UNGASS COUNTRY PROGRESS REPORT
Trinidad and Tobago

Reporting Period: January 2006-December2007

Submission Date: 31 January 2008

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STATUS AT A GLANCE

It was in 1983 that the first AIDS cases were reported among homosexual men in Trinidad and Tobago. By the end of the third quarter of 2007, 18,378[1] HIV positive cases, 5,835 AIDS cases and 3,604 deaths due to AIDS had been reported to the National Surveillance Unit. The estimated number of deaths due to AIDS in 2006 was 113.[2]

In 2006, just about four new cases of HIV/AIDS were reported every day. The main mode of transmission was heterosexual with a male to female ratio of 51:49 with a significantly higher number of female cases (340 or 60.2%) than males in the 15-34 age group. On the other hand males 35-49 accounted for 62.4% of new infections in that age group.

The epidemic continues to grow most rapidly in both sexes between the ages of 15 and 49 with 69.2% of new HIV infections occurring in this age group in 2006. Forty-seven (47) percent of new HIV cases reported occurred among females where as 69.8% of new infections among 15-29 year olds were detected in females. It must be noted however, that we are seeing more women being tested (?) through the Government of the Republic of Trinidad and Tobago's (GoRTT) Prevention of Mother to Child Programme which has promoted testing among pregnant women, and at the testing sites where data disaggregated by gender was available for 2006, a significantly higher number of females than males were tested.

Constraints in Tracking The Epidemic

Though gaps still remain in the available epidemiological data, and, the surveillance system still focuses primarily on coverage of the public sector, the completion of a few studies have provided more insights into the socio-cultural and economic forces which drive the epidemic, as well as the range, quality and volume of services available. The NACC has recruited consultants to undertake a review of the surveillance data collection and flows and to recommend an appropriate surveillance data collection system and companion information technology platform. New materials reviewing or documenting service provision and epidemiological and behaviour trends include:

The HIV/AIDS Service Provision Assessment Reports for Trinidad and Tobago
"The National Household Knowledge, Attitudes, Behaviour and Beliefs (KAPB) Survey on HIV"
The PAHO/WHO Assessment of the National Services for the Prevention of mother-to-child transmission of HIV and Syphilis.

While there has been some progress with regard to the conduct of research studies some additional areas for further study have been identified in the recently concluded studies as well

[1] Ministry of Health, the Republic of Trinidad and Tobago, National Surveillance Unit, HIV/AIDS Mortality and Morbidity Report, Quarter 1 Report, 2007
[2] Ibid

as in earlier conducted studies such as "Many Partnered Men: A Behavioural and HIV Seroprevalence Study of Men who Have Sex with Men"[3]. Some of these issues and areas are:

- The roles of ethnicity, history of early sexual abuse, educational attainment and psychiatric illness in assessing HIV risk among substance abusers
- Homosexual and bisexual behavior and the types of sexual practices between men in Trinidad and Tobago
- The role of Sexually Transmitted Infections in HIV transmission
- Sex Workers

Main Challenges in Managing and Implementing the National Response

i. Stigma and Discrimination remains pervasive particularly against persons living with AIDS and most at risk groups and thus create barriers to accessing testing and treatment services;
ii. Lack of adequate reporting of services provided in the private sector;
iii. Different departments report HIV infections, on AIDS morbidity and mortality and on TB/HIV infection;
iv. Systems put in place to ensure confidentiality and the anonymity of persons seeking services may result in duplication of individual records;
v. Limited participation of the medical professional associations in supporting reporting;
vi. Inadequacies of existing reporting forms which exclude critical data
vii. Absorptive capacity of several civil society organisations which have key roles to play in the national response; and
viii. Most at risk populations remain cautious about being identified.

The following table provides summary information on the status of the HIV/AIDS epidemic and some of the targets attained.

TABLE 1

CORE INDICATORS FOR THE IMPLEMENTATION OF THE DECLATATION OF COMMITMENT ON HIV/AIDS

UNGASS Core Indicators	**Amount Calculated for indicator**	**Remarks/Response to Date**
Total Amount of Domestic and International spending for public and private sector	2005: $56,302,458 2000: $86,039,142	National Spending Information for 2007 has not yet been compiled
National Composite Policy index (Areas covered gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society	See Appendix	

[3] A study conducted in 2004 in Trinidad and Tobago by researchers of the Special Programme on Sexually Transmitted Infections of the Caribbean Epidemiology Centre on men who have had sex with other men.

involvement, and monitoring and evaluation		
Percentage of donated blood units screened for HIV in a quality assured manner	2006: 100% 2007: NA	All blood is screened by the National Blood Transfusion Unit for HIV/AIDS. 19,771 units were screened in 2006 and the sero-prevalence was 0.21%
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2006: 49% 2007: 54%	Data reported by the MoH covering seven treatment sites
Percentage of HIV-positive women who received anti-retrovirals to reduce the risk of mother-to child transmission	2006: 86.07%	
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	2006: 8.12 (Ali, et al., 2007)	It must be noted that about one half of those surveyed did not provide a response. It was not possible to deduce what percentage knew their results as some 54.3% of those who indicated that they had ever had an HIV test did not respond to this question.
Percentage of young women and men aged 15-24 who are able to correctly identify ways of preventing the sexual transmission of HIV	56%	High levels of knowledge co-exist with misconceptions as 36.4% and 25.8% respectively identified praying and avoiding people with AIDS as means of preventing transmission
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	2006: 11.6%	Baseline data provided by the KAPB Study
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: 85.31%	Of the 1,798 persons interviewed, 1,178 indicated that they had had sexual intercourse in the past 12 months preceding the study
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2004: 47% (Lee, Poon-King, Legall, Samiel, & Trotman, 2005)	Information obtained from "A Behavioural and HIV Seroprevalence Study of Men who have Sex with Men" in 2004. 307 MSM were surveyed.
Percentage of young women and men aged 15-24 who are HIV infected	2006: 1.64%	
Percentage of most-at-risk populations who are HIV infected	2004 - MSM: 20% (Lee, Poon-King, Legall, Samiel, & Trotman, 2005)	An HIV prevalence of 20% for a study conducted in 2004 is high and this may reflect recruitment bias due to the use of NGOs which work primarily in HIV/AIDS work to recruit respondents through their social networks
Amount of bilateral and multi-lateral financial flows (commitments and disbursements)	2005: $5,157,603	

	2006: $3,446,050	

OVERVIEW OF THE AIDS EPIDEMIC

At present the National Surveillance Unit (NSU) classifies cases as HIV positive only if they have been confirmed by the Trinidad Public Health Laboratory or the Caribbean Epidemiology Centre. Thus the data presented in this report excludes testing in the private sector. The Ministry of Health will have to give consideration as to how it will record cases detected through the recent introduction of rapid testing at several testing sites.

At present the collection of data relating to Tuberculosis (TB), TB/HIV cases is the responsibility of the County Health Visitor. All information is fed into the National Register from the following sources:

- Caura Chest Hospital
- Medical and Surgical Thoracic Units Eric Williams Medical Sciences Complex(EWMSC)
- Chest Clinics i.e. 3 diagnostic and treatment centres (San Fernando General Hospital, Port of Spain General Hospital, Scarborough General Hospital.

As a result, data on TB/HIV is not fed to the NSU. The reports received from the Thoracic Unit indicate an increasing trend with regard to TB/HIV co-infection for the period 2004-2006.

HIV/AIDS Morbidity and Mortality

The reports provided by the NSU for the period January 2006 to September 2007 reveal that there has been a decline in AIDS morbidity and mortality. The very small increase in the number of new HIV + cases reported in 2005 was followed by a small decline in 2006 and data available thus far for 2007 indicates a possible further decline. The morbidity data needs to be interpreted with caution as it only covers the public sector or testing sites which then refer their tests to the Trinidad Public Health Laboratory or the Caribbean Epidemiology Centre for confirmation.

According to Table 2 below there were a total of 1,425 new HIV positive cases reported in 2006 of which 1,334 have been classified as HIV non-AIDS, the number of AIDS cases was 194 when these two figures are taken together the total exceeds the number of new HIV cases reported by 103. This implies that persons are only presenting for testing when they have developed full blown AIDS. There is an urgent need to improve data collection within the existing public sector monitoring system and to establish and adhere to one standard method to classify AIDS or non-AIDS at the source of data.

The total number of AIDS related deaths reported in 2006 was 113 and for 2007, there were 32 deaths reported as at September 30, 2007.

TABLE 2

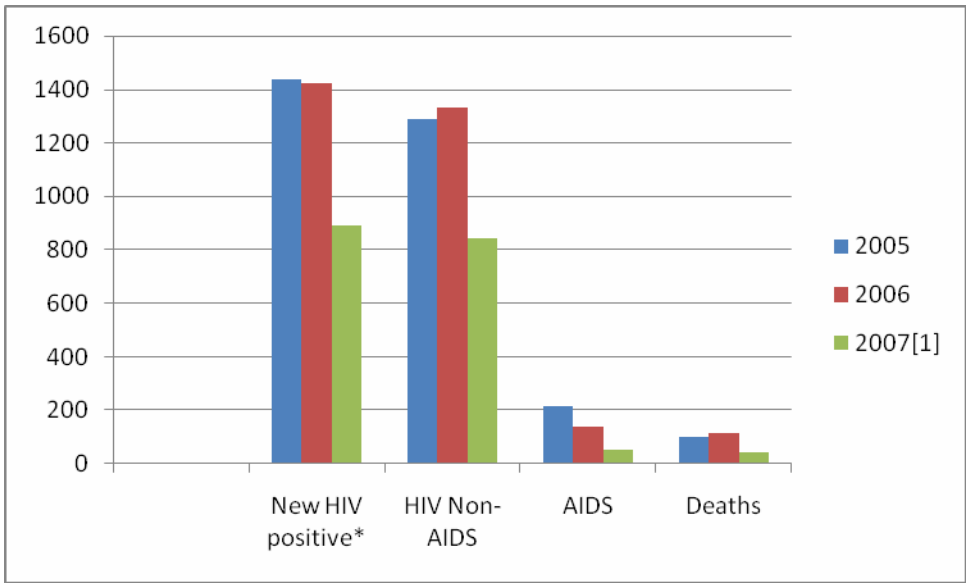
HIV/AIDS MORBIDITY AND MORTALITY SUMMARY 2006-2007

Cases	2005	2006	2007[4]	Cumulative Total 1983-2007
New HIV positive*	1,436	1,425	978	18,378
HIV Non-AIDS**	1,288	1,334	845	12,379
AIDS	217	194	75	5,835
Deaths	101	113	42	3,604

***Total New HIV Laboratory confirmed cases from TPHL/CAREC**
**** Includes HIV asymptomatic and symptomatic (Non-AIDS cases)**
Source: National Surveillance Unit

GRAPH 1

HIV/AIDS MORBIDITY AND MORTALITY SUMMARY 2005-2007

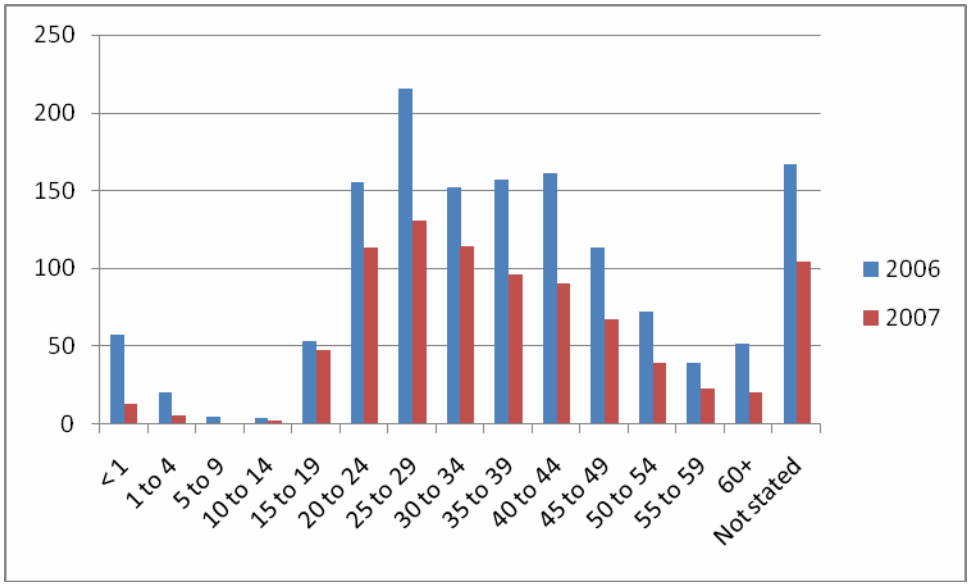


The proportion of AIDS to HIV cases was1:15 in 2005, 1:14 in 2006 and 1:8 in 2007. Early indications are that there will be fewer AIDS related deaths in 2007 than in 2006. In both 2006 and 2007 the highest number of AIDS reported deaths occurred in the 35-39 age-group.

In the period under review most new HIV positive cases were diagnosed among persons who were 20-49 years old or among the most productive age group in the population.

[4] Data for three quarters of 2007

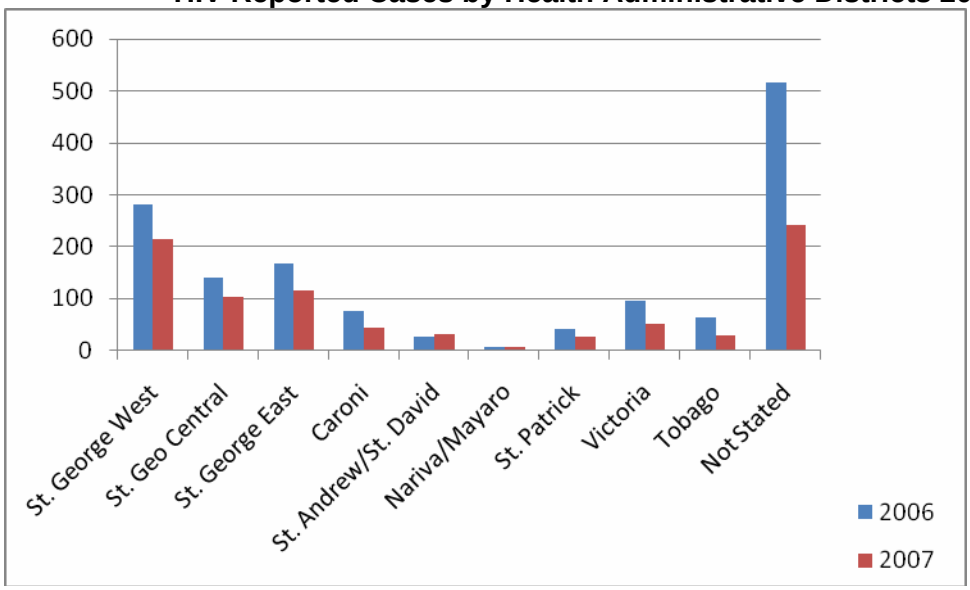
GRAPH 2
New HIV Positive Cases at THPL by Age Group 2006-2007



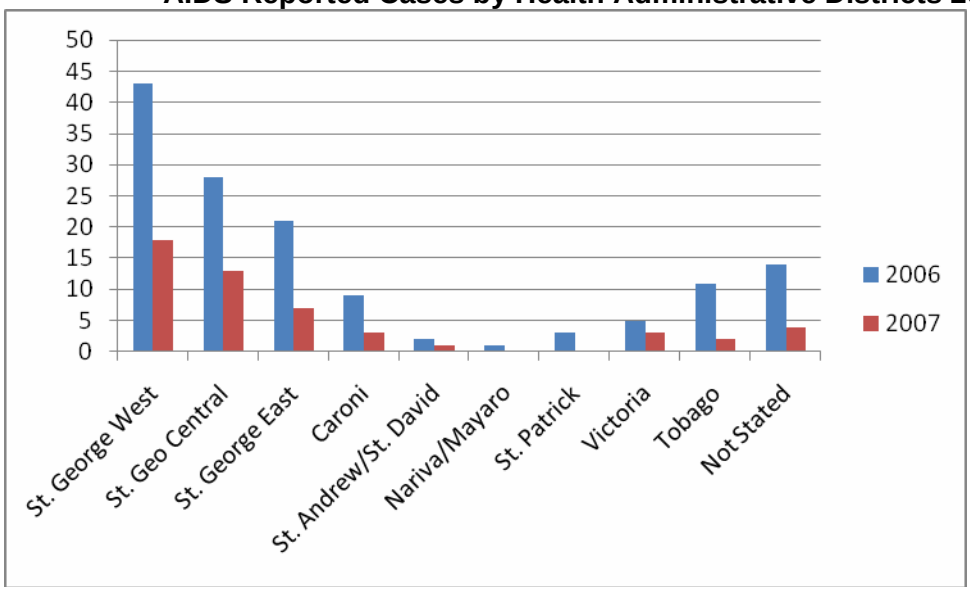
The apparent decline in new HIV infections between 2006 and 2007 as demonstrated in Graph 2 is encouraging, however the non-inclusion of data on testing in the private sector which is believed to be conducting a significant number of testing means that the graph only tells part of the story. It should be noted that in both 2006 and 2007 in excess of 100 persons did not provide information regarding their age or counselors failed to record this information. This pattern may be indicative of the pervasiveness of stigma and discrimination directed towards persons living with and affected by the disease as many persons tested also did not provide information relating to their residence as seen in Graph 3.

Graph 3 also shows that the epidemic remains concentrated in the most populated area of Trinidad and Tobago with St. George accounting for 41.6% of new HIV cases in 2006 with 36.4% of those testing positive not providing information regarding their place of residence in 2006.

GRAPH 3
HIV Reported Cases by Health Administrative Districts 2006-2007



GRAPH 4
AIDS Reported Cases by Health Administrative Districts 2006-2007



As seen in Graph 4 the county of St. George also recorded the highest number of new AIDS case in 2006 92 and 38 in 2007. Tobago also accounted for a very high number of AIDS cases relative to its population of approximately 55,000. This requires further investigation as it could mean that persons are moving as far as is possible away from their normal domicile for testing or that prevalence rates are higher in Tobago.

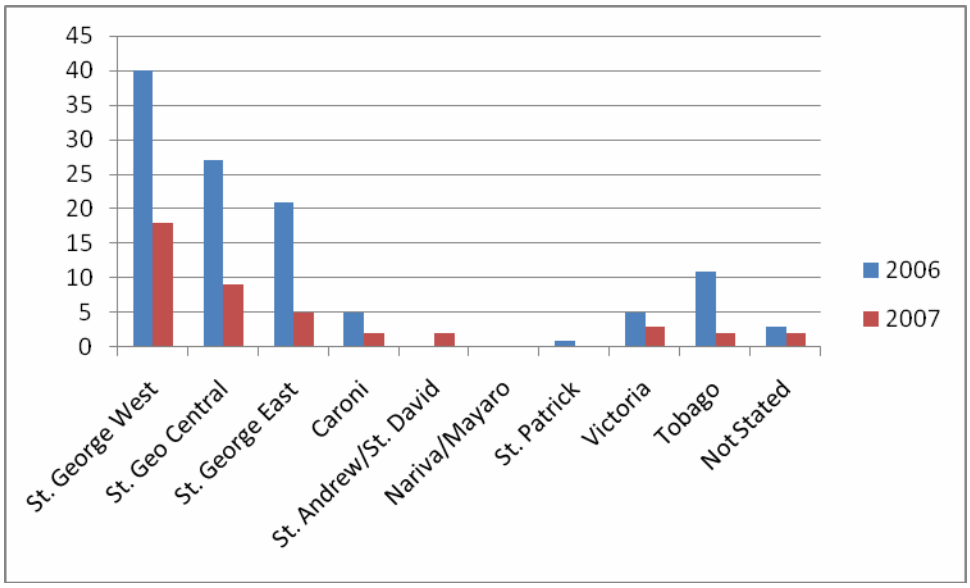
Table 3 below reflects a mortality pattern consistent with the morbidity pattern described above in which the highest number of AIDS related deaths occurred in the County of St. George the most populous county. A relatively high number of deaths were also recorded in Tobago

probably indicative of a trend of late diagnosis as persons remain reluctant to access testing services.

TABLE 3
Deaths Reported by Health Administrative Districts 2006-2007

County	2006	2007[5]	Total 2006-2007
St. George West	40	18	58
St. George Central	27	9	36
St. George East	21	5	26
Caroni	5	2	7
St. Andrew/St. David	0	2	2
Nariva/Mayaro	0	0	0
St. Patrick	1	0	1
Victoria	5	3	8
Tobago	11	2	13
Not Stated	3	2	5
All Counties	113	42	155

GRAPH 5
Deaths Reported by Health Administrative Districts 2006-2007

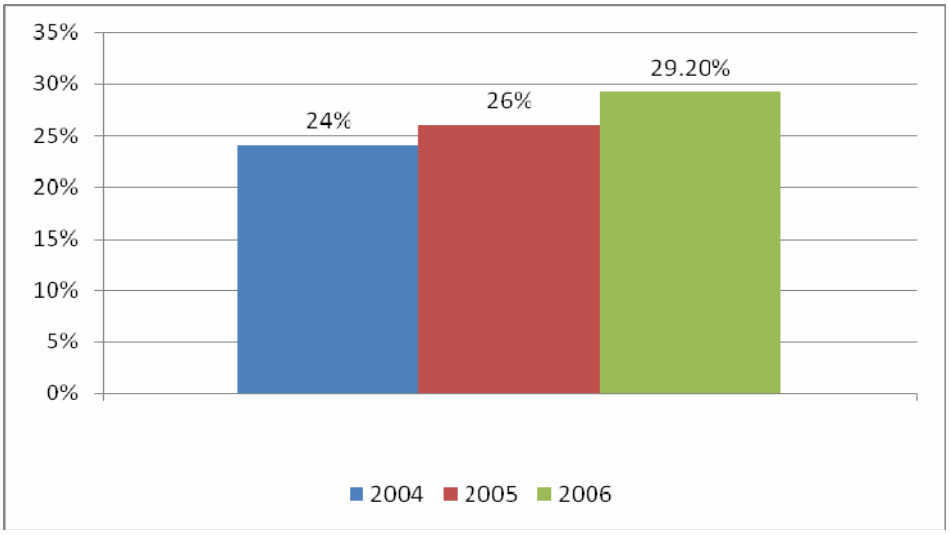


[5] Data for three quarters of 2007

TB/HIV

TB is one of the most common opportunistic infections linked to HIV and AIDS and is one of the main causes of death in HIV-infected persons. TB diagnosis and treatment is viewed as an essential component of care for persons who are HIV positive. The incidence of TB/HIV co-infection increased from 24% in 2004 to 29% in 2006. As demonstrated in Graph 5 below. 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 Graph 6 below.

GRAPH 5
TB/HIV CO-INFECTION



GRAPH 6

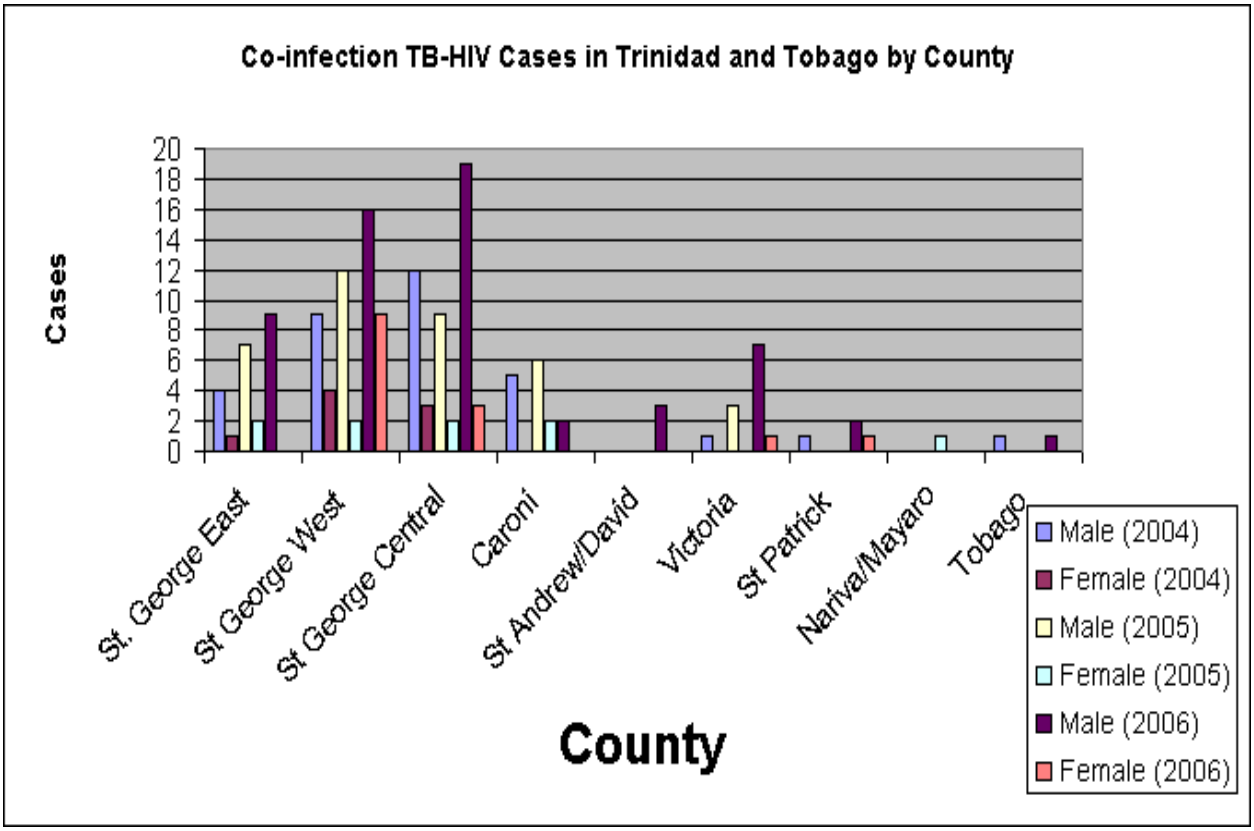


Table 4 below presents information on treatment outcomes for TB/HIV patients. In 2004 a default rate of 29.4% as well as a death rate of 29.4% were observed. This high default and death rate reflect the non-existence of a comprehensive direct observed treatment short course (DOTS) programme. An even higher death rate of 41.7% was recorded in 2005, though there was some reduction in the default rate which was 19.4%. The issue of adherence requires urgent attention. In this regard the MoH will need to pay particular attention to existing referral systems for the Opportunistic Infections which affect HIV/AIDS patients.

Table 4
TB/HIV Treatment Outcomes

Year	**2004**		**2005**	
Cured	7	20.6%	4	11%
Comp. Rx	7	20.6%	10	28%
Died	10	29.4%	15	42%
Defaulted	10	29.4%	7	19%
Total New TB Cases	34	100%	36	100%

Table 5

Seroprevalence rates for 2006

	Result
No. of HIV Tests Done	250
HIV Positive	73
HIV Negative	177
HIV/TB Deaths	22
HIV/LTBI	2

As can be seen in Table 5, 250 TB patients were tested for HIV and 73 were confirmed positive indicating a HIV/TB co-infection rate of 29.2%. Twenty two persons or 30.14% of those who were co-infected with TB/HIV died in 2006.

All suspected cases of TB, TB/HIV are referred to the Caura Hospital. In order to improve TB, TB/HIV data collection there is need to develop an extended surveillance system linking all other departments e.g. MRF, QPC&C, VCT centres, private hospitals and laboratories.

NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Trinidad and Tobago's HIV response continues to be coordinated and managed by the National AIDS Coordinating Committee comprised of representatives of the full range of stakeholders. The Trinidad and Tobago HIV and AIDS national response is a multi-faceted, multi-sectoral response which is guided by the National Strategic Plan (NSP) 2004-2008. The key responsibilities of the NACC are coordination of the national expanded response and policy advice. NACC has representation from the public and private sectors, civil society and people living with HIV and AIDS (PLWHAs) and is divided into five sub-committees consistent with the five priority areas identified in the NSP 2004-2008. Several of the Sub-Committees have formed working groups which co-opt ad-hoc members as required. The Chairs and Vice-Chairs of the various committees comprise the Executive Committee which meets regularly to examine critical issue and make key policy decisions.

In the final quarter of 2007, the NACC Secretariat initiated discussions with the Health Economics Unit of the University of the West Indies, St. Augustine with regard to a review of progress made on attaining the objectives of the current NSP, and preparation of terms of reference and a schedule for the development of the new NSP.

The NSP 2004-2008 proposed a major role for the public sector relating to mainstreaming HIV/AIDS within the public sector. This involves the formulation and implementation of policies that can and will influence the course of the HIV and AIDS pandemic and its impact on the public sector and the rest of the society. During the period under review efforts to further deepen the multi-sectoral response and expand the public sector response were further intensified with the assumption of duty of eight HIV/AIDS Coordinators in key ministries, including, the Ministry of National Security; the Ministry of Education; the Ministry of Sports and Youth Affairs; the Ministry of Community Development, Culture and Gender Affairs; the Ministry of Tourism; the Ministry of Local Government; the Ministry of Health and the Ministry of Labour, Cooperatives and Small and Micro Enterprise Development. These officers will act as co-coordinator and focal point for each ministry's response. The HIV/AIDS Coordinators have received training in HIV and AIDS mainstreaming and behaviour change and are expected to lead the efforts of the various ministries to fully integrate or mainstream HIV/AIDS into their normal work so that it becomes a part of their core business. The Ministry of Labour, Cooperatives and Small and Micro Enterprise Development has developed a workplace policy which has been submitted for approval; and the Ministry of National Security is receiving assistance from UNAIDS and the United States of American Department of Defense to develop a HIV/AIDS policy for the uniformed services.

TABLE 6

Priority Areas and Strategies in the NSP 2004-2008

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 behavior change intervention programmes targeted to young females. • Introduce behavior change interventions targeted to youths in and out of school. • Support behavior 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 PLWHAs and to the affected.
Advocacy and Human Rights	• Promote openness and acceptance of PLWHA in the workplace and in the wider community. • Creation of a legal framework that protects the rights of the PLWHA 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 PLWHA to better respond to the epidemic and increase the number of these support groups.

Prevention

PMTCT Programme

GORTT has placed tremendous emphasis on prevention and one of the lynchpins of its prevention programme is the Prevention of Mother to Child Transmission programme operated in all government pre-natal clinics. Pregnant women are offered Voluntary Counselling and Testing (VCT) and if tested positive are eligible to receive free anti-retrovirals. Table 7 presents information on the uptake of VCT by pregnant women attending public health facilities for 2006 (Data for 2007 is not yet available):

Table 7

Uptake of VCT by Pregnant Women attending Public Health Facilities

Category	2006
New Pregnant Women	13,589
No. of Women tested	15,378
Percentage of Women Tested	94.44%
No. of Women Previously Tested Positive	68
No. HIV positive ELISA	133

The total number of live births for all pregnant women in both private and public facilities in 2006 was 17,375 thus approximately 22% of pregnant women did not attend the public health facilities for ante-natal care. No data is available on prevention of mother to child transmission practices in the private sector.

Some of the challenges faced by the PMTCT programme are:

- Adherence of mothers who are HIV positive to the recommended treatment regime due to factors such as stigma and discrimination, provision of incorrect addresses, non-disclosure to partner/family regarding HIV status, migration within districts in Trinidad and Tobago etc.
- The quantity of formula for Nutritional Replacement feeding for HIV exposed infants was inadequate and appropriate requirements should be considered. It was suggested that formula should be offered up to age two (2) years. This component of the programme is being reviewed.

- Lack of coordination between doctors at the treatment centres and the doctors at the antenatal clinics;
- Low uptake in the testing of exposed infants;
- The absence of definitive and documented guidelines for health providers to follow resulting in inconsistencies in the management of HIV infected pregnant women, exposed infants, partners and families affected; and
- Non-adherence to all components of antiretroviral prophylaxis.

A comprehensive review of the PMTCT programme was undertaken during the first quarter of 2007, the review paid specific attention to the issues highlighted above and this has resulted in some measures being put in place to address these issues.

Counselling and Testing

During the period under review the Ministry of Health took several steps to develop a comprehensive counseling and testing policy to include, not only, VCT, but rapid testing and Provider Initiated Counselling and Testing. (PITC). As a result, rapid testing is now available at seven sites with several more sites scheduled to come on stream in 2008. As of September 2007, 7,842 rapid tests had been completed at the various sites with all positive tests being referred to THPL for confirmation. One Non-government organization offers counseling and testing services.

Knowledge, Attitudes and Behaviour Change

During the period under review a baseline survey of Knowledge, Attitudes, Practices and Beliefs (KAPB) was conducted by the University of the West Indies on behalf of the NACC. The study surveyed a representative sample of the 15-49 population with the aim of collecting information on KAPB with regard to HIV/AIDS for that age group and providing information to inform policy and programme design.

In general, the survey results revealed that there were high levels of awareness of HIV/AIDS in the population with 98% of the sample reporting that they had heard of HIV or AIDS. These high levels of awareness were evident across the entire country and social groups. Notwithstanding, knowledge of the difference between HIV and AIDS was not as widespread. Of the 1,798 persons interviewed 69% stated that there was a difference between HIV and AIDS. Knowledge of the difference between HIV and AIDS was found to be more widespread among those earning higher incomes, those engaged in professional and skilled occupations and those who had higher levels of educational attainment. Additionally, knowledge of the difference between HIV and AIDS was found to differ by geographic location.

The survey revealed that the impact of HIV/AIDS on the general population has been quite widespread as about 37% of those surveyed indicated that they knew someone who had HIV or had died from AIDS. A greater percentage of persons aged 25-49 (39.2%) indicated that they knew someone with HIV or who had died from AIDS. There was also significant variation by geographic location with Tobago and Port of Spain having the highest (46% and 43.1%, respectively) of respondents knowing someone who had HIV or had died from AIDS while, Victoria, St. Andrew and San Fernando had

the lowest percentages. It is to be noted that some 63.3% of the respondents declined to indicate if they had a close friend or relative who is HIV-positive or who died from AIDS. This appears to be consistent with a population in which stigma and discrimination against those living with and affected by HIV/AIDS remains pervasive.

On the whole, the survey found quite high levels of knowledge regarding ways to curb the transmission of HIV with no noticeable differences by age group. Approximately 90% of those surveyed were able to identify six key measures which can reduce the transmission of HIV. These were:

- Using a condom correctly every time;
- Having one uninfected faithful partner;
- Abstaining from sexual intercourse altogether;
- Avoiding intercourse with homosexuals;
- Avoiding intercourse with prostitutes; and
- Making sure that injections are done with clean needles.

Though all blood collected by the Blood Bank is screened for HIV, some 74.5% of those surveyed identified refusing a blood transfusion as one way of preventing the transmission of HIV. Though correct, future information, education and communication initiatives should make the population aware that the blood supply in Trinidad and Tobago is safe and that there has been no reported cases of HIV that can be attributed to a blood transfusion.

Close to two thirds (65%) of the respondents indicated that they had heard of the NACC's "What's your position" (WYP) campaign. It is important to note that the main target of the WYP campaign, youth (15-24) did indicate more widespread knowledge of the WYP with 73.3% of youth interviewed indicating that they had heard of the campaign. Some 78% of men and 82.6% of women in the sample revealed that the information received from the WYP campaign had led them to adjust their HIV risk behavior.

With regard to knowledge of the location of an HIV testing site 65.9% of those surveyed, stated that they were aware of a site where testing was done. It should be noted that a slightly higher percentage of females (67.9%) than males (63.3%) responded that they knew a site where HIV testing was done and that only 54.7% of youth 15-19 years knew where testing was available. This becomes all the more important in the context of the findings of the HIV/AIDS Service Provision Assessment (Measure Evaluation Project: University of North Carolina, Chapel Hill, NC and Macro International, Calverton, Maryland, 2006) which reported that there were no youth friendly testing sites in Trinidad and Tobago.

Sexual Practices

A key indicator of the practice of HIV risk reduction is postponed initiation of sexual activity. The KAPB study revealed a median age for initiating sexual activity of 18 years and that when compared to all other ages groups those 15-24 years had lesser proportions for every age of initiation of sexual activity with the exception of age 16. Further research is needed to determine if, during the most recent decade of the epidemic young persons have begun to delay the initiation of sexual activity. The survey

also pointed to the greater probability of youth 15-24 years (62.2%) using a condom during their first sexual encounter as compared to 38.5% for adults 25-49 years of age.

Treatment, Care and Support

MoH of Trinidad & Tobago is responsible for developing and managing care and treatment programmes for persons living with HIV infection and its complications. An essential aspect of this programme is the acceleration of training for caregivers. A small number of health care providers from Trinidad & Tobago have benefited from HIV/AIDS-related training by attending Caribbean HIV and AIDS Regional Training (CHART) Network's activities elsewhere in the Caribbean and to a lesser extent outside of the region. The recent launch of the Trinidad and Tobago Training Centre which is a collaborative effort of the MOH, the University of the West Indies St. Augustine, the South West Regional Health Authority, the International Training and Education on HIV and CHART will impact on the number of health care workers who are able to provide care and treatment services to PLWHAs. The Medical Research Foundation is the main national centre providing comprehensive treatment and care to adults with HIV/AIDS. Other care and treatment delivery sites are the Cyril Ross 'Nursery', which provides residential and out-patient care for less than 100 children with HIV/AIDS, the Paediatric Hospital at Mt. Hope, the San Fernando General Hospital, the Scarborough Regional Hospital and the Health Promotion Clinic.

During the 2006 and 2007 MOH treatment support services at the various delivery sites were enhanced with the provision of CD4 machines at four of the treatment sites.

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. A 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 has been undertaken and the report is being finalized.

Surveillance and Research

Two major studies were conducted and reported on during 2006 and 2007. These were the KAPB Study of a representative of the 15-49 population and the HIV/AIDS Service Provision Assessment. These studies have provided critical baseline data on a wide range of indicators relating to knowledge, attitudes, beliefs and actions taken to reduce risk, the volume, quantity, quality and range of services currently being provided, availability of policies and guidelines at service delivery sites and capacity gaps. This information will inform the development of the NSP for 2009-2013.

Programme Management, Coordination and Evaluation

A Programme Officer, Strategic Planning was recruited and commenced work in May 2007 to enhance the coordination efforts of the NACC and to provide critical support to the HIV/AIDS Coordinators assigned to the eight ministries.

Civil Society Organisations

NGOs continue to provide critical prevention, treatment, care and support services and are important partners of the NACC. Some of these NGOs facilitate access to the most at risk groups including:

- CSW
- MSM
- PLWHA
- Orphans and Vulnerable children

The NACC funds a range of proposals from NGOs and also provides technical assistance in support of the implementation of proposals. NGOs have been involved in the implementation of projects and activities which support some of the priorities of the NACC.

Prevention

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.

In 2006, there were 21 NGOs which undertook 1,293 prevention outreach activities directed at the general population. The following table provides summary information of the work done by NGOs in 2006.

TABLE 8

Summary Information on the Work done by NGOs in 2006

Type of Intervention	**No. of target group reached in 2006**
PLWHA Counselling	684
Home Based Care of PLWHA	1,186
Training in Home Based Care	42
Community Based Treatment Adherence Counselling (Persons trained)	57
Peer Education	872

Source: NACC Report on Civil Society Organisation Activities in 2006

Treatment Care and Support

In the third quarter of 2007, the Caribbean HIV/AIDS Alliance collaborated with the NACC, MoH, South West Regional Health Authority and South AIDS Support, conducted

a review of users perception of the quality of care at Ward 2 of the San Fernando General Hospital. Users reported general satisfaction with the quality of care provided and made suggestions with regard to more flexible clinic hours to facilitate employed PLWHAs and the need to sensitize health care workers in other wards and service delivery sites at the hospital in order to address stigma and discrimination.

BEST PRACTICES

National Prevention of Mother to Child Transmission Programme

Services for PMTCT are offered at all public antenatal and delivery services facilities. The key components of the PMTCT programme include:

- Pre- and post-HIV test counselling and testing of pregnant women for HIV
- Providing HIV positive women with counselling on infant feeding practices and importance of family planning to prevent transmission
- Provision of prophylactic ARV to the HIV positive women and her newborn (within seventy-two hours of birth)

The goal of the programme is to reduce transmission rate by 50% by2010. A review of the available data suggests that some success was achieved. In 2000, 19% HIV exposed infants tested positive, 81% tested negative; in 2005 among those tested 6.8% were positive and 93.2% negative. In 2006, 93.4%tested negative and 5.6% tested positive. Public antenatal services are decentralized and covered some 78% of pregnant women in 2006.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

The major challenges currently being faced and some actions that would contribute to the achievement of milestones and targets are summarized below:

CHALLENGES	ACTION REQUIRED
Limited sites which provide youth friendly services	Increase the number of sites which provide youth friendly services
Absence of a comprehensive surveillance system for HIV/AIDS which covers both the public and private sectors	Collaborate with consultants retained to review existing systems and urgently implement the recommendations that are accepted by GoRTT
Large numbers of persons particularly among the most at risk population segments remain reluctant to access testing and treatment and care services	Mount an intensive campaign to root out stigma and discrimination
Record-keeping and documentation of services provided are not routine	Incorporate the importance of accurate record-keeping and documentation in all training and support initiatives to enhance the surveillance system.
Policy guidelines for service delivery are not readily available nor diligently adhered to	Develop/Adapt national guidelines; conduct the appropriate training in the use of the guidelines and disseminate copies of the guideline to all service provision sites and service providers
ART services remain centralized	Establish new service ART treatment sites staffed with qualified and trained personnel and implement system to supervise and monitor sites
Availability and willingness of clinicians to provide HIV/AIDS care and treatment services	Provide incentives to attract clinicians and disseminate information on Universal Precautions and existing protocols for post exposure prophylaxis;
Enough training opportunities to update the skills of all the members of the treatment team	Intensification of training activities by the Trinidad and Tobago Training centre
Provider stigma is still evident	Intensive sensitization and training for all health care workers
Interventions tend to be targeted to the general population with limited	• Utilize the information provided by the KAPB Study to design

interventions specially designed and directed at high risk groups	appropriate targeted interventions • Finance research and studies of the most at risk groups

SUPPORT FOR 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) have been 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 Joint United Nations Programme on HIV/AIDS (UNAIDS) has provided support in the critical areas of monitoring and evaluation, advocacy and human rights, programme management and coordination and management of strategic information. The International Labour Organisation (ILO) provides ongoing support related to the development of work place policies and programmes, the United Nations Children's Fund (UNICEF) supports the design and implementation of prevention activities for in-school youth and the United Nations Fund for Women (UNIFEM) has supported an assessment to determine how well gender has been infused into the current NSP.

Actions that Need to be Taken by Development Partners

A review of donor activity in Trinidad and Tobago over the last two years reveals that there has often been duplication of efforts. Harmonization and coordination of donor efforts is thus an imperative. In 2007, several UN agencies resident in Trinidad and Tobago or in the Caribbean which service Trinidad and Tobago agreed to cooperate on the development of a joint programme of work on AIDS for the UN system in Trinidad and Tobago as a means of promoting a more effective and efficient use of resources. This is a very positive step which other development partners should be encouraged to emulate.

Monitoring and Evaluation environment

Monitoring and Evaluation (M&E) remains a challenge to the national HIV/AIDS response. This is mainly because of the lack of culture for M&E that exists among certain key stakeholders in the HIV and AIDS response. While there have been attempts by the NACC to establish a reporting system for the Ministry of Health and other civil society organizations, this has not as yet materialized. Therefore, the various sources of information have to approached in order to obtain the data required. The situation with respect to the Ministry of Health (the main source of information) is expected to improve with the recruitment of an M&E Officer that is expected to come on board by the beginning of February 2008.

Within the NACC, there exists no M&E Unit for monitoring and evaluation of the national response. There remains an M&E officer who is often faced with challenges in obtaining regular updates on implementation progress from program and project components. There is clearly a need for the establishment of a reporting system on key indicators for the monitoring and evaluation of the progress made in the multi-Sectoral response.

Eleven (11) coordinators for key Government Ministries have been recruited and are fully operational in the respective ministries. Their main focus is to mainstream

HIV/AIDS in all Governmental ministries. They report to the NACC on a monthly basis on progress made towards their objectives. There is also a CSO Coordinator that work closely with the Civil Society Organizations and report on their achievements.

Therefore, while as a country we are not where we would like to be with respect to M&E there are progress which are being made to improve it and our reporting.

ANNEX 1

There have been several consultations to date which have contributed to the preparation of this report. In 2006 focus groups discussions were held with key stakeholders (most being CSO) related to Universal Access to Prevention and Treatment and Care services.

Subsequently, there were consultations with key stakeholders most of which were CSO representatives in 2007 dealing with the selection of key indicators and the setting of targets. These indicators were selected based on World Bank and UNGASS requirements.