REPUBLIC OF
TRINIDAD AND TOBAGO

NATIONAL HIV AND AIDS STRATEGIC PLAN 2013 - 2018

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2013 – 2018

Office of the Prime Minister

Republic of Trinidad and Tobago

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The Plan reflects the vision and aspirations of the range of partners and stakeholders in the HIV response who contributed fully and enthusiastically to the development process.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral
ASAP	AIDS Strategy and Action Plan
CARe	Community Action Resource
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community Based Organization
CDC	Centers for Disease Control
CHART	Caribbean HIV AIDS Regional Training Network
CHRC	Caribbean Health Research Council
CME	Continuing Medical Education
COHSOD	Council of Human and Social Development
CSO	Central Statistical Office
CSOs	Civil Society Organizations
CSTI	Conventional Sexually Transmitted Infection
CSW	Commercial Sex Worker
CT	Counselling and Testing
DBS	Dried Blood Spot
EAP	Employee Assistance Programme
ECA	Employers Consultative Association
EWMSC	Eric Williams Medical Sciences Complex
FBO	Faith Based Organizations
FPA	Family Planning Association
GoTT	Government of Trinidad and Tobago
HAART	Highly Active Antiretroviral Therapy
HACU	HIV and AIDS Coordinating Unit
HASC	HIV and AIDS Workplace Advocacy and Sustainability Centre
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HYPE	Helping Youth Prepare for Employment
IDU	Intravenous Drug Use
IEC	Information, Education and Communication

ILO	International Labour Organization
IRO	Inter-Religious Organization
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MIC	Metal Industries Company Ltd
MLSMED	Ministry of Labour and Small and Micro Enterprise Development
MoAG	Ministry of the Attorney General
MoAM	Ministry of Arts and Multiculturalism
MoE	Ministry of Education
MoF	Ministry of Finance and the Economy
MoGYCD	Ministry of Gender, Youth & Child Development
MoH	Ministry of Health
MoNS	Ministry of National Security
MoOP	Ministry of Planning and Sustainable Development
MoPSD	Ministry of the People and Social Development
MoS	Ministry of Sport
MoSTTE	Ministry of Tertiary Education and Skills Training
MRC	Medical Research Centre
MRF	Medical Research Foundation
MSM	Men Who Have Sex with Men
MUST	Multi-Sector Skills Training Programme
NAC	National AIDS Committee
NACC	National AIDS Coordinating Committee
NADAPP	National Alcohol and Drug Abuse and Prevention Programme
NAP	National AIDS Programme
NAPCU	National AIDS Programme Coordination Unit
NATCU	National AIDS Technical Coordination Unit
NBTU	National Blood Transfusion Unit
NESC	National Energy Skills Centre
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NSU	National Surveillance Unit
NWRHA	North West Regional Health Authority
NYC	National Youth Council
OHS	Occupational Health and Safety
OI	Opportunistic Infection
OPM	Office of the Prime Minister

PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PEP	Post Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POSGH	Port of Spain General Hospital
PSBO	Private Sector Business Organization
QPCC&C	Queens Park Counseling Centre and Clinic
RHA	Regional Health Authority
SARA	Situation and Response Analysis
SFGH	San Fernando General Hospital
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAS	Tobago AIDS Society
THA	Tobago House of Assembly
THACC	Tobago HIV and AIDS Coordinating Committee
TNSP	Transitional National Strategic Plan
TPHL	Trinidad and Tobago Public Health Laboratory
TTHTC	Trinidad and Tobago Health Training Centre
UN	United Nations
UNAIDS	United Nations Joint HIV and AIDS Programme
UNDP	United Nations Development Programme
UNJTA	United Nations Joint Team on AIDS
USAID	United States Agency for International Development
UWI	The University of the West Indies
VCT	Voluntary Counselling and Testing
YAPA	Youth Apprenticeship Programme in Agriculture
YTEPP	Youth Training and Employment Partnership Programme

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EXECUTIVE SUMMARY

Twenty nine (29) years have elapsed since the first case of HIV was reported in Trinidad in 1983. Since then, the Government of Trinidad and Tobago, in recognizing HIV and AIDS as a development issue, has sustained a national response, in conformity with the changing profile of the epidemic. The first National Strategic Plan (NSP) for HIV and AIDS, 2004-2008, was formulated and adopted in order to expand the national response beyond the health sector by incorporating multi-sectoral partners, due to the diverse and varied range of factors influencing the epidemic. Under the astute management of the Cabinet appointed National AIDS Coordinating Committee (NACC), which was established to coordinate and monitor the activities of the NSP and function in an advisory role, an effective multi-sectoral response has been promoted with the involvement of government, Civil Society Organizations (CSOs) trade unions, the business sector and international organizations.

The coordinated multi-sectoral response has yielded great gains. There were significant gains achieved during the life of the 2004-2008 NSP, as shown in **Box 1** below.

Box 1: Successes to date

- Decrease in number of newly diagnosed infections from 1,448 in 2008 to 1,390 in 2009, 1,154 in 2010 and 1,077 in 2011
- Considerable decrease in numbers of HIV infected infants born to HIV positive mothers (e.g Tobago has achieved 0% infection in infants)
- Significant increase in number of pregnant women tested and treated for HIV infection
- Mainstreaming of HIV and AIDS in the Workplace Programme in government ministries and private sector, along with adoption of National HIV and AIDS Workplace Policy
- Significant increase in the number of HIV testing and treatment sites
- Significant increase in the provision of free anti-retroviral medication for those requiring it, allowing people living with HIV to live longer more productive lives
- Significant reduction in AIDS related deaths
- Establishment of a Human Rights Desk to investigate cases of HIV related discrimination
- Legislative review of national laws and their impact on PLHIV and high risk groups informing draft National HIV and AIDS Policy
- Improved monitoring of the epidemic through strengthened surveillance and harmonisation of monitoring and evaluation indicators across implementing partners

The national response to HIV and AIDS is now at a critical juncture with the epidemic characterized as being both generalized and concentrated, since HIV prevalence is greater than 1% in the adult population and greater than 5% in at least one of the key populations at higher risk. There are still pressing reasons why the Government and its partners should continue to invest resources, time and effort into halting new HIV infections completely in the country. These include:

- The impact HIV and AIDS is having on achievement of the Government's poverty reduction and social transformation targets. Those who are unemployed and poor are more vulnerable to contracting HIV and AIDS, especially if they are female and once infected their chances of improving their economic status become even more limited. At the same time, there is an impoverishment effect on those who are non-poor and who then become HIV infected.

- Despite the gains made in the last decade HIV and AIDS also remains the eighth most important cause of mortality in Trinidad and Tobago and there continues to be three new cases of HIV infection every day. By ensuring the rights of the whole population to non-discriminatory HIV prevention, testing, counselling, treatment and care, and by targeting these interventions where they are most needed during the period of this NSP, the Government will have a good chance to make significant reductions in HIV incidence and AIDS related deaths, while enhancing its health and development agenda.

- There is still relatively low comprehensive knowledge about HIV among our young people who continue to engage in high risk behaviour. Without the necessary investment in this strategic plan Trinidad and Tobago will not achieve Goal 6 of the Millennium Development Goals by 2015.

There is agreement that although HIV and AIDS Information, Education and Communication (IEC) has had a wide reach, there has not been enough of a change in behaviour among the general population nor amongst most at risk populations, while stigma and discrimination perpetuated against PLHIV and some key populations, threaten to drive the epidemic underground. This National Strategy lays out the key areas that the government needs to invest in so as to maintain its positive momentum to the point where the Government of Trinidad and Tobago can claim zero new HIV infections, zero AIDS related deaths and zero stigma and discrimination by 2015.

The full picture of HIV and AIDS in Trinidad and Tobago remains incomplete with gaps in the epidemiological and behavioural data. Certain segments of the private health sector have remained out of the reporting loop, as the surveillance system mainly depicts coverage in the public sector. Furthermore, there are significant gaps in

knowledge about HIV prevalence and risk amongst vulnerable populations such as sex workers, injecting drug users, prisoners and men who have sex with men (MSM) due to discrimination against these groups preventing their access to testing, treatment and care. Geographically, treatment sites are centralized and treatment is not sufficiently integrated into the health services. Among PLHIV, adherence to anti-retroviral medical is inconsistent. There are also geographic disparities in HIV incidence, prevalence and mortality.

In light of the above, bearing in mind the generalized nature of the epidemic, the 2013-2018 HIV and AIDS National Strategic Plan will continue the focus on behavior change and safe sexual practices among the general population, especially youth aged 15 to 24, while scaling up the interventions for key vulnerable populations; the provider initiated testing and counselling (PITC) model; opportunities for greater involvement of CSOs in care and support of PLHIV; promotion of positive prevention among PLHIV; mainstreaming HIV and AIDS in the workplace; greater integration of HIV prevention and treatment in the health services; scaling up universal access; developing a comprehensive HIV information system; reducing stigma and discrimination; and ensuring that the national response is evidenced-informed.

In the way forward, the intent of this NSP is to fully establish the HIV response in the approach to national development that promotes the health and wellbeing the population; building on the best practices and progress made since the initial NSP in 2004 and defining where the resources invested will have the greatest impact.

In order to achieve real impact, and bearing in mind the needs of the diverse social and geographic communities across Trinidad and Tobago, those implementing this National Strategic Plan will need to focus their attention on fewer, more critical areas of intervention. The response to 2018 will emphasize prevention across all modes of transmission, adopting a life cycle approach and focusing on:

- **Framing a stronger enabling environment for safe sexual health practice** for all in Trinidad and Tobago. This includes approving the National HIV and AIDS Policy as well as reviewing and revising legislation that may discriminate against key populations who are more vulnerable to HIV infection.
- **Improving our understanding of the scale, nature and causes of poor sexual health and HIV infection** through strengthened clinical and behavioural surveillance and a unified monitoring and evaluation system.
- **Preventing new HIV and sexually transmitted infections** through behaviour change and communication programmes and combination prevention programmes, with a focus especially on youth aged 15 to 24 and key populations such as sex workers and their clients, as well as men who have sex with men, substance abusers, prisoners and migrant workers.

- **Assuring universal access to treatment and support** for persons living with HIV (PLHIV), their families and orphans
- **Enhancing positive attitudes and compassion towards PLHIV and key populations** through increasing awareness and understanding amongst the general population in work place programmes, community strengthening and work with faith based organisations.

The context for the National Strategic Plan:

The NSP is located in the national, regional and international effort to eliminate HIV and AIDS. The Plan takes account of the Millennium Development Goal (Goal 6); the 2011 UN Declaration of Commitment to Action on HIV and AIDS, the International Labour Organization Recommendation 200 regarding HIV in the workplace and the Caribbean Regional Strategic Framework.

The NSP also responds to the Government of Trinidad and Tobago's vision for national development, which is founded on seven interrelated 'pillars'. In the context of Pillar 1, the Government acknowledges the threat of the HIV epidemic to the social and economic wellbeing of the people of Trinidad and Tobago alongside CNCDs, and commits to scaling up the HIV response[1] viz.

1. People-Centred Development- *We Need Everyone and All Can Contribute*
2. Poverty Eradication and Social Justice- *Preference for Poor and Disadvantaged*
3. National and Personal Security- *Human Security for Peace and Prosperity*
4. Information and Communication Technologies- *Connecting T&T and Building the New Economy*
5. A More Diversified, Knowledge Intensive Economy- *Building on the Native Genius of Our People*
6. Good Governance- *People Participation*
7. Foreign Policy- *Securing Our Place in the World*

The Seven Pillars inform the Government's Medium Term Policy Framework (MTPF) 2011 – 2014 which identifies five strategic priorities for national development viz. Crime and Law and Order; Agriculture and Food Security; Health Care Services and Hospitals; Economic Growth, Job Creation, Competitiveness And Innovation; and Poverty Reduction and Human Capital Development. In the context of 'Health Care Services', the Government reaffirms its commitment to addressing HIV and AIDS not only as a health issue, *"…but an economic one that poses a serious threat to national development efforts"*[2]. The MTPF sets a goal to reduce the number of new HIV infections and a target to achieve a 0.5% adult prevalence[3].

[1] Manifesto of the People's Partnership Government, p. 44
[2] Medium Term Policy Framework 2011 - 2014, p. 48
[3] Ibid. p. 47

Vision and Mission to 2018:

Vision

A future without new HIV infections, reduced AIDS related deaths and no stigma or discrimination associated with living with HIV.

Mission

To challenge and encourage the national community to work in partnership to prevent and treat HIV and to mitigate its negative impacts, in an environment that promotes respect, care and support for all

Priority Areas:

The priority areas over the plan period are:

Priority Area 1:	Prevention Combining Behavioural, Biomedical and Structural Interventions
Priority Area 2:	Optimizing Diagnosis, Treatment, Care and Support Outcomes
Priority Area 3:	Advocacy, Human Rights and an Enabling Environment
Priority Area 4:	Strategic Information
Priority Area 5:	Policy and Programme Management

Overarching Goals

Three (3) overarching goals form the basis of the National Strategic Plan 2013-2018. These are:

- To reduce the incidence of HIV infections in Trinidad and Tobago
- To mitigate the negative impact of HIV and AIDS on persons living with HIV and affected by HIV and AIDS in Trinidad and Tobago.
- To reduce HIV and AIDS related discrimination in Trinidad and Tobago

Guiding Principles of the National Strategic Plan:

This National Strategic Plan for Trinidad and Tobago 2013-2018 is founded upon the following *principles: Respect for Human Rights, Inclusion, Focus on Safe Sexual Behaviour, Ownership, Sustainability, Measurement and Accountability, Universal access, Equity and Gender Mainstreaming.*

Organizational Structure

The NSP will be implemented through the cooperative efforts of the implementing partners across various sectors. A new Interim HIV Agency has been established along with a Secretariat, which will provide national leadership and coordination of the response, with a view to this transitioning to an autonomous Statutory agency with responsibility for HIV and other health issues (such as sexual and reproductive health) needing a multi-sectoral approach. In relation to Tobago, the response would continue to be implemented by the Tobago House of Assembly (THA) through the Tobago HIV and AIDS Coordinating Committee (THACC).

Cost of the National Strategic Plan

The strategic response to the HIV and AIDS epidemic for the period 2013-2018 will be executed under the *Five Priority Areas* with corresponding cost over the six year period as shown in the following table.

Table ES 1: NSP SIX YEAR IMPLEMENTATION COSTS

Priority Area	Six-Year Total (TTD)
1. Prevention	146,170,000
2. Care, Treatment and Support	308,210,000
3. Advocacy and Human Rights	30,000,000
4. Strategic Information	25,311,380
5. Policy and Programme Management	70,895,500
Total for All Five Priorities	**TT$ 580,586,880.00**

Expected Impact

The NSP 2013 to 2018 intends to achieve the following long-lasting impact on Trinidad and Tobago's HIV epidemic:

1. Reduce the incidence of new infections to zero in infants and less than 500 per annum in young people and adults
2. Reduce the prevalence of HIV infection to less than 1% within the general population
3. Halve the rate AIDS related mortality

4. Reduce HIV and AIDS related stigma and discrimination by 75%
5. Reduce the direct and indirect costs associated with preventing and treating HIV and AIDS as a result of reduced numbers of HIV infected individuals.
6. Increase in comprehensive knowledge and reduction in risk behaviours
7. Achievement of Goal 6 of the MDGs which is to combat HIV/AIDS, malaria and other diseases

Other benefits to be derived from the HIV response include:

- Improvement in maternal and child mortality and morbidity rates
- Improvement in the Human Development Index as impacted by health
- Improvement in the status of chronic disease and related illnesses.

Concluding Remarks

The prevailing stakeholders' perception is that introduction of the ARV programme, which has resulted in significant reduction in AIDS-related mortality, has lulled the general population, including policy makers, into believing that the country has passed the worst in relation to the HIV and AIDS epidemic. While it is true that Trinidad and Tobago has made very good progress in managing its HIV and AIDS epidemic, there is still a substantial distance to travel before the country will achieve international goals of 'zero new infections, zero AIDS related deaths and zero stigma and discrimination'. However, these goals are within reach, as long as the Government of Trinidad and Tobago, and its partners, invest sufficient resources now to address the causes and consequences of HIV infection and poor sexual and reproductive health more generally. This NSP provides the pathway for 'Getting to Zero', achieving universal access to HIV/AIDS treatment, care and support and the Millennium Development Goals.

1.0 INTRODUCTION

The Trinidad and Tobago National Strategic Plan (NSP) is in its second cycle. The first NSP was developed in 2004 and was an important step in articulating a shared strategy among the various stakeholders to address the spread of HIV in the country. This Plan spelt out key result areas for the HIV response in Trinidad and Tobago viz. Prevention of HIV transmission; treatment and care persons living with HIV (PLHIV); advocacy and the protection of the human rights of persons infected and affected by HIV; surveillance and research and programme management coordination and evaluation.

This National Strategic Plan 2013 – 2018 seeks to consolidate the gains of the past strategic planning period to 2009 and to date, while addressing the weaknesses in the delivery of services, programme implementation and management, with a view to scaling up the response to meet local, regional and global targets for mitigating the spread of HIV.

1.1 THE APPROACH TO THE DEVELOPMENT OF THE NSP 2013 - 2018

There is a clear continuity between the first HIV National Strategic Plan 2004 – 2009 and the current National Strategic Plan 2013 – 2018. Two of the overarching goals and three of the five strategic priority areas are the same. This makes sense because of the comprehensive nature and sound quality of the first NSP, as well as the significant work that remains to be done in order to meet the main strategic objectives and the overarching goals. At the same time, the NSP 2013 – 2018 will build on the lessons of experience (achievements and challenges) of the national response to date.

A participatory process has been followed in the development of the NSP. An NSP core group of the then National HIV AND AIDS Coordinating Committee (NACC) was established to oversee and guide the process. Local and overseas (Caribbean) consultants were contracted to facilitate the process and to prepare a draft plan. Several rounds of meetings were held with a wide range of stakeholders and a number of focus groups and key informant interviews were held (**Annex 1**), in order to identify the priority issues and concerns as well as the strategies that would best address the needs of the national response to 2018.

Numerous documents, reports and studies were reviewed as evidenced in the footnotes. Five Technical Advisory Groups were established in keeping with the priority areas of the NSP in order to guide the preparation of the document. The drafts of the relevant sections of the NSP were shared with the Technical Advisory Groups that are aligned to the respective priority areas, which provided feedback and direction. Following preparation of a draft NSP, two targeted public consultations were held and the deliberations and decisions were used to develop the final draft of the HIV and AIDS National Strategic Plan 2013 - 2018.

The life of the NACC which was tied to a World Bank loan expired in 2011. The Office of the Prime Minister (OPM) in collaboration with the Pan Caribbean Partnership Against HIV and AIDS, sought the services of consultants to complete the Draft NSP through a final round of consultation (see **Annex1**), to prepare a two-year operational plan to support the first two years of the implementation of the NSP (**see Annex 3)** and to develop the Monitoring and Evaluation Plan for the NSP (**see Annex 4**), further to initial work done as part of the NSP planning process (as outlined in **Section 8**). A third consultancy was undertaken in early 2013 to polish the work done by previous teams and to finalize all the key national strategy documents.

The NSP therefore reflects the vision, recommended strategy and desired outcomes of the range of stakeholders in the national HIV response in Trinidad and Tobago. Further, it reflects the sustained commitment of these partners to implementation of the NSP and achieving the vision of a 'future without new HIV infections'.

2.0 BACKGROUND AND SITUATION ANALYSIS

2.1 POLICY ENVIRONMENT

In the context of Pillar 1 of the Seven Pillars for Sustainable Development, the Government acknowledges the threat of the HIV epidemic to the social and economic wellbeing of the people of Trinidad and Tobago alongside CNCDs, and commits to scaling up the HIV response[4] viz.

- *Strengthen implementation of the national HIV/AIDS policy*
- *Develop culturally relevant public sensitization programmes designed to change behaviour and lifestyles and eliminate fear of Chronic Diseases*
- *Collaborate with NGOs and Faith-Based Organizations in care programs*
- *Establish the national HIV coordinating mechanism as a Statutory Authority*
- *Strengthen the system of preventative care and early detection throughout the school system*

The Seven Pillars inform the Government's Medium Term Policy Framework 2011 – 2014 which identifies five strategic priorities for national development viz. Crime and Law and Order; Agriculture and Food Security; Health Care Services and Hospitals; Economic Growth, Job Creation, Competitiveness And Innovation; and Poverty Reduction and Human Capital Development.

In the context of 'Health Care Services', the Government reaffirms its commitment to addressing HIV and AIDS not only as a health issue, *"…but an economic one that poses a serious threat to national development efforts"*[5]. The MTPF sets a goal to reduce the number of new HIV infections and a target to achieve a 0.5% adult prevalence rate[6].

The MTPF acknowledges that *"Combating the HIV and AIDS epidemic will require a collaborative effort from the Government, private sector and civil society to reduce the incidence of HIV and improve the levels of treatment and care for people living with HIV*

[4] Manifesto of the People's Partnership Government, p. 44
[5] Medium Term Policy Framework 2011 - 2014, p. 48
[6] Ibid. p. 47

(PLHIV)"[7]. To that end, the MTPF proposes that the programme of action laid out in the NSP focus on increasing awareness and effecting positive behaviours as it relates to safe sexual practices and reproductive health. Indeed, a key strategy for the Government to 2014 is to *'inculcate a Lifelong Commitment to Health'* which emphasizes self-managed care and healthy choices on the part of the individuals and families, supported by[8]:

- Policy to promote healthy lifestyles with emphasis on sport, nutrition and exercise
- National Health Promotion
- Emphasis on early diagnostic screening
- 'Healthy public policy' across all state agencies and sectors
- Partnerships between public and private sector, that catalyse environmental, social and policy changes that promote health

Further to the national agenda outlined above, the Draft National HIV and AIDS Policy, which is due to be finalized in 2013, *presents the overall vision and direction for the prevention and management of HIV and AIDS in Trinidad and Tobago*[9].

The objectives of the draft National HIV and AIDS policy[10] are to:

a) Define the framework for an effective multi-sectoral response to the HIV epidemic to reduce the incidence of HIV infections in Trinidad and Tobago, and mitigate the negative impact of HIV and AIDS on persons infected and affected, through a consultative process

b) Outline the roles of multi-sectoral partners including the community of People Living with HIV and vulnerable populations

c) Affirm the rights and responsibilities of People Living with HIV; of those interacting with them, including health care providers; and of vulnerable populations

[7] Ibid, p. 48
[8] Ibid, p. p.50
[9] Draft National Policy on HIV and AIDS, August 2010, p. 11
[10] Ibid, p. 11

d) Establish the framework for the development of legislation

e) Guide the method for provision of financing for the expanded response in keeping with the resources required to reduce new infections and mitigate negative impact

f) Define a framework for assistance and cooperation from international, regional and national development partners

g) Delineate the mechanisms for effective implementation

To date, the Government of Trinidad and Tobago has made substantial progress in controlling its HIV epidemic in the last decade, especially in monitoring HIV infection in pregnant women and reducing HIV infections in infants. However, there are still pressing reasons why the Government and its partners should continue to invest resources, time and effort into halting HIV and AIDS completely in the country. One major reason is the impact HIV and AIDS is having on achievement of the Government's poverty reduction and social transformation targets. Research in Trinidad and Tobago has shown that those who are unemployed and poor are more vulnerable to contracting HIV and AIDS, especially if they are female and once infected, their chances of improving their economic status become even more limited. At the same time, there is a, slower, impoverishment effect on those who are non-poor and who then become HIV infected.[11]

Despite the gains made in the last decade, HIV and AIDS also remains the eighth most important cause of mortality in Trinidad and Tobago. By ensuring the rights of the whole population to HIV prevention, testing, counseling, treatment and care, and by targeting these interventions where they are most needed during the period of this NSP, the Government will have a good chance to make significant reductions in HIV incidence and AIDS related deaths, while enhancing its health and development agenda.

Moreover, there is low comprehensive knowledge of HIV among youth. Only 54% of female youth have comprehensive knowledge about HIV while the proportion is even

[11] Scott, E., Simon, T., La Foucade, A. Theodore, K. and Gittens-Baynes, K-A 2011. Poverty, Employment and HIV/AIDS in Trinidad and Tobago. International Journal of Business and Social Sciences. Vol 12, No. 15

lower among adolescents (49%). This is of concern given that only 51% of females used condoms at their last high risk sex [12].

2.2 THE HEALTH SITUATION

Over the past thirty years, Trinidad and Tobago has experienced general improvement in key health indicators. Life Expectancy has increased to 68.3 years and 73.68 years for males and females respectively. Infant Mortality rate reduced to 13.2 deaths per 1000 live births in 2008.

However, there is great concern with consistent growth trend in chronic non-communicable diseases, linked to lifestyle habits. Over the past 20 years, the top three causes of death were Heart Disease, Malignant Neoplasm (cancer); Diabetes. These are followed by cerebrovascular disease (resulting mainly from hypertension)[12] (see **Table 2.1** below).

[12] MOH Draft Situational Analysis 2010, developed by the HPR&P Division, p. 13

Table 2.1: Leading Causes of Mortality in Trinidad and Tobago, All Ages – Trends[13]

Rank	1990	2000	2006
1	Heart Disease	Heart Disease	Heart Disease
2	Malignant Neoplasm	Malignant Neoplasm	Malignant Neoplasm
3	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus
4	Cerebrovascular Disease	Cerebrovascular Disease	Accidents/Injuries
5	Accidents/Injuries	Accidents/Injuries	Cerebrovascular Disease
6	Respiratory Diseases	Respiratory Diseases	Respiratory Diseases
7	Digestive System Diseases	**HIV AND AIDS**	Digestive System Diseases
8	Ill-defined Conditions	Digestive System Diseases	**HIV AND AIDS**
9	Genito-urinary Diseases	Causes of Perinatal Morbidity	Nervous System Diseases
10	Causes of Perinatal Morbidity	Genito-urinary Diseases	Genito-urinary Diseases

2.3. HIV AND AIDS EPIDEMIOLOGY IN TRINIDAD AND TOBAGO

The HIV and AIDS epidemic in Trinidad and Tobago is characterized as both a generalized and concentrated epidemic since HIV prevalence is greater than 1% in the adult population and higher than 5% in at least one of the most at risk (key) populations. The primary mode of infection of HIV has been identified as heterosexual exposure[14].

In 1983, the first cases of AIDS in Trinidad and Tobago were reported among eight (8) homosexual men, of which six had died by the end of the year[15]. From 1983 through 2011, there have been 23,906 reported cases of HIV infection, of which 6,440 became AIDS cases. Of this amount, 4,041 died of AIDS-related conditions. The number of new HIV cases, AIDS cases and AIDS related deaths for the period 2006-2011 are shown in **Table 2.2**

[13] Draft Situational Analysis of the Health Sector in Trinidad and Tobago, Ministry of Health, Health Policy, Research & Planning Division, 2010
[14] NACC/UNAIDS (2010) Progress towards Universal Access 2010 Status Report – a Snapshot- Republic of Trinidad and Tobago
[15] Bartholomew C, Raju CC and Jankey N (1983) The Acquired Immune Deficiency Syndrome in Trinidad. A Report on two cases. WIMJ; 32(3): 177-180.

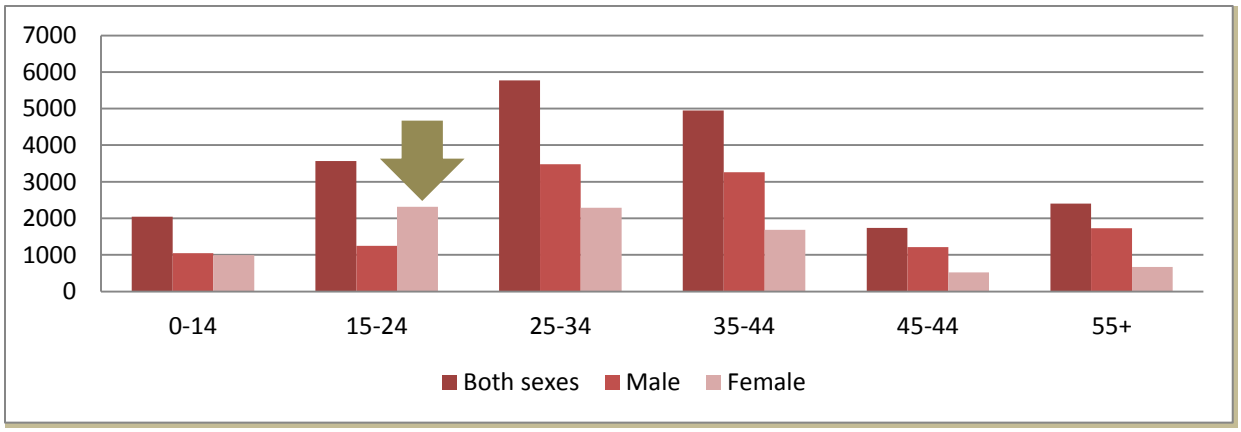
Table 2.2: HIV and AIDS Morbidity and Mortality Summary, 2006-2011

Cases	2007	2008	2009	2010	2011	Cumulative Total 1983-2011
New HIV positive*	1,429	1,448	1,390	1,154	1,077	**23,906**
AIDS	163	97	124	72	33	**6,440**
AIDS related Deaths	114	87	77	72	42	**4,041**

**Total New HIV Laboratory confirmed cases from TPHL*
*** Includes HIV asymptomatic and symptomatic (Non-AIDS cases)*
Source: National Surveillance Unit (Report 2012)

Other data shows that females in the 15-24 age groups constitute the group with the higher incidence of HIV infection. However, in all other age cohorts, males show the higher incidence of HIV infection (**Fig.2.1**).

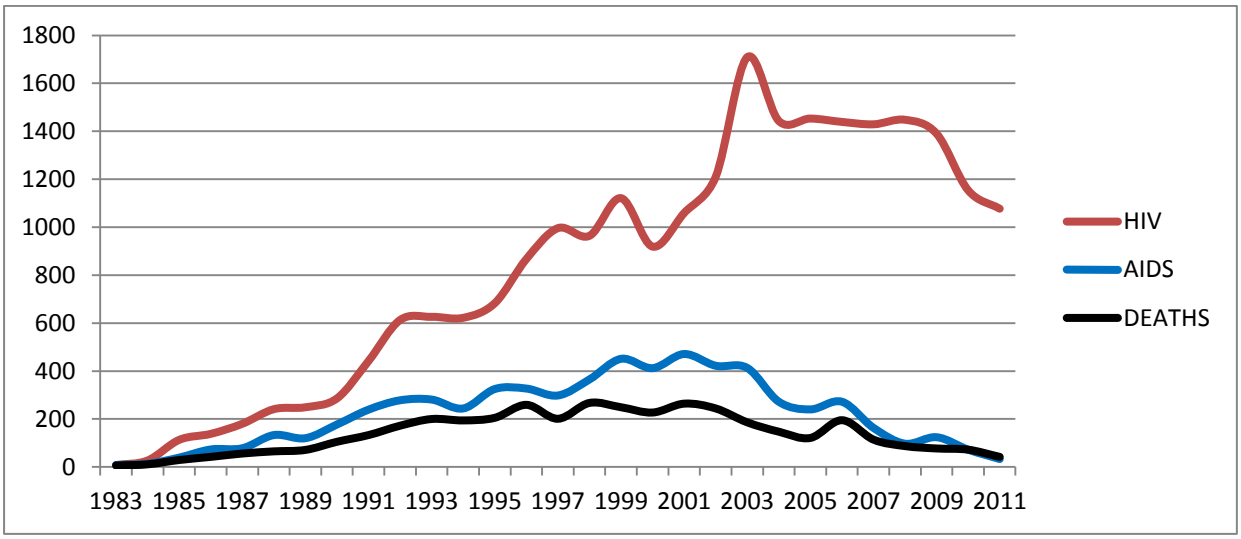
Fig.2.1: Cumulative HIV cases by Age and Sex, 1983-2010[16]



[16] Global AIDS Progress Report: Trinidad and Tobago Country Report (2012)

The number of AIDS related deaths was reduced by sixty-one percent (63%) from 114 to 42 during the period 2007 to 2011. **Figure 2.2** shows data for the 1983-2011 period.

Fig.2.2: Annual Newly Diagnosed HIV infection, AIDS Cases and AIDS-related Deaths,1983-2011



The HIV positive male to female ratio was approximately 2:1 until the mid-1990s, 1.2 between 2000 and 2005, 1:1 in 2006 and 2007, and 1:1.1 since 2008 (**Fig.4.1**). The larger proportion of female HIV cases to males may be due to the fourfold greater HIV testing among women compared with men. It is quite likely that significantly more men than the recorded number are HIV positive in Trinidad and Tobago (an unknown proportion of whom are MSM and bisexuals) but they are unaware of their HIV status and are therefore not accessing services.

2.4. HIV TESTING AND COUNSELLING[17]

The number of sites offering same day testing and counseling increased from 1 in 2005 to 31 in 2010 while there were three additional mobile testing sites established in 2010. There has been a significant increase in testing from 26,147 in 2007 to 55,221 in 2011, with a total of 1095 positive cases being identified.

[17] Global AIDS Progress Report: Trinidad and Tobago Country Report 2012

The majority of HIV positive cases were identified at the hospital labs and this contributed to the relatively high prevalence of 6.1% amongst those tested when compared with HIV testing in other settings. This confirms that the majority of HIV positive cases in the public sector are identified through hospital lab testing.

2.5 HIV, STIs and TB

Mortality among persons co-infected with Tuberculosis and HIV has declined from 30.1% in 2006 to 22.4% in 2010 due to expanded HIV testing of TB patients which facilitated earlier detection and treatment of HIV among TB patients (Table 4.5). In 2009 there were no registered cases of Multi Drug Resistant TB. Most Tuberculosis cases are HIV tested and between 25% - 30% are found to be co-infected[18].

2.6 KEY POPULATIONS

In Trinidad and Tobago, social vulnerability, due to a variety of adverse social conditions and circumstances, contributes to certain population groups being considered at higher risk of HIV infection. These key or most at risk populations (MARPs) include men who have sex with men (MSM), sex workers (SW), substance users, the youth, infants born to HIV positive mothers, prisoners and migrant workers.

2.6.1 Men who have Sex with Men

A study conducted in 2006 revealed that there was an HIV prevalence of 20.4% among MSM in Trinidad and Tobago at that time[19]. A later assessment of the vulnerability and risk among key populations[20] revealed that MSM have limited access to HIV prevention, care and support services due to the stigma and discrimination meted out to that group which resulted in their continued practice of risk taking behaviour.

2.6.2 Sex Workers

HIV prevalence among sex workers (SW) is not known. Although some sex workers have been facilitated by CSOs to have HIV testing, the results have not been analyzed or reported. No sero-surveys have been conducted amongst SW in recent years.

[18] NACC (2010) UNGASS Country Progress Report Trinidad and Tobago: January 2008-December 2009
[19] Lee RK, Legall G, Trotman C and Samliel S (2006) Risk behaviours for HIV among men who have sex with men in Trinidad and Tobago.....
O'Leo Lo Kai (2009) Research on Risk Factors of Key Populations for contracting HIV and other STIs. RED Initiative

Transient partners of sex workers often engage in high risk behaviour including non-use of condoms, which puts SWs at an increased risk of infection. Many SWs reported having limited access to sexual and reproductive health services and information or social support[21].

2.6.3 Substance users

Data from 121 female substance users admitted to an all-female rehabilitation center in Trinidad and Tobago between 1996 and 2002 were reviewed retrospectively to determine human immunodeficiency virus (HIV) sero-prevalence and associated risk factors. HIV sero prevalence was 19.8%, which is six times higher than in the general population. The univariate analysis identified poor educational attainment, history of a sexually transmitted infection (STI), and use of crack cocaine as factors associated with HIV infection[22]. Homeless drug users are at even greater risk of HIV infection. Approximately 35% of the sample had at some time been diagnosed with a sexually transmitted disease and 25% of the sample reported being HIV-positive. Approximately 40% had a history of trading sex for crack or money[23].

2.6.4 Youth

Young people have unique characteristics and needs that are different from that of other Key Populations. Young women in particular are vulnerable to STI such as chlamydia and gonorrhea due to changes in the cervix at puberty. The presence of STI predisposes them to the risk of HIV infection. Unprotected sexual intercourse sometimes results in pregnancies among female teenagers with the potential for HIV infection among both partners. Births to teenage mothers increased from 2,014 in 2005 to 2,142 in 2006, accounting for 11.8% of all live births[24]

2.6.5 Children born to HIV positive women

The number of children reported with HIV AND AIDS has declined significantly since the introduction of ART for HIV positive pregnant women in 2002 in order to prevent mother to child HIV transmission. Mother-to-child transmission accounts for the vast

[21] O'Leo Lo Kai (2009) Research on Risk Factors of Key Populations for Contracting HIV and Other STIs. RED Initiatives
[22] Reid S D (2006) Poor educational attainment and sexually transmitted infections associated with positive HIV serostatus among female inpatient substance abusers in Trinidad and Tobago *Drug and Alcohol Dependence* 82(1):S81-S84
[23] Day M, Devieux JG, Reid SD, Jones DJ, Meharris J and Malow RM (2004) *ABNF J.* 15(6):121-6
[24] CSO (2006) Population and Vital Statistics Report

majority of new HIV infections in children. Without intervention, HIV-infected mothers have a 35% overall risk of transmitting HIV to their children during pregnancy, delivery and breastfeeding[25]. In 2011, 7.6% of live births from HIV positive mothers were found to be HIV positive[26]. Tobago has no known reported cases in infants for several years. The percentage of new ante-natal care attendees tested increased from 16% in 2000 to 97.9% in 2009 and then declined slightly to 95% in 2011. In 2010, there were 13,997 new attendees of which 12,744 were tested for HIV. Among those tested, the seroprevalence rate was 1.6%. Of this 85 represented new cases with a positivity rate of 0.7%.

2.6.6 Other Possible High Risk Groups

There are two other possible high risk groups that need further attention: prisoners and migrant workers. Very little work has been done to assess HIV prevalence within these groups and there have been very few interventions that cater to their particular needs, though one study estimated that 15% of the male prison population is HIV positive.[27] Male prisoners in are doubly challenged, as their primary route of infection would be through having sex with other male prisoners. Both male and female migrant workers are vulnerable as they are often in Trinidad and Tobago without their families and do not know how to, or are afraid to, access health and social services.[28]

2.6 FACTORS UNDERLYING THE EPIDEMIC

Surveillance data indicate and anecdotal evidence suggest that there are some underlying factors to the HIV and AIDS epidemic in Trinidad and Tobago:

2.6.1 Stigma and discrimination

The strong stigma and discrimination associated with Key Populations impacts on their access to available services and complicates the provision of special services that they need. Some of the existing laws of Trinidad and Tobago discriminate against MSM, sex workers and drug users and criminalize their activity, making it more difficult for these

[25] PEPFAR (2009) Prevention of Mother-to-Child Transmission http://www.pepfar.gov/press/79674.htm
[26] Ministry of Health NIV and AIDS Coordinating Unit
[27] As reported in the Trinidad Express, 10 December 2010
[28] GIZ, PANCAP and Government of Trinidad and Tobago (2010) Improving Access to HIV Services for Mobile and Migrant Populations in the Caribbean

groups to access services. The stigma associated with MSM contributes to a deep-seated sense of shame, resulting in their non- reporting of incidents of sexual violence, risk taking and reluctance to seek health and social services including medical treatment. This is especially true within prisons. Based on their HIV status, PLHIV also encounter discrimination in the workplace, in healthcare settings and in the provision of goods and services such as credit and insurance services. ***Within this discriminatory environment, risk taking behaviour among these most at risk groups is perpetuated, further contributing to the spread of HIV[29].***

2.6.2 Concurrent Partners

Multiple partnering is very common in some areas of Trinidad and Tobago, where some men spend money to support casual relationships with women, many of whom accept money from more than one partner at a time.[30]. Another common practice is that some girls or young women become involved with boys and men several years their senior. The 2007 KAPB[31] revealed that 85% of females 15-19 years old and 91% of those in the 20-24 years age group had had sex in the last 12 months with a partner who was 10 or more years older. The situation is compounded by gender inequity and stereotypic gender roles that put women and girls at a disadvantage in sexual relationships and increase their vulnerability to risk behaviour and HIV infection. The situation is also further compounded by high levels of migrant labour, where husbands and wives are separated for longer periods of time. Ethnographic studies in both Trinidad and Tobago have found that much unsafe sexual behaviour is underpinned by gendered realities[32]. ***Tackling gender inequity, gender violence and improving safe sexual behaviours are key to preventing new HIV infections in Trinidad and Tobago.***

2.6.3 Low condom use

The national KAPB study[33] found that among respondents reporting sexual intercourse with a regular partner in the past year, 35.1% of men and 30.7% of women indicated that they had used a condom at last sexual encounter. Other studies have found

[29] UNGASS Country Progress Report (2010) Trinidad and Tobago
[30] Hawkins K, Joseph J, Longfield K and Best T (2007) Concurrent and Intergenerational Relationships: Study of Young Women and the Management of Sexual Relationships of Two Communities in Trinidad
[37]The University of the West Indies, St Augustine (2007) Baseline Survey of Knowledge, Attitudes, Practices and Beliefs (KAPB) on HIV AND AIDS of the national population 15-49 years old residing in Trinidad and Tobago
[32] Rogers T HIV AND AIDS Social and Behavioural Mapping East Tobago, mimeograph report.
[33]The University of the West Indies, St Augustine (2007) Baseline Survey of Knowledge, Attitudes, Practices and Beliefs (KAPB) on HIV AND AIDS of the national population 15-49 years old residing in Trinidad and Tobago

similarly low rates of condom use[34],[35].[36]. In relation to the female condom, limited knowledge and access have resulted in limited use[37]. Generally, among men in Trinidad and Tobago, the use of condoms conflicts with their macho male image and lifestyle. However, gender dynamics allow males to control safe sex practices such as condom use in relationships.

2.6.4 Youth Lifestyle

Various studies indicate that by the age of 15 a significant proportion of adolescents have already become sexually active. Another study that involved sexually active youth in Trinidad[38] revealed that they are more likely to have unprotected sex and multiple sex partners compounded by peer pressure, gender stereotyping, and a lack of access of prevention education, psychosocial support and condoms, which may lead to risk taking behaviour. ***Trinidad and Tobago must focus particularly on improving youth's understanding, attitudes and sexual health practices if it is to halt new infections entirely in the country.***

2.7 RISK ANALYSIS FOR THE HIV AND AIDS RESPONSE

Further to the overview of the status of the HIV epidemic in Trinidad and Tobago above, there are a number of other factors that will influence the successful implementation of the NSP going forward. Among the most critical to be addressed/pursued over the planning period to 2018 are the following:

Key External Issues

a) ***Clear Government Position on the HIV Response*** – In its Medium Term Policy Framework 2011 - 2014 the Government gives a commitment to priority action that would result in reducing the adult prevalence rate of HIV to 0.5%. Notwithstanding this assurance, there is no National Policy on HIV and AIDS that presents a clear position, which is needed to encourage wide commitment to HIV and AIDS targets across the public sector. In that regard, a high priority

[34] O'Leo Lo Kai (2009) Research on Risk Factors of Key Populations for Contracting HIV and Other STIs. RED Initiatives
[35] ` Hawkins K, Joseph J, Longfield K and Best T (2007) Concurrent and Intergenerational Relationships: Study of Young Women and the Management of Sexual Relationships of Two Communities in Trinidad
[41]PSI Research Division Trinidad and Tobago (2009) HIV and AIDS TRAC Study evaluating condom use among sexually active youth 16-26 years in Tobago.
[37] UNAIDS (2010) The Republic of Trinidad and Tobago Universal Access 2010 Status Report
[38] O'Leo Lo Kai (2009) Research on Risk Factors of Key Populations for Contracting HIV and Other STIs. RED Initiatives

activity in the NSP going forward to finalize the draft National Policy on HIV and AIDS and to have the policy approved by the Cabinet and subsequently by Parliament. Legislation also discrminates against high risk groups, such as MSM and sex workers. During this NSP period, a follow up to the review of this legislation done in 2010 will need to be undertaken and debated to see how to create a more enabling policy and legal environment with regards to HIV and sexual health more generally.

b) ***Commitment to HIV Targets Across the Public Sector*** – Further to a) the commitment of sector-based state agencies must be translated into specific action taken on an annual basis to contribute to national HIV targets, together with a willingness to provide human, technical and/or financial resources to implement sector-based initiatives.

c) ***Commitment to HIV Targets Across the Private Sector*** – As with the Public Sector, there is an urgent need to have strengthened commitment to HIV targets from the private sector, including the informal sector, building on the initiatives of the past years with the Employers Consultative Association and others.

d) ***Resourcing the NSP in a Global Economic Crisis*** – There is no doubt that the global economic crisis will affect development funding for some time to come, including HIV AND AIDS related programmes. In Trinidad and Tobago the crisis has 'hit home' despite some buffers such as low public debt and high international reserves. Moreover, recent announces by the Governor of the Central bank (June 2012) signalled a downgrade of the 1% projected growth projected for 2012 to 0.5%. In addition to these circumstances, as a high income developing state Trinidad and Tobago is less eligible for development funding assistance. In this regard, there must be high optimization and accountability in the use of resources made available for the national response.

e) ***Competing Priorities*** - The on-going economic challenges means a competition among developmental priorities for Trinidad and Tobago. Economic growth, education and social services are perennial concerns that will impact on the resources available for the HIV and AIDS Response, as will competing priorities

within the health sector itself (e.g. the rising incidence of chronic non-communicable diseases). Partners in the national response must take on *opportunities for collaboration that will show how addressing HIV and AIDS will engender benefits in other priority sectors* - for example linking the well population (through implementation of the HIV Workplace Policy) with higher levels of worker productivity and economic growth, and linking the management of HIV to the management of CNCDs.

f) ***High Risk Lifestyle Habits*** - As discussed in the Situational Analysis the major threat to the HIV and AIDS response in the new planning period is the persistence of high risk behaviours such as multiple partnering, unprotected sex, drug use (including alcohol), and transactional sex. For this reason the NSP will focus on behaviour change. Moreover, these strategies will extend beyond the HIV and AIDS response to the wider issues of good sexual and reproductive health.

g) ***Socio-cultural Drivers of HIV and AIDS*** - Again, as discussed in the Situational Analysis above; persistent poverty, gender roles of men and women in the society that promote gender inequity, stigma and discrimination, sexual taboos and misinformation, lack of education and migration are among the critical issues that must be addressed in tandem with the HIV and AIDS response to achieve success. These are the socio-cultural drivers of the disease that emphasize the importance of a strong cross-functional, multi-sectoral approach to eliminating the spread of HIV.

Key Internal Issues

a) ***Build on Gains Made*** – Trinidad and Tobago has had significant success in critical areas such as prevention, education and awareness, access to care and treatment and building the framework for good management. It will be important to maintain or expand these successful initiatives in the new planning period.

b) ***Effective leadership and operating structure and systems*** – The HIV response must have a sustainable and effective operating structure and systems, and must be well positioned in national governance arrangements, with the authority to facilitate the successful implementation of the NSP via a multi-sectoral approach. There is an urgent need to build leadership and strong systems across all sectors - public, private and civil society - in order to realize sustainable outcomes and impacts from the HIV and AIDS Response. At present there is general agreement that the work of the Response is focused on a relatively small group of stakeholders. In the new planning period, strategies will be put in place to attract and develop new leadership and systems across the response, particularly among PLHIV and CSOs.

c) ***Consistent Performance of Key Players*** – There is an urgent need to implement measures that will support consistent good performance among critical agents in the Public Sector (e.g. HIV Coordinators) and Civil Society. This will be a measure of the viability of the multi-sectoral response.

d) ***Resourcing the NSP*** - There must be a clear commitment on the part of Government, the private sector and other partners to secure the resources required for implementation of the NSP. This extends beyond financial resources to human and technical resources. Certainly in light of the economy and other factors, the approach to resourcing the NSP will have to be creative. Nonetheless, a commitment from stakeholders to provide resources on an annual basis would be essential going forward.

e) ***Monitoring and Evaluation*** – Without a doubt, developing a robust monitoring and evaluation system to support the HIV and AIDS response is at the forefront of issues to be addressed in the next planning period. The M & E framework must be simple, transparent and flexible enough to allow all partners in the multi-sectoral response to report accurately and consistently.

f) ***Strategic Review and Adaptation*** - Enhanced monitoring and evaluation will facilitate improved planning and programme delivery over the medium to long term. With more accurate and timely data, stakeholders are empowered to

assess and amend initiatives to ensure these interventions are relevant and effective

g) ***Sustainability of the multi-sectoral response*** – The response must have the long term commitment of key stakeholders for resources (human, financial, technical etc.), as well as the institutional flexibility to respond to changes that will occur over time. In that regard, the response must be well located in the national and international development agenda and must be able to demonstrate its contribution to national development through good monitoring, evaluation and reporting.

2.8 THE WAY FORWARD

The findings of the strategic analyses summarized above viz. the situational analysis and the risk analysis highlight a number of issues to be addressed in the next planning period. These have been converted to strategic priorities. A more detailed Background and Situation Analysis is available in **Annex 2**.

3.0 STRATEGIC FRAMEWORK TO 2018

3.1 STRATEGIC CONTEXT FOR THE NSP

The global commitment to reverse the spread of HIV and AIDS and mitigating the impacts of the disease, is enshrined in the Millennium Development Goals (2000) (MDGs), the United National General Assembly Special Session (UNGASS) on HIV and AIDS (2001) and other regional and international agreements. With Goal 6 of the MDGs, nations including Trinidad and Tobago, have agreed to pursue a programme of action that will:

- Have halted by 2015 and begun to reverse the spread of HIV and AIDS
- Achieve universal access to treatment for HIV and AIDS for all those who need it.

These objectives are enshrined in national policy cited in Section 2.1. Beyond these broad objectives Trinidad and Tobago's HIV and AIDS response is also aligned with other global and regional commitments including:

- UNAIDS' strategic thrust of *"getting to zero"* - zero new infections, zero discrimination, zero AIDS-related deaths[39] as well as
- the 2011 Political Declaration on HIV secured the commitment of all signatory nations to ten targets to 2015[40] as provided in Box 1,
- ILO Recommendation 200, which calls for the *development, adoption, monitoring and effective implementation of national policies*

Box 2: 2011 UN Political Declaration on HIV Ten Targets

1. Reduce sexual transmission of HIV by 2015
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths
4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015
6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.
7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms.
9. Eliminate HIV-related restrictions on entry, stay and residence.
10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

[39] www.unaids.org
[40] 2011 United Nations General Assembly Political Declaration on HIV/AIDS: Targets and Elimination Commitments, www.unaids.org

and programmes on HIV and AIDS in the world of work, which are to be integrated into national development plans and poverty reduction strategies[41].

- The second Caribbean Regional Strategic Framework (CRSF) for HIV and AIDS 2008 - 2012 proposed action in six priority areas that includes: a) an enabling environment that fosters universal access to HIV prevention, treatment, care and support services, b) an expanded and coordinated multi-sectoral response to the HIV epidemic, c) prevention of HIV transmission, d) treatment, care and support, e) capacity development for HIV and AIDS services and f) monitoring, evaluation and research. The CRSF emphasizes that implementation across the six priority areas must be facilitated by strong information and communication and adequate, sustained funding.

The clarity of vision for the mitigation of the HIV AND AIDS pandemic at the global and regional level provides an explicit, well-developed framework for action at the national level. The goals and targets that have been established at the global and regional level are a benchmark for Trinidad and Tobago and the NSP, to be pursued, attained or surpassed over the planning period.

3.2 THE STRATEGIC DIRECTION FOR THE NSP TO 2018

Within the context of the global, regional and national mandate as outlined above, the vision and mission for the HIV Response in Trinidad and Tobago to 2018 are:

3.2.1 Vision

> *A future without new HIV infections, reduced AIDS related deaths and no stigma or discrimination associated with living with HIV.*

3.2.2 Mission

> *To challenge and encourage the national community to work in partnership to prevent and treat HIV and to mitigate its negative impacts, in an environment which promotes respect, care and support for all*

[41] www.ilo.org; HIV and The World of Work: Why and How We Should All Advocate for the Implementation of the ILO Recommendation On HIV and the Workplace

3.2.3 Core values

The Core Values that must underpin the multisectoral response are:

- Caring
- Partnership
- Communication
- Commitment
- Inclusion
- Economy (in use of resources)
- Sustainability
- Accountability

3.2.4 Expected impact of the NSP

The NSP 2013 to 2018 intends to achieve the following long-lasting impact on Trinidad and Tobago's HIV epidemic:

1. Reduce the incidence of new infections to zero in infants and less than 500 per annum in young people and adults
2. Reduce the prevalence of HIV infection to less than 1% within the overall population
3. Halve the rate AIDS related mortality
4. Reduce HIV and AIDS related stigma and discrimination by 75%
5. Reduce the direct and indirect costs associated with preventing and treating HIV and AIDS as a result of reduced numbers of HIV infected individuals.
6. Increase in comprehensive knowledge of HIV and reduction in risk behaviours
7. Achievement of Goal 6 of the MDGs which is to combat HIV/AIDS, malaria and other diseases

Other benefits to be derived from the HIV response include:

- Improvement in maternal and child mortality and morbidity rates
- Improvement in the Human Development Index as impacted by health (see **Figure 3.1**)

- Improvement in the status of chronic disease and related illnesses (see **Figure 3.2**)

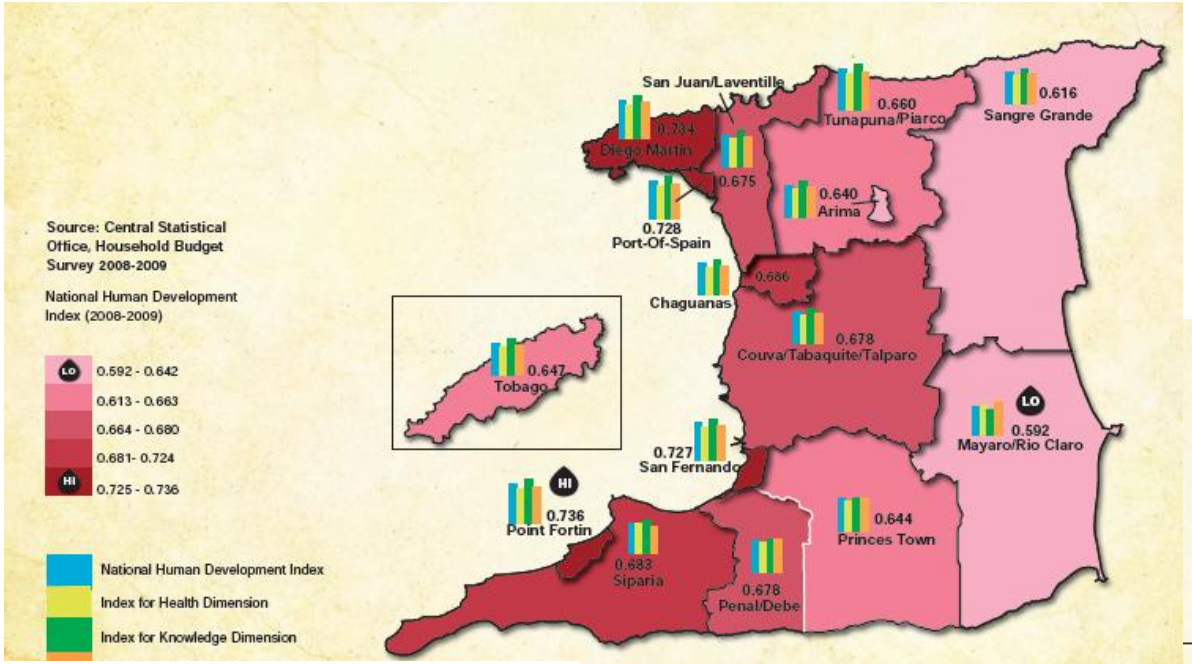


FIGURE 3.1: NATIONAL HUMAN DEVELOPMENT INDEX AND DIMENSION INDICES (2008-2009) BY ADMINISTRATIVE AREAS

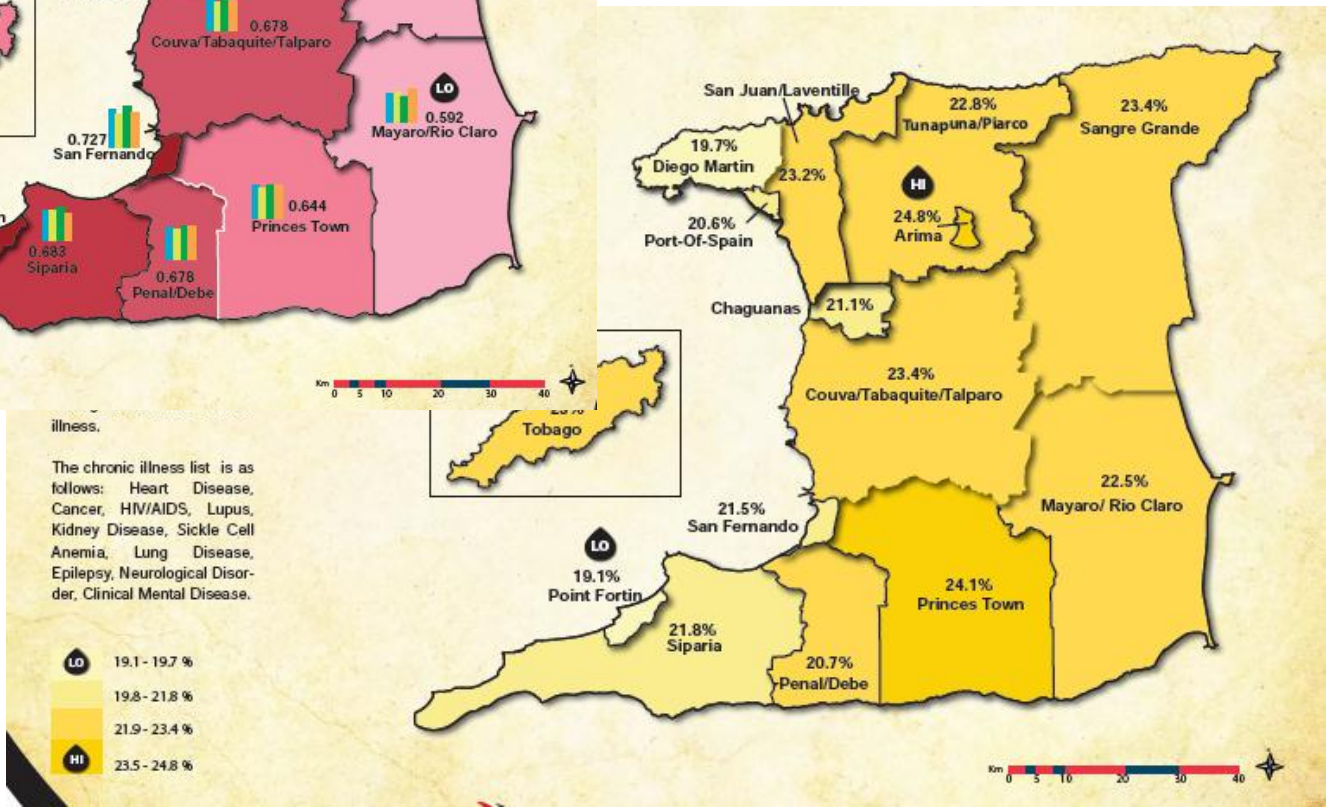


FIGURE 3.2: PERCENTAGE OF POPULATION HAVING CHRONIC ILLNESS (2008-2009) BY ADMINISTRATIVE AREAS

Source: Trinidad and Tobago Human Development Atlas 2012

4.0 THE STRATEGIC APPROACH TO 2018: GOALS, PRIORITIES, OBJECTIVES & EXPECTED OUTCOMES

4.1 THE NSP AS A FRAMEWORK FOR ACTION TO 2018

This NSP will guide Trinidad and Tobago's expanded national response to the HIV epidemic for the period 2013-2018. It sets out the fundamental principles guiding the response, the priorities, and the strategic objectives to move the country from the current situation to its desired position. The NSP will guide the preparation of annual operational plans that will spell out the specific activities to be conducted to meet the overall objectives.

The National Strategic Plan also:

- ***Provides the structure*** for guiding agents and advocates in the public sector, private sector and civil society in taking action
- ***Provides a context, framework and guidelines*** for organizing and scheduling activities
- ***Provides guidelines and indicators*** for measuring the country's achievements in its response to the epidemic
- ***Is the main vehicle*** in the identification of resources and financing for the programmes and projects

4.1.1. The Multi-Sectoral Approach

In the last decade, Trinidad and Tobago has adopted a multi-sectoral response to HIV and AIDS. This approach is in keeping with international best practice and has been embraced in the national context with the acknowledgement that HIV and AIDS impacts and is impacted by the social and economic development agenda for Trinidad and Tobago.

In that regard, realizing the vision of a 'future with no new infections', will require the collaborative, concerted efforts of stakeholders across the public and private sectors and civil society. The coordination of these efforts becomes paramount to ensure the most effective and efficient use of resources *towards achieving the set targets*, bearing

in mind the challenging economic outlook for Trinidad and Tobago over the planning period, and the need to, at the same time, expand HIV services of the population, particularly for vulnerable sub-populations. Indeed, a well-coordinated and well managed multi-sectoral response remains a critical success factor in the way forward.

Within the context of the multi-sectoral approach Trinidad and Tobago ascribes to the *Three Ones Principles*: 1) One agreed HIV and AIDS Action Framework that forms the basis for coordinating the work of all partners, 2) One National AIDS Coordinating Authority with a broad based multi-sector mandate and 3) One agreed M & E framework for overall national monitoring and evaluation.

The multi-sectoral approach will be strengthened in the new planning period to 2018 and in the context of the first Principle; the NSP provides the framework for action for all stakeholders in the response.

In that regard, for efficient and effective management of the multi-sectoral response (in light of Principle II), the governance structure and arrangements, along with the operating systems and communication protocols that will enable the implementation of the NSP must be clearly defined. These requirements are discussed further in **Section 6.**

4.2 THE OVERARCHING GOALS TO 2018

The overarching goals of the National Strategic Plan 2013 - 2018 are:

- To reduce the incidence of HIV infections in Trinidad and Tobago;
- To mitigate the negative impact of HIV and AIDS on persons living with HIV and affected by HIV and AIDS in Trinidad and Tobago.
- To reduce HIV related stigma and discrimination in Trinidad and Tobago

4.3 THE OVERALL STRATEGY FOR THE NSP TO 2018

In light of the overarching goals, this NSP will fully establish the HIV response in the approach to national development which promotes the health and wellbeing the

population; building on the best practices and progress made since the initial NSP in 2004.

In order to achieve real impact, and bearing in mind the needs of the diverse social and geographic communities across Trinidad and Tobago, those implementing this National Strategic Plan will need to focus their attention on fewer, more critical areas of intervention. The response to 2018 will emphasize prevention across all modes of transmission, adopting a life cycle approach and focusing on:

- **Framing a stronger enabling environment for safe sexual health practice** for all in Trinidad and Tobago. This includes approving the National HIV and AIDS Policy as well as reviewing and revising legislation that may discriminate against key populations who are more vulnerable to HIV infection.
- **Improving our understanding of the scale, nature and causes of poor sexual health and HIV infection** through strengthened clinical and behavioural surveillance and a unified monitoring and evaluation system.
- **Preventing new HIV and sexually transmitted infections** through behaviour change and communication programmes and combination prevention programmes, with a focus especially on youth aged 15 to 24 and key populations such as sex workers and their clients, as well as men who have sex with men, substance abusers, prisoners and migrant workers
- **Assuring universal access to treatment and support** for persons living with HIV, their families and orphans
- **Enhancing positive attitudes and compassion towards PLHIV and key populations** through increasing awareness and understanding amongst the general population in work place programmes, community strengthening and work with faith based organisations.

The emphasis on prevention reflects an acknowledgment of the critical importance of averting new HIV infections (including eliminating new HIV infections among children) with the desired social and economic benefits to be derived for Trinidad and Tobago. Indeed, effective prevention education that leads to changes in behaviour, can engender a range of benefits such as general reduction in the incidence of STIs, unwanted pregnancies and drug use; improved sexual and reproductive health; reduction in the

incidence of gender inequities and gender based violence; and other outcomes which will positively impact the long term cost of health care, worker productivity, the strength of the economy, and the general quality of life for the individuals, families and communities of Trinidad and Tobago.

This positioning of the national HIV response requires an enabling environment where steps are taken to address the social and economic drivers of HIV (for example gender inequities that lead to gender based violence), win the commitment of partners, access sustained resources and develop operating systems and processes that are efficient and effective. Indeed, strengthening the capacity of stakeholders, particularly at the community level, is paramount for ensuring that those communities that show a heavier burden of the disease viz. viral load, new infections and HIV related deaths will benefit from customized, effective interventions.

In light of this two part agenda – i) strengthening the delivery of HIV related services, and ii) strengthening the institutional arrangements of the multi-sectoral response - the NSP's overall strategy to 2018 will be based on the Values Discipline approach (Treacy and Wiersema, 1990); focusing on the core values disciplines of *customer intimacy* and *operational excellence*.

4.4 THE GUIDING PRINCIPLES OF THE NSP

The lessons of experience over the past 30 years in addressing the disease and mounting a multi-sectoral response (since 2004) have stressed the importance of a principled approach to engagement, planning and implementation.

This National Strategic Plan for Trinidad and Tobago 2013-2018 is founded upon the following guiding principles in Table 4.1 below.

Table 4.1: Guiding Principles of the National Strategic Plan for HIV and AIDS

• *Respect for Human Rights:*	the human rights of persons living with HIV (PLHIV), of those most vulnerable, and of all affected persons will be protected
• *Inclusion:*	the strategic response will reflect the involvement of all major sectors and stakeholders; respect for the diversity of perspectives (e.g. cultural and professional) and approaches
• *Ownership*	Committed leadership from the public, private and civil society sectors, along with the sustained commitment of resources to enable the response
• *Sustainability*	The strategies and financing for the expanded response will be consistent with available resources, structures and opportunities and in keeping with what is required to reduce and mitigate the impact of the disease
• *Measurement and Accountability*	There will be continuous monitoring, evaluation and reporting to all stakeholders and the national community
• *Universal access*	Ensuring high quality, affordable HIV and related services are available and accessible with equity to all
• *Equity*	Initiatives to ensure the absence of socially unjust or unfair disparities in all aspects of the national response[42]
• *Gender Mainstreaming*	Analysis and uptake of the specific needs of women, men, boys and girls in policy development, planning, programming initiatives in, and evaluation of, the NSP

4.5 THE PRIORITIES AREAS TO 2018

In the context of the international vision and strategy for reversing the HIV and AIDS pandemic; the national human development mandate as articulated in the Seven Pillars for National Sustainable Development; and the overarching goals for Trinidad and Tobago with respect to HIV; and overall strategic thrust to 2018; the NSP will be executed under the following *Five Priority Areas,* which build on the gains and lessons of experience of the multi-sectoral response to date. These are:

42 Adapted from the definition in '**Defining equity in health'** by Braveman and Cruskin, *J Epidemiol Community Health*2003

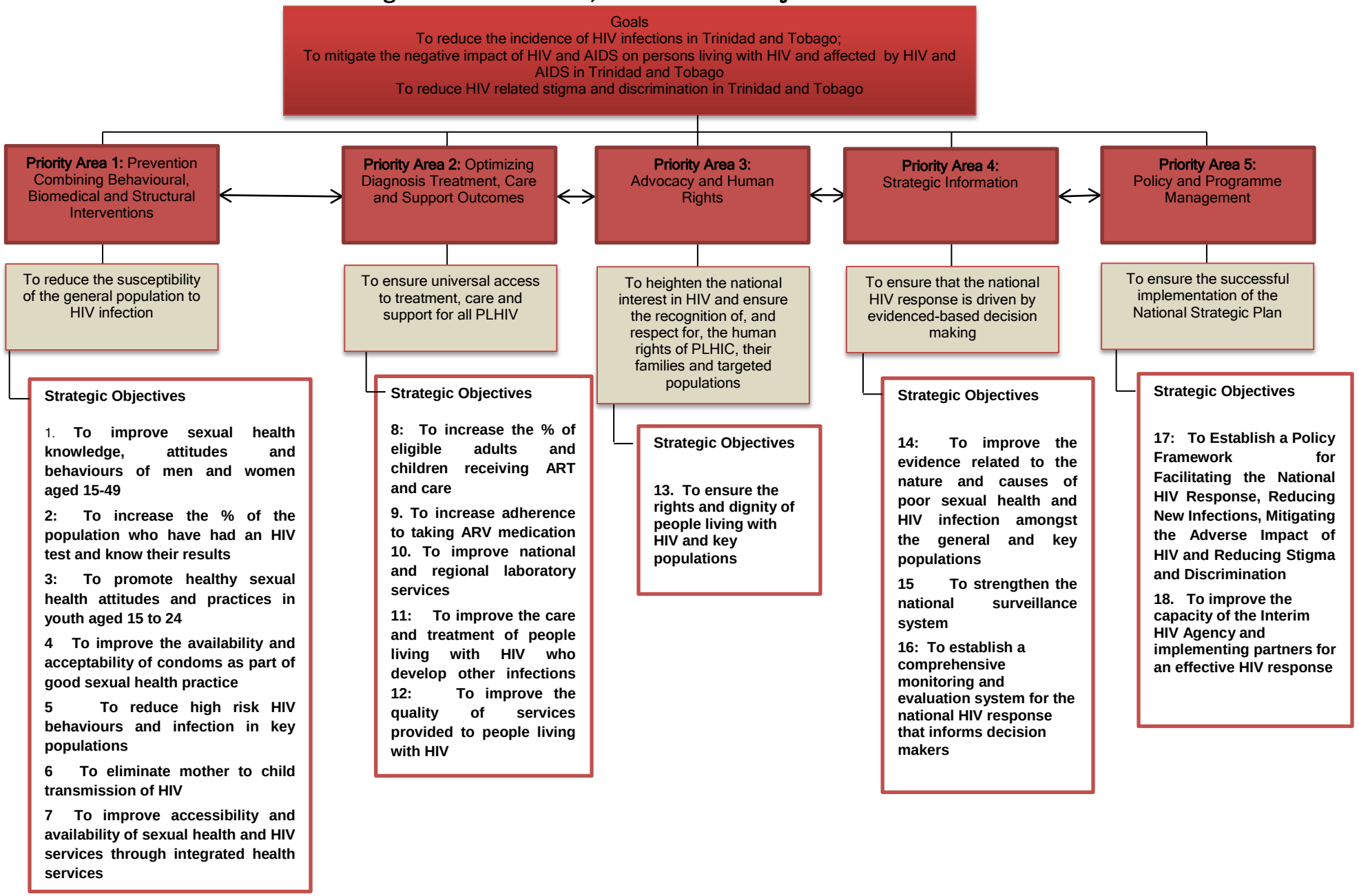
Priority Area 1:	Prevention Combining Behavioural, Biomedical and Structural Interventions
Priority Area 2:	Optimizing Diagnosis, Treatment, Care and Support Outcomes
Priority Area 3:	Advocacy, Human Rights and an Enabling Environment
Priority Area 4:	Strategic Information
Priority Area 5:	Policy and Programme Management

These Priority Areas, though addressed as separate in the discourse which follows, are in the context of the NSP, interdependent, with action or inaction is any area impacting the viability of other areas. This is especially true of Priority Areas 1 and 2. For example, the combination prevention approach in Priority Area 1 relies on strategies to improve the provision of treatment, care and support services in Priority Area 2; and the National HIV and AIDS Policy to be developed in Priority Area 5 will enable initiatives to protect to rights of PLHIV outlined in Priority Area 3. At the same time, Priority Area 4 underpins the work of the other Areas as Strategic information arising from surveillance research and monitoring and evaluation is the foundation for informing decisions in these Areas. This is an important attribute to be kept in mind by programme managers and sponsors as the NSP is implemented over the planning period.

Another consideration is the need for 'customization' of strategy in each of the Priority Areas to take account of unique needs at the regional and community levels. This is especially important for Tobago, and in that regard, the strategic thrust for Tobago to 2018, in the context of the NSP, is outlined at **Section 6.7**.

The NSP goals, priorities and objectives to 2018 are summarized in **Figure 4.1** which follows.

Figure 4.1: NSP Goals, Priorities and Objectives to 2018



4.6 THE EXPECTED OUTCOMES TO 2018

PRIORITY 1	*Prevention Combining Behavioural, Biomedical and Structural Interventions*

The goal of the PREVENTION component of the NSP is to reduce the susceptibility of the population of Trinidad and Tobago to *HIV infection*, taking account of the fact that the epidemic is generalized with an estimated adult prevalence rate of 1.5%[43].

In that regard, the mix of prevention programmes seeks to achieve coverage of all sexually active persons, those young people poised to become sexually active, as well as those persons and children who are not sexually active; with the aim of engendering safe sexual behaviours and avoiding, minimizing or eliminating risky sexual behavior. In addition, given a concentration of the epidemic (5% and over prevalence rate) among some populations, specific interventions will be developed for those key populations groups[44] who are most at risk of HIV such as men who have sex with men, sex workers and their clients, young women and men engaging in transactional sex, victims of abuse and substance users.

The youth will also get special attention, including Youth PLHIV, and those persons in the population made vulnerable by limited education, poverty, social circumstances, disabilities, gender inequity and incarceration. This will include[45] the homeless, prison inmates, migrant workers. Sero-discordant couples and HIV infected and uninfected infants and children will also be given attention through appropriate interventions including 'treatment as prevention' and PMTCT Plus programmes.

The behaviour-driven initiatives noted above will be complemented by a range biomedical and structural interventions over the period, to address for example, alcohol consumption, drug trafficking and use, violence prevention, trafficking of women and children, and the strengthening community social and governance systems. Some of

[43] Global Aids Response Progress: Trinidad And Tobago Country Progress Report, January 2010-December 2011, p. 3
[44] The range of target populations may be adjusted over the plan period in response to research on vulnerable groups in Trinidad and in Tobago
[45] Further defined through research - See the Research Agenda at Priority #4

these interventions will take form as advocacy or policy/legislative development to create an enabling environment for success.

The general expected outcomes to 2018 for prevention are summarized below.

EXPECTED OUTCOMES BY 2018

- *70% of women and men 15-49 years correctly identify ways of preventing transmission of HIV and who reject major misconceptions about HIV transmission*
- *<40% of persons aged 15 years and older who have had sex with more than one sexual partner in the last 12 months*
- *55% of the general population 15 or older, and 80% of key population group constituents have had a HIV test in the last 12 months and know their status,*
- *90% of young people aged 15 - 24, correctly identify ways of preventing transmission of HIV and who reject major misconceptions about HIV transmission*
- *70% of young people 15 - 24 practice safe sexual health behaviours*
- *65% of women and men 15-49 years who had more than one partner in the last 12 months, report condom use at last intercourse with other than main partner.*
- *70% increase in adoption of HIV prevention behaviours amongst key populations*
- *Incidence of mother to child transmission of HIV reduced to 0%*
- *50% of health facilities offering integrated health services including HIV*

PRIORITY 2	*Optimize Diagnosis, Treatment, Care and Support Outcomes*

The goal of this Priority Area is to ensure universal access to treatment, care and support for all persons living with HIV in Trinidad and Tobago, including the provision of ARV treatment for all those who are in need. It recognizes that treatment is also a means of preventing new infections of HIV, and therefore a critical component for both prevention and for caring for those living with HIV.

In order to achieve this goal, HIV testing will be promoted widely among all sexually active persons (as discussed in Priority Area #1), especially among targeted populations most at risk of HIV, in order to identify persons living with HIV who are unaware of their status, and ensure access to treatment and support.

ARV treatment will continue to be provided by appropriately trained HIV physicians and health care professionals. However, this specialist treatment will be further decentralized as well as integrated into the health services with programmes to support adherence to medication and provision of adequate supplies of ARV drugs and drugs to treat TB and other opportunistic infections. Laboratory services will be improved to support ARV treatment on a more decentralized basis.

For Tobago there is a need to establish laboratory services (multipurpose facility integrating STIs, HIV, OI and TB) and expand ARV stores from the current weekly supply to quarterly supply, which will address any challenges that may arise with respect to the air/sea bridge.

More HIV physicians and health care professionals will be trained and measures taken to strengthen confidentiality and reduce stigma among health staff.

Bearing in mind the principle of universal access, to cope with the desired increased demand for testing and care, parallel initiatives will be undertaken to ensure that public health facilities can keep pace with demand in terms of infrastructure and personnel. This will extend to social and other supports services needed by PLHIV. In the short to medium term, stronger collaboration with civil society organizations can ensure services keep pace with demand.

Expected outcomes by 2018:

- *85% of adults and children with advanced HIV infection receiving ART*
- *90% of eligible PLHIV in Trinidad and Tobago are receiving ARV therapy and HIV care*
- *95% of PLHIV known to be on treatment 12 months after initiation of anti-retroviral therapy*
- *95% of laboratories with national HIV testing protocols in public and private health care institutions*
- *100% of PLHIV receiving ART and medication for TB or other infection*
- *80% of PLHIV (women and men) and people affected by HIV, including orphans, report satisfaction with access to and quality of service from public health facilities and CSOs*

PRIORITY 3	Advocacy and Human Rights

The overall goal of this component is to heighten the national interest regarding HIV issues and to ensure the recognition of, and respect for, the human rights of PLHIV, their families, targeted populations most at risk of HIV such as SW, MSM, and other vulnerable groups.

This requires measures to significantly reduce stigma and discrimination associated with HIV and with vulnerable populations across all sectors and institutions, including the family, school, church, community and workplace. There is a need to mainstream and integrate into common knowledge, societal attitudes and caring behaviours around HIV in the society, particularly the health services. There is also a critical need to address gender related issues that increase women's vulnerability and making them more at risk for becoming HIV infected, while also ensuring the protection of minors who are vulnerable to early initiation of sexual activity.

Expected Outcome by 2018:

a. *50% of PLHIV and key populations reporting they feel less discriminated against*
b. *90% of people express accepting attitudes towards PLHIV*

PRIORITY 4	Strategic Information

The goal of this component of the NSP is to ensure that the national HIV response is evidence based. To that end, adequate information systems will be put in place for all aspects of the response: prevention; treatment, care and support; advocacy; policy development and management; and programme management.

The priority area will focus on: i) research, ii) strengthening the surveillance system, iii) developing the single M & E system for HIV (in alignment with the Three Ones Principles) to support monitoring, reporting and information sharing across partners and with the general public; and; iv) developing the communication strategy and protocols for sharing

information on the HIV response with the Government, the public, international entities and others.

Research studies will be conducted on an ongoing basis to continually improve understanding of the epidemiology of HIV in Trinidad and Tobago as well as the attitudes and behavior associated with the disease, particularly attitudes and behaviours of those populations most at risk.

Undoubtedly, the strengthening of the HIV case surveillance system to effectively capture HIV related data from both the public and private health systems[46] is an essential factor in the management of the response. Data flow into the surveillance system will be supported by formal memoranda of understanding and/or service agreements to support timely information sharing with the Interim HIV Agency and the partners in the response. Alongside the surveillance system there will be concomitant action to develop a laboratory information system and a medical record system to facilitate care and treatment, as well as introduce the unique identifier (noted earlier) for testing, treatment and care.

As it relates to monitoring and evaluation, the Three Ones principles, stresses the importance of *'one agreed M & E framework for overall national monitoring and evaluation'***.** To that end, all components of the national response, including the activities of civil society, will be monitored using a standardized system and key (agreed upon) outcomes and impact indicators will be evaluated. Standardization of the M & E system will also assist in reducing duplication of efforts among partners for more effective use of resources; as well as ensuring the data is available for timely and accurate evaluation of the response as all partners share the framework for data collection, measuring success and reporting.

[46] Monitored by CMOH in each county

Expected Outcomes by 2018:

a. *% increase in studies done to understand the scale and nature of the HIV epidemic and underlying causes in key populations*
b. *A comprehensive HIV information system in place comprising national surveillance, a laboratory information system and computerized HIV medical records.*
c. *HIV policy and programme development is evidenced-based*

PRIORITY 5	*Policy and Programme Management*

An effective national response to the HIV epidemic depends on the strength of the national HIV leadership, the role and support provided by the country's leaders, the policies that the leaders adopt and the capacity of the National Coordinating Mechanism (The Interim HIV Agency) to organize and guide a truly multi-sectoral response that is evidence based, creative and based in Trinidad and Tobago's culture.

Expected Outcomes by 2018

a) *National Composite Policy Index areas all covered*
b) *100% of National operational plan and targets achieved*

5.0 THE NSP RESULTS MATRIX 2013 - 2018

GOALS:
To reduce the incidence of HIV infections in Trinidad and Tobago;
To mitigate the negative impact of HIV and AIDS on persons living with HIV and affected by HIV and AIDS in Trinidad and Tobago
To reduce HIV related stigma and discrimination in Trinidad and Tobago

Level	Indicators	Baselines	Targets	Assumptions
Impact 1	**Incidence of HIV infections reduced (% decrease in incidence in population groups)**	Infants – 7.6% Women aged 15 - 24: TBD Men aged 15 – 24: TBD Women aged 15 – 49: TBD Men aged 15 – 49: TBD MSM: TBD Sex Workers: TBD Injecting Drug Users: TBD	Infants: 0% Women aged 15-24: TBD Men aged 15-24: TBD Women aged 15 - 49: TBD Men aged 15 – 49: TBD MSM: reduced by 0% Sex Workers: reduced by 50% Injecting Drug Users: reduced by 50%	Government of Trinidad and Tobago reduces structural and legal barriers to access for key population groups affected by HIV and AIDS and adopts the National HIV and AIDS Policy Positive international, regional, and national economic climate enables increased funding for NSP in first three years. Rapid reduction in incidence occurs, bringing down overall costs of treatment and care for Persons Living with HIV and AIDS by 2018 Commitment to achieving all HIV targets is demonstrated across all sectors(private, public, civil society, and institutions) Government demonstrates pro-active commitment to gender equity and equal opportunity for all
Impact 2	**Prevalence of HIV infection reduced**	General population: 1.6% Men and Women aged 15 – 24: 0.08% MSM: 20% Sex Workers: TBD IDUs: TBD	General population < 1% Men and Women aged 15 – 24 < 0.05% MSM: < 15% Sex Workers: TBD IDUs: TBD	
Impact 3	**AIDS related mortality reduced**	General Population:	By 50%	
Impact 4	**Stigma and discrimination against key populations reduced**		By 75%	
Impact 5	**Costs associated with HIV and AIDS reduced**		By 5%	

Strategic Priority Area 1: Prevention Reduced susceptibility to HIV infection in both general and key populations				
Level	**Indicators**	**Baselines**	**2018 Targets**	**Assumptions**
Strategic Objective 1: To improve sexual health knowledge, attitudes and behaviours of men and women aged 15-49				Funding is allocated for greater numbers of organisations to reach out to and work with all population groups, especially most affected populations. HIV prevention promotion is significantly more integrated into other lifestyle and well-being promotion programmes
Outcome 1.1	% of population who correctly identify two ways of preventing transmission of HIV and who reject the two most common misconceptions about HIV transmission	Women 15 – 49: 40% Men 15 – 49: 40% MSM: TBD Sex Workers: TBD Substance Abusers: TBD Prisoners: TBD	70% 70% 75% 75% 75% 75%	
Outcome 1.2	% of persons aged 15 years and older who have had sex with more than one sexual partner in the last 12 months	80% 94%	<40% <40%	
Output 1.1.1	% of persons reached with prevention programmes	Women and Men 15 – 49: TBD Key Populations: TBD	TBD 60%	
Output 1.1.2	% adults aged 15 – 49 years who accurately perceive their potential risk of HIV infection	Women: TBD Men: TBD	**65%** **65%**	
Output 1.1.3.	% of population who know the beneficial effects of male circumcision	Women: TBD Men: TBD	60% 60%	
Output 1.1.4	No. of organisations providing prevention services to key populations	TBD	TBD	

Level	Indicators	Baselines	2018 Targets	Assumptions
Strategic Objective 2: To increase the % of the population who have had an HIV test and know their results				
Outcome 1.3	**% of population who have been tested for HIV and STI in the last 12 months and know the results**	Women: (15-49) 38.9%[47] (2007) Men (15-49): 32.9% (2007) Women (15-24): 41% (2007)[48] Men (15-24): 41% (2007) MSM: TBD Sex Workers: TBD Substance Abusers: TBD Prisoners: TBD	55% 55% 80% 80% 80% 80% 60% 80%	Current levels of HIV counselling and testing are grow steadily for the wider population, while increased attention is given to testing most at risk groups. Health providers demonstrate positive attitudes towards key populations to encourage them to come for testing
Output 1.3.1	% of sites providing HIV/STI Counseling and Testing	Public Primary Care: TBD Private primary care: BD CSOs: TBD All128 / 88% (2010)[49]	100% 80% 50%	
Output 1.3.2.	No of people tested for HIV	Children <15: TBD Women >15: TBD Men > 15: TBD MSM: TBD Sex Workers: TBD Substance abusers: TBD Prisoners: TBD All: 55,000 persons (2011)	TBD TBD TBD TBD TBD TBD TBD All: 400,000	
Output 1.3.3	% of testing centres in Trinidad and Tobago include Risk Assessment Counselling and social services	TBD	60%	
Output 1.3.4	% of population receiving HIV CT and treatment through integrated services	STI/SRH: TBD TB: TBD NCD: TBD	85% 100% 50%	
Output 1.3.5	% of new admissions to correctional facilities tested for HIV and who know the results.	TBD	75%	

[47] KAPB Study 2007
[48] KAPB Study 2007
[49] Universal Access Status Update 2010

Level	Indicators	Baseline	2018 Targets	Assumptions
Strategic Objective 3: To promote healthy sexual health attitudes and practices in youth aged 15 to 24				Schools and youth workers provide a supportive and pro-active environment for students and young people to learn about positive relationships and safe sexual health practices
Outcome 1.4	% of persons aged 15-24 who correctly identify two ways of preventing transmission of HIV and who reject the two most common misconceptions about HIV transmission	Women 15-24 63.2%[50] Men 15 -24 63.2%[51]	95% 95%	
Output 1.4.1	% of schools that provided life skills-based HIV education in the last academic year	Primary TBD Secondary TBD	TBD TBD	
Output 1.4.2	% of school-age children and teens are receiving continuing age-appropriate HIV prevention education in schools, in consultation and with parents	Aged 13 – 17 TBD Aged 15 – 24 30%[52]	70% 80%	
Output 1.4.3	% of students reached through life skills based HFLE interventions in school	**TBD**	**TBD**	
Output 1.4.4	No. of persons aged 15 -24 reached through HIV prevention interventions in out of school settings	**TBD**	**TBD**	
Output 1.4.5	No. of persons 15 – 24 years accessing services from youth friendly clinics	**TBD**	**TBD**	
Outcome 1.5	**% of youth who practice safe sex behaviours**	No sex last 12 months (15-19) TBD Women 15 -24 using dual protection TBD	80% 80% 80%	
Output 1.5.1	% of never married youth aged 15-24 years who never had sex	Aged 15 – 19: 64% Aged 20 – 24: TBD	80% TBD	
Output 1.5.2	% of persons aged 15 to 24 who had sex before age 15 years[53]	Aged 15 – 24 12%	5%	
Output 1.5.3	% of youth age 15-24 years who know of at least one formal source of condoms	Aged 15 – 24: TBD	TBD	

[50] GAPR 2012
[51] HIV Prevention Interventions in Trinidad and Tobago (2010), p. 6
[52] MICS 2011
[53] Baseline from KAPB 2007

Level	Indicators	Baselines	2018 Targets	Assumptions
Output 1.5.4	% youth age 15-24 years who had sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months	Aged 15-19: TBD Aged 20-24: TBD	TBD TBD	
Output 1.4.5	% of youth age 15-24 years who used a condom during sexual intercourse with their last non-marital, non-cohabiting sex partner in the last 12 months	Women 15-19): 31%[54] Men 15-19) Women 20-24) Men (20-24	80% 53% (2007)[55]	
Output 1.5.6	% of women aged 15- 19 who had non-marital sex with a man 10 years or older than them in last 12 months	15 – 19 20 – 24 (KAPB 2007)	85% 90%	
Strategic Objective 4	**To improve the availability and acceptability of condoms as part of good sexual health practice**			Quality and supply of condoms remains consistent and able to meet demand.
Outcome 1.6	**% of sexually active adults 15 – 49 with more than one sexual partner using condoms with other than main partner**	Women 15-49: 12% Men 15-49: 37%[56]	80% 80%	
Output 1.6.1	% of persons aged 15 – 49 that report use of a condom at last intercourse with regular partner	Women 15 – 49: 30.7% Men 15 - 49: 35.1%	60% 60%	
Output 1.6.2	% of women and men 15-49 years old know where to get a condom when they need them	Women 15-49: 92% Men15:49: 95%	**100%** **100%**	

[54] GAPR 201295.2%
[55] HIV Prevention Interventions in Trinidad and Tobago (2010), p. p.6
[56] KAPB 2007

Level	Indicators	Baselines	2018 Targets	Assumptions
Strategic Objective 5	**To reduce high risk HIV behaviours and infection in key populations**			Legal and social barriers to working constructively with key populations are removed
Outcome 1.7	**% of persons in most at risk groups practicing HIV prevention behaviours (aggregate figure)**	**TBD**	**70%**	
Output 1.7.1	% persons belonging to a 'most at risk group' report using a condom during last sexual intercourse	MSM (last anal sex): 95% Sex Workers: w/ non-client: TBD Substance abusers: TBD PLHIV: TBD	97% 65% 80% 90%	
Output 1.7.2	% of women and men IDUs reporting using sterile injecting equipment	**TBD**	**70%**	
Output 1.7.3	% of sex workers reporting using a condom at last sexual intercourse with their most recent client	TBD	90%	
Strategic Objective 6	**To eliminate mother to child transmission of HIV**			100% of pregnant women access ANC services and receive Provider Initiated Counseling and Testing for both HIV and Syphilis HIV positive mothers accept virological testing for their infants. **0%**
Outcome 1.8	**% incidence HIV infants born to HIV infected mothers**	**7.6% (2011)**	**0%**	
Output 1.8.1	% of women age 15-49 years who correctly identify all three means of mother to child transmission of HIV	Women (15-49): TBD	TBD	
Output 1.8.2	% of all pregnant women attending at least one Antenatal Clinc (ANC)receive HIV and syphilis testing and counseling and know the results	HIV: 95% (2011)[57] Syphilis: TBD	**99%**	
Output 1.8.3	% prevalence of HIV (and syphilis) among pregnant women	HIV : 1.6% (2010)[58] Syphilis: TBD	< 1% TBD	
Output 1.8.4	% of HIV positive women receive ARV to reduce mother to child transmission	83% (2011)	95%	
Output 1.8.5	% of infants born to HIV positive women receive virological test for HIV within 2 months of birth	40% (2011)	80%	
Output 1.8.6	% of HIV positive mothers known to be on ARV treatment 12 months after delivery		TBD	80%

[57] Ministry of Health HACU
[58] GAPR 2012

Level	Indicators	Baseline	2018 Targets	Assumptions
Strategic Objective 7 To improve accessibility and availability of sexual health and HIV services through integrated health services				Rapid progress is made with introducing more integrated services for sexual and reproductive health, HIV and other communicable and non-communicable diseases.
Outcome 1.9	**% of health facilities offering integrated health services including HIV**	**TBD**	**80%**	
Output 1.9.1	% of physicians in both the private and public sectors equipped with skills to provide HIV testing and risk reduction counselling	TBD	50%	
Output 1.9.2	% of cases of seroconversion following exposure to HIV	TBD	0%	
Output 1.9.3	% of cases of occupational and non-occupational exposure cases receiving PEP	TBD	TBD	
Output 1.9.4	HIV/STI Prevention integrated with MOH NCD Prevention Programmes	TBD	TBD	

Strategic Priority Area 2: Treatment, Care and Support **Universal access to treatment, care and support services for all PLHIV in Trinidad and Tobago ensured**				
Level	**Indicators**	**Baseline**	**2018 Targets**	**Assumptions**
Strategic Objective 8: To increase the % of eligible adults and children receiving ART and care				Good adherence to ARV treatment reduces levels of resistance so cheaper first line treatment remains effective
Outcome 2.1	% of adults and children with advanced HIV infection receiving ART	Adults: 50.77% (2010)[59] Children: TBD	**85%** **90%**	
Outcome 2.2	% of eligible PLHIV are receiving ARV therapy and HIV care	Adults: 70% (2011) Children: TBD	90% 90%	
Output 2.1.1	% of health facilities providing HIV treatment and care with appropriately trained pharmacists and counsellors	w/Pharmacists: TBD w/counseling training: TBD	100% 100%	
Output 2.1.2	No. of RHAs with adult and paediatric sites		**9**	
Output 2.1.3	Percentage of health facilities dispensing ARV that experienced a stock-out of at least one required ARV in the last 12 months	Public: TBD Private: TBD	0% 0%	
Strategic Objective 9: To increase adherence to taking ARV medication				ARVs are consistently available in health facilities Integrated services and task shifting ensure greater number of facilities are able to offer ARVs and manage health needs of PLHIV
Outcome 2.3	**% of PLHIV known to be on treatment 12 months after initiation of antiretroviral therapy**	**83% (2011)[60]**	**95%**	
Output 2.3.1	% adults and children receiving ART in accordance with the national approved treatment protocol/guidelines	Adults: TBD Children: TBD	100% 100%	
Output 2.3.2	% of PLHIV receiving ARV therapy fully adhere to their medication	Adults: TBD Children: TBD	85%	
Output 2.3.3	% of treatment centres using the National Adherence Plan	TBD	90%	
Output 2.3.4	% of PLHIV accessing adherence services by region	TBD	TBD	

[59] Universal Access Status Update
[60] Ministry of Health HACU

Level	Indicators	Baselines	2018 Targets	Assumptions
Strategic Objective 10 To improve national and regional laboratory services				
Outcome 2.4.	**Rate of laboratory compliance with national HIV testing protocols in public and private health care institutions**	**TBD**	**95%**	
Output 2.4.1	% of national reference and regional labs accredited		100%	
Strategic Objective 11: To improve the care and treatment of people living with HIV who develop other infection%				Integrated services and task shifting ensure greater number of facilities are able to offer ARVs and manage health needs of PLHIV
Outcome 2.5	**% TB/HIV and HIV/OI co-infected patients will be offered ART and TB or OI medication**	**TB: 6.32 (2009)[61]** **OI: TBD**	100% 90%	
Output 2.5.1	% of HIV sites providing TB and OI treatment	TBD	TBD	
Output 2.5.2	% of treatment sites with health care professionals trained in identification of OIs in PLHIV	TBD	TBD	
Output 2.5.3	% TB patient tested for HIV,	TBD	100$	
Strategic Objective 12: To improve the quality of services provided to people living with HIV				
Outcome 2.6	**% of PLHIV report satisfaction[62] with quality of service from public health facilities and CSOs**	**TBD**	80%	
Output 2.6.1	Percent of health care facilities that protect against discrimination (e.g., HIV tests with informed consent)		80%	
Output 2.6.2	% of new PLHIV are in a peer support programme	**TBD**	**100%**	
Output 2.6.3	% of PLHIV and persons affected by HIV receiving supportive counseling	**PLHIV: TBD** **Persons affected by HIV: TBD**	**100%** **100%**	
Output 2.6.4	No. of PLHIV and orphans receiving free social support	PLHIV: 1500 (2008)[63] Orphans: TBD	TBD	
Output 2.6.5	% of orphans and non-orphans aged 10-14 attending school	Orphans: TBD Non-Orphans: TBD	100%	

[61] GRPR 2010
[62] Satisfaction data will be triangulated using satisfaction data of all adults accessing HIV services, mystery shopper of HIV Services, focus groups of PLHIV and non PLHIV
[63] Universal Access Status Update 2010

Strategic Priority Area 3: Advocacy and Human Rights **Recognition of, and respect for the human rights of PLHIV, their families and key populations ensured and national awareness of HIV issues heightened**				
Level	**Indicators**	**Baseline**	**2018 Targets**	**Assumptions**
Strategic Objective 13	**To ensure the rights and dignity of people living with HIV and key populations**			Government is willing to make changes to discriminatory laws in line with recommendations made in various legal reviews. Private sector organizations are willing to encourage healthy work place policies and supportive environments for PLHIV, especially organizations with high numbers of migrant workers.
Outcome 3.1a	% of PLHIV and key populations reporting they feel less discriminated against	**TBD**	**TBD**	
Outcome 3.1b	% of population 15-49 express accepting attitudes towards PLHIV and key populations	**66%**	**100%**	
Output 3.1.1	National AIDS Policy enacted		**By end 2013**	
Output 3.1.2	% of work places that have HIV Workplace Policies and programmes that include anti-discrimination sensitisation	Public 50% Private 30	Public 100% Private 75%	
Output 3.1.3	% reduction in reported cases of discrimination	TBD	TBD	
Output 3.1.4	% of HIV related discrimination complaints successfully	TBD	TBD	
Output 3.1.5	% of workers in public and private sector exposed to HIV prevention and anti-discrimination interventions	TBD	TBD	
Output 3.1.6	No. of Training/capacity building interventions held for HIV focal points in workplaces and with CSOs	TBD	TBD	
Output 3.1.7	Reduction in no. of reports in the media with negative images of PLHIV and key populations	TBD	TBD	
Output 3.1.8	No. of speeches by key political leaders calling for end to stigma and discrimination	TBD	TBD	

Strategic Priority Area 4: Strategic Information To ensure that the national HIV and AIDS response is driven by evidence-based decision making				
Level	**Indicators**	**Baseline**	**2018 Targets**	**Assumptions**
Strategic Objective 14: To improve the evidence related to the nature and causes of poor sexual health and HIV infection amongst the general and key populations				All partners commit to using evidence to inform their policy and programme decisions
Outcome 4.1	% of programmes using evidence derived by studies to address needs of key population groups		**100%**	
Output 4.1.1	% of HIV Research Agenda implemented on an annual basis		**100%**	
Output 4.1.2	No. of research studies conducted with general public and key populations	General public: 1 PLHIV: 1 Sex Workers: 1 IDUL: 1 MSM: ! Youth 15-24: 1 Prisoners: 1	**3** **6** **6** **6** **6** **6** **6**	
Strategic Objective 15 To strengthen the national surveillance system				
Outcome 4.2	A comprehensive HIV information system in place comprising national surveillance, a laboratory information system and computerized HIV medical records		**All in place**	
Output 4.2.1	A comprehensive and integrated and functional HIV surveillance system established	• % of elements in place: TBD	All elements of surveillance system are operational throughout the year	
Output 4.2.2	National HIV surveillance protocols and procedures in place and used	TBD	**TBD**	
Strategic Objective 16: To establish a comprehensive monitoring and evaluation system for the national HIV response that informs decision makers				All decision makers commit to using evidence to inform their policy and programme decisions. Capacity and capability available for setting up and managing M&E within all partner organisations
Outcome 4.3	HIV policy and programme development uses routine monitoring data to inform decision making	% w citations in policy/prog docs: Partners reporting on NSP results indicators	**100%**	
Output 4.3.1	Comprehensive and unified system of M&E in place	12 components of M&E: TBD	**100%**	
Output 4.3.2	% of partners regularly reporting using national M&E protocols	TBD	**100%**	

Strategic Priority Area 5: Policy and Programme Management Successful implementation of the Trinidad and Tobago NSP and an effective national response to the HIV epidemic ensured				
Level	**Indicators**	**Baselines**	**2018 Target**	**Assumptions**
Strategic Objective 17: To Establish a Policy Framework for Facilitating the National HIV Response, Reducing New Infections and Mitigating the Adverse Impact of HIV and Reducing Stigma and Discrimination				National HIV Policy, Gender Policy, Youth Policy and Work Place Policy are all enforced
Outcome 5.1	National Composite Policy Index areas all covered		**All areas covered**	
Output 5.1.1	% programme compliance with the National HIV Policy	TBD	70%	
Output 5.1.2	% work place compliance with the National HIV and AIDS Workplace Policy	Public Sector: TBD Private Sector: TBD	70% 70%	
Output 5.1.3	% work place compliance with sector based HIV related policy in Health and Education	Health: TBD Education : TBD	90%	
Output 5.1.4	% compliance with National Gender Policy and Youth Policy	Gender Policy: TBD Youth Policy: TBD	100% 100%	
Output 5.1.4	% of persons 15 to 49 who are satisfied with the national response	PLHIV: TBD Women and men: TBD	90% 70%	
Strategic Objective 18: To improve the capacity of the Interim HIV Agency and implementing partners for an effective HIV response				Interim HIV Agency arrangements are formalized within a (potentially mulit-health issue) statutory agency.
Outcome 5.2	% of National annual operational plan and targets achieved		**100%**	
Output 5.2.1	% of GDP allocated to HIV (all sectors)	0.06% (2009)	0.05%	
Output 5.2.2	Domestic and international AIDS spending by categories and financing sources	Total: TBD Domestic: TT$98.95m [64] International: TBD	TBD TT$95.75m TBD	
Output 5.2.3	% compliance with international reporting responsibilities	TBD	100%	
Output 5.2.4	% of implementing partners achieving annual targets	TBD	90%	
Output 5.2.3	% of partners are satisfied with the management of the national response to HIV	TBD	95%	

[64] Summary National HIV and AIDS Spending Assessment 2002 - 2009 (Draft)

6.0 IMPLEMENTING THE NSP

The NSP 2013 - 2018 is a multi-sectoral plan, in keeping with the preferred approach for Trinidad and Tobago and international best practice. In that regard, the management of the NSP is a complex undertaking that must be supported by:

a. Well negotiated, clearly defined roles and responsibilities that will inform agreements on the level of participation of all partners

b. Strong communications, mechanisms for sharing information

c. Motivated, committed, well-resourced HIV Coordinators (in the various Government Ministries) and Implementing Agencies

d. Strong collaboration and inclusion of all stakeholders, in particular target populations and CSOs

e. Strong leadership, negotiation and project management skills among HIV Coordinators and Implementing Agencies

f. Strong oversight (monitoring and evaluation) by a STATUTORY Agency with clear responsibility for HIV

g. Good resource assessment and budgeting

h. Effective systems for transparency and accountability

i. Regular strategic review and adjustment informed by consistent environmental scanning

These operational and managerial requirements highlight the importance of those skills and competencies required by the entities in the governance structure for the NSP.

In the new planning period careful attention will be given to ensuring that these requirements are met. This will include strengthening of the governance structures and arrangements as well as the communication, operating and monitoring and evaluation (M & E) systems; and capacity building for the INTERIM HIV AGENCY and

partners, while transitioning to a new Statutory agency with responsibility for HIV. The 'enabling priorities and initiatives to 2018 are discussed below.

6.1 GOVERNANCE ARRANGEMENTS FOR IMPLEMENTING THE NSP

The multi-sectoral response to HIV and AIDS in Trinidad and Tobago is made possible through the coordinated efforts of a range of organizations including public and private sector entities, civil society organizations and international partners.

As noted in Section 2, a coordinating mechanism (the National AIDS Coordinating Committee) was established in the Office of the Prime Minister to provide leadership and direction to enable the multi-sectoral response. To ensure a parallel response in Tobago, the Tobago HIV and AIDS Coordinating Committee was created in the Office of the Chief Secretary. THACC, as a member of the national coordinating mechanism ensures consistency with the direction of the NSP and the national standards and policies in the context of Tobago.

The responsibilities of these entities and other key partners as it relates to the NSP are summarized at **Table 6.1**. An organizational structure is shown at **Fig. 6.1** which follows.

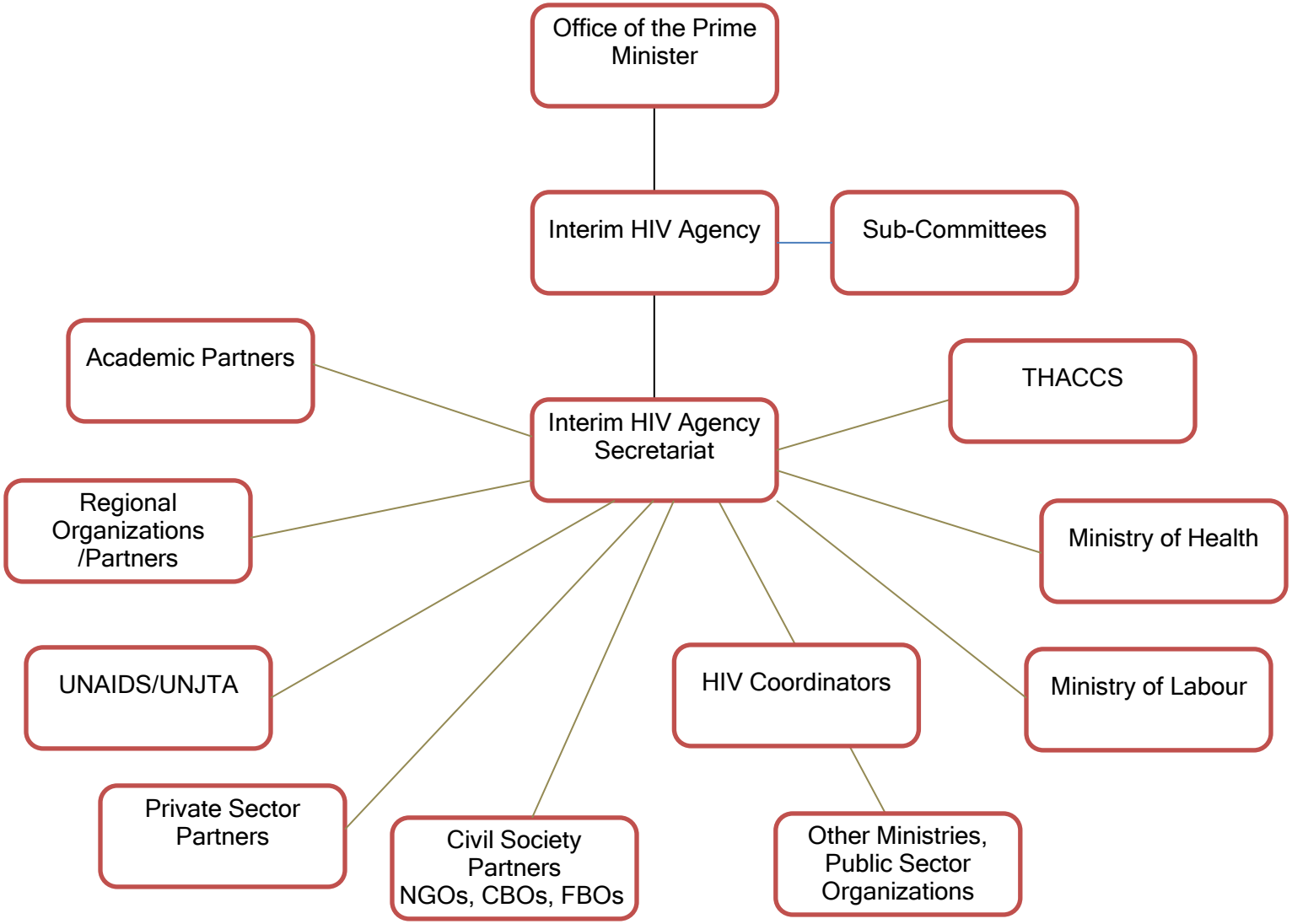
These governance arrangements will be 'tested' and refined over the planning period with the establishment of the new INTERIM HIV AGENCY, and eventually a new Statutory Agency with responsibility for HIV. The goal is to ensure that the governance arrangements and relationships facilitate efficient and effective implementation of the NSP.

Table 6.1: Responsibilities Under the NSP Framework

Office of the Prime Minister	The government body responsible for facilitating the execution of the NSP viz. monitoring the performance of the Interim HIV Agency, mobilizing resources, mobilizing other government agencies and reporting to relevant bodies e.g. the Cabinet and Parliament
Interim HIV Agency	Provides national leadership and coordination of the expanded HIV national response having a coordinating, monitoring and advisory role. The key areas of responsibility are: • Coordination of the national HIV response • Definition of national policies • Setting of national targets and preparation of annual work plans • Establishment of national standards • Evaluation and monitoring of the HIV response at the national level
Secretariat to the Interim HIV Agency	Responsible for the (day-to-day) management and coordination of the NSP viz. reporting on progress, coordinating stakeholder efforts, providing advice and technical assistance to implementing agencies and a clearinghouse of information. Specifically: • Developing annual work plans and budgets for implementation of the NSP • Reporting to the OPM, partners, other entities and the Public on the multisectoral response and NSP implementation • Monitoring and evaluation which will includes a framework of performance monitoring and evaluation of implementing agencies' activities • Formulate updates on the HIV AND AIDS situation in collaboration with MOH for the political directorate and other stakeholders • Assist in policy development • Help source technical assistance for implementing agencies to develop project proposals • Mobilize resources and other needed support for the implementing agencies • Involve new partners • Maintain a library of HIV AND AIDS-related information and material • Liaise with key technical agencies local, regional and international and develop partnerships
Tobago HIV AND AIDS Coordinating Committee	Coordinate Tobago's expanded response to the prevention and control of the HIV epidemic in alignment with national response. Specifically to: • To identify relevant policies for the development of HIV and AIDS Response in Tobago • To provide an avenue for the effective collaboration of all sectors and organizations in implementing Tobago HIV Response Program. • To review the development of strategic implementation plans, programs /projects in the Tobago HIV and AIDS Response

	• To ensure the development and implementation of effective strategies and interventions to support the mandate of the Tobago HIV and AIDS /STI response ; • To approve reports and annual work plans and budgets submitted through the THACC Secretariat • To support the development of strategic frameworks and plans for mainstreaming in the public and private sectors • To facilitate the cooperation of the public and private sectors, as well as civil society in the HIV and AIDS response in Tobago. • To provide support in the creation and strengthening of partnerships for the Tobago HIV and AIDS/STIs Response Programme. • Appoint sub committees and ad hoc working groups as deemed necessary by the Office of the Chief Secretary.
HIV AND AIDS Coordinators in the Public Sector	Works in collaboration with the Interim HIV Agency, responsible for coordinating HIV activities in their ministry and sector. In addition: • Work as a liaison for their ministry and sector • Submit progress reports and budgeted annual work plans • Provide updates on the implementation of key sector-based initiatives (critical to NSP outcomes) • Advise on policies and strategies including development of sector plans and budgets • Develop and promote a multi-sectoral approach to the execution of the NSP • Profile issues related to HIV and AIDS to a wide cross section of the society • Mobilize resources
Implementing Agencies	Public, private, civil society, other advocates and international organizations responsible for implementation of projects in the NSP - community, sector, national levels. In addition, to: • Communicate regularly with Interim HIV Agency • Prepare progress reports and budgeted annual work plans • Mobilize resources • Promote the policies and strategies of the national response within the sectors/communities

Fig. 6.1: The Trinidad and Tobago HIV and AIDS National Response Organizational Structure



6.2 STRENGTHENING THE PARTNERSHIP TO SUPPORT IMPLEMENTATION OF THE NSP

6.2.1 The HIV Coordinators in Government Ministries

Through the Office of the Prime Minister steps are being taken to re-establish HIV Coordinators in every ministry of government, as a basis for 'mainstreaming' the HIV response. There is acknowledgement that the HIV Coordinators are a key element of the governance framework for the HIV response, widening the sphere programme management and coordination at the sector level. Indeed, over the years these Coordinators have facilitated important initiatives for the advance of the HIV agenda.

However, the cadre of Coordinators has not been consistent over time due in large measure to the competing interests and work schedule of the members and the movement of these officers to pursue career opportunities. Going forward, in addition to increasing the number of Coordinators, these officers will need to be supported by:

a. Agreement that the officer can be dedicated to HIV projects and initiatives or is given a specific allotment of time to dedicate to these responsibilities
b. Clear definition of the expectations of Coordinators and in that regard, the development of selection criteria that are aligned to performance expectations;
c. Support to develop sector based work plans are designed to address NSP priorities;
d. Support to build their technical and project management capacity (i.e., provide training to new Coordinators and continued training to original Coordinators);
e. Create a forum for on-going interacting, information sharing and teaming among Coordinators and other partners such as CSOs
f. Ensure that performance of their HIV work is included in their performance assessment in their respective ministries

6.2.2 Implementing Agencies

The Implementing Agencies represent the 'front line' of the HIV response. Without the committed action of these organizations the NSP cannot be implemented. While there

is good participation from organizations across all sectors in the new planning period steps will be taken to increase participation of the Private Sector as well as NGOs, CSOs and FBOs, in the HIV response, particularly in the priority areas treatment, care and support, advocacy and human rights and strategic information.

6.2.3 Building Capacity for Implementation

As noted under Priority Area 5, a two year Technical Support Plan 2012 - 2014 (TSP) will be developed that will ensure that partners in the national response are well able and well equipped to implement to tasks assigned to them in the NSP. Specifically, the TSP will:

a. Identify the needs of service provider organizations in the response
b. Identify existing support services to address the needs identified
c. Identify services needed which not currently available so that these can be put in place
d. Identify the priorities and interventions required to build the technical capacity within the agencies responsible for delivering services that make significant and measurable impacts on the HIV response in Trinidad and Tobago

The implementation of the Technical Support Plan then, will be a critical success factor for ensuring that the desired outcomes from the 'roll out' of the NSP can be realized.

6.3 HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

The Interim HIV Agency has a responsibility to build competence for the national response among its partners, sponsors and advocates. In that regard, the Agency will work with partners provide a range of training and education opportunities to develop key skills and competencies needed for an effective national response.

In light of the above, HR initiatives going forward would include:

a) The development of **a Training Plan to support the NSP**, informed by the needs assessment and recommendations emanating from the Technical Support Plan

b) Development of the **performance management framework** for the NSP that allows for accountability, assessment and capacity building support of partners involved in implementation the NSP

c) ***Continuous Leadership Development*** among all stakeholder groups involved in the implementation of the NSP, but with special emphasis on policy developers, PLHIV, youth, CSOs and health professionals; bearing in mind the strategic thrust of the NSP to 2018.

6.4 STRATEGIC COMMUNICATION MANAGEMENT

Strengthening internal and external communications is a critical initiative in the context of the NSP over the planning period. Strong, effective communication is the 'lifeblood' of the multi-sectoral response, especially in light of the need to ensure that good data is available in a timely fashion for decision making and programme management.

With regard to external communications, there is an urgent need to re-establish the national response in the public domain, to promote and secure buy in for the strategy and initiatives of the new NSP and regain some momentum that had fallen away in the past year. To this end, despite likely constraints in resources, the Interim HIV Agency will use a mix of media – print, electronic, internet, outdoor, 'corporate' branding, public relations etc. – emphasizing those that are cost effective with the best reach.

Another key aspect of external communications will be to build up customer interface and feedback systems to consistently gather information pertaining to i) needs the target groups in the national response and ii) the perception of the performance of the national response. This engagement will also support collection of data as it relates to satisfaction with the services in the national response for the general public and target

populations (client satisfaction is a performance indicator for Priority Areas 1 and 2). This information will be used to guide continuous improvement of the national response.

External Communication also extends to reporting on the progress of the NSP and the achievement of national and internal targets for the mitigation of HIV and AIDS. Reporting requirements will include the Government national development targets (e.g. in the MTPF 2011 - 2014), MDGs, UNGASS, CARICOM and others. To that end, the communication system must enable the following:

a. Continuous reporting to partners in the national response
b. Quarterly Reports on the status of implementation of the NSP
c. Specific Project/Programme Status Reports
a. International reporting requirements
b. Biannual/Annual reports to the General Public

The reporting requirements outlined above for the NSP will be integrated into the M & E system for tracking the progress of HIV outcomes for Trinidad and Tobago (see **Section 8**).

Internal Communications, communications among partners in the response, will also be strengthened broadening the range of media to ensure that all partners across Trinidad and in Tobago have ready access to data and information to support their action in the national response. Strategies for doing this could include increase fora for interaction, discussion and sharing information among partners; the NSP website, electronic notice boards. Wherever appropriate, computer technology will be used to facilitate effective communication. To support the ramp up of communications as envisaged, it is critical that this function is well resourced in the new Interim HIV Agency.

6.5 ORGANIZATIONAL DEVELOPMENT: MANAGEMENT AND OPERATING SYSTEMS TO SUPPORT THE NSP

Once the Interim HIV Agency is in place there will be a need to quickly establish key operating systems to enable the organization's functioning. This will involve *inter alia* determining the arrangements, policies, procedures and practices with respect to:

- Governance and Decision Making System
  - a. The governance structure to support the national response is discussed in NSP. From an operational perspective there must be clarification of roles and responsibilities between OPM, the Interim Agency, the Secretariat, THACCS, any working groups appointed.
  - b. Modes of decision making within the Interim Agency, in the Secretariat and with its line Ministry, OPM, must also be clear.
- Internal and External Communications & Public Relations
  - Information, Education and Communications
    - a. Communication and information sharing are key roles of the Interim Agency, effected through the Secretariat.
    - b. There must be clear protocols and procedures for good 'internal' communications which will be the 'lifeblood' of the multispectral response to ensure that implementing partners have access to information for decision making and effective delivery of services
    - c. The standard operating procedures for external communications and public relations must also be developed an address communication and sharing of information with the public as well as local and international stakeholders and interest groups
    - d. A Marketing and Communication Strategy will be developed to support information and education programmes led by the Interim Agency
    - e. Another critical aspect of the Communication system will be the Reporting protocols within the national response and to external stakeholders.
- Management Information Support/Data Management Systems
  - a. The management information support (MIS) system and infrastructure for the Interim Agency is vital bearing in mind that Agency will function as a clearinghouse for a full range of information on HIV and AIDS. The system must be robust and well

protected while at the same time customized for the multi-sectoral response which would mean access by a wide range of stakeholders. The system must support the basic managerial needs of the Interim Agency e.g. project management and financial management interfaces; as well as more complex functions including database management, storage and cataloguing of documents.

- Project Coordination & Management

a. This 'system' is essential given the multi-sectoral response which involves several organizations working concurrently to achieve the shared deliverables and target in the Operational Plan. As a main source of funding and other resources for implementing partners, the Agency must have clear, well –defined processes for evaluating work plans and project proposals from partners, with standardized formats for same.

- Monitoring & Evaluation System

a. Building on the MIS outlined above the M & E system must facilitate input of data and information from a range of sources including reports of implementing partners and research. The development of the M & E system will be guided by the M & E Framework and Plan. Protocols, procedures and standardized templates must be developed to guide stakeholders contributing to the system or reporting on implementation of projects and programmes. Protocols for persons and organizations wishing to access information from the system must also be developed.

- Human Resource Management & Development System

a. The HR system will take account of the needs of the persons at the Interim Agency and the Secretariat and as well the capacity development needs of the implementing partners (implementation of the Technical Support Plan)

- Financial Management
  - Procurement System

a. The financial management system must allow the Interim Agency to meet the requirements of the Public Service (Ministry of Finance) with respect to financial management, accounting, budgeting and procurement.

b. The financial system must include clear, well defined protocols for assessing proposals from implementing partners, and for tracking use of funds by implementing partners including standardize budgeting and reporting templates

7.0 COSTING THE NSP 2013 - 2018

Cost estimates were developed for a draft of the NSP in 2011 by consultants[65]. The estimates were developed using an activity based costing methodology and are provided in Trinidad and Tobago Dollars (TTD). The strategy activities outlined in the NSP Matrix were used as a base to begin the costing estimate. Consultations were held with key stakeholders including a sample of: technical working group participants, civil society organizations, ministry HIV and AIDS coordinators and regional health authorities, in order to breakdown the strategy activities into implementable activities that could be costed. Stakeholders represented the range of activities included in the NSP covering each of the five NSP priority areas: 1) Prevention, 2) Treatment, Care and Support, 3) Advocacy and Human Rights, 4) Strategic Information and 5) Policy and Programme Management. In addition, key documents were reviewed from as many government and non-government sources as were available and accessible, including: program action plans, budgets for FY11 and expenditure data from the recent National HIV and AIDS Spending Assessment.

These resources provided a basis for including implementable activities and associated unit costs for the NSP cost estimates. Standard unit costs were identified for common cost items such as consultancy fees and workshop costs. Targets by year were determined for each activity based on documents provided.

These estimates were maintained with adjustments made for activities prioritized in the first two years of the NSP in the Operational Plan (**Annex 3**).

[65] Prepared by Katie Senauer and Martha Benezet, USAID Health Systems 2020 (HS2020) NSP Costing Consultants

7.1 Overall Cost Summary

The total Six-year cost for implementation of the strategy activities under the five NSP priority areas is estimated at 490 million TTD (76.43 million USD using the January 2013 exchange rate). The average per year needed to implement the NSP is estimated at 98 million TTD. This estimate is based on costable activities that were developed based on available resources at the time of the estimate and are consistent with the strategic activities in the NSP Matrix. The estimates should be adjusted based on final inputs on activities, targets and progress towards the anticipated targets, and on an annual basis with the review and 'rolling' of the Operational Plan and the preparation of budget estimates for the Ministry of Finance.

Table 7.1: Estimated NSP Cost Summary by Priority Area Over the Five-Year Period (TT$)

Priority Areas	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
Prevention	22,310,000	24,760,000	25,650,000	25,150,000	24,200,000	24,100,000	**146,170,000**
Care, Treatment and Support	46,670,000	52,115,000	53,450,000	52,125,000	52,100,000	51,750,000	**308,210,000**
Advocacy and Human Rights	5,000,000	5,500,000	5,250,000	5,000,000	4,750,000	4,500,000	**30,000,000**
Strategic Information	6,600,000	4,830,000	3,355,080	3,403,360	3,772,440	3,350,500	**25,311,380**
Policy and Programme Management	11,325,000	11,575,000	11,810,000	12,065,000	12,070,500	12,050,000	**70,895,500**
TOTALS	**91,905,000**	**98,780,000**	**99,515,080**	**97,743,360**	**96,892,940**	**95,750,500**	**580,586,880**

The majority of the resources (53%) is estimated to be directed for Priority Area 2: Care, Treatment and Support, followed by Priority Area 1: Prevention at 25% of the total resources. Priority Area 5: Policy and Programme Management accounts for 12% of the estimated total cost followed by Priority Areas 3 and 4 each at 5%.

Fig. 7.1: Total Six Year NSP Cost Estimate Distribution by Priority Area (%)

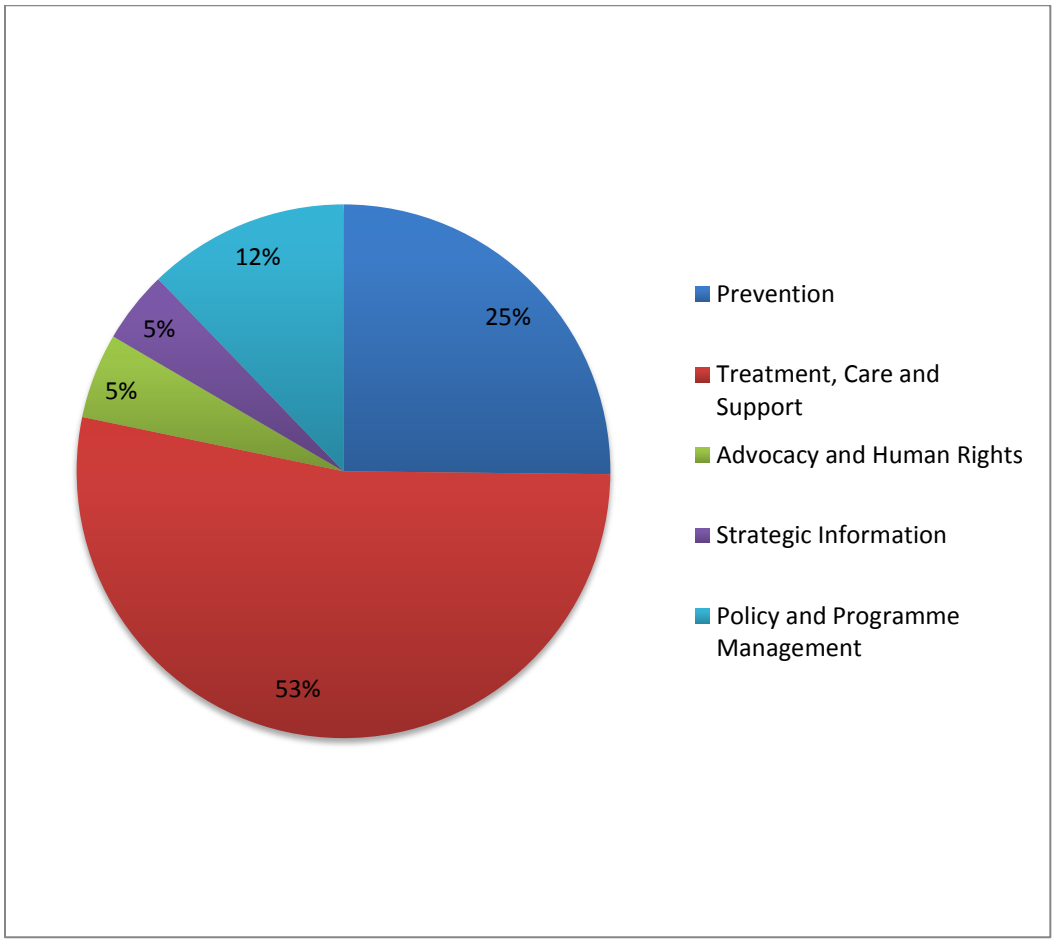


Table 7.2 which follows provides the estimates for each priority area for strategic objective for each of the six years.

Table 7.2: Estimated Cost by Priority Area, Strategy Objectives and Year

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
PRIORITY AREA I: PREVENTION COMBINING BEHAVIOURAL, BIOMEDICAL AND STRUCTURAL INTERVENTIONS							
Goal: To reduce the susceptibility of the general population in Trinidad and Tobago to HIV infection							
1. To improve sexual health knowledge, attitudes and behaviours of men and women aged 15-49	6,500,000	7,250,000	7,500,000	7,100,000	7,000,000	7,000,000	**42,350,000**
2: To increase the % of the population who have had an HIV test and know their results	1,750,000	2,000,000	2,000,000	2,250,000	2,500,000	2,500,000	**13,000,000**
3: To promote healthy sexual health attitudes and practices in youth aged 15 to 24	3,000,000	3,500,000	3,500,000	3,500,000	3,250,000	3,250,000	**20,000,000**
4 To improve the availability and acceptability of condoms as part of good sexual health practice	1,210,000	1,310,000	1,400,000	1,500,000	1,550,000	1,550,000	**8,520,000**
5 To reduce high risk HIV behaviours and infection in key populations	7,500,000	8,300,000	8,500,000	8,250,000	7,500,000	7,500,000	**47,550,000**
6 To eliminate mother to child transmission of HIV	1,500,000	1,500,000	1,750,000	1,800,000	1,800,000	1,750,000	**10,100,000**
7 To improve accessibility and availability of sexual health and HIV services through integrated health services	850,000	900,000	1,000,000	750,000	600,000	550,000	**4,650,000**
TOTAL for Priority Area 1: Prevention	**22,310,000**	**24,760,000**	**25,650,000**	**25,150,000**	**24,200,000**	**24,100,000**	**146,170,000**

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
PRIORITY AREA II: OPTIMIZING DIAGNOSIS, TREATMENT, CARE AND SUPPORT OUTCOMES							
Goal: To ensure universal access to treatment, care and support services for all PLHIV in Trinidad and Tobago							
8: To increase the % of eligible adults and children receiving ART and care	42,620,000	48,475,000	50,000,000	49,500,000	49,500,000	49,500,000	**289,595,000**
9: To increase adherence to taking ARVs	1,000,000	790,000	600,000	600,000	600,000	500,000	**4,090,000**
10 To improve national and regional laboratory services	1,250,000	1,000,000	1,000,000	500,000	500,000	500,000	**4,750,000**
11: To improve the care and treatment of people living with HIV who develop other infections	550,000	600,000	750,000	775,000	750,000	750,000	**4,175,000**
12: To improve the quality of services provided to people living with HIV	1,250,000	1,250,000	1,100,000	750,000	750,000	500,000	**5,600,000**
TOTAL for Priority Area 2: Treatment, Care and Support	**46,670,000**	**52,115,000**	**53,450,000**	**52,125,000**	**52,100,000**	**51,750,000**	**308,210,000**

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
PRIORITY AREA III: ADVOCACY AND HUMAN RIGHTS							
Goal: To heighten the national interest in HIV issues and to ensure the recognition of, and respect for the human rights of PLHIV, their families and targeted populations							
13 To ensure the rights and dignity of people living with HIV and key populations	5,000,000	5,500,000	5,250,000	5,000,000	4,750,000	4,500,000	**30,000,000**
TOTAL for Priority Area 3: Advocacy and Human Rights	**5,000,000**	**5,500,000**	**5,250,000**	**5,000,000**	**4,750,000**	**4,500,000**	**30,000,000**

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
PRIORITY AREA IV: STRATEGIC INFORMATION							
Goal: To ensure that the national HIV and AIDS response is driven by evidence-based decision making							
14: To improve the evidence related to the nature and causes of poor sexual health and HIV infection amongs the general and key populations	2,950,000	3,305,000	2,133,820	2,296,420	2,671,940	2,500,000	**15,857,180.00**
15 To strengthen the national surveillance system	2,825,000	1,225,000	1,101,040	1,000,000	1,000,000	750,000	**7,901,040.00**
16: To establish a comprehensive monitoring and evaluation system for the national HIV response that informs decision makers	825,000	300,000	120,220	106,940	100,500	100,500	**1,553,160.00**
TOTAL for Priority Area 4: Strategic Information	**6,600,000**	**4,830,000**	**3,355,080**	**3,403,360**	**3,772,440**	**3,350,500**	**25,311,380**

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	TOTAL
PRIORITY AREA V: POLICY AND PROGRAMME MANAGEMENT							
Goal: To ensure successful implementation of the Trinidad and Tobago NSP and an effective national response to the HIV epidemic							
17: To Establish a Policy Framework for Facilitating the National HIV Response, Reducing New Infections and Mitigating the Adverse Impact of HIV	75,000	75,000	60,000	65,000	70,500	50,000	**395,500.00**
18: To improve the capacity of the Interim HIV Agency and implementing partners for an effective HIV response	11,250,000	11,500,000	11,750,000	12,000,000	12,000,000	12,000,000	**70,500,000.00**
TOTAL for Priority Area 5: Policy and Programme Management	**11,325,000**	**11,575,000**	**11,810,000**	**12,065,000**	**12,070,500**	**12,050,000**	**70,895,500**
TOTAL For All Five Priority Areas	**91,905,000**	**98,780,000**	**99,515,080**	**97,743,360**	**96,892,940**	**95,750,500**	**580,586,880**

8.0 MONITORING AND EVALUATION

Efficient monitoring and evaluation of the NSP will require the development of a strong M&E system. A robust M & E system to support the NSP is a partnership between the Ministry of Health (in the main, given its responsibility for health data), the Interim HIV Agency and the implementing agencies in the response.

Annex 4 of this NSP outlines an M & E Framework with a set of output, outcome and impact indicators which can be used to measure the progress of the national response against set targets. The Monitoring and Evaluation Framework itself must be converted to an M & E Plan through discussions with stakeholders, which will include agreement on the set of indicators that will be used. There is already good support for the development of the M & E Plan from CHRC, which has a mandate to enable monitoring and evaluation of HIV in the Region.

The requirements of the M & E system and the attendant costs ought to be considered and clearly articulated in the M&E Plan which will serve as a companion document to the NSP. Issues related to the capacity for monitoring and evaluation within the Interim HIV Agency, including relevant staff (M&E Specialists, M&E Officers, IT specialist, Data Entry personnel, Research Scientists) as well as database and equipment needs will be proposed in the M & E Plan.

Trinidad & Tobago benefits from the input of several regional and international agencies mandated to support countries with the development of M&E Systems. Sound paper-first data collection and reporting systems need to be rolled out. Consequently, data collection and collation must be strengthened, and data and information sharing among stakeholders must be entrenched. Strategies for achieving this will be outlined in the M&E Plan which will be developed as a companion to this Strategic Plan.