officer at the NACC Secretariat is currently vacant. The purpose of the M&E Framework is to improve the implementation of NSP 2004-2008/10 and to provide evidence-informed data that can contribute to national decision-making and policy development. The NACC, without adequate M&E staff, has been unable to adopt a comprehensive approach to report to donors

Notwithstanding, there has been progress with regard to the implementation and use of Information Technology to enhance the capacity to collect and compile data at the National Surveillance Unit of the Ministry of Health and at the Medical Research Foundation which is the major treatment site. The result has been improvement in the timeliness in collation and the delivery of data from these agencies. Limited progress has been made at the San Fernando General Hospital which is the second largest treatment and care site.

NACC's M&E Unit has not been operationalized and as a result the ongoing compilation of regular reports on the National Blood bank, HIV and AIDS Morbidity and Mortality, TB/HIV Coinfection, Testing and Counselling and Treatment, Care and Support have not been prepared on a regular basis. NACC did not produce annual M&E reports summarizing progress on indicators including trends in national HIV prevalence during the period under review. Monitoring and evaluation during the period remained donor driven and ad hoc. National M&E reports that mark progress in implementing NSP 2004–2008/10 were not compiled.

Monitoring HIV prevalence and impact is done through about 115 antenatal clinics (ANCs) on women making their first visit for their current pregnancy and taking a test for the first time. Population-based household studies such as KAPB 2006 provided information on the

demographic and socio-economic characteristics. Based on the data collected from the ante-natal clinics, the Spectrum Model was used to forecast prevalent rate to 2015 and the demand to ARVs.

Prevention

The NSP 2004-2008/10 strategies for prevention are:

- Heighten HIV/AIDS education and awareness
- Improve the availability and accessibility of condoms.
- Extend the responsibility for the prevention of HIV to all sectors of government and civil society.
- Introduce behaviour change intervention programmes targeted to young females.
- Introduce behaviour change interventions targeted to youth in and out of school.
- Support behaviour change programmes targeted to MSM.
- Implement a nationwide MTCT programme.
- Develop a comprehensive national VCT programme.
- Promotion of VCT services.
- Ensure the availability of adequate post exposure services.
- Increase knowledge and awareness of the symptoms of STIs
- Ensure effective syndromic management of STIs.
- Provide "youth friendly" sexual and reproductive health services.

Information collected from recent studies on most-at-risk groups indicates the need to give more detailed attention the psycho-social needs of the various target audiences in the design of prevention programmes.

During 2009 guidelines for Post Exposure Prophylaxis as a result of medical and non-medical exposure for the Ministry of Health were developed and circulated.

NGOs have played key roles in prevention interventions directed at in school youth and work places. They have also played critical roles in the dissemination of information on sexual and reproductive health, STIs and distribution of condoms.

PMTCT Programme

The prevention of mother-to-child transmission continues to be a one of the main prevention strategies employed by the Ministry of Health to curb the spread of HIV among infants. The Ministry of Health continued to implement its Prevention of Mother to Child (PMTCT) Programme at all government ante-natal clinics. Some 18,715 women received pre-test counselling. The total percentage of ante-natal clinic attendees tested increased from 94.4% in 2006 to 97.9% in 2008. Both Tobago and Caroni-North were able to achieve 100% testing of clinic attendees.

The largest percentage of pregnant women who tested positive, 34.56% belonged to the 25-29 age group. Overall 84.79% of pregnant women who tested positive were aged between 20 to 34 years, in 2008. Table 9 below provides information for 2008 and 2009 on the number of pregnant women who were new to the clinics, the number of pregnant women tested and the number of women who tested positive. A total of 182 women were referred to four main treatment sites where anti-retroviral therapy is available free of charge.

Table 9
Pregnant Women Tested and Results

Category	2008	2009[4]
New Pregnant Women	15,963	12,059
No. of Women first tested this pregnancy	15,625	11,662
Percentage of Women Tested	97.9%	96.7%
No. of Women Previously Tested Positive	94	NA
No. HIV positive ELISA	123	73
No. of Positive cases	217	130

The total number of new attendees during the period January to September 2009 for public ante-natal clinic excluding Tobago was 12,059. Dried blood spot testing was introduced in 2008 and 98 infants were tested using this method in 2008 with 91 negative and seven HIV positive results. Between January to September 2009, 65 infants were tested using the dried blood spot testing and seven infants were determined to be positive. The Eastern Regional Health Authority and the South West Regional Health Authority have implemented support groups for infected mothers and expanded their services to provide care and support to affected families. Table 10 below provides further details on HIV test results for pregnant women by county.

Table 10
HIV test Results and Sero-prevalence for Pregnant Women by County 2008

Health Centre/ Hospital	# of +ve rapid test result	# of +ve Elisa test result	# of +ve women counselled	sero prevelance rate	# of women previously tested	total # of +ve cases
ST. GEORGE WEST	24	24	41	1.4	17	41
ST. GEORGE CENTRAL	36	36	41	3.9	5	41
ST. GEORGE EAST	21	21	42	2.4	21	42
CARONI - NORTH	6	6	6	1.0	4	10
CARONI - SOUTH	2	2	3	0.4	2	4
ST. ANDREW/ST. DAVID	4	4	10	1.0	6	10
NARIVA/MAYARO	4	4	4	0.9	1	5
VICTORIA	12	12	33	1.0	21	33
ST. PATRICK	5	5	13	0.8	8	13
TOBAGO	9	9	18	3.0	9	18
TOTAL	123	123	211		94	217

Several gaps still persist in the PMTCT programme which can be summarized as follows:

[4] Data for 2009 excludes Tobago and only includes data for the nine-month period, January to September.

(a) challenges in accessing all the babies who need to be tested
(b) adherence of mothers and infants to the prescribed treatment regime
(c) disclosure to partners
(d) testing of partners and other children
(e) Loss to follow up of mothers and babies

Counselling and testing

Over the past three to four years, and especially during the current reporting period, there has been a substantial increase in the number of people who present themselves for testing. This has largely been due to expansion of rapid testing services. For example, the number rapid testing sites increased from five in 2007 to 28 in 2009. In 2009, 94.44% of TB patients were tested.

Quality assurance, training for government counsellors and data-capturing systems all need improvement. For instance, the effect of VCT on behaviour change has not yet been investigated. There are no reports on the uptake of VCT by at-risk groups such as migrant workers and sex workers (SWs) due to lack of adequately disaggregated data and inconsistency in data collection.

The NACC and the Ministry of Health should give attention to collecting the data on HIV testing from private testing sites, which currently are not required to report and therefore do not report on the tests which they have conducted.

The CSO Perspective

CSOs felt that Trinidad and Tobago has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations. The specific responses of the participating CSOs are included below.

All the legislation is hetero normative. If you get convicted for consensual buggery there is mandatory HIV test.

The main challenges related to the existence or continuation of abstinence only programmes in schools, age discrimination in testing, cultural insensitivity reflected in the times of operation of the service delivery sites, policies related to age eligibility for the purchase of condoms. The laws assume homogeneity and that there are no sub cultures.

Exclusion of the gender policy i.e diversity.

Potential conflict between statutory rape and marriage at the age of 14 with parental consent. Certain types of sexual practices are criminalized irrespective of the age of the participants.

Age discrepancies for reporting 15-24-impacts on age for consent which legally stands at 16 and 18.

Discrimination of children as they cannot get access to testing without parental consent.

Laws need to consider behaviour for access to services.

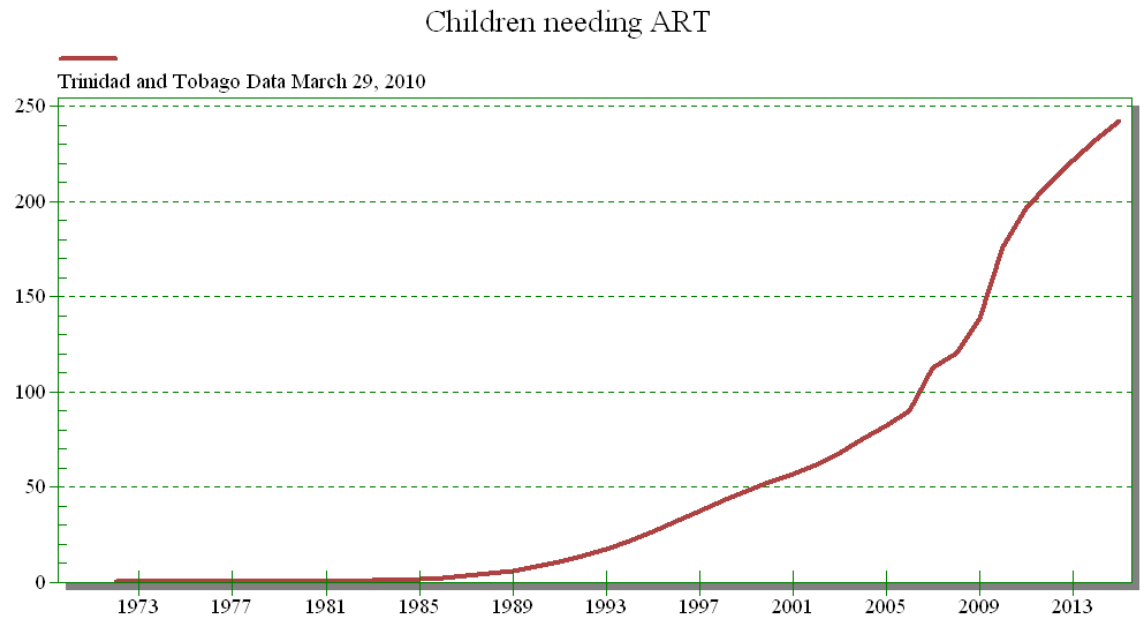
CSOs felt that adequate provisions had not been made for the elderly.

Treatment Care and Support

By year end 2007 there were 5,075 HIV/AIDS patients receiving treatment and care in Trinidad and Tobago with 2,592 on ART. By year end 2009 3,592 patients were on ART while 6,646 were receiving treatment and care. The Medical Research Foundation is the main provider of treatment and care service with 45.4% of its patients on ART being patients of this organization which operates under a special provider agreement with the Ministry of Health. The largest providers of treatment and care for pediatric AIDS patients were the Eric Williams Medical Science Complex and the Cyril Ross Nursery treating 79 and 78 patients respectively. Other pediatric treatment sites are the Scarborough Regional Hospital in Tobago and the Sangre Grande Hospital. The Clinton Foundation provided support for the monitoring of the care and treatment of the Pediatric HIV. A dedicated Pediatric social worker has been assigned to the Cyril Ross Nursery.

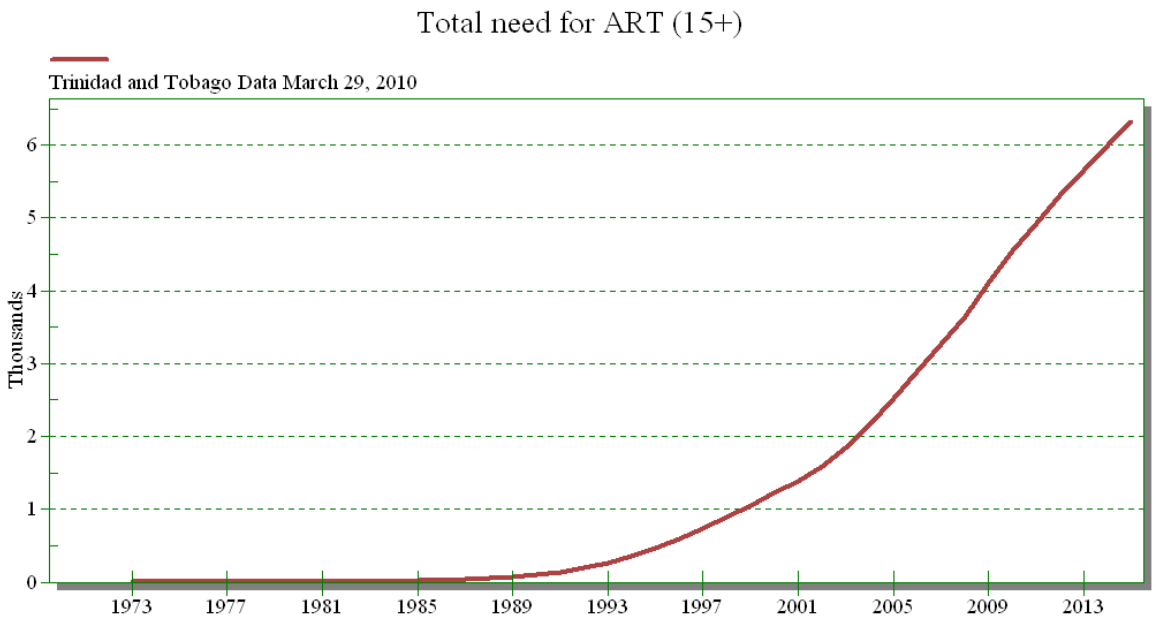
Estimates of the number of persons who would require ART by 2015 were calculated using Spectrum and these estimates are provided below.

Estimate of Children needing ART CD4<200

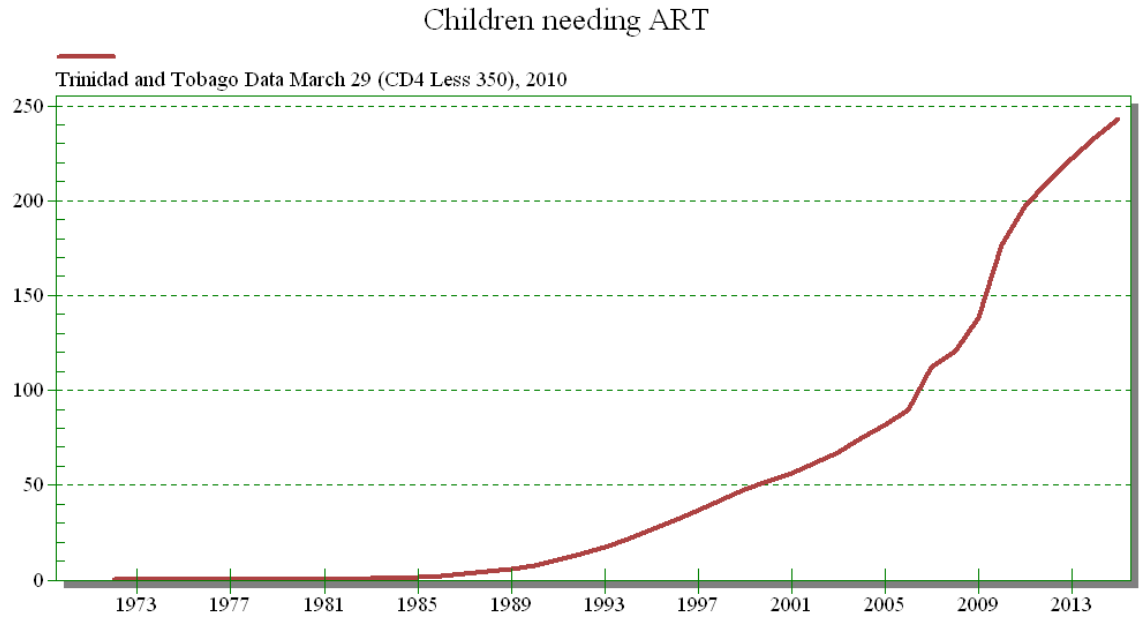


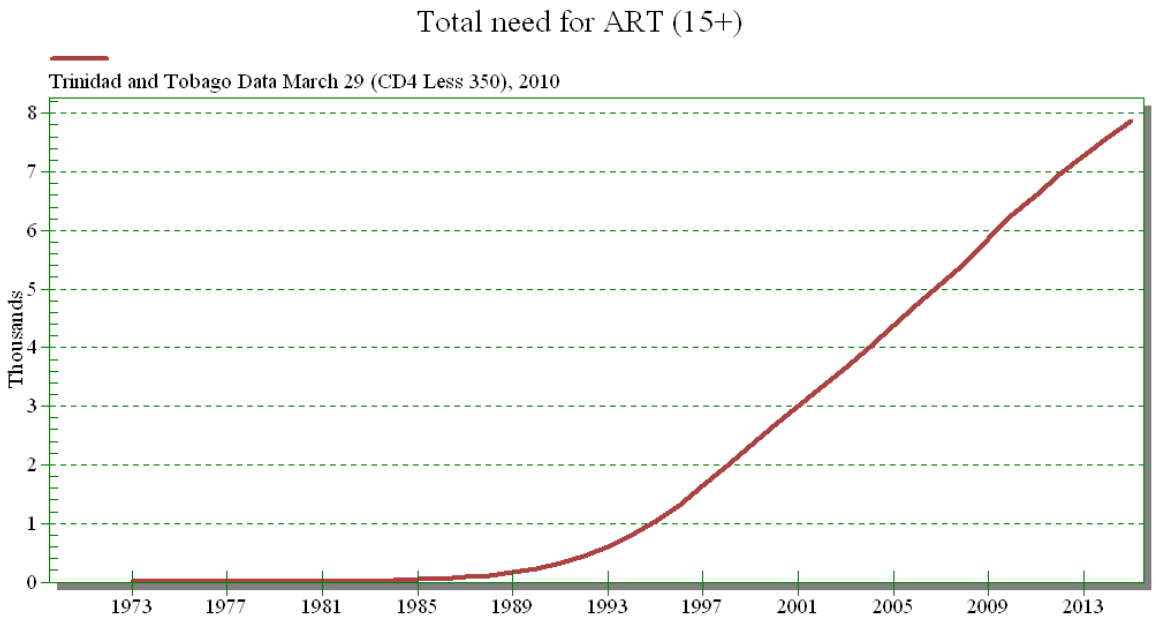
As shown in the graph above it is projected that 222 children will require ART in 2013 if a CD4 threshold of less than 200 is used. Additionally 5,650 adults over 15 years of age would require ART by 2013.

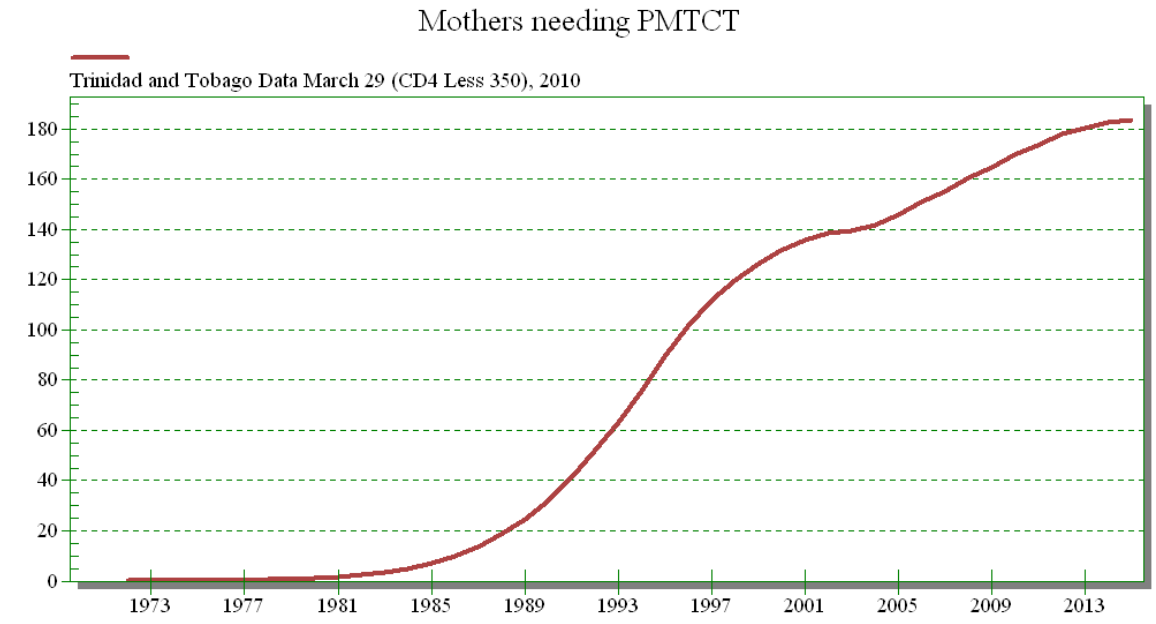
Adults needing ART CD4 <200



The increase in the number of children requiring ART when a CD4 threshold of 350 is used is negligible moving from 222 to 223. On the other hand, the number of adults requiring ART increases sharply when a CD4 threshold of 350 is utilized moving from 5,650 to 7,280.







Projections regarding the number of HIV positive pregnant women who will require ART indicate a fall off with a projected 181 women requiring ART as compared to the 217 pregnant women who tested positive in 2008. See graph above.

The Civil Society Perspective

Some patients have raised the issue of the times at which treatment clinics are conducted as they sometimes experience challenges in getting the required time off from their jobs. This situation could also be improved by staggering appointments. Further, despite the expansion of treatment sites, the main treatment sites are located in the capital city, the city of San Fernando and in Scarborough Tobago. This is a two edged sword are some patients are happy with the anonymity which treatment away from their work and home may provide as stigma and discrimination still remains pervasive. At the same time they often have to take off an entire day from work to attend clinics. Efforts to decentralize the delivery of services need to be intensified.

CSOs who participated in the workshops to review the level of participation in the national response and in the provision of services stated that CSOs play critical roles in prevention programmes for youth, in the reduction of stigma and discrimination, home-based care and programmes for orphans and vulnerable children. The Table below summarize how CSOs perceive their level of involvement.

Table 11
Provision of Services by CSOs

	TRINIDAD	TOBAGO
Prevention for youth	51-75%	>75%
Prevention for most-at-risk populations - Men who have sex with men - Sex workers	 >75% >75%	 <25% <25%
Testing and Counselling	<25%	<25%, >75%
Reduction of Stigma and Discrimination	<50%	51-75%
Clinical services (ART/OI)	<25%	<25%
Home-based care	51-75%	51-75%
Programmes for OVC	51-75%	51-75%

Advocacy and Human Rights

A Human Rights desk has been established to document discrimination and infractions against the rights of people living with HIV and AIDS in Trinidad but a similar service has not yet been established in Tobago. One of the complaints received at the Human Rights desk is the difficulties faced by some national PLHIVs when attempting to travel to the United States of America, despite the lifting of the ban which had previously denied PLHIV entry. CSOs felt that this points to a need for more information sharing among all parties concerned. The final report of a recent legislative assessment to determine how the existing legal framework facilitates the enjoyment of the human rights of those living with and affected by HIV/AIDS was completed in April 2009.

The assessment found that PLHIV encounter discrimination based on their HIV status in the workplace, in health care settings and in the provision of goods and services such as credit and insurance services. There is no protection in the law however against discrimination on the ground of 'HIV status or suspected HIV status'. General anti-discrimination legislation (the *Equal Opportunity Act 2000*) exists, but 'HIV status or suspected HIV status' is not included as a prohibited ground of discrimination. 'Disability' is included but its narrow definition effectively excludes 'HIV' or 'AIDS'. The Act prohibits discrimination in the areas of employment, education, the provision of accommodation and the provision of goods and services which are the areas where discriminatory acts faced by PLHIV are most frequently encountered. The Act also makes provision for conciliation procedures for the resolution of complaints in the first instance –a process which is more appropriate for dealing with complaints by PLHIV given the highly stigmatized nature of the disease. The Act, however, is not yet operational.

Thus, the avenue currently open for PLHIV to seek redress is the Constitution of the Republic Trinidad and Tobago, which declares a citizen's entitlement to certain fundamental rights and freedoms and guarantees these rights and freedoms without discrimination by reason of race, origin, colour, religion or sex. Though HIV was not stipulated, it was not excluded. As stated in the Legislative review, the Constitution is only binding on the state and limited remedies may be obtained under certain statues eg. the Industrial Relations Act and the Judicial Review Act.

Awareness of legal, treatment and reproductive rights among PLHIV and health workers is low as information on rights is not posted at health facilities and other pertinent sites.
Trinidad and Tobago law criminalizes homosexuality, sex work and drug use, thus presenting obstacles to effective HIV prevention and care for most-at-risk populations.

The legislative assessment has provided and agenda for reform.

The Civil Society Perspective

Civil Society groups in Trinidad felt that there was legislation in place which addressed the concerns of women and young people- such as The Equal Opportunities Act, Sexual Offences Act, Domestic Violence Act, and the Children's Act. No legislation is currently in place, which address other most-at-risk groups including the socially displaced. In fact, they opined that there are laws which discriminate against vulnerable persons. There is a need to consider other types of drug use and not intra-venous drug users as well as differently abled people.

CSOs are not sure of the mechanism for people to seek redress under the laws. How can redress be sought under the Domestic Violence Act? What is the role of the police? How are private matters dealt with?

CSOs in Trinidad also raised many other issues which are quoted below. People are charged under sexual offences act – are judges familiar with these laws and how they can apply in respect to HIV.

CSOs believed that there is abuse of existing laws relating to sex workers and solicitation, vagrancy and migrant populations. They thought that the Laws were inadequate. Additionally it is difficult to provide training to police and 'criminalized groups'.

CSOs have limited confidence in the judicial and police systems and raised questions relating to confidentiality, enforcement, variation(inconsistency) in the sentencing, They felt that there needed to be regular review of these systems and that they needed to be involved in these reviews.

CSO representatives suggested that there are existing laws which may not directly include HIV but that they can be appropriately amended.

Mechanism for protection is the equal opportunity commission.

CSOs from Tobago did not demonstrate an awareness of the issues and challenges relating to human rights.

Overall, CSOs rated the enforcement of human rights as very poor.

Human Rights Policy Development

The Civil Society Perspective

Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

The current NSP mentions human rights but there is a need to look at general legislation
CSOs based in Tobago stated that yes, the NSP mentions rights but it did not address the legislative framework and how the basic human rights were to be enforced. CSOs also felt that there was not enough awareness about the NSP and that the National Workplace Policy, which they referred to as the "ILO Workplace Policy" were lying on shelves collecting cobwebs.

Involvement of PLHIV in Policy and Programme Design and Implementation

The Civil Society Perspective

CSOs indicate that they have been involved in consultation events to inform policy development for example in the Legislative Review and the development of NSP 2004-2008 (now extended to 2010). CSOs confirmed participation in workshops at the start of the policy development process. MSM and PLHIV appear to be represented on at least two of the NACC's sub-committees. This involvement only began in earnest in 2003 well into the last cycle of the preparation of the NSP.

CSOs based in Tobago felt that sometimes recommendations are made but there is no implementation and that PLHIV snd affected are not included in the policy design.

Mitigation of social and economic impact

Impact studies

The NACC has conducted a study on the impact of the world financial crisis and recession on the budget allocations for the national HIV/AIDS response. The study found that the overall budget and expenditure on HIV & AIDS programmes from within the capital budget increased between 2007 and 2008 from TT$58.8m (US$9.33) to TT$73.2m (US$11.62) an increase of 24%. This change represented an increase in the share of the allocation to HIV and AIDS of the total capital programme budget from 1.7% to 1.9%. Actual expenditure exceeded the budget in 2007 by TT$1.6m (US$0.25m) and although expenditure fell short of the budget in 2008 the expenditure nevertheless increased by TT$2.37m (US$0.38m) above the expenditure in 2007. The extent of the cutbacks and their potential negative impact on HIV & AIDS programmes are highlighted in the budgeted and actual expenditures for 2009. The budget for 2009 was cut by a significant 47% to give an HIV & AIDS budget for 2009 of TT$38.67m (US$6.14m), a reduction of TT$34.54m (US$5.48m) on the 2008 budget. With the additional restrictions placed on funding of programmes from the capital budget, expenditure even fell short of the budget in 2009 by a small margin. For 2010, despite the ongoing economic crisis there has been a small increase in the budget of 8.2% over and above the 2009 budget.

Community Engagement and Empowerment

The NSP 2004–2008/10 aims to empower community organizations and faith based organizations to use and strengthen existing systems for coping with the impact of HIV and AIDS, with particular reference to providing prevention and care and support services for most-at-risk groups and providing access to dormitory, treatment and care and psycho-social services to HIV orphans. The Cyril Ross Nursery, which is operated by the St. Vincent de Paul Society has been the beneficiary of several grants from the NACC and receives an annual subvention from the Ministry of Social Development.

Workplace initiatives

The Trinidad and Tobago National Workplace Policy on HIV and AIDS was completed, approved and launched in April 2008. A broad consultative process, supported by the International Labour Ogranisation and the Joint UN Team on HIV and AIDS, was undertaken. Additionally to address the negative effects of HIV and AIDS on productivity, measures are currently being undertaken in the public sector, through the HIV and AIDS focal points in line ministries to develop workplace programmes that sensitize staff and to prevent discrimination against those who are infected. Some ministries such as the Ministry of Health have developed a comprehensive HIV and AIDS workplace policy and implementation plan.

Major challenges and remedial actions taken

CHALLENGES IDENTIFIED IN the UNGASS 2008 REPORT	ACTION TAKEN
Limited sites which provide youth friendly services	THACC Secretariat has procured 7 modified porta cabins and these will be located throughout the island to house youth healthy spaces.
Absence of a comprehensive surveillance system for HIV/AIDS which covers both the public and private sectors	An IT platform has been established at the National Surveillance Unit to support the collation and compilation of data.
Large numbers of persons particularly among the most at risk population segments remain reluctant to access testing and treatment and care services	Many of the cultural and structural issues which deter these groups from accessing services were identified in recent studies and manner in which services are delivered will be reviewed to take the relevant considerations on board.
Record-keeping and documentation of services provided are not routine	Attempts have been made to introduce electronic record keeping but there have been delays in addressing data entry for old records.
Policy guidelines for service delivery are not readily available nor diligently adhered to	National Treatment and Care Guidelines have been approved and circulated
ART services remain centralized	One additional treatment delivery site has been added.
Availability and willingness of clinicians to provide HIV/AIDS care and treatment services	An Infectious Disease Specialist has been recruited by the South West Regional Health Authority who also services the Sangre Hospital treatment site.
Enough training opportunities to update the skills of all the members of the treatment team	The Trinidad and Tobago Health Training Centre (TTHTC) has implemented several training courses. Donors have also supported the participation of treatment providers at

	regional and international training events.
Provider stigma is still evident	Workshops on Stigma and Discrimination have been conducted in Trinidad and Tobago and the issue also receives attention in all training workshops conducted by the TTHTC.
Interventions tend to be targeted to the general population with limited interventions specially designed and directed at high risk groups	Some important studies have been undertaken to identify the special needs of these groups. The main findings of these studies were summarised in Table 9 of this report. These findings will inform the design of future IEC and BCC interventions and service provision.

One of the main challenges confronting the national response during the period under review related to human resource capacity, which, was exacerbated by the departure of management and key staff in the NACC Secretariat and delays in the recruitment new staff.

The period under review also witnessed a sharp decline in the volume of government resources allocated to the implementation of the NSP as a result of contractions in the national economy. The European Commission provided a grant of TT$23.84 million to support the implementation of the NSP. Delays in project start up and the complex procurement procedures led to only TT$8.30 million or 34.81% of the grant being utilized. Of grave concern is the fact that HIV is slipping off the agenda – non communicable disease, the economy and global warming are increasingly given higher priority. With regard to the specific allocation of resources for the funding of HIV programmes, there is poor understanding of the role of management accounting in the public sector especially identifying cost centres and beneficiary populations. CSOs also expressed their serious concern with the very limited resources, and in some instances, no resources being made available to them by the NACC to implement community projects and programmes.

Stigma and discrimination continues to limit access to the most-at-risk populations and consequently there are limited targeted behaviour change prevention programmes with M&E input.

Support from the country's development partners

Key support received

With regard to assistance from development partners – a loan from the World Bank and a grant from the European Union (EU) continued to be the most significant support received from donors. The Clinton Foundation and the United States Agency for International Development have provided assistance to build capacity for the clinical management of HIV/AIDS patients. The Clinton Foundation has also provided assistance in support services for paediatric patients.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) Country Office in Trinidad and Tobago (UCO)has provided support in the critical areas of monitoring and evaluation, advocacy and human rights, programme management and coordination, CSO engagement and management of strategic information. The International Labour Organisation (ILO) provided support for the development and review of a National Workplace Policy on HIV and AIDS. The UN System has adopted a coordinated approach to the provision of assistance and has developed a multi-year joint programme of support implemented by the UN Joint Team on AIDS, which is coordinated by UCO

Actions that need to be taken by development partners

Based on the review, there are two main areas which urgently require donor attention – monitoring and evaluation and CSO capacity building. Urgent attention is required to implement the M&E framework and donors should commit to providing assistance to provide both financial and technical support to ensure that the M&E Unit at the NACC Secretariat in Trinidad ,as well as in Tobago are fully functional. Donors may also wish to give consideration to financing a joint annual review of the national HIV programme (NSP).

The NSP 2004-2008/10 identifies a major role for CSOs. A look at the portion of CSO funding from the national budget in 2009 does not bear this out. Donors must therefore find creative ways to build institutional capacity and strong management and operating systems in CSOs so that they are able to play the role envisaged for them.

Additionally the NACC will require support to review the current NSP and develop a new plan for 2010 and beyond.

Monitoring and evaluation environment

Monitoring and evaluation has not been afforded adequate attention and as a result there is no single comprehensive M&E system for the national response to HIV. The introduction of IT solutions has made it possible to complete data entry more expeditiously and it is possible to collate the available data and to generate a number of reports. However, issues relating to data collection and data completeness have not been addressed and as a result critical information such as age, gender and place of residence are often not captured. While stigma and discrimination may continue to make persons reluctant to provide information on their place of residence, data on age and gender are critical to gaining a better understanding of the epidemic.

The NACC needs to move urgently to recruit the required staff and to establish an M&E Unit in order to operationalize the national HIV and AIDS M&E plan and to establish a national database with HIV related data.

Annex 1

Consultation/preparation process for the Trinidad and Tobago report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Consultations were held in Trinidad and Tobago from January-February 2010. Two consultations were held with civil society representatives, inclusive of representative of the PLHIV community and vulnerable populations. The first consultation was held in Trinidad and the second consultation was held in Tobago. The representatives of civil society were primarily NGOs who are involved in work with the NACC and not the entire NGO community of Trinidad and Tobago.

The second set of consultations was held with government representatives. The same process for civil society representatives was repeated for government officials where the first consultation was held in Trinidad and the second consultation was held in Tobago. The participants of the government representatives included the focal points for HIV and AIDS in the Ministries, including the Ministry of Health.

Participants who were unable to attend the consultations were contacted individually and their comments were included in the respective stakeholder group.

In March, a consultant was hired to collate, verify, and prepare the UNGASS report in time for the deadline of March 31, 2010.

Appendix 2: National Composite Policy Index

Introduction

The questionnaire to compile the National Composite Policy Index (NCPI) was extracted from the *Guidelines on Construction of Core Indicators: 2010 Reporting (UNGASS 2009) and* distributed to several government ministries, the Tobago HIV and AIDS Coordinating Committee and the Joint UN Team on HIV and AIDS in December 2009 after a briefing meeting. Completed questionnaires were received from:

- The Ministry of National Security
- The Tobago HIV and AIDS Coordinating Committee Secretariat
- The Ministry of Education
- The Ministry of Social Development
- The Ministry of Health
- The Ministry of Sport and Youth Affairs
- The United Nations Joint Team on HIV and AIDS

Findings

1. Strategic plan

Trinidad and Tobago has developed a national multi-sectoral strategy or action plan to combat AIDS; the current plan originally scheduled to run from 2004 to 2008 but the implementation period was extended to September 2010 as a result of delays in implementation. The sectors covered in the framework include, health, education, labour, military and police, women and young people with earmarked budgets. The framework addresses women and girls, MSM, Sex Workers, OVC, drug users, workplace, schools, prisons, human rights protection, involvement of PLHIV, stigma and discrimination and gender empowerment. The framework includes an operational plan with formal programme goals and clear targets and milestones. Target populations were identified through a process of needs assessment or needs analysis. Target groups identified include men who have sex with men, sex workers, drug users, young people and women and girls.

There was moderate civil society involvement in developing the framework but there has been regular engagement of CSOs since. The major external development partners have endorsed the framework and have aligned and harmonized their HIV and AIDS programmes with the national multi-sectoral strategy and action framework. The country has integrated HIV and AIDS into its national development plan (Vision 2020) and United Nations Development Assistance Framework for Trinidad and Tobago (UNDAF TT). The key areas included in the national development plans are HIV prevention, treatment for opportunistic infections, ARV, care and support, HIV impact alleviation, reduction in gender inequalities, reduction in stigma and discrimination and women's economic power. The country has evaluated the impact HIV and AIDS have made in its planning for socio-economic development and a score of "2" was adjudged.

Trinidad and Tobago has a strategy and action framework for addressing HIV and AIDS among uniformed services. Its programmes for BCC, STI services and care and support have been implemented beyond the pilot stage. HIV testing & counseling is voluntary however, there is mandatory testing as part of the medical of recruitment and if posted overseas if the reciprocal country mandates this. The country has non-discrimination laws or regulations which specify protections for women and young people. In Trinidad and Tobago protection can be sought under the Equal Opportunities Act which is not fully operational. Respondents indicated that Trinidad and Tobago has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for young people and to some extent MSM as although homosexuality is not illegal, buggery is an offence and there is significant stigma and discrimination associated with being homosexual. Sex workers have problems in accessing services due to discrimination.

The country has followed up on commitments towards universal access made during the high-level AIDS review in June 2006. However, the National Strategic Plan and budgets have not been revised accordingly. Estimates of the main target population subgroups are updated on an ongoing basis and programme-coverage monitoring of the PMTCT programme, at the county (medical region) level.

Trinidad and Tobago has developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs. The rating of planning results for 2009 was:

0	1	2	3	4	5	**6**	7	8	9	10

2. Political support

High officials speak publicly and favourably about AIDS efforts in major forums at least twice a year. The country has an officially recognized national multi-sectoral AIDS management and coordination body with terms of reference, an action plan and functioning secretariat. The NACC and the THACC have active government leadership and defined membership that includes civil society participants, people with HIV and the private sector. NACC meets at least quarterly but these meeting are not generally oriented to the review of actions on policy decisions, and the pro-active promotion of policy decisions. Some respondents were concerned that the meetings were merely talk shops.

The NACC provides technical guidance, coordination, capacity building and information on priority needs to CSOs.

A legislative assessment has been undertaken, a draft national policy has been prepared and is to go out to consultation in 2010. Upon approval of the policy, draft legislation on HIV will be prepared. The legislation will deal with issues of HIV and stigma & discrimination. Overall the level of political support was given a rating of 4.

0	1	2	3	**4**	5	6	7	8	9	10

There have been regular addresses on HIV by the prime minister and other government ministers.

3. Prevention

The country has a policy or strategy that promotes information, education and communication on HIV to the general population. The key messages that are explicitly promoted include abstinence, delaying sexual debut, being faithful, using condoms consistently, engaging in safer sex greater involvement of people with HIV, know your status and PMTCT.

The country has a policy or strategy that promotes HIV-related reproductive and sexual health education for young people but structured programmes are only currently being implemented in teachers' training colleges. Trinidad has developed strategies to promote information, education and communication and other preventive health interventions *for the following* most-at-risk or other vulnerable sub-populations

a. Targeted information on risk reduction MSM, other- Drug users
b. Stigma & discrimination reduction MSM, Sex workers, clients of sex workers, prison inmates, other - drug users
c. Condom promotion. MSM, Sex workers, clients of sex workers, prison inmates, other - drug users

0 1 2 3 4 5 **6** 7 8 9 10

Policy efforts in the area of prevention was given a rating of 6 on a scale of 0 to 10.
Key achievements in this area were approval of the HIV testing policy and the National Workplace Policy on HIV & AIDS, final draft policies on PMTCT, prophylaxis, youth, sexual & reproductive health and education for the education sector.

Specific needs for prevention programmes have been identified from the conduct of situational analyses in 1999 in Tobago, 2003 in Trinidad, Knowledge, Attitudes, Behaviour and Perceptions survey 2007 and Young Women and the Management of Sexual Relationships 2009. HIV prevention has been implemented in the following areas:

a. Blood safety
b. Universal precautions
c. Prevention of PMTCT
d. IEC on S&D
e. Condom promotion
f. HIV testing
g. Risk reduction for MSM
h. Risk reduction for sex workers
i. Reproductive health services STI
j. Other drug users.

Overall rating for efforts in this area:

0 1 2 3 4 5 6 **7** 8 9 10

The key achievement identified included increase in the number of rapid testing sites, Provider Initiated Testing and Counselling (PITC) training, VCT and rapid testing. RapPort interventions with in and out of school youth were also mentioned.

4. Treatment, care and support

The country has a strategy to promote comprehensive HIV treatment which does not address barriers for women and most-at-risk populations. The need for care, treatment and support services has been ascertained. The country has access to regional procurement and supply for critical commodities including, Antiretrovirals, condoms, opportunistic infection drugs, laboratory reagents and equipment.

The following are the care, treatment and support services which have been implemented:

a. ARV
b. Paediatric AIDS Treatment
c. STI Management
d. Psycho-social support for PLHIV and their families
e. Home-based care
f. Palliative care and treatment of common HIV related infections
g. HIV Testing and Counselling for TB patients
h. PEP for occupational exposures to HIV and rape
i. Cotrimoxazole prophylaxis in HIV exposed infants

Overall rating for efforts in this area:

0 1 2 3 4 5 6 **7** 8 9 10

The major achievements in this area related to: One new treatment and care site at Sangre Grande; Approved Adult and Paediatric Treatment and Care Guidelines; Procurement of CD4 and viral load machines; Hiring of infectious disease specialists; Training of multidisciplinary teams in Treatment, Care and Support; Decrease in national stockouts of ARV.

5. Monitoring and evaluation

The country has one national monitoring and evaluation plan, which is not operational. The main challenges with regard to the implementation of the plan relate to staffing limitations. The plan includes a data collection and analysis strategy, behavioural surveillance, HIV surveillance, a well-defined standardized set of indicators, guidelines on tools for data collection, a strategy for assessing the quality and accuracy of data, and a data dissemination and use strategy. A budget is currently being developed for M&E activities and there is currently no M&E Unit in place at the national level.

There is a national M&E Committee or Working Group but this group has not met regularly. PLHIV are represented on the working group. Currently there is not national database with HIV related data, however, databases exists at the sub-national level for sites that deliver HIV treatment services, Trinidad Public Health Laboratory, National Surveillance Unit, Blood Bank, STI treatment, counseling and testing sites and RapPort.

The Table below summarises the extent to which M&E data is used.

Area	Rating					
	Low					High
Developing and revising the National AIDS Strategy	0	1	2	3	4	5
Resource Allocation Trinidad & Tobago has not conducted a national AIDS spending assessment since 2006.	0	1	2	3	4	5
Programme Improvement	0	1	2	3	4	5

6. Human rights

Civil Society groups in Trinidad felt that there was legislation in place which addressed the concerns of women and young people- such as The Equal Opportunities Act, Sexual Offences Act, Domestic Violence Act, and the Children's Act. No legislation is currently in place, which address other most-at-risk groups including the socially displaced. In fact, they opined that there are laws which discriminate against vulnerable persons. There is a need to consider other types of drug use and not intra-venous drug users as well as differently abled people.

CSOs are not sure of the mechanism for people to seek redress under the laws. How can redress be sought under the Domestic Violence Act? What is the role of the police? How are private matters dealt with?

CSOs in Trinidad also raised many other issues which are quoted below. People are charged under sexual offences act – are judges familiar with these laws and how they can apply in respect to HIV.

CSOs believed that there is abuse of existing laws relating to sex workers and solicitation, vagrancy and migrant populations. They thought that the Laws were inadequate. Additionally it is difficult to provide training to police and 'criminalized groups'.

CSOs have limited confidence in the judicial and police systems and raised questions relating to confidentiality, enforcement, variation(inconsistency) in the sentencing, They felt that there needed to be regular review of these systems and that they needed to be involved in these reviews.

CSO representatives suggested that there are existing laws which may not directly include HIV but that they can be appropriately amended.

Mechanism for protection is the equal opportunity commission.

CSOs from Tobago did not demonstrate an awareness of the issues and challenges relating to human rights.

Overall, CSOs rated the enforcement of human rights as very poor.

7. Civil society participation

CSOs indicate that they have been involved in consultation events to inform policy development for example in the Legislative Review and the development of NSP 2004-2008 (now extended to 2010). CSOs confirmed participation in workshops at the start of the policy development process. MSM and PLHIV appear to be represented on at least two of the NACC's sub-committees. This involvement only began in earnest in 2003 well into the last cycle of the preparation of the NSP.

CSOs based in Tobago felt that sometimes recommendations are made but there is no implementation and that PLHIV and those affected are not included in the policy design.