REPUBLIC OF TRINIDAD AND TOBAGO

UNGASS 2006

HIV/AIDSREPORT

United Nations General Assembly Special Session on HIV/AIDS

COUNTRY REPORT

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The TRINIDAD AND TOBAGO REPORT to the UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION (UNGASS) ON HIV/AIDS

STATUS AT A GLANCE

The first AIDS cases in Trinidad and Tobago (T&T) were reported among homosexual men in 1983. From then to the end of December 2005, a cumulative total of 15,940 HIV positive cases, a total of 5,603 AIDS cases with 3383 deaths due to AIDS were reported to the National Surveillance Unit of the Ministry of Health.

In the year 2004 in Trinidad and Tobago, an average of four new cases of HIV/AIDS were reported every day. The predominant mode of HIV transmission is heterosexual, with a male to female ratio of 55:45 with more females than males in cases reported in the 15-34 age group. 'Multiple sexual partners' is cited as the most frequent risk factor for HIV infection. Median age of reported HIV positive cases is 35 in males and 29 in females, with more than 85% of all AIDS cases reported are among the 20-59 year olds (Source NSU).

The epidemic is growing most rapidly in both sexes between 15 to 49 years. Forty-five percent (45%) of new infections occur in females, and 70% of new infections among 15-24 year olds occur in females. UNAIDS estimates HIV prevalence rate in adult population of Trinidad and Tobago at approximately 3.2% and the PLWHA population is estimated at approximately 29,000.

CONSTRAINTS IN TRACKING THE EPIDEMIC

The lack of an adequate surveillance system makes it difficult to determine trends over time. Other factors such as under-diagnosis, under-reporting and delayed reporting affect the completeness and quality of the information for analysis and planning. The figures stated by the National Surveillance Unit (NSU) are likely to be underestimated, since many HIV and AIDS cases may be missed by the existing surveillance system. Of the reported AIDS cases, a significant proportion is diagnosed within a few months of HIV positive result (only few cases are picked-up in the early stage of HIV disease). TPHL/CAREC is the only source of reported HIV positive cases, since comprehensive reporting from the private sector has yet to be established. AIDS cases are picked up by the National Surveillance Unit (NSU) from five (5) public hospitals.

There are a number of cases for which key information regarding socio-economic status, such as educational level and occupation, and co-factors for exposure for example, sexual contacts, partner information, condom usage, crack/cocaine use, is not available. This limits usage of the

surveillance data for targeting interventions for high-risk sub-populations. The surveillance system for Communicable Diseases in general and STIs in particular also requires strengthening.

CHALLENGES OF TRACKING HIV/AIDS

The challenges are as follows:

- HIV disease can be asymptomatic for years
- Stigma, discrimination and fear of disclosure create barriers to testing and treatment
- HIV and AIDS are reported differently which pose a challenge to standardize reports and analysis
- Different sources report HIV infections, AIDS cases and deaths
- Sensitive personal data and the need for confidential encoding-decoding cause risk of duplication
- Marginalized populations do not wish to be identified
- Incomplete reporting from the private sector
- Data collection forms are thus far inadequate to capture the required information
- Lack of cooperation of some medical personnel

The following table shows the status of the HIV/AIDS Epidemic and the response to date:

No.	UNGASS Core indicators	Amount calculated for indicator	Remarks/Response to date
1.	Amount of national funds disbursed by government	2003: TT$27,553,260 2004: TT$36,032,579	Comprehensive National AIDS Accounting has been done for 2003 and 2004
2.	National Composite Policy Index	Annex 2	The National Composite Policy Index has been completed through consultation with key stakeholders. The results are included in the report
3.	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	2005: 7.19%	75 Guidance Officers and Social workers have been trained in 2005 and 30 are presently conducting life skills classes in schools

4.	Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	2005: 11%	A Telephone Survey was done of 185 enterprises/companies to ascertain if they have HIV/AIDS workplace policies and programmes
5.	Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	2005: 48.5%	A 2005 STI Survey was conducted by a Consultant to assess the quality of STI Care. This report is being used to ensure that the decision makers take the necessary steps to improve STI services
6.	Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	2003: 85.01% 2004: 71.37%	All 104 health centres and all 6 public hospitals offer antenatal PMTCT services
7.	Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	2003: 91.39% 2004: 96.54% 2005: 96.95%	There are to date 7 HIV treatment centres in Trinidad & Tobago. Information was obtained from each treatment centre and aggregated
8.	Percentage of transfused blood units screened for HIV	2003: 100% 2004: 100% 2005: 100%	All blood (100%) is screened by the National Blood Transfusion Unit for HIV/AIDS. 12,967 and 13,742 blood units were transfused in 2003 and 2004 respectively
9.	Percentage of young women and men aged 15-24 who are HIV infected	2003: 15.5% 2004: 15.5% 2005: 16.3%	This information was collected from Sentinel reports prepared by the Ministry of Health, National Surveillance Unit. This data may be unreliable and unrepresentative due to small sample size and to sourcing from STI clinics etc.
10.	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy		This information is not readily available and it exists in patients' files. Information is to be collected from seven (7) treatment centres and aggregated
11.	Percentage of infants born to HIV infected mothers who are infected	2003: 8.76% 2004: 8.67%	There is no comprehensive system in place to date to test infants. In early 2006 we will begin PCR testing babies in the PMTCT Programme. There are approximately 600 babies to be tested.

OVERVIEW OF THE AIDS EPIDEMIC

The National Surveillance Unit (NSU) considers as HIV positive those cases which are only reported/confirmed by TPHL/CAREC. As was previously stated, HIV/AIDS cases are picked-up by NSU from five (5) public hospitals and classified by a Medical Epidemiologist from TPHL forms.

HIV/AIDS MORBIDITY AND MORTALITY

For the period under review, January 2003 to November 2005, the records show that there has been a decline in AIDS morbidity and mortality. There has been a steady decline in the overall number of new HIV positive cases, AIDS cases and deaths for the period.
From 1996 to 2004 was a 50% decrease in reported deaths due to AIDS. The highest number of reported AIDS deaths occurred in the year 1996 followed by 1998, in which there were respectively 256 and 254 reported deaths due to AIDS.
The reported deaths in 2004 due AIDS were 128.

From 2001 to 2004 there was a 44% decrease in reported AIDS cases
The highest number of reported AIDS cases occurred in the year 2001 followed by 2003, in which there were respectively 440 and 418 cases of AIDS reported.
In 2004 there were 246 cases of AIDS reported.

The mortality in 2005 shows a decrease, 43% of AIDS cases, in comparison with 50% in 2003. This decrease is likely due to antiretroviral treatment which has become more accessible in recent years. This is shown in table 1 below:

TABLE 1

HIV/AIDS Morbidity and Mortality Summary
2003-2005

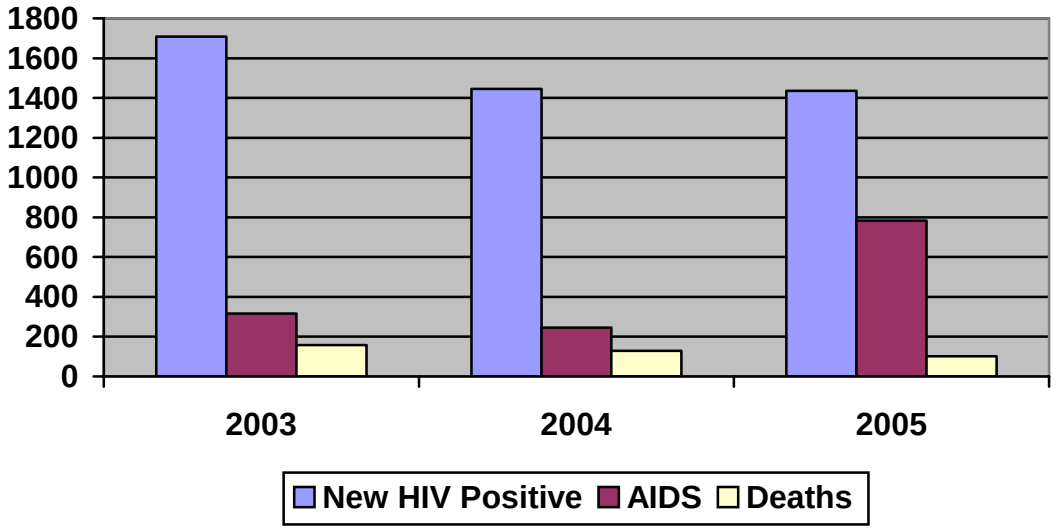
Cases	2003	2004	2005[a]	Total 2003-2005	Cumulative Total[a] 1983-2005
New HIV positive*	1718	1445	1436	4599	**15940**
HIV Non- AIDS**	1418	1266	1288	3972	**10936**
AIDS	321	246	216	783	**5494**
DEATHS	166	128	101	395	**3345**

[a] Provisional data for 2005
*** Total New HIV Laboratory confirmed cases from TPHL/CAREC**
**** Includes HIV asymptomatic and symptomatic (Non-AIDS cases).**
Source: National Surveillance Unit

From January 2003 to December 2005, there were reported 4,599 HIV positive cases, 783 cases of AIDS and 395 deaths.

GRAPH 1

HIV/AIDS MORBIDITY AND MORTALITY SUMMARY
2003-2005



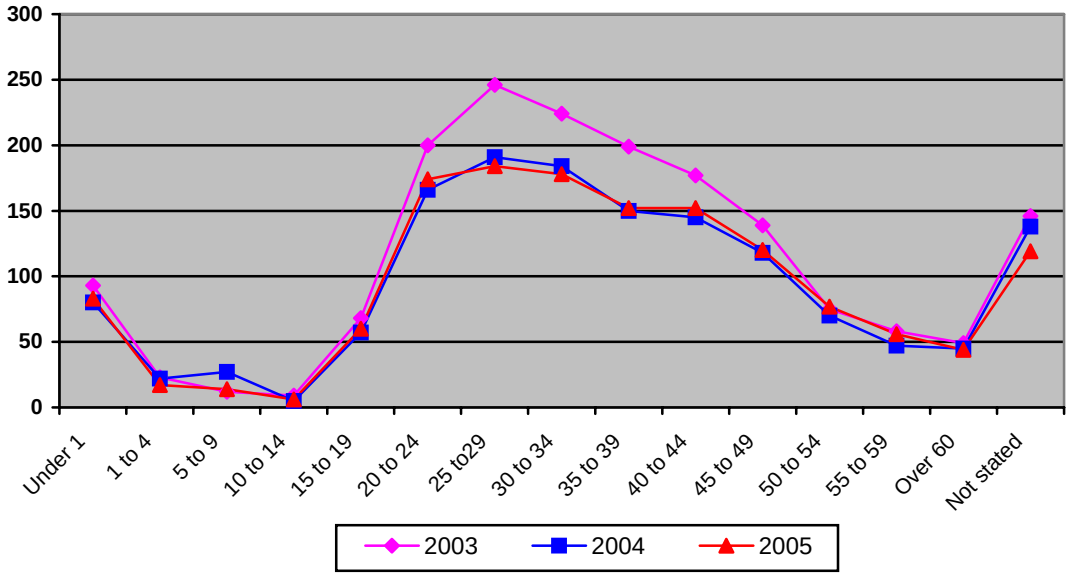
The proportion of AIDS cases to HIV cases was 1:19 in 2003, 1:17 in 2004 and 1:15 in 2005. The AIDS mortality trend in 2005 shows a decrease in deaths in comparison with 2003.
In 2003, the highest number of AIDS deaths occurred in the 30-34 years age group (27 cases). In 2004, the highest recorded number of deaths was in the 40-44 years age group (32 cases).

In the period under review, most positive cases were reported between 20 to 49 years old; 69 % of new HIV positive cases in 2003, 66% in 2004 and 67% in 2005. However, female positive cases from 15 to 29 years were more reported than males in the same age group averaging 65% of reported cases. This maybe the result of increased VCT services at antenatal clinics in Trinidad and Tobago's Health Centres through the PMTCT programme.

From 2003 to 2005 there has been a shift in the ratio of males and females from age group 30-49 with more males than females constituting the new HIV cases. The highest ratios of male to female new HIV cases were recorded in 2005.

Graph 2

New HIV Positive Cases at TPHL by Age Group
2003-2005



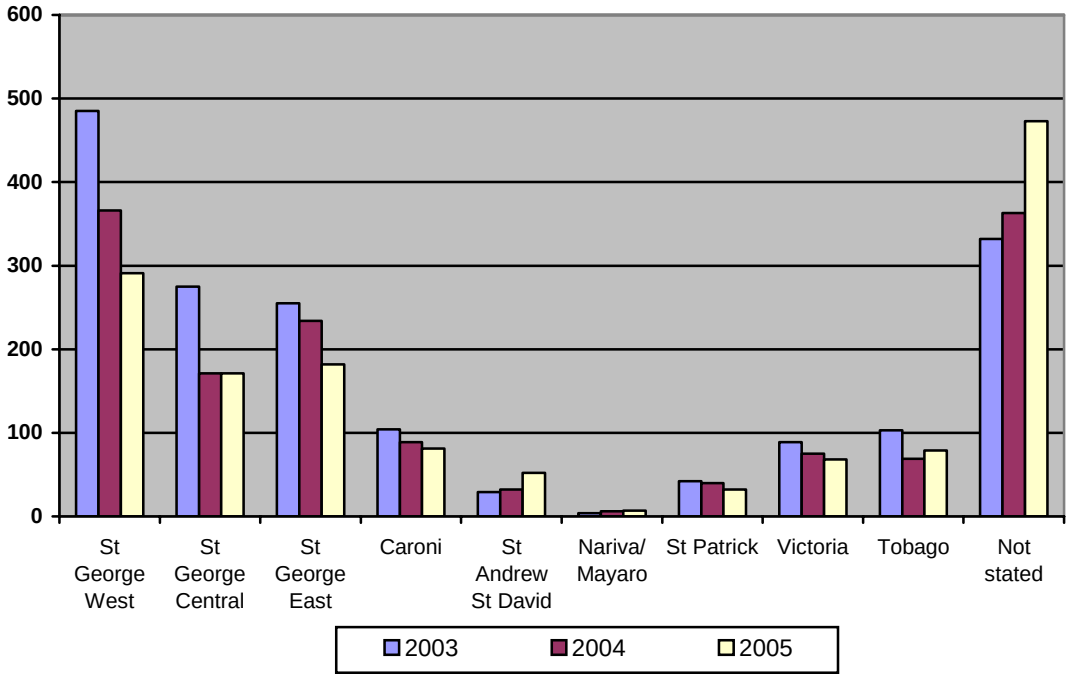
[a] **Provisional data for 2005**
Source: National Surveillance Unit

Graph 2 shows that there has been a steady decline in new HIV infections over the period 2003 to 2005. This may be due to the acceleration of the prevention programmes undertaken by the NACC, other government ministries, Civil Society and the private sector which have resulted in more responsible behaviour from some of the population. Even though there is much more work to be done, the statistics are encouraging.

During 2003 to 2005, sex was reported as "unknown" for 3% of HIV positive cases and age was not recorded for 9% of HIV cases. This trend indicates that some patients did not give complete and reliable data, which could be due to fears related to confidentiality and social discrimination.

Graph 3

HIV Reported Cases by Health Administrative Districts
2003-2005

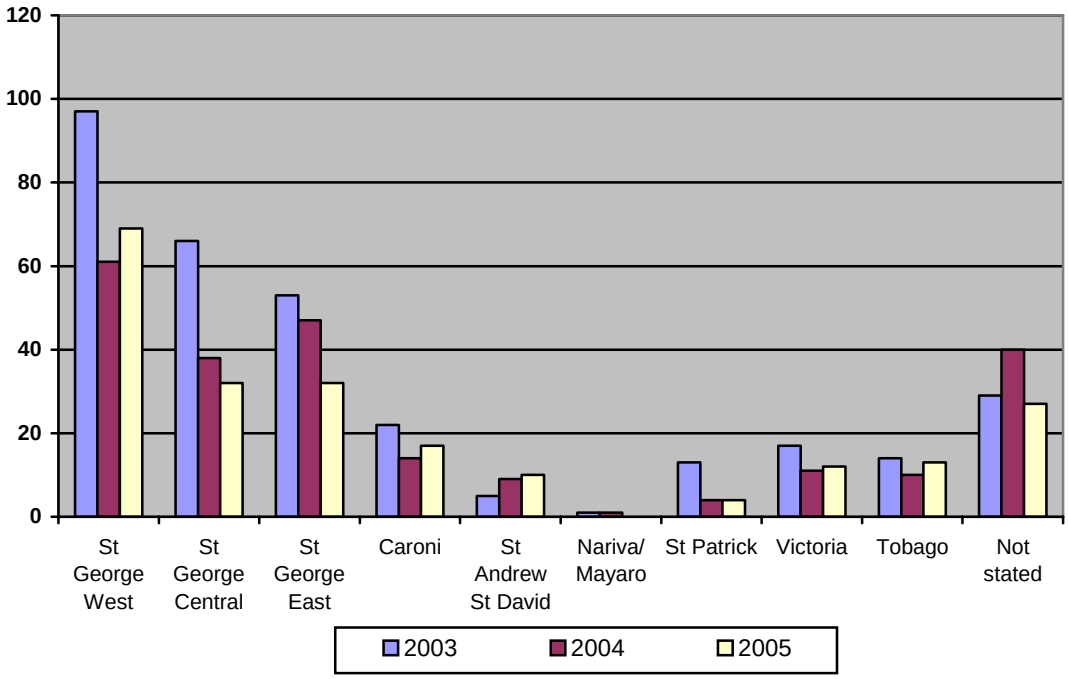


[a] **Provisional data. For 2005**
Source: National Surveillance Unit

County St George (west, central and east) is the most populated area in Trinidad and Tobago with 541,855 habitants, which accounts for 43% of the country's population (C.S.O. Census 2000). Most HIV positive cases (78%) were reported from St George and unidentified (not stated) area, in the period under review. However, the proportion of patients from County St. George has decreased from 59% in 2003 to 46 % in 2005, and from "not stated areas" has increased from 19% in 2003 to 32% in 2005. This could be due to patients desiring to seek care outside of their catchment area, persons seeking testing and treatment from other Caribbean islands and migration from rural to urban areas.

Graph 4

AIDS Reported Cases by Health Administrative Districts
2003-2005



[a] **Provisional data for 2005**
Source: National Surveillance Unit

During January 2003 to December 2005, 831 cases of AIDS were reported. Most of these AIDS cases, 370, were reported in 2003. There is a possibility that the fall in AIDS cases by 42% from 2003 to 2005 is due to increased accessibility to ARV. As a consequence persons are progressing to AIDS more slowly than before.

As shown in the graph above, by areas, St George West reported more HIV/AIDS cases in this period; 91, 61 and 69 cases for 2003, 2004 and 2005 respectively. All patients were referred to the treatment centres for ART. Compared to other counties, St. George is considered a high prevalence area.

Table 5

Deaths Reported by Health Administrative Districts
2003-2005

County	2003	2004	2005 [a]	Total 2003-2005
St George West	67	53	34	**154**
St George Central	31	22	17	**70**
St George East	26	19	17	**62**
Caroni	8	9	7	**24**
St Andrew/ St David	6	4	5	**15**
Nariva/ Mayaro	0	0	0	**0**
St. Patrick	3	1	5	**9**
Victoria	8	6	5	**19**
Tobago	1	4	3	**8**
Not Stated	7	10	8	**25**
All Counties	157	128	101	386

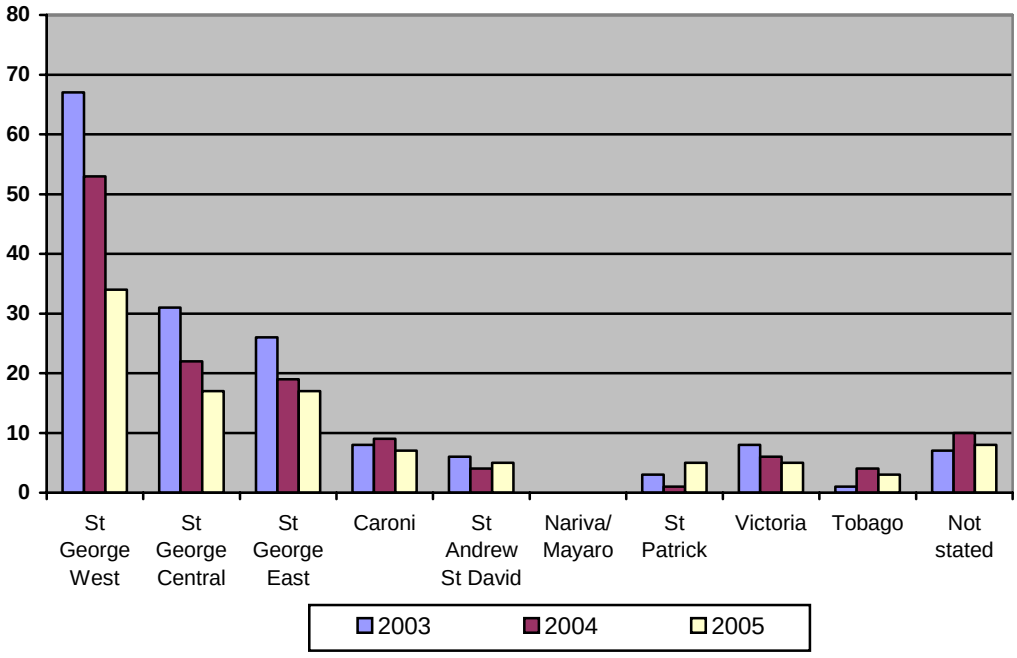
[a] Provisional data for 2005
Source: National Surveillance Unit

From the above table, most deaths, 74%, were reported from County St George (Central, East and West) in the period under review. This is not surprising, given that this county accounted for the highest number of AIDS cases.

The number of deaths has decreased more quickly than the AIDS incidence rate, indicating that the people with HIV are progressing at a slower rate and PLWHA are living longer.

Graph 5

Deaths Reported by Health Administrative Districts
2003-2005



[a] **Provisional data. For 2005**
Source: National Surveillance Unit

Over the period under review, there has been a decline in HIV cases, AIDS cases and the number of AIDS related deaths in the St. George County. There was a significant decline in HIV cases between 2003 and 2005 across all counties averaging 248.

Table 6

Co-factors for exposure in HIV cases
2003-2005

Sexual Exposure	2003	2004	2005 [a]
Men who have sex with men	26	9	17
Men who have sex with women	241	150	113
Men who have sex with women and men	10	13	17
Women who have sex with men	275	155	101

[a] **Provisional data. For 2005**
Source: National Surveillance Unit

Table 7

Co-factors for in HIV transmission by Route and Sex
2003-2005

Transmission	2003			2004			2005 [a]		
	M	F	T	M	F	T	M	F	T
Sexual Exposure	276	271	**547**	129	116	**245**	147	101	**248**
IV Drug Use	3	0	**3**	0	0	**0**	0	0	**0**
Blood Transfusion	0	0	**0**	0	0	**0**	0	0	**0**

[a] Provisional data for 2005
Cases reported as having used intravenous drugs and had blood transfusion

In the period under review 92% of HIV/AIDS patients contracted HIV through heterosexual exposure. This is the main mode through which persons are exposed to the disease. There was no case reported from blood transfusion. In 2003 three males who contacted the disease were IV drug users (see tables 6 and 7). It is uncertain whether these infections were acquired in Trinidad and Tobago or abroad (e.g. before relocation/deportation).

Table 8

Paediatric HIV cases
2003-2005

Paediatric HIV cases	2003	2004	2005 [a]
Infants of HIV positive mothers	60	31	41
Paediatric cases under investigation	108	138	91
Total	168	169	132

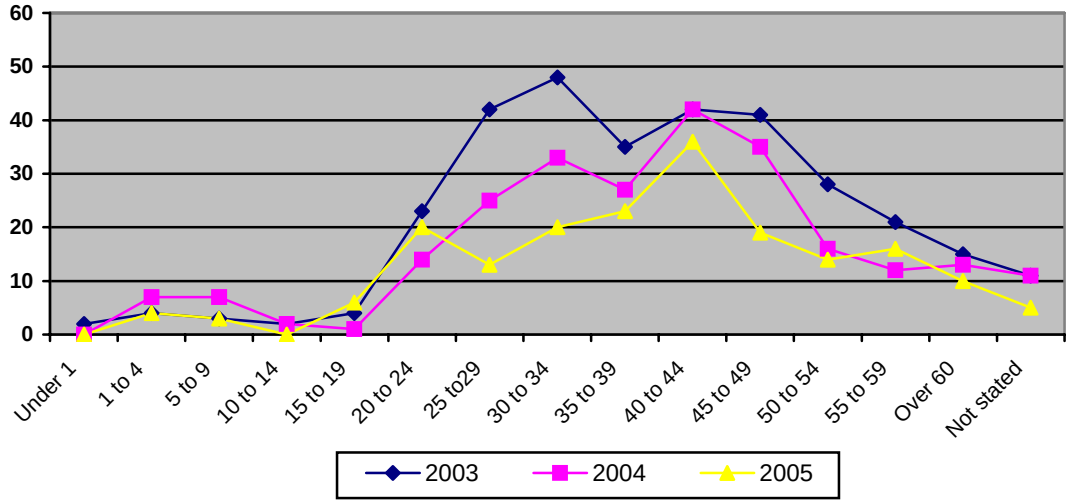
[a] Provisional data for 2005
Paediatric cases are children under 13 years old

HIV and AIDS among women present an increased concern because of the potential for transmission to their infants. Infants of HIV positive mothers have declined from 60 in 2003 to 41 in 2005. This is because of the excellent PMTCT Programme of the Ministry of Health, where a total of 95% of pregnant women attending public antenatal clinics are tested. If they are HIV positive, they are offered prophylaxis to prevent transmission to their babies.

During the period under review, most of the cases were Paediatric cases under investigation. Pre-natal HIV testing of pregnant women is encouraged at all health centres to avoid the perinatal transmission.

Graph 6

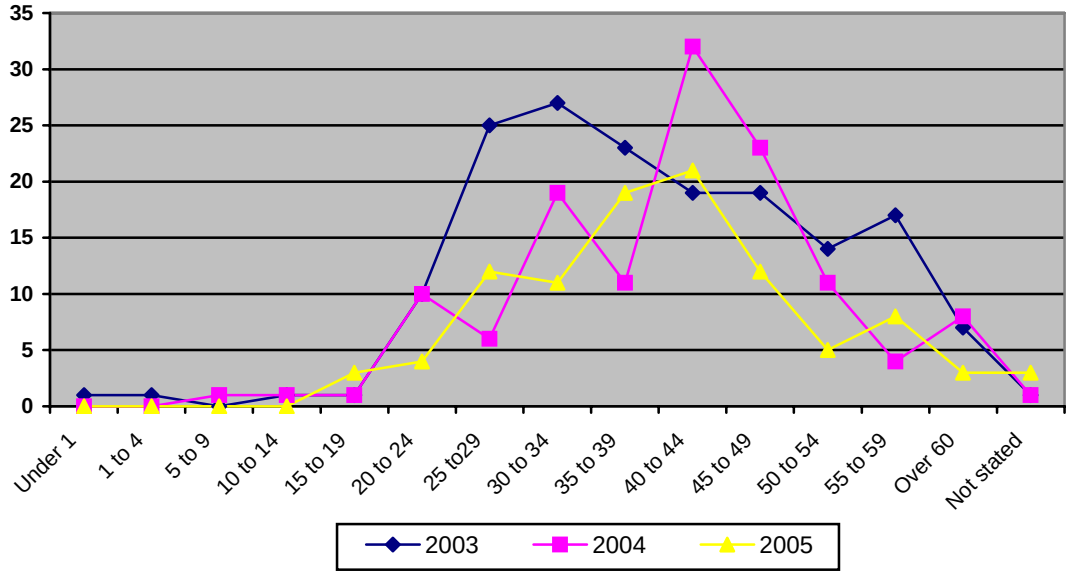
AIDS Reported Cases by Age Group
2003-2005



In the period under review, most cases were reported between 20 to 49 years old, 72% of all the cases in 2003, 72% (2004) and 70% (2005). Overall, there has been a steady decline in AIDS reported cases.

Graph 7

AIDS Reported Deaths by Age Group
2003-2005



Most deaths were in males averaging 64%. This trend could be due to women being detected and treated with antiretroviral drugs through antenatal clinics very early. Additionally, most deaths were reported between the 20-49 age group. This accounted for 74% of all deaths in 2003, 79% in 2004 and 76% in 2005. This age group is considered a high risk group for HIV infection.

Table 9

Paediatric AIDS Cases and Deaths
2003-2005

Paediatric HIV cases	2003		2004		2005 [a]	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Infants of HIV positive mothers	0	0	1	0	2	0
Paediatric cases under investigation	15	3	19	1	8	0
Total	**15**	**3**	**20**	**1**	**10**	**0**

[a] Provisional data.
Source: National Surveillance Unit
Paediatric cases are children under 13 years old

There was no case of death of infants of HIV positive mothers reported in this period. In addition, AIDS paediatric cases and deaths have decreased significantly in the period. This trend may be due to antiretroviral treatment that has been more accessible.

NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Trinidad and Tobago's HIV response is now being managed by the National AIDS Coordinating Committee, Office of the Prime Minister.

Historically, the Ministry of Health established a National AIDS Programme in 1986 with assistance from the WHO Global Programme on AIDS. A National Multi-sectoral AIDS committee was formed and a national programme was launched. The main focus of the programme was on prevention of HIV transmission. Initiatives included media campaigns peer education, use of art form in various outreach programmes, incorporation of HIV/AIDS in family life education in schools and training of church leaders.

There appeared to be widespread knowledge of HIV/AIDS as a result of these efforts. While these efforts seemed appropriate at the time, the rate of infection continued to increase. In 2003, the government of Trinidad and Tobago with technical and financial assistance from international agencies embarked on an expanded response to HIV/AIDS.

This programme was informed by the Regional Strategic Plan developed under PANCAP, as well as 'The Three Ones' concept.

The National AIDS Coordinating Committee (NACC) was launched in March 2004 in the Office of the Prime Minister. This body is mandated to coordinate a wide range of HIV/AIDS activity as part of the national expanded response to the epidemic. The NACC is a policy advising body with representation from public and private sectors, civil society, and PLWHA. Sub-committees of the NACC for each of the five (5) priority areas have been established to give greater attention to the comprehensive range of strategies devised to reverse the impact of the epidemic.

The National AIDS Strategic Plan (NSP) 2004-2008 was developed with assistance from the Health Economics Unit of the University of the West Indies. The Plan incorporates policy and strategies to address the key priority areas in response to the AIDS epidemic.

A major accomplishment in 2005 was the approval by Cabinet of full-time HIV Focal Points in 8 Government Ministries, to work with the NACC in scaling up the multi-sectoral effort.

Table 10

Priority areas and Strategies

No.	Priority areas	Strategies
1	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 pose exposure services. • Increase knowledge and awareness of the symptoms of CSTIs. • Ensure effective syndromic management of CSTIs. • Provide "youth friendly" sexual and reproductive health services.
2	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.
3	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.
4	Surveillance and research	• Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. • Conduct effective epidemiological research and clinical trials.
5	Programme Management, Coordination and Evaluation	• Develop an appropriate management structure for the national expanded response. • Gain wide support for the National Strategic Plan. • Mobilize adequate and sustained resources to support implementation of the strategic plan (NSP). • Monitor the implementation of policies and programmes as outline in the NSP. • Strengthen the key constituents of NACC. • Strengthen support group for PLWHA to better respond to the epidemic and increase the number of these support groups.

Prevention:

PMTCT Programme

In Government's response to HIV/AIDS, there has been the implementation of a comprehensive PMTCT programme. Pregnant women in all government pre-natal clinics are offered VCT and those who are positive have free access to ARVs. ARVs are also being provided free of charge to all PLWHA who need them, however clinical care needs to be more decentralized. This is being addressed at present.

The following is the uptake of VCT by pregnant women attending Public Health Facilities for 2003 and 2004 (data not yet available for 2005):

Category	Year 2003	Year 2004
New pregnant women	15,986	11,589
# of women tested	15,295	11,001
% of women tested	96%	95%
# of women previously tested positive	20	37
# HIV positive ELISA	124	113
Positive rate per 1000	8.1	10.2

Voluntary Counselling and Testing

Since 2003 several VCT training programmes have been undertaken and a wide range of VCT sites established. Despite the availability of VCT, the major challenges are stigma, discrimination and confidentiality, which act as a deterrent to accessing care and treatment. Additionally, the legislative framework to protect the rights of PLWHA is currently being reviewed and updated. Government has also shown its commitment by making funds available for training in this area.

Knowledge and Behaviour change

The NACC has a mandate which includes the coordination of communication strategies that engage the public at large to effect behaviour change, in order to curb the spread of HIV in Trinidad and Tobago. In August 2004 the NACC formed the Information Education and Communication (IEC) Committee to undertake this task. Through a series of consultations, the committee has developed a National Communication Strategy for HIV/AIDS. A Behaviour Change Consultant has been identified and is soon to assist the NACC in refining its ongoing IEC Campaign to effect change in behaviour.

In the expanded IEC campaign HIV/AIDS issues have been more visible through the use of print and electronic media as well as through other public education initiatives. There are various government and non-governmental organizations involved in promoting IEC initiatives in order to bring about behaviour change. The NACC has been very successful in partnering with the country's calypso and soca artistes, as well as popular media personalities in reaching out to the youth. There have been a series of strong carnival campaigns designed to reduce risky behaviour.

The NACC has procured the University of the West Indies to undertake a Knowledge Attitude, Practices and Behaviour (KAPB) Survey of the general population between the ages of 15-49 years. The Survey is expected to take place early in the first quarter of

2006. This would give the NACC much needed information to better design its IEC interventions. Other behavioural surveys are being planned for high risk populations in Trinidad and Tobago: youths in and out of school, MSM, CSW etc. Expressions of Interest have already been received to undertake these surveys.

Advocacy and Human Rights:

An Advocacy and Human Rights Subcommittee formed working groups to concentrate on three aspects: the establishment of a legislative framework to protect the rights of PLWHAs; communication issues and public awareness; and the world-of-work issues as it relates to HIV and AIDS.

A Steering Committee was formed to develop a Terms of Reference to procure a consultant who is reviewing the legal framework, policies and existing laws in Trinidad and Tobago as they relate to HIV and AIDS and will make recommendations for new legislation to protect against human rights infringements and AIDS-related stigma and discrimination.

Civil Society Organizations

These organizations have been strong strategic partners in the national response to HIV/AIDS. The NACC has given wide support to Faith-based groups, Comminity Organisations, and NGOs by providing computer equipment, laptops, multimedia projectors, filing cabinets, printers, scanners, photocopiers and other material relevant to HIV work. The NACC also funds a range of proposals submitted by these groups for activities in support of the NSP.

The following are some of the areas in which civil society organizations have been involved:

Prevention:

The NGO community has been deeply involved in prevention work, from as early as the 1980s. They have been the pioneers in school and workplace sensitization, condom distribution, and the dissemination of information on STIs and other sexual and reproductive issues. This work continues today, with more civil society organisations joining the fight continuously.

There are 17 NGOs at present that undertake prevention programmes for the general public and 26 NGOs that undertake youth specific prevention programmes. During 2004 and 2005 there were a total of 1,678 and 1,498 prevention outreach activities being undertaken by NGOs respectively. The following table shows the work done by NGOS for 2004 and 2005:

Type of Programme	No. of programmes for 2004	No. of programmes for 2005
Prevention outreach activities	1,678	1,498
Peer educators trained	754	771
PLWHA Support Counselling	797	810+
Home or community based care	101+	197
Persons trained in Home-based care	797	792
No. of persons trained in adherence counselling	58	135

Source: NGO Consultant Report

Treatment, care, and support:

Cyril Ross Nursery, a home for HIV/AIDS orphans, has been in operation since the 1980s, and is the only home existing in T&T specifically to care for children living with HIV/AIDS. In addition to their 38 children, they run a successful out patient clinic on weekends for children living with HIV/AIDS whose parents are still alive or who are fortunate to have guardians.

NGOs run quality, regularly scheduled support group meetings throughout Trinidad and Tobago for the following groups:

- MSM
- CSW
- PLWHA (general)

In addition, there is soon to be a support group specifically for young persons, as ground work for this programme has already begun.

Knowledge and Behaviour Change:

In this area, significant work has been done where collecting information is concerned. The list below itemises some of the documents produced:

- FPATT produced a 2000 report on Youth and Sex in Tobago conducted in collaboration with the Netherlands Embassy

- In 2003, the T+T HIV/AIDS Alliance produced an Ethnographic Survey of the clients of their 12 support groups.

- 1999, 2001, and 2005 – Baseline surveys on sexual behaviour among young people in the villages along the North East coast of Trinidad were conducted by the Toco Youth Sexuality Project

- Also in 2005, the Toco Youth Sexuality Project conducted a survey on drug use and HIV/AIDS in the North Eastern Coastal villages of Trinidad.

Studies such as those above have been useful in informing the format for NGO community interventions, peer educator training curricula, and sensitization programmes.

Advocacy and Human Rights:

- The NGO community has always been very present in all facets of the media, sharing information with the public, as well as advocating the government to hold to various regional and international commitments and agreements. In addition, this community has been instrumental in the country's observance of World AIDS Day, holding various activities throughout the country, from marches, to health fairs, to workplace sensitization, and panel discussions on radio and television.

Major Challenges faced and actions needed to achieve the goals/targets

The following are an outline of some of the major challenges faced to date and the action needed to achieve the goals/targets:

CHALLENGES	ACTION NEEDED TO ACHIEVE GOALS/TARGETS
Bureaucratic approval process which often delay projects	To give more autonomy to the NACC
To get Ministries to develop Sector Plan for HIV/AID and implement them	More visible political commitment t response Increased human resources needed
Greater involvement of NGOs and coordination of the work	Human and financial resources, mobilizati capacity building for NGOs
Lack of monitoring and evaluation capacity which makes collection of information difficult	Establishment of a national M&E System and the resources and commitment to implement it
Inadequate surveillance system	Training, capacity building and developm databases
Lack of human capacity to implement many of the projects	Have dedicated staff for HIV/AIDS projects/activities, need for training

Challenges faced within the PMTCT Programme

- More trained personnel to function effectively in the area of voluntary pre and post test counselling as well as care and treatment
- Staff shortage among nursing personnel, nutritionist, psycho-social support
- Additional infrastructure to enable privacy and confidentiality
- Migration of mothers within the country, therefore there is lack of follow-up
- Lack of partnership with private doctors to provide VCT
- Stigma and discrimination
- Perception of lack of confidentiality
- Lack of a computerized data system
- Limited sites for treatment and care
- Lack of adequate accommodation for administration and management of the programme
- PTMTCTP needs to be integrated into the Maternal Child Health Services in the country

RECOMMENDATIONS

- Maintain ongoing training of health personnel in the areas of pre and post test counselling; stigma and discrimination; follow-up care and treatment
- Increase the number of sites to access care and treatment with appropriate training of staff
- Appoint liaison officers to maternity units at large hospitals to maintain continuity of care and to identify cases who were not tested prior to admission for delivery or other interventions
- Provide databases that will allow for an efficient data collection and analyses in a timely manner
- Integrate PMTCT data with National Surveillance Unit data
- Establish partnership with private doctors in order to offer VCT to 100% of pregnant women
- Research socio-economic and cultural factors as they relate to HIV/AIDS in T&T
- More visible political commitment and openness to PLWAs.
- Continued expansion of the multi-sectoral response.
- Scaling-up of school-based prevention activities in a comprehensive manner.

Views from civil society organizations on major challenges faced and actions needed

The following are some of the general comments made:

Political will should be evidenced by greater and more visible involvement of senior officials and politicians in national HIV/AIDS activities. It is critical that continuous sensitization be conducted with senior officials and politicians.

The human rights of PLWHAs are still sometimes disregarded as manifested by their isolation on hospital wards and use of disposable dishware, which is not the lot of other patients.

The lack of appropriate research and surveillance tools has been highlighted as a major predicament in responding to the epidemic. Critical to success is the need more mass sensitization and relevant communication and skills building on a more sustained basis throughout the community. This coupled with culturally sensitive and innovative behaviour change interventions and advocacy strategies that are properly packaged, can result in further success.

Other challenges to the national response to the epidemic are highlighted below:

- Stigma and discrimination against PLWHAs; MSM and Gay Communities; Drug Abusers; Sex workers
- Inadequate inclusion of PLWHA driving the response to the epidemic
- Lack of thorough drug abuse rehabilitation programmes
- Restricted insurance coverage for some groups re: PLWHAs
- Unsupportive legislature re: Sodomy/Buggery Laws, laws against CSWs.
- The need for more decentralized access to Treatment & Medication (both in Trinidad and Tobago)
- Confidentiality breeches re: public health care providers
- Lack of adequate follow-up regarding pre- and post-test counselling
- No contact tracing for HIV/AIDS
- Abstinence Only education targeting Youth and Schools by some Ministries
- Inadequate of HIV/AIDS Education and Prevention initiatives targeting Prison System (personnel and inmates)

There are insufficient services targeting MSM communities. MSM individuals identified confidentiality issues with public and private Health Care Services and getting tested. Some stated their preference to be anonymously tested in other neighbouring islands. MSM communities also stated that stigma and discrimination and personal bias was practiced by some public healthcare providers in which they still believed that HIV/AIDS was a gay/drug user/sex worker disease. MSM individuals identified the need to sensitize public healthcare providers as to the issues and concerns of MSM communities.

SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Development partners can assist country in achieving their goals/targets by:

- Becoming more involved in the planning and implementation of various projects
- Offering technical assistance to implementation partners
- Supporting the inclusion of NGOs as equal partners in HIV/AIDS strategic planning and ensuring adequate resources for HIV/AIDS activities in budgets
- Greater support for M&E and the establishment of M&E Systems
- Building the capacity of the public sector
- Capacity community building through training and exchange programmes
- Offering broad support to the priorities of the National Response, as opposed to the agenda of their particular agency.

MONITORING AND EVALUATION ENVIRONMENT

Programme activity monitoring represents the main challenge facing the NACC. The country lacks essential systems and procedures, particularly those required for:

- Monitoring programme progress of recipients and communicating achievements; and
- Reviewing overall national programme progress, with particular reference to geographic focus, coverage and equity, interventions and service to vulnerable groups.

With the establishment of the NACC, the M&E Coordinator has sought to establish the infrastructure for establishing a national M&E system. To date the following have been achieved:

- The identification of national indicators for the HIV/AIDS response
- The establishment of an M&E Technical Committee comprising of representatives from various stakeholder agencies.
- Development of an M&E Plan and Framework

On-going technical assistance is provided by the M&E Adviser, UNAIDS Caribbean RST in collaboration with other partners.

A regional M&E Technical Working Group was formed in September 2003 comprising CAREC, CCNAPC, CHRC, UWI, UNAIDS, USAID/Measure Evaluation, CDC, PAHO and the World Bank. The group meets bi-monthly and has responsibility for coordination of technical assistance provision, advisory, harmonization, and advocacy. The TWG's strategic activities in the region include:

- Technical revision of Caribbean indicators and measurement tools – in line with GFATM/WB and other donor harmonization
- Development of regional M&E Framework to guide collaborative process of M&E systems strengthening.

The current focus of the TWG is on multi-partner data collection missions to support GFATM and UNGASS reporting and strengthening national M&E systems. Trinidad and Tobago has requested support from the M&E TWG for assistance with the following:

- Data flow mapping
- Data collection and abstraction forms
- Informatics
- Timely reporting to donors
- Data use and dissemination for improved programming

Further M&E assistance required:

- Design of an overall M&E system
- Ensuring that the M&E system is tested, refined and fully implemented by the NACC, and specifying further steps that the NACC must take
- Training in M&E for implementation partners
- Establishment of a database for M&E indicators
- Review of forms for capture of data for indicators

Annex 1: Consultation/preparation process for the national report

The Monitoring and Evaluation Coordinator was responsible for the collected of the UNGASS indicators and the development of the UNGASS report for the period January 2003 to December 2005. This process was supported by the M&E Technical Committee comprising of stakeholders from but local and international agencies. These stakeholders provided technical feedback on indicators and the preparation of the report.

The following were the steps for the development of the country report for UNGASS:

1. Data needs and sources of information were identified with the input from the UNAIDS M&E Advisor
2. Information on ART existed in the flies at the various clinics. Therefore persons were identified by the various clinics to be contracted to put the information on a data base and at the same time provide the information needed for the indicators
3. Discussions were held with key stakeholders from civil society in order to get their inputs for the report
4. The National Surveillance Unit was approached to get information on the status of the epidemic
5. Data was collected from the various sources and analysed
6. Data was inputted into the CRIS
7. Report was drafted based on information from various sources
8. Report was drafted and circulated to the various stakeholders
9. Meetings were held with stakeholders which included government, international agencies, and civil society and comments were incorporated in report in order to finalize it
10. Finalization of report

Surveys carried out:

1. In order to get information on the indicators the following surveys and meetings were carried out:
2. STI Survey
3. Stakeholders meeting for the National Composite Policy Index
4. Workplace survey which was done in-house
5. Survey of Civil society by consultant for their input into the report

ANNEX 2– List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retrovirals
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CAREC	Caribbean Epidemiology Centre
CBO	Community Based Organisation
CDC	Centres for Disease Control
CHRC	Caribbean Health Research Council
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
GOTT	Government of Trinidad and Tobago
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have sex with men
NACC	National AIDS Coordinating Council
NGO	Non Governmental Organization
FBO	Faith based organization
NSU	National Surveillance Unit
PAHO	Pan American Health Organisation
WHO	World Health Organisation
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
RST	Regional Support Team
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing
TPHL	Trinidad Public Health Laboratory
CSO	Central Statistical Office
MSM	Men who have sex with men
CSW	Commercial sex worker
IEC	Information Education and communication