
# GLOBAL AIDS RESPONSE PROGRESS REPORT, COUNTRY NARRATIVE REPORT, TRINIDAD AND TOBAGO, 2016

REPORTING PERIOD: JANUARY TO DECEMBER 2015

# Country Progress Report, 2016 –Trinidad and Tobago

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- Ministry of Health departments (HACU, NSU,PPU, Health Education),
- Office of the Prime Minister
- HIV Co-ordinators in line ministries
- HIV AIDS Advocacy Sustainability Centre (HASC)
- TT Police Service, CAPA
- NGOs,
- CSOs and PLHIVs involved in HIV response
- International and regional organisations and partners

Without the contributions of these individuals this report would not have been possible.

# Contents

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AIS | AIDS Indicator Survey |
| ARV | Antiretroviral Therapy |
| BBSS | Bio-Behavioural Surveillance Survey |
| BCC | Behaviour Change Communication |
| CAPA | Crime and Problem Analysis |
| CSOs | Civil Society Organizations |
| FPATT | Family Planning Association of Trinidad and Tobago |
| FSW | Female Sex Workers |
| HACU | HIV AND AIDS Co Coordinating Unit within the Ministry of Health |
| HASC | HIV/AIDS Workplace Advocacy and Sustainability Centre |
| HFLE | Health And Family Life Education |
| HIV | Human Immunodeficiency Virus |
| HTC | HIV Testing and Counselling |
| IHA | Interim HIV Agency |
| IPY | Intimate Partner Violence |
| KABP | Knowledge, Attitudes, Beliefs, Perception |
| KP | Key Population |
| LGBT | Lesbian, gay, Bisexual, Transgender |
| MICS | Multiple Indicator Cluster Survey |
| MDGs | Millennium Development Goals |
| MOH | Ministry of Health |
| MOU | Memorandum Of Understanding |
| MSDFS | Ministry of Social Development and Family Services |
| MSM | Men having Sex with Men |
| NACC | National AIDS Coordinating Committee |
| NGO | Non-Government Organization |
| NSO | National Statistical Office |
| NSP | National Strategic Plan |
| NSU | National Surveillance Unit |
| PAHO/WHO | Pan American Health Organization/ World Health Organization |
| PANCAP | Pan Caribbean Partnership against HIV & AIDS |
| PEPFAR | President Emergency Fund for AIDS Relief |
| PEP | Post Exposure Prophylaxis |
| PITC | Physician Initiated Testing and Counselling |
| PLHIV | Persons Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PPU | Population Programme Unit within the Ministry of Health |
| PSI | Population Services International |
| QPCC&C | Queen's Park Counselling Centre & Clinic within the Ministry of Health |
| RH | Reproductive Health |
| RHAs | Regional Health Authorities which are part of the Ministry of Health |
| SRH | Sexual and Reproductive Health |
| STIs | Sexually Transmitted Infections |
| TPHL | Trinidad Public Health Laboratory |
| TTPS | Trinidad and Tobago Police Service |
| UNAIDS | United Nations Joint Programme on AIDS |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| VCT | Voluntary Counselling and Testing |

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# I. Status at a Glance

### 1. Inclusiveness of stakeholders in the report writing and review process.

The HIV Secretariat led the compilation of the 2016 narrative report in collaboration with other government ministries, and civil society. A questionnaire was designed which solicited information from HIV Co-ordinators in Government line ministries, civil society groups and PLHIV groups, bilateral organisations. These organisations were invited to submit annual and progress reports to the HIV Secretariat. These organisations were invited to give feedback on the narrative report which was partially based on the findings and issues of the questionnaire. Due to time constraints face to face consultations could not be held with stakeholders but they were engaged using other methods. The HIV Secretariat worked with the HIV/AIDS Co-ordinating Unit in the Ministry of Health in addressing and reviewing the health indicator requirements for the report. Data were also requested from sources such as the Crime and Problem Analysis Branch of the Trinidad and Tobago Police Service.

### 2. Status of the Epidemic

Over the period 1983-2014 there was a cumulative total of 27,207 new HIV infections, 6,589 AIDS cases and 4167 AIDS related deaths. Just over 1000 new HIV positive infections were reported and diagnosed in 2014 (1053). This represents a decline of 9% over the 2010 figure of 1154 and 27% over the 2005 figure of 1453.Women accounted for 43% of the reported new HIV infections in 2014 and 47% in 2005. The adult prevalence rate remained stable over the period 2009 to 2012 at 1.5% but increased moderately in 2013 to 1.65%.

New cases were mainly diagnosed among the age group 15-49 years which accounted for 64% of new infections in 2014. Youths represented 12% of new infections. There was also increasing proportions of older persons over 50 being diagnosed with HIV infection over the period 2010 to 2014 from 12% to 17% in 2014

All regions were affected by the epidemic. St George, Caroni and Victoria were the regions with the highest number of new HIV cases in 2014

The bio-behavioural men's surveillance survey found that HIV prevalence among MSM was estimated to be 27.7%

### 3. Policy and Programmatic Response

The government remains committed to a comprehensive, integrated, multisectoral response to HIV and AIDS. All sectors are engaged Public sector government ministries, the private sector, civil society, academia and research. The strategy requires close co-operation and co-ordination. During the reporting period there was drafting of and review of major policies such as the Sexual and Reproductive Health Policy. This was undertaken with input from a wide multisectoral committee comprising MOH, CSOs, RHAs, HIV Secretariat. The process for the review of the National HIV Workplace Policy commenced in 2015.The HIV Testing and Counselling Policy was also reviewed in 2015. A draft situational analysis for the national HIV and AIDS Policy was completed.

## 4. Indicator table overview (See Appendix I)

# II. Overview of the HIV and AIDS Epidemic

## 1. Introduction

This section provides an overview of the status and trends in the HIV and AIDS epidemic in Trinidad and Tobago. The data used for the analysis are derived from different sources which include population based surveys, school based surveys, primary questionnaires, ministry of health programme data, bio-behavioural survey data, case based surveillance data and data from the estimates and models using the software SPECTRUM. These statistics represent data from the public health sector and some of the private labs that comply with reporting to the Trinidad Public Health Laboratory. There are currently data strengthening activities in progress to improve on apparent data gaps as current data many not be completely reflective of characteristics of the epidemic in certain risk groups and districts due to under and delayed reporting in the newly established surveillance system. HIV and AIDS Surveillance Data for 2015 are not available due to a fire at the Trinidad Public Health Laboratory. The case based surveillance was introduced in 2013 and currently there is dual reporting of HIV. However the data from the case based surveillance are subject to reporting delays as well as undercoverage. Deaths due to AIDS related illnesses have not been received from the CSO since 2008.

Spectrum is one component of a package of tools developed to assist national programmes and international organisations to estimate the impact of the AIDS epidemic and the needs for treatment and prophylaxis (Stover, J., Johnson, P., e tal., 2010). The software is continuously updated to incorporate the latest research findings and provide indicators needed for programme planning. Spectrum ® reports using country based data, allows for yearly updates and is a mechanism to monitor the international pandemic however Trinidad and Tobago has experienced variable estimate values for key indicators over successive periods of software improvement.

## 2. Status and Trends in the Epidemic, 1983-2015

More than 30 years have elapsed since the first case of AIDS was diagnosed in Trinidad and Tobago in 1983, progressing from eight (8) HIV positive males in that year, to a cumulative figure of 27,207 new HIV positive cases reported by the end of 2014 (See Table 1). From 2004 to 2009, newly diagnosed infections have averaged 1,400 annually**.** From 2008 to 2011 there was an overall decline of 25% in new infections diagnosed. In 2012 an increase to 1284 newly diagnosed HIV cases was observed and this was followed by a decline of 25% in 2013 to 964 and a moderate increase in1053 in 2014. Data for 2015 are not available due to a fire at the Trinidad Public Health Laboratory. The declines in new HIV diagnoses could be explained by the government's decision to offer ARV therapy free of cost to patients infected with HIV thereby reducing the community viral load. by reduced risk behaviours as evidenced by increased condom use and reduction in the number of partners in the general and key populations.

Over the 10 year period 2005 to 2014 there was an overall 27% decline in new HIV infections, an 80% decline in AIDS cases and a close to 70% decline in AIDS related deaths. The decline in deaths was largely due to provision of free antiretroviral drugs by the government which enabled persons with HIV to live longer more productive lives. Despite the declines there is need to be vigilant so that previous gains achieved are not reversed. Moreover, the 27% decline

in persons newly infected falls short of the target of reducing sexual transmission of HIV by 50% by 2015.

**Table 1 : Trends in HIV Cases, AIDS Cases and AIDS Deaths, 1983-2014**

| Year | New HIV Cases | HIV non-AIDS Cases | AIDS Cases | AIDS Deaths |
|---|---|---|---|---|
| 1983 | 8 | 0 | 8 | 6 |
| 1984 | 27 | 5 | 13 | 11 |
| 1985 | 113 | 45 | 39 | 29 |
| 1986 | 138 | 52 | 73 | 42 |
| 1987 | 180 | 84 | 78 | 56 |
| 1988 | 241 | 93 | 133 | 65 |
| 1989 | 249 | 111 | 120 | 71 |
| 1990 | 286 | 89 | 177 | 105 |
| 1991 | 442 | 153 | 239 | 133 |
| 1992 | 613 | 278 | 278 | 172 |
| 1993 | 626 | 300 | 281 | 200 |
| 1994 | 622 | 318 | 244 | 194 |
| 1995 | 683 | 354 | 325 | 205 |
| 1996 | 867 | 484 | 327 | 259 |
| 1997 | 996 | 607 | 298 | 201 |
| 1998 | 964 | 553 | 365 | 267 |
| 1999 | 1121 | 652 | 451 | 249 |
| 2000 | 919 | 489 | 412 | 227 |
| 2001 | 1059 | 648 | 471 | 264 |
| 2002 | 1210 | 827 | 422 | 244 |
| 2003 | 1709 | 1274 | 413 | 186 |
| 2004 | 1443 | 1180 | 272 | 147 |
| 2005 | 1453 | 1242 | 240 | 121 |
| 2006 | 1439 | 1261 | 272 | 195 |
| 2007 | 1429 | 1322 | 163 | 114 |
| 2008 | 1448 | 1394 | 97 | 87 |
| 2009 | 1390 | 1338 | 124 | 77 |
| 2010 | 1154 | 1119 | 72 | 72 |
| 2011 | 1077 | 1065 | 33 | 42 |
| 2012 | 1284 | 1261 | 47 | 55 |
| 2013p | 964 | 924 | 56 | 33 |
| 2014p | 1053 | 1007 | 46 | 38 |
| **Cumulative** | **27207** | **20529** | **6589** | **4167** |

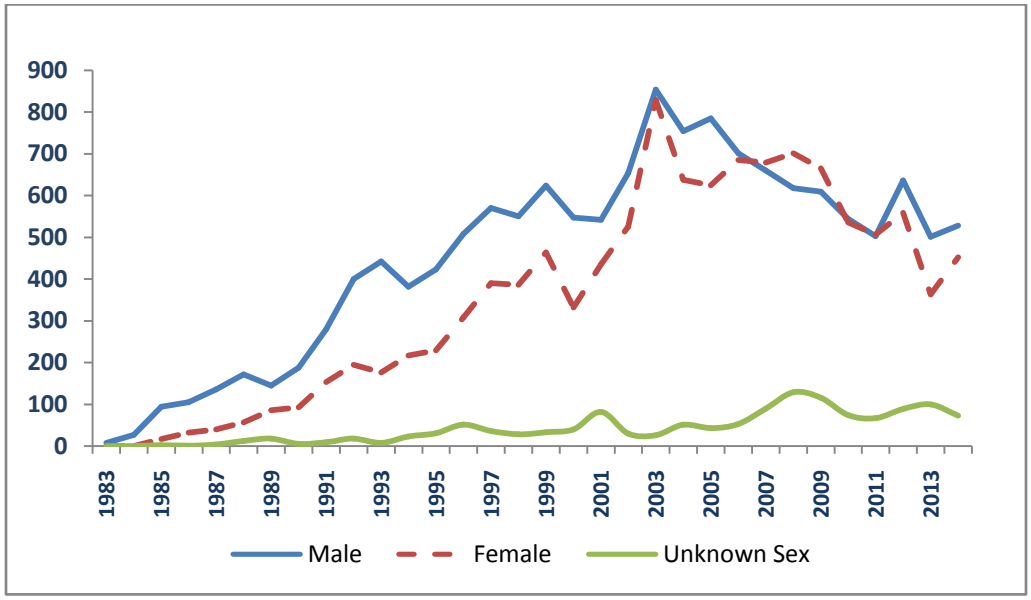
**Source: NSU and HACU Surveillance Reports. Data for 2013 and 2014 are provisional (p). Death data for 2013 and 2014 are from the HACU Annual Programme Report**

According to mathematical models derived from SPECTRUM, adult prevalence rates have remained stable over the period 2009 to 2012 at 1.5% and increasing only slightly in 2013 to 1.65%. Mathematical models from the SPECTRUM software also estimate that about 14,000 persons are living with HIV in 2013 however this figure may be under-estimated due to unavailability of national data to inform some of the model parameters for the SPECTRUM software. According to SPECTRUM, the estimated number of persons living with HIV in 2015 is suggested to be approximately 9,000. Differences in model specification from 2013 to 2016 have affected the estimate for Trinidad and Tobago declining from 14000 to 9000 cases. This requires further exploration of gaps in data collection mechanisms and the utilization of different sources of data for triangulation.

## 3. Sex and Age distribution of New HIV Diagnoses

From 1983 to 2006, newly diagnosed infections among males outstripped newly diagnosed infections among females. From 2007 to 2009, a higher number of new infections were reported among females than males. However, this trend was reversed over the last three years 2012 to 2014 as more new HIV infections were observed among males compared to females. This is a pattern being observed that while more women than men come forward to be tested, more males than females are testing positive. Women accounted for 43% of new infections in 2014 while males represented 50%. However, there are significant age and sex differentials in the new cases of HIV infections. For example among young adults, females accounted for 60% of all new infections among adolescents aged 15-19 and just over 50% among young adults 20-24 in 2014.

**Figure 1: Trends in new HIV infections by Sex and Year of Diagnosis, 1983-2014**

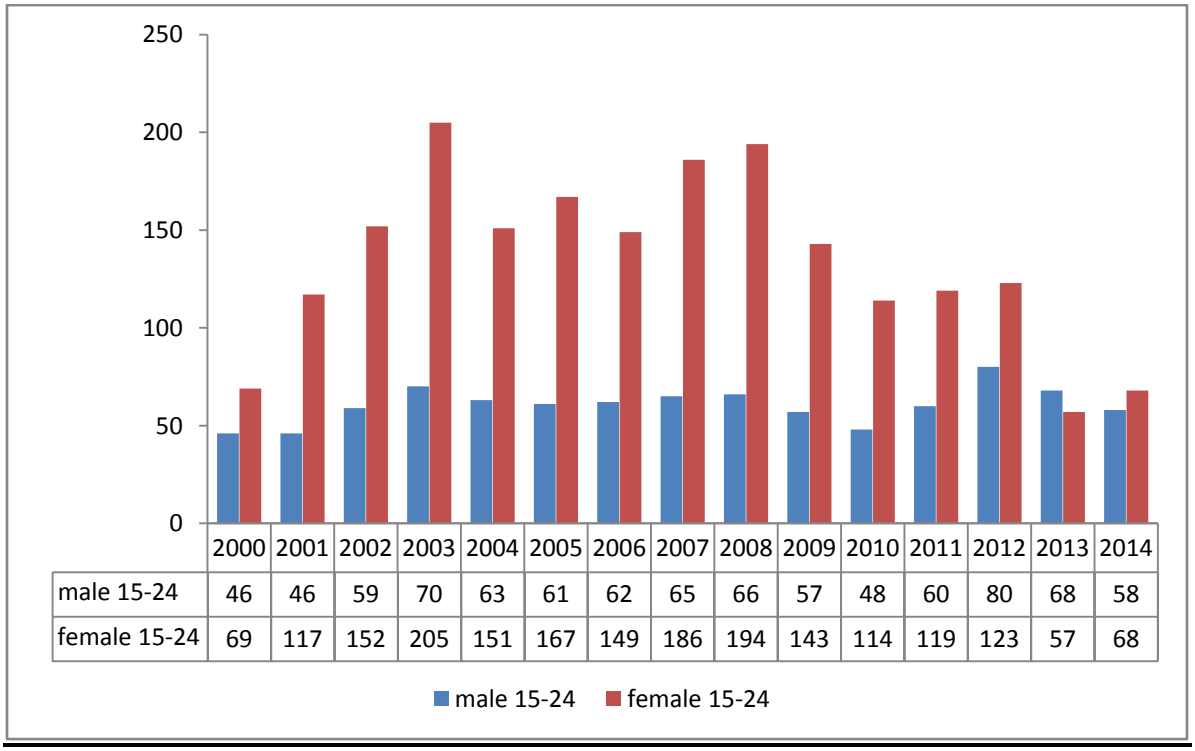



**Source of data: NSU and HACU Reports**

Overall there has been a decline in the proportion of HIV cases diagnosed among youth. The observed feminization of HIV among youth could be reflective of the intergenerational sex among adolescents and young females whose sex partners are often more than 10 years older than themselves.

New cases of HIV infections were mainly concentrated among the age group 15-49 years which accounted for 64% of new infections in 2014. Among this broad group, young adults represented 12% of new infections in 2014. The burden of new HIV infections mainly impacts the working population in their productive prime. As a consequence, productivity in the workplace can be negatively impacted through absenteeism and the loss of skilled and experienced workers if these trends continue unchecked. This can result in rising employer costs due to the replacement, training and re-training of staff.

**Figure 2: Trends in new HIV infections among male and female youth, 15-24 years, 2000-2014**




| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| male 15-24 | 46 | 46 | 59 | 70 | 63 | 61 | 62 | 65 | 66 | 57 | 48 | 60 | 80 | 68 | 58 |
| female 15-24 | 69 | 117 | 152 | 205 | 151 | 167 | 149 | 186 | 194 | 143 | 114 | 119 | 123 | 57 | 68 |

**Source of data: NSU and HACU Reports**

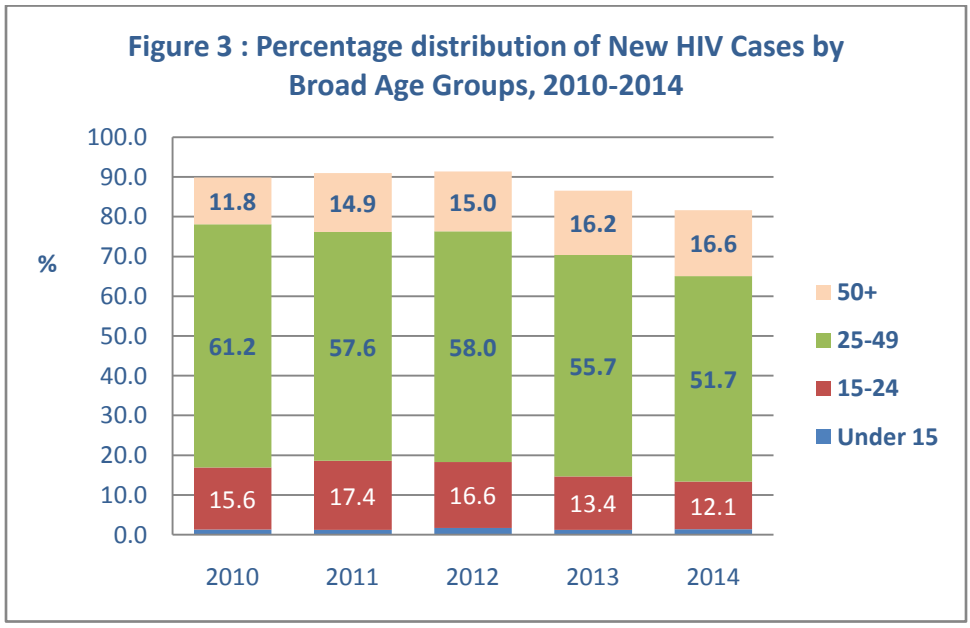
The majority of new HIV positive cases among females occurred in the 20-24 age group while the largest number of newly diagnosed infections among males were found in the 45-49 age group.

**Table 2 : New HIV Cases by Broad 10 year Age Group, 1983-2014**

| Year | Under 15 | 15-24 | 25-49 | 50+ | Not stated | All Ages |
|---|---|---|---|---|---|---|
| 1983 | 0 | 1 | 7 | 0 | | 8 |
| 1984 | 0 | 5 | 16 | 1 | 5 | 27 |
| 1985 | 4 | 38 | 51 | 9 | 11 | 113 |
| 1986 | 10 | 44 | 74 | 8 | 2 | 138 |
| 1987 | 14 | 50 | 93 | 13 | 10 | 180 |
| 1988 | 13 | 61 | 132 | 12 | 23 | 241 |
| 1989 | 19 | 42 | 146 | 15 | 27 | 249 |
| 1990 | 20 | 55 | 185 | 13 | 13 | 286 |
| 1991 | 31 | 78 | 278 | 35 | 20 | 442 |
| 1992 | 42 | 98 | 379 | 53 | 41 | 613 |
| 1993 | 47 | 86 | 399 | 65 | 29 | 626 |
| 1994 | 43 | 82 | 382 | 61 | 54 | 622 |
| 1995 | 46 | 93 | 400 | 82 | 62 | 683 |
| 1996 | 61 | 121 | 474 | 105 | 106 | 867 |
| 1997 | 64 | 133 | 610 | 94 | 95 | 996 |
| 1998 | 65 | 127 | 563 | 126 | 83 | 964 |
| 1999 | 98 | 174 | 670 | 116 | 63 | 1121 |
| 2000 | 69 | 116 | 518 | 104 | 112 | 919 |
| 2001 | 68 | 168 | 594 | 112 | 117 | 1059 |
| 2002 | 89 | 213 | 674 | 138 | 96 | 1210 |
| 2003 | 143 | 275 | 992 | 181 | 118 | 1709 |
| 2004 | 134 | 220 | 796 | 161 | 132 | 1443 |
| 2005 | 119 | 236 | 802 | 178 | 118 | 1453 |
| 2006 | 84 | 219 | 809 | 166 | 161 | 1439 |
| 2007 | 42 | 255 | 813 | 152 | 167 | 1429 |
| 2008 | 18 | 278 | 792 | 170 | 190 | 1448 |
| 2009 | 13 | 212 | 807 | 171 | 187 | 1390 |
| 2010 | 15 | 180 | 706 | 136 | 117 | 1154 |
| 2011 | 13 | 187 | 620 | 160 | 97 | 1077 |
| 2012 | 22 | 213 | 745 | 193 | 111 | 1284 |
| 2013p | 12 | 129 | 537 | 156 | 130 | 964 |
| 2014p | 14 | 127 | 544 | 175 | 193 | 1053 |
| **Cumulative** | **1432** | **4316** | **15608** | **3161** | **2690** | **27207** |
| **Cumulative%** | **5.3** | **15.9** | **57.4** | **11.6** | **9.9** | **100** |

**Source of data: NSU and HACU Reports**

In Trinidad and Tobago we are experiencing an aging population. Older adults 50 years and over represented 12% of new infections in the cumulative period 1983-2014. In fact the older age group over 50 showed an increasing trend in the proportion of new HIV cases. As TRT progressively becomes an aging population it is likely that the prevalence of HIV will also increasingly affect the sexually active older population as well as older persons living with HIV are likely to be increasingly affected with non-communicable chronic diseases.




**Source of data: NSU and HACU Reports**

## 4. HIV in Key Populations

The National Strategic Plan 2013-2-18 identifies vulnerable and key populations as MSM, sex workers, youth, PLHIVs, substance users, prisoners. A rapid HIV situational assessment of key populations was conducted in 2015 by FHI360.

The reported stated:

***Box 1:***

***"Despite its strong health infrastructure, Trinidad and Tobago's centralized health service delivery approach has led to challenges in effective programming for key populations. HIV-related stigma and discrimination against men who have sex with men, sex workers and transgender people remain high. These and other structural barriers hinder access, uptake, and retention in services, and have further marginalized members of key populations.***

***Many of the elements of a comprehensive network model are in place, but outreach modalities need to be updated based on current evidence, and case management models need to be strengthened to ensure that individuals who are referred to care and treatment remain within the network.***

***There remain considerable gaps in information on service usage, and effective linkage between services as part of the continuum of care. Compounding this, there are challenges with the national HIV/AIDS coordinating mechanisms..." [1]***

**Source: [1] Vincent Guillin and Ken Morrison. Reality and Responses: Rapid HIV Situational Assessment for Key Populations in Trinidad and Tobago, 2015**

### a) Results from the Men's Bio-Behavioural Surveillance Survey (BBSS)

The first men's bio-behavioural survey (BBSS) was conducted over the period 2010 to 2015. The survey yielded a sample size of 246 MSM participants out of a target of 576.The main results are shown in Box 2.

***BOX 2 : KEY RESULTS FROM MEN'S BIO-BEHVIOURALSURVEY***

***Some of the BBSS results showed that among the 246 participants:***

- ***HIV prevalence was 26.6%***
- ***24% were unaware of their HIV status***
- ***37% were older than 30 years***
- ***Prevalence was higher in Northwest Trinidad , African MSM, and among MSM completing less than tertiary level education***
- ***91% knew where to access an HIV test***
- ***About four-fifths of MSMs in the survey reported ever being tested***
- ***The main reasons for not testing were knowing/trusting oneself (46%) and being afraid to learn one's status (43%)***
- ***Over half did not know the status of their last partner***
- ***Reported easy access to condoms and lubricants***
- ***About two-thirds (65%) preferred to use private facilities***
- ***One in four engaged in transactional sex in the previous 12 months***
- ***More than one third (38%) had unprotected anal intercourse with partner of opposite or unknown status in the previous12 months***

**Source: Men Bio Behavioural Surveillance Survey Report, MOH, 2014**

### b) HIV among homeless drug users

There is a general paucity of studies on HIV and drug users in Trinidad and Tobago. One community based NGO conducted a pilot study among homeless non-injecting drug users in 2015 in Port-of-Spain's east side which sought to ascertain the prevalence of HIV among drug users. The study revealed that 11.5% were HIV positive.

### c) Female sex workers

No new studies have been conducted among sex workers or prisoners to ascertain the HIV prevalence levels. The MOH is in the process of conducting another BBSS among female sex workers. The research protocol has been prepared and is being reviewed by the ethics committee. The formative assessment has been completed to support the FSW study.

## 5. HIV incidence and prevalence among children, youth and older population

For the period 1983 to 2012, 3000 pediatric cases under age 13 were reported, however the vast majority of these were under investigation. For example in 2012, the National Surveillance Unit reported 129 pediatric HIV cases and all of these were being investigated.

Youth continue to face elevated risks of being infected with HIV. Young people 15-24 years accounted for 12% of those newly infected in 2014. Overall there has been a decline in the proportion of youth newly diagnosed with HIV from 17% in 2011 to 12% in 2014. However the percentage of young people living with HIV increased over the period 2009 to 2011 from 1.3% in 2009 to 1.4% in 2010 and 1.8% in 2011.

The number of new HIV cases also increased among older people 50 years and over from 0 in 1983 to 156 in 2013. For the period 2010 to 2014, the proportion of older people being newly infected with HIV increased from 12% to 17% respectively (Figure 3)

## 6. Risk behaviours

Risk behaviour can also be gleaned from the new case based surveillance system which showed that among clients reporting risk behaviours. Risk data is collected as listed below for several behaviours:

**Box 3: Transmission categories from Case Based Surveillance**

- Had unprotected sex (oral, anal, vaginal) with male(s) in the past 12 months
- Had unprotected sex (oral, anal, vaginal) with female(s) in the past 12 months
- Had sex (oral, anal, vaginal) with sex worker(s) in the past 12 months
- Exchanged sex for money, drugs or material gain in the past 12 months
- Used non-injected illicit drug (e.g. crack, cocaine, marijuana ) in the past 12 months
- Injected nonprescription drugs (e.g. heroin) in the past 12 months
- Had sex with person(s) of known HIV-positive status in the past 12 months
- Any history of incarceration in prison in the last five years
- Perinatal exposure to HIV (children born to HIV positive mothers)
- Received transfusion(s) of blood, blood products or clotting factors
- Received a transplant of tissue or organ or artificial insemination
- Had an occupational exposure (e.g. needlestick injury)
- Had a non occupational exposure (e.g. rape, incest, sexual violence)

Risk is not collected as mutually exclusive events in order to capture overlapping risk in individuals. Information collected from the Case based surveillance system indicated that for persons reporting risk characteristic, the most frequently reported risk categories for newly diagnosed HIV cases in 2014 was unprotected sex with a male (43.9%) followed by unprotected sex with a female (28.6%) and non-injecting drug use (15.7%). Roughly7% had a non-occupational exposure through rape, incest or sexual violence (6.7%). Among females the most frequently reported risk transmission category was having unprotected sex with a male (68.6%), having sex with a known HIV positive person (6.3%). Among males having unprotected sex with a female was the most frequently reported (52.3%), having unprotected sex with a male (20.4%) and having sex with a person of known HIV status (6.4%). **(Source: HACU Annual Surveillance Report, 2014).**

## 7. Geographic distribution of New HIV Infections

All counties and regions have been affected by the epidemic. In 2013 there was an unusually low number of not stated compared with previous years. It is possible that because of the transitioning to the new case based surveillance system there in under-reporting. In 2014 Of the 533 cases with health district reported, the majority were from St.George (64%), followed by13% from Caroni and Victoria (8%). Tobago which normally has about 30 cases, reported only 10 in 2014.

**Table 3: New HIV Cases Reported by Health Administrative Districts, 2000-2014**

| Year | St. George | Caroni | St. Andrew/St. David | Nariva/Mayaro | St. Patrick | Victoria | Tobago | Not Stated | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2000 | 529 | 43 | 31 | 7 | 25 | 94 | 59 | 131 | 919 |
| 2001 | 610 | 53 | 30 | 8 | 37 | 71 | 73 | 177 | 1059 |
| 2002 | 675 | 48 | 18 | 4 | 27 | 77 | 87 | 274 | 1210 |
| 2003 | 1028 | 104 | 28 | 5 | 42 | 92 | 106 | 304 | 1709 |
| 2004 | 775 | 89 | 32 | 6 | 42 | 75 | 69 | 355 | 1443 |
| 2005 | 654 | 86 | 52 | 8 | 32 | 70 | 82 | 469 | 1453 |
| 2006 | 604 | 85 | 29 | 7 | 42 | 99 | 66 | 507 | 1439 |
| 2007 | 650 | 62 | 53 | 12 | 33 | 73 | 75 | 471 | 1429 |
| 2008 | 558 | 62 | 41 | 7 | 27 | 64 | 33 | 656 | 1448 |
| 2009 | 583 | 80 | 26 | 7 | 32 | 63 | 50 | 549 | 1390 |
| 2010 | 549 | 66 | 32 | 2 | 39 | 67 | 36 | 363 | 1154 |
| 2011 | 523 | 60 | 32 | 11 | 39 | 65 | 30 | 317 | 1077 |
| 2012 | 538 | 100 | 38 | 9 | 38 | 88 | 32 | 441 | 1284 |
| 2013p | 578 | 143 | 15 | 2 | 7 | 169 | 30 | 20 | 964 |
| 2014p | 343 | 72 | 9 | 13 | 41 | 45 | 10 | 520 | 1053 |

**Source: NSU**

## 8. AIDS Related Deaths

Deaths due to AIDS related illnesses are sourced from the National Surveillance Unit in the MoH as well as from the Central Statistical Office. Due to relocation and issues the CSO has not been in a position to provide deaths by cause after 2008.

In relation to AIDS cases there was a cumulative total of 4,096 AIDS related deaths from 1983-2012 with these deaths peaking in 1998 at 267. From 2008 to 2011 a steady decline was recorded from 87 to 42 in 2011 after which an increase was observed to 55 deaths in 2012. The significant decline in AIDS cases and mortality rates, can be attributed to the free availability of anti-retroviral therapy (ART) since April 2002.

AIDS related Mortality occurred mainly among the productive age groups 25-49 years which accounted for 60% of all reported cumulative deaths due to AIDS related causes while youth under 25 years accounted for 14% of cumulative deaths.

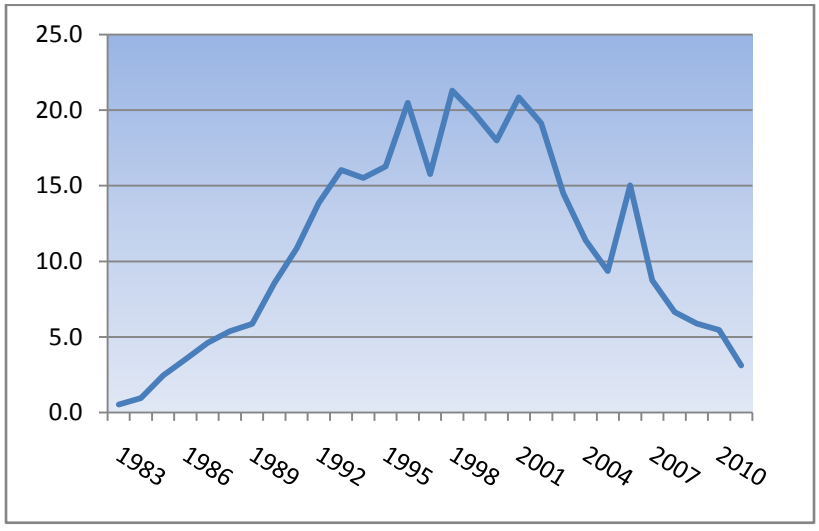
**Table 4 : Deaths due to AIDS related Illnesses by Age, 2000-2012**

| Year | Under 15 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60 + | Not Stated | All Ages |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2000 | 6 | 2 | 15 | 23 | 30 | 48 | 31 | 32 | 17 | 7 | 8 | 8 | 227 |
| 2001 | 10 | 7 | 26 | 30 | 47 | 40 | 35 | 29 | 12 | 14 | 11 | 3 | 264 |
| 2002 | 3 | 2 | 16 | 37 | 34 | 42 | 33 | 35 | 17 | 14 | 7 | 4 | 244 |
| 2003 | 3 | 1 | 10 | 28 | 32 | 27 | 24 | 21 | 15 | 17 | 7 | 1 | 186 |
| 2004 | 2 | 1 | 13 | 6 | 23 | 15 | 35 | 26 | 11 | 5 | 9 | 1 | 147 |
| 2005 | 0 | 3 | 5 | 13 | 15 | 21 | 25 | 16 | 5 | 9 | 6 | 3 | 121 |
| 2006 | 7 | 4 | 10 | 19 | 26 | 34 | 28 | 24 | 19 | 15 | 7 | 2 | 195 |
| 2007 | 1 | 0 | 7 | 13 | 9 | 21 | 19 | 20 | 10 | 10 | 3 | 1 | 114 |
| 2008 | 1 | 2 | 5 | 5 | 20 | 9 | 13 | 11 | 13 | 2 | 6 | 0 | 87 |
| 2009 | 2 | 1 | 6 | 8 | 7 | 8 | 11 | 14 | 13 | 4 | 3 | 0 | 77 |
| 2010 | 2 | 0 | 2 | 9 | 8 | 14 | 7 | 11 | 8 | 3 | 8 | 0 | 72 |
| 2011 | 0 | 1 | 2 | 1 | 6 | 2 | 11 | 5 | 7 | 1 | 6 | 0 | 42 |
| 2012 | 0 | 0 | 4 | 3 | 7 | 10 | 7 | 6 | 9 | 4 | 3 | 2 | 55 |
| **Cumulative** | **174** | **70** | **326** | **519** | **690** | **634** | **531** | **440** | **301** | **182** | **159** | **70** | **4096** |

**Source: NSU**

AIDS related death rates peaked in 1998 at 21.3 deaths per 100,000 population and thereafter steadily declining in the period 2006 to 2012 from 15.0 to 3.5 deaths per 100,000 population.

**Figure 4 : AIDS Mortality Rates per 100,000 Population, 1993-2012**




**Source: Mortality data NSU and Population data : National Statistical Office**

# III. National Response to the AIDS Epidemic

The National response is guided by the National Strategic Plan 2013-2018 which has five priority areas

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

The three 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

For the period 2003 to 2011 the national response was multisectoral in nature and was tied to a World Bank Loan and executed by the NACC. After the term of the NACC expired a new interim mechanism called the Interim HIV Agency which was also multisectoral in nature was established and approved by Cabinet in 2012. The life of this Agency which was housed in the Ministry of Health and expired in January 2015. The new political administration which assumed office in September 2015 has since re-established the NACC under the ageis of the Office of the Prime Minister in 2016. This committee will have a life of two years and would work towards setting up an independent body to overseer the national HIV AIDS response. The new NACC would have representatives from Government, private sector, academia, PLHIVs, youth, CSOs, employee organisations as well as increased representation from Tobago. The body would be guided by the NSP which is due for review in 2016-2017.

## a. Prevention

The first priority area in the National Strategic Plan is Prevention combining behavioural, biomedical and structural interventions. Our national response therefore recognises that HIV is not only a health issue but a social, development concern which is impacted by health, behavioural, cultural, structural and policy and other factors. Due to the expiry of the Country co-ordinating mechanism in January 2015, the Prevention sub-committee of the IHA also ceased operations. However the HIV Secretariat continued to function with severely limited human resources since the unit comprised the Director, M&E officer and secretarial staff.

The approach to prevention is multifaceted and includes biomedical interventions such as the prevention of mother to child transmission, provision of HIV testing to enable persons to know their status, provision of condoms, and non-biomedical approaches risk assessment, avoidance and reduction, and interventions targeting behaviours such as delaying onset of sex among youth, multiple partnerships, condom use, gender inequalities and gender based violence, intergenerational sex.

There has also been strengthening of the Prevention with Positive (PWP) programme including STI screening, improved access to condoms via distribution to Civil Society Organizations such as Jabulous and CARe, South AIDS Support, HIV Counselling and Testing sites as well as Treatment and Care Sites. Risk screening such as screening for new partners and disclosure is done as well as pregnancy screening.

## Prevention of MTCT

Trinidad and Tobago has achieved great progress in the thrust towards the elimination of mother to child transmission. During 2014 and 2015 meetings were held with key stakeholders to give feedback on the co-ordination, successes and challenges of the PMTCT Programme. An increasing number of pregnant women attending antenatal clinics in the public sector have been tested. Over the five year period 2010 to 2014 clinic attendees being tested for HIV increased by 50%.

For at least 5 consecutive years the rate of mother to child transmission has been at 2% or lower during the period 2009 to 2014. Treatment coverage of HIV positive pregnant women increased steadily since 2010 from 81% to 85% in 2014. Trinidad and Tobago is on target to achieving elimination of mother to child transmission and is awaiting confirmation of elimination of MTCT status. Factors which have been responsible for the improvements in reduced mother to child transmission include improvements in the cohort register, mentoring in the PMTCT programme, feedback and teach back mechanisms.

**Table 5: Antenatal Care Attendees who were Positive for HIV, 2009-2014**

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|
| Number of antenatal care attendees who were tested for HIV | 12,325 | 12,744 | 13,010 | 14,049 | 13,467 | 19,208 |
| Number of antenatal attendees who tested positive for HIV | 144 | 205 | 220 | 233 | 188 | 162 |

**Source: HACU Annual Programme Reports**

**Table 6: Prevention of Mother to Child Transmission and Treatment Indicators, 2000-2014**

| Year | Estimated percentage of child HIV infections from HIV positive women delivering in the last 12 months | Percentage of HIV positive pregnant women who received antiretroviral drugs during the last 12 months to reduce the risk of mother to child transmission |
|---|---|---|
| 2000 | 16.28 | Na |
| 2001 | 4.63 | Na |
| 2002 | 6.96 | Na |
| 2003 | 6.79 | Na |
| 2004 | 4.94 | Na |
| 2005 | 2.16 | Na |
| 2006 | 1.99 | 86.07 |
| 2007 | 2.73 | Na |
| 2008 | 3.23 | 67.3 |
| 2009 | 0.69 | 54.81 |
| 2010 | 0.00 | 81.3 |
| 2011 | 2.27 | 81.85 |
| 2012 | 0.90 | 82.49 |
| 2013 | 0.00 | 85.8 |
| 2014 | 0.63 | 84.47 |
| 2015 | NA | NA |

**Source: HACU Annual Programme Reports**

## HIV testing

HIV testing is provided free of charge in the public sector. With the expansion of testing sites, same day testing, outreaches etc testing has been significantly scaled up and is routinely offered. The number of same day testing sites more than doubled from 31 in 2010 to 64 in 2014. There are testing sites throughout the country which include primary health care centres in regions, STI clinics, public hospitals, NGOs sites, private labs. The population also can access Testing through community and workplace interventions. HIV testing is performed by trained health care providers and lay testers.

According to programme data the number of clients being tested more than doubled between 2007and 2014 increasing from approximately 26,000 in 2007 to 71,000 in 2014. Moreover, there was an annual increase in the number of persons being tested over the period 2005 to 2014. The data in Table 7 shows that while testing increased annually, the number of new HIV infections showed a declining trend from 2008 until 2012.

Of the newly diagnosed HIV cases only 36% had a first CD4 Count in 2014. Those with severe and advanced immunological diagnosis accounted for 48.5%. This implies that a substantial proportion of newly diagnosed persons are presenting late for testing and hence treatment and

that earlier diagnosis is required. With the change to a case based HIV surveillance system from March 2013 persons receiving an HIV positive test result also have a blood sample drawn to determine CD4 count at or closest to date of diagnosis. Advanced HIV and AIDS cases are now lab diagnosed as persons with a CD4 count < 350 cells/$mm^3$ and CD4 Count < 200 cells/$mm^3$ respectively. Access to retesting occurs when the case is linked to care with evidence.

CSOs also play a critical role in supporting and supplementing government efforts to increase HIV testing in the general population and among key populations. These CSOs are certified by the MOH as lay testers to provide testing and report their results to the MOH. The activities of these organisations improve accessibility to testing, and psychosocial support among key populations

Testing is also carried out at major seasonal times of the year during Carnival, World AIDS Day and Regional Testing Day. Regional Testing Day is an initiative of the PANCAP which is in its 10 year. The goals include the mobilisation of Caribbean people to be tested and heighten public awareness and education on the critical importance of VCT; reduction of HIV related Stigma and discrimination, creation of the first media led initiative to raise awareness and share information about HIV testing. According to data from PANCAP, in 2015 testing for RTD was carried out in 21 countries at over 300 testing sites across the Caribbean. The twin island republic of T&T led the way in the number of persons being tested with 2364 at 65 locations which was also the largest number of sites in any country. (Source: PANCAP Correspondence)

Despite the scale up of HIV testing there is still a great need for significantly scaling up HIV testing services and interventions especially for key populations and high risk youth, if we are to achieve the first 90 of the 90-90-90 targets i.e 90% of persons living with HIV knowing their status. Moreover there were also challenges in 2015 as laboratories reported shortages and stock outs of supplies of HIV testing kits. There is some level of self-testing or anonymous testing but this is not supported by the Ministry of Health. Only testing which leads to a confirmed diagnosis and can be linked to treatment and care is supported by the government of Trinidad and Tobago.

A service level agreement was signed in 2015 between the MOH and the RHA to increase testing but this does not specify key populations and therefore remains a challenge given relatively high levels of stigma and discrimination displayed by some health service providers towards key populations such as MSMs and Sex workers.

**Table 7: HIV Testing Sites, Clients Tested and New HIV infections, 2005-2014**

| Year | No of HIV testing and counselling sites | No. Of Persons tested | No of new HIV infections |
|---|---|---|---|
| 2005 | 1 | | 1453 |
| 2006 | 6 | | 1439 |
| 2007 | 14 | 26,147 | 1429 |
| 2008 | 18 | 27,567 | 1448 |
| 2009 | 28 | 27,385 | 1390 |
| 2010 | 31 | 39,032 | 1154 |
| 2011 | 39 | 54,507 | 1077 |
| 2012 | 43 | 50,021 | 1284 |
| 2013 | 57 | 65,912 | 964 |
| 2014 | 64 | 70,776 | 1053 |

**Source: HACU Annual Programme Reports**

**Figure 5: World AIDS Day Commemoration, 2015. Hon. Minister of Health, Mr Lennox Deyalsingh engaging CSOs and getting tested**

**Figure 6 : World AIDS Day 2015. Hon. Mrs Cherrie-Ann Crichlow-Cockburn, Minister of Social Development and Family Services giving the feature address at the Ministry's World AIDS Day Commemoration**


**Source: Ministry of Social Development and Family Services**

Youth under the age of 19 are accessing testing but need parental guidance and support to know their status. For the age group 0-4 years there appears to be a downward from 2012 in children getting tested. However the reverse is true for children aged 5-9 where an increase is observed from 2012 to 2014. There was fluctuation in testing levels among adolescents 15-19 years Figure 6.

**Figure 7 : Trends in HIV Testing in the ages 0-9 years, 2010-2014**

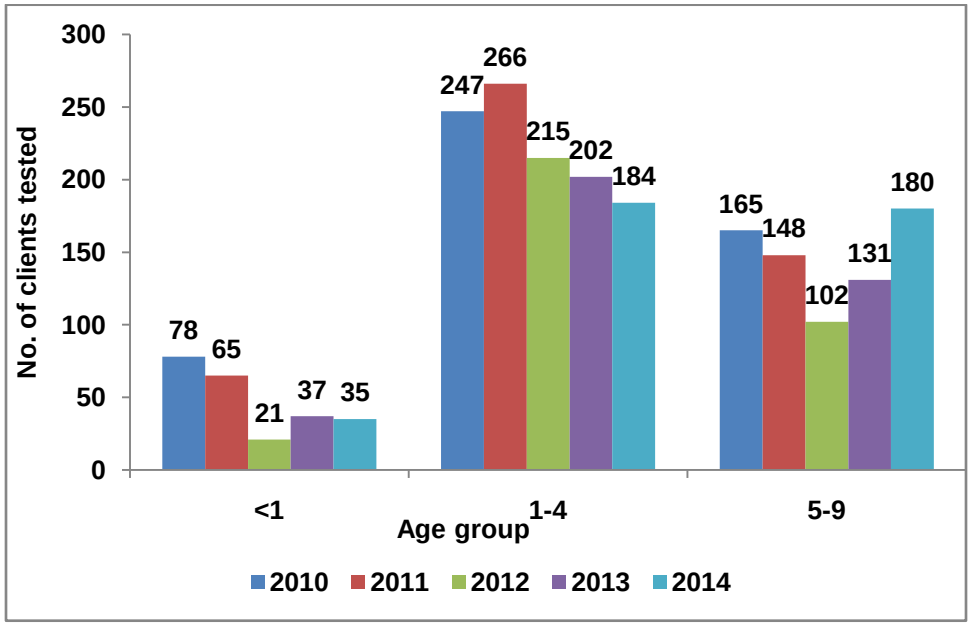
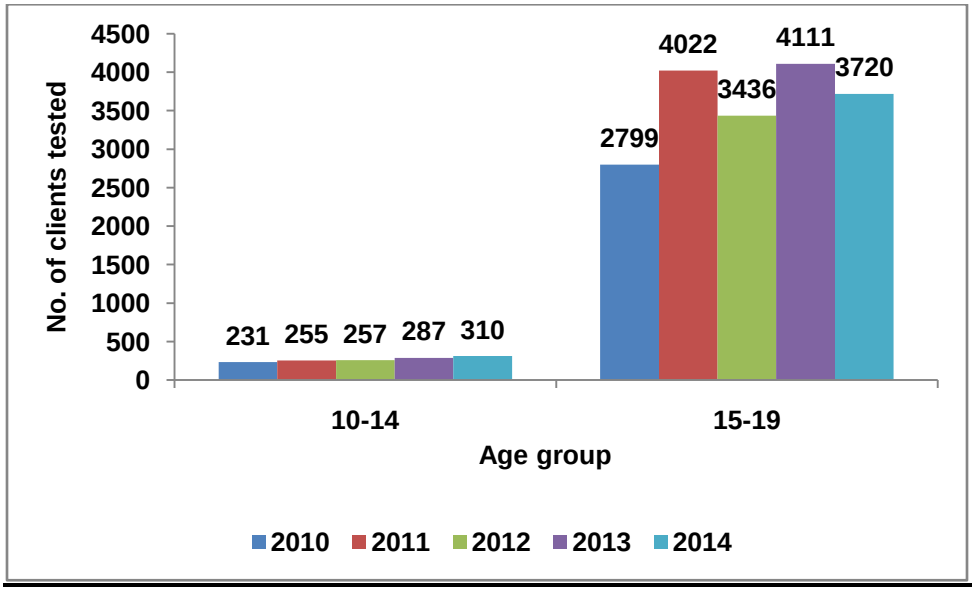



**Figure 8: Trends in HIV testing in youth 10-19 years, 2010-2014**




**Source: Annual Programme Data, HACU**

**Number of persons tested by age and sex, 2014,**

Of the 70,000, plus clients tested in 2014 and sex and age data were provided for 52,444. Of these three out of five were female and about 37% were male. One quarter of clients tested were youth 15-24 years in 2014. Females outnumbered males by about 2:1 of those getting tested in each age group with the exception of the age group 55-59 and 60+ where males accessing testing exceeded females

**Table 8:Clients Tested by Age and Sex, 2014**

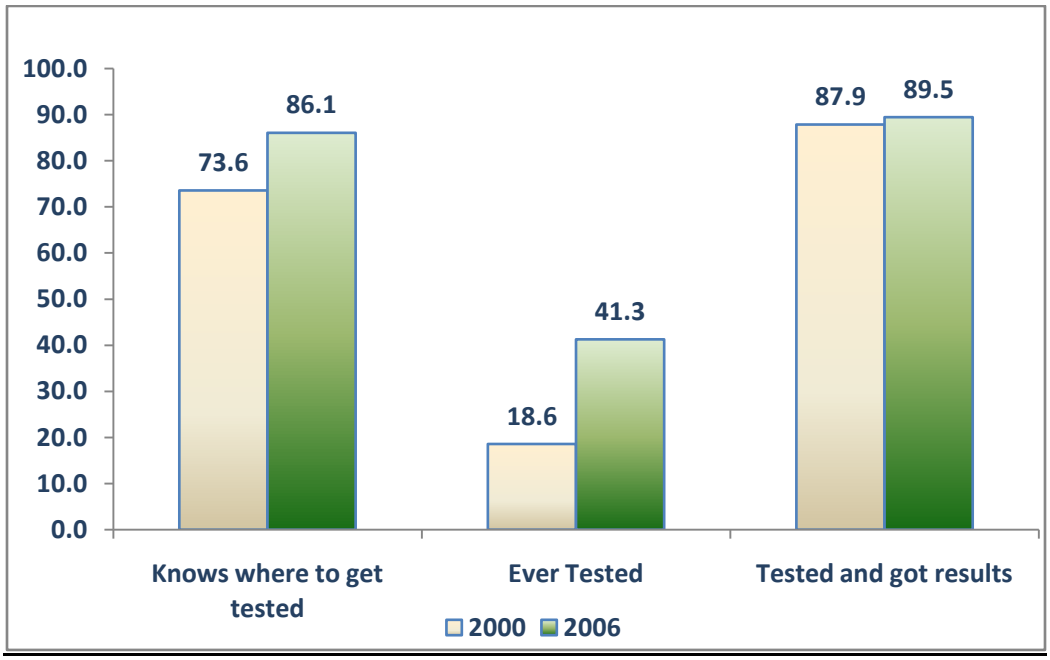
| AGE | MALE | FEMALE | UNKNOWN | TOTAL |
|---|---|---|---|---|
| **<1** | 20 | 13 | 2 | **35** |
| **1-4** | 84 | 89 | 11 | **184** |
| **5-9** | 73 | 94 | 13 | **180** |
| **10-14** | 109 | 192 | 9 | **310** |
| **15-19** | 983 | 2691 | 46 | **3720** |
| **20-24** | 2823 | 6043 | 65 | **8931** |
| **25-29** | 3103 | 6519 | 82 | **9704** |
| **30-34** | 2600 | 5173 | 81 | **7854** |
| **35-39** | 1771 | 3229 | 53 | **5053** |
| **40-49** | 2427 | 3539 | 68 | **6034** |
| **50-54** | 1232 | 1260 | 40 | **2532** |
| **55-59** | 1014 | 780 | 38 | **1832** |
| **60+** | 2100 | 1227 | 44 | **3371** |
| **NOT STATED** | 1190 | 1150 | 259 | **2599** |
| **TOTAL** | **19529** | **31999** | **811** | **52339** |

**Source: Annual Programme Data, 2014 HACU**

## Trends in self-reported HIV testing behaviours among women

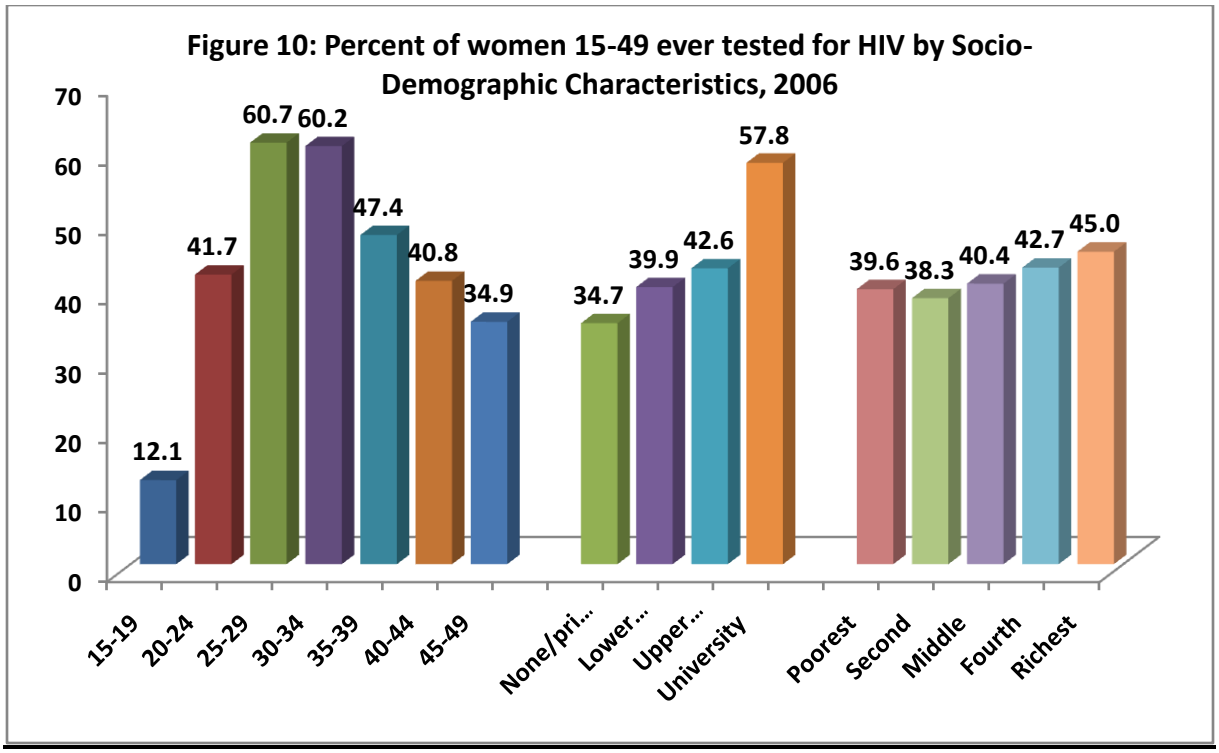
Trends in HIV testing behaviours can be assessed using the MICS survey. Comparable data from two rounds of the MICS survey show that there have been significant improvements in self reported testing knowledge and behaviours among women. More than 80% of women aged 15-49 years knew where to get tested in 2006 compared with about three quarters in 2000. While high proportions knew testing locations significantly lower proportions had ever been tested. However there were dramatic increases in reported testing from 18% in 2000 to about 40% in 2006. In 2011 it is expected that these proportions would increase even further due to the significant scale up in opportunities for testing made available by several public sector ministries and at community levels as well as at primary care institutions.

**Figure 9 : Trends in HIV Testing Knowledge and Behaviour among women 15-49 years, 2000 and 2006, MICS**




**Source: MICS, 2000 and 2006**

The socio-demographic background of women who reported ever being tested for HIV is shown in Figure 6. HIV testing is lowest among adolescents, older women 45-49 years and among the poorest SES groups. This suggests that testing campaigns should target these women who are sexually active in these socio-demographic groups.




**Source: MICS 2006**

## Public Attitudes towards HIV testing

A public attitude poll carried out in 2013 in 29 locations under the auspices of UNAIDS on sexual and reproductive health, abuse, violence and discrimination, revealed that the concerns about stigma if their status were revealed (46%) and confidentiality concerns (41%) were the most important factors discouraging persons from being tested. (Source: A Mandate to Act: Findings from a Poll on Public Attitudes to Sexual and Reproductive health, Violence, Abuse and Discrimination, Trinidad and Tobago ,2013). These findings therefore highlight the fact that despite scale there is still the need to protect the confidentiality of HIV positive persons.

## Condom distribution

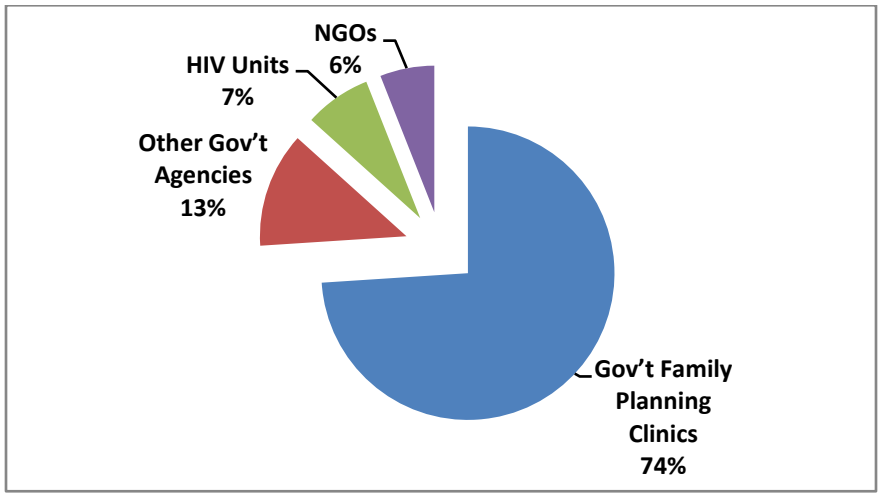
Another aspect of the prevention thrust of the national response is the promotion of correct and consistent condom use among high risk and key populations. The distribution of condoms in the public sector is carried out by the population programme unit in the Ministry of Health. The distribution of condoms in the public sector is carried out by the Population Programme Unit in the Ministry of Health which has the responsibility for providing condoms to the Family Planning as well as the STI programme. In excess of 800,000 condoms were distributed by the Population Programme Unit (PPU) in 2014 and just about 700,000 in 2015. The overwhelming majority of condoms distributed were male condoms (98%). The low distribution of female condoms suggest the need to engage in greater sensitization of the public of benefits, utility, effectiveness and safety of female condoms. The majority of condoms were distributed to govt family planning clinics, government agencies, HIV units and NGOs (See Figure 11). Other organisations such as CSOs may source condoms independently of the PPU. Additionally UNFPA also distributes condoms and lubricants as well as HACU and the HIV Secretariat.

**Table 9 : Condoms distributed by the PPU, 2010-2015**

| Number/Type | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|
| **Male** | 81,352 | 130,696 | 187,356 | 533,644 | 790,225 | 703,299 | 2,426,572 |
| **Female** | Na | Na | na | 15,833 | 15,610 | 8,717 | 40,160 |

**Source: Population Programme Unit (PPU)**

**Figure 11: Distribution of Condoms to Type of Organisation, 2014**




**Source: PPU**

## Health and Family Life Education (HFLE)

HFLE is a critical component of HIV prevention in the national response. The national strategic plan 2013-2018 identifies a number of actions to be undertaken for the implementation of HFLE. Moreover the Ministry of Education has indicated that HFLE is to be a component on the curriculum in all primary and secondary schools. In 2015 the Ministry of Education in collaboration with UNFPA and UNESCO provided training for 63 teachers and principals as master trainers. A few NGOs involved in HIV response were also included in this training. The sessions were conducted by trainers from Jamaica and the project was an example of effective South-South co-operation.

## HIV Prevention in the workplace

The ministry of labour, small and microenterprises leads the national response to HIV in the workplace. The work is done through the HASC Board and executed by a secretariat. **Two (2)** MOUs were signed between the HASC (MLSED) and (a) a Credit Union and (b) a personal services small business in 2015. Among other significant outcomes of the work of the HASC were:

No of companies that signed MOUs - 2
No of companies with workplace policies - 5
No of ministries with workplace policies - 5

Additionally HASC implemented the Workplace HIV and Wellness Voluntary Counselling and Testing Campaign (WVCT@Work) 2015 in collaboration with the Ministry of Health/ RHAs, Tobago House of Assembly, FPATT, UNAIDS and ILO and other public sector ministries. This was a major exercise which aimed at promoting HIV testing to enable 5,000 workers to know their status by December 2015, promoting wellness counselling and testing in a package of interventions to persons who have little or no access to these services, facilitating access to antiretroviral treatment (ART), care and support for workers who test positive and reducing stigma related to HIV through the implementation of an integrated wellness package of screening and testing at the workplace and workplace HIV and wellness dialogues. The outcome of this significant intervention resulted in 423 workers being sensitised and 596 being tested for HIV. The HASC also distributed a total of one thousand, two hundred and thirty two (1,232) safer sex commodities were distributed at outreaches and workplace events.

## HIV Co-ordination in the Public Sector

HIV prevention and impact alleviation in the workplace as well as the community is also undertaken by HIV Co-ordinators or focal points in seven ministries. Currently the ministries with HIV focal points include the Ministry of Agriculture, Ministry of National Security, Ministry of Social Development and Family Services, the Attorney General's Office, Ministry of Community Development, Culture and the Arts, Public Utilities. They also are responsible for developing and implementing HIV workplace policies for their respective sectors.

Some highlights of the work of the HIV Co-ordinators in 2015 include:

- ✓ In addition to providing support for vulnerable populations including PLHIVs, the Ministry of Social Development and Family Services addressed key issues of HIV education and awareness among persons with disabilities and the elderly. In Trinidad and Tobago about 5% of the population is reported to have some type of disability according to the 2011 Census. The number of persons with disability increased from 45,496 in 2000 to 52,244 in 2011. Persons with disabilities do engage in sexual behaviours and need to have equal access to prevention, treatment, care and support. In this regard, the HIV Co-ordinating Unit and the Disability Affairs Unit held five sessions with five organisations for persons with disabilities. Approximately 208 persons were reached during May-June 2015. The programme comprised Edu-theatre, condom demonstrations, lectures etc and was customised to suit the particular disability.

  Contrary to popular opinion older persons are engaging in sexual activity and may also engage in high risk behaviours. Statistics show that an increasing proportion of new HIV infections are being diagnosed among the older population reflecting the changing epidemiology of HIV and the ageing demographic profile of Trinidad and Tobago. The proportion of persons aged 50 and over diagnosed with HIV increased from 12% in 2010 to 17% in 2014 (NSU data). To promote HIV awareness and health seeking behaviour among the older population, the ministry embarked on a programme targeting this subpopulation. The programme addressed HIV sensitization and awareness, prevention, stigma and discrimination, lifestyle behaviours, etc. A total of 95 persons were reached in three elderly activity centres in south and east Trinidad. The correct use of Condoms was demonstrated and IEC materials distributed

- ✓ The Ministry of Agriculture is one of the largest in the public sector and plays a critical role in ensuring food production security for the general population. The work of this ministry is critical since the good quality nutritional intake of PLHIV is required for ensuring PLHIVs live longer and healthier. In addition to conducting HIV sensitizations a total of 10 outreaches in the form of knowledge fairs were completed in 2015. A total of 461 persons were tested in these outreaches, 278 males and 183 females. The HIV Co-ordinator provided support for persons in domestic violence situations as well as assisted in securing PEP for clients experiencing sexual violence. Over 4000 male condoms and 2000 female condoms were distributed at the various community events. The Ministry also held preliminary discussions with the FAO in terms of developing an initiative on HIV Nutrition, Livelihoods and Food security.

- ✓ Ministry of National Security (The Guard and Emergency Branch of the Trinidad and Tobago Police Service) in collaboration with the MOH hosted a Health and Wellness Fair for members of the Trinidad and Tobago Police Service (T.T.P.S), their families and civilian employees. This event was held on Saturday 14th November 2015 in Port of Spain. Programme Officers for the HACU participated in this outreach effort, bringing awareness and safety demonstrations to those in attendance.

  The Ministry of National Security -HACU conducted outreach sessions for the staff of General Administration on July 10th, 2015; and on November 14th, 2015 for the Police Guard and Emergency Branch for their health and wellness day. The objective of these exercises was to promote HIV & AIDS awareness by engaging staff members of General Administration and the Police service in HIV & AIDS education.

- ✓ The Ministry of Community Development, Culture and the Arts designed programmes that targeted different groups. These included HIV Puppet shows for the 225 students in the four districts of the Retirees Adolescents Partnership Programme(RAPP), a donation drive to assist the wards attached to the Cyril Ross Nursery as well as programmes for the 112 parents attached to the Community Mediation Parenting Support.

- ✓ The Ministry of Public Utilities conducted outreach in its respective communities thereby promoting HIV testing and other health seeking behaviours such as NCD screening."

## Role of CSOs

The National response therefore also focuses on general and key populations (KP) that include children born to HIV positive women, Men who have Sex with Men (MSM), prisoners, sex workers, substance abusers, and youth. Recent PEPFAR data estimated the number of KP in Trinidad to be around 28,528.

As a result of stigma and discrimination, KPs face increased risk and vulnerability and MSMs have limited access to HIV prevention, care and support services. In 2013, National HIV Continuum of Care data showed ARV coverage was approximately 48% among all PLHIV and major gaps existed in the proportion of positively diagnosed persons linked to and retained in care.

NGOs such as Red Initiatives, CAISO, Com Talk, Friends for Life, Care, provide HIV prevention services targeting MSMs, PLHIV and LGBTQI, substance users. Their interventions include advocacy, health promotion, peer support, risk assessments, Outreach, Hotline Counselling & Psycho-Social Therapeutic interventions with LGBTQI and Trans Sex Workers, Gender based violence screening, referrals etc.

Jabulous, Red Initiatives and FPATT work with sex workers and assist them in accessing sexual and reproductive health services, prevention education. Trinidad has experienced an increase in sex worker populations from many Caribbean and Latin American countries and NGOs such as these have engaged these communities with health promotion services.

The general population and PLHIV are targeted mainly by faith based organisations such as Celebrating Life, Rescue Mission as well as CBO such as Red Cross, South AIDS Support, Voice of One Overcomers, Toco Foundation, Women Advocating for Change, Save Our Society Foundation

Public sector organisations such as RAPPORT work alongside youth to educate and sensitize them and assist in risk management,

With the support of regional entities such as PEPFAR and CVC/COIN, a number of key initiatives have been implemented. These include providing support, testing and referrals to persons who use drugs as well as marginalized youth. Additionally, a series of sexual health/sexuality workshops have been conducted with MSM, sex workers and marginalized youth.

NGOs also play a critical advocacy role in the promotion of human rights for PLHIVs and key populations. They have representation on National Boards such as the HASC, the former NACC and IHA and play strategic role in research and getting community participation in research studies. They engage in training and capacity building with sex workers, youth as well as government entities. NGOs seek support from the government as well as regional and international partners to support the implementation of their routine programmatic and research activities. NGOs can also access funding from government entities such the HIV Secretariat, the Ministry of Social Development and Family Services, the Ministry of Community Development, Culture and the Arts in the form of proposal funding, grants and subventions. In addition, the MOH supports access to Testing reagents some certified CSOs.

## b. Treatment, Care and Support

In Trinidad and Tobago access to care is provided free of charge and Treatment is provided through adult and 4 paediatric treatment sites. Of the 7 adult sites, only two are integrated and provide other health services. Currently based on the current treatment threshold CD4 <350 cells/$mm^3$not everyone in the clinic is on ARV. Survival of patients on ARVs indicates better adherence

According to programme data 8376 patients were alive and enrolled in a facility at the end of 2014. Three quarters of these patients (6281) were receiving ART indicating that adherence to treatment may be problematic. The proportion of adults and children receiving ART has been improving over the period 2013-2015. This proportion increased consistently from 48% in 2013 to 71% and then to 74% in 2015. There is universal HIV care coverage as the percentage of people currently receiving HIV care was 99%.

There was a moderate decline in rates of retention in HIV care as the 12 month retention rate fell from 95% in 2014 to 90% in 2015.

Three hundred and seventy eight adults were on first line treatment and 51 on second line. CD4 counts were obtained for 2270 patients on HAART while 1734 viral load tests were performed.

Among children all 114 enrolled in care were on ART, 21 were on first line, 16 on second line treatment. About 97% of paediatrics (111) had obtained CD4 results and 96 had viral load tests done. (Annual Programme Report, 2014)

The second 90 of the 90-90-90 targets is that 90% of all PLHIVs receive sustained antiretroviral therapy. Currently T&T is treating at CD4+ cell count of 350 cells/mm3 and has engaged in studies for example the treatment 2.0 mission which assessed the country's readiness for treating at CD >500.

A joint treatment 2.0 Mission conducted by PAHO and other partners in 2015 found that there was need to strengthen the national response in order to achieve the 90-90-90 targets. The treatment cascade revealed significant data gaps in the capacity to generate a reliable care and treatment cascade and monitor progress of the response in achieving the 90-90-90 targets. The Mission also recommended that the achievement of the second 90 target requires updating treatment guidelines, improving retention and quality of care, ensuring constant supply and effective management of ARV medicine, community participation and guaranteeing access to lab technologies, decentralization and integration of care and treatment in the public sector,

sites, districts, regions, among others (Joint Technical Mission for the expansion and sustainability of HIV Care under the Treatment 2.0 Initiative). Trinidad and Tobago is in the process of obtaining the evidence to support the implementation of the new WHO guidelines from treat at 350 as this would imply the need for establishing additional testing sites, creating more opportunities for testing, increased psychosocial support, purchasing more medication which is freely available in T&T, acquiring more staff as well as laboratory supplies and infrastructure.

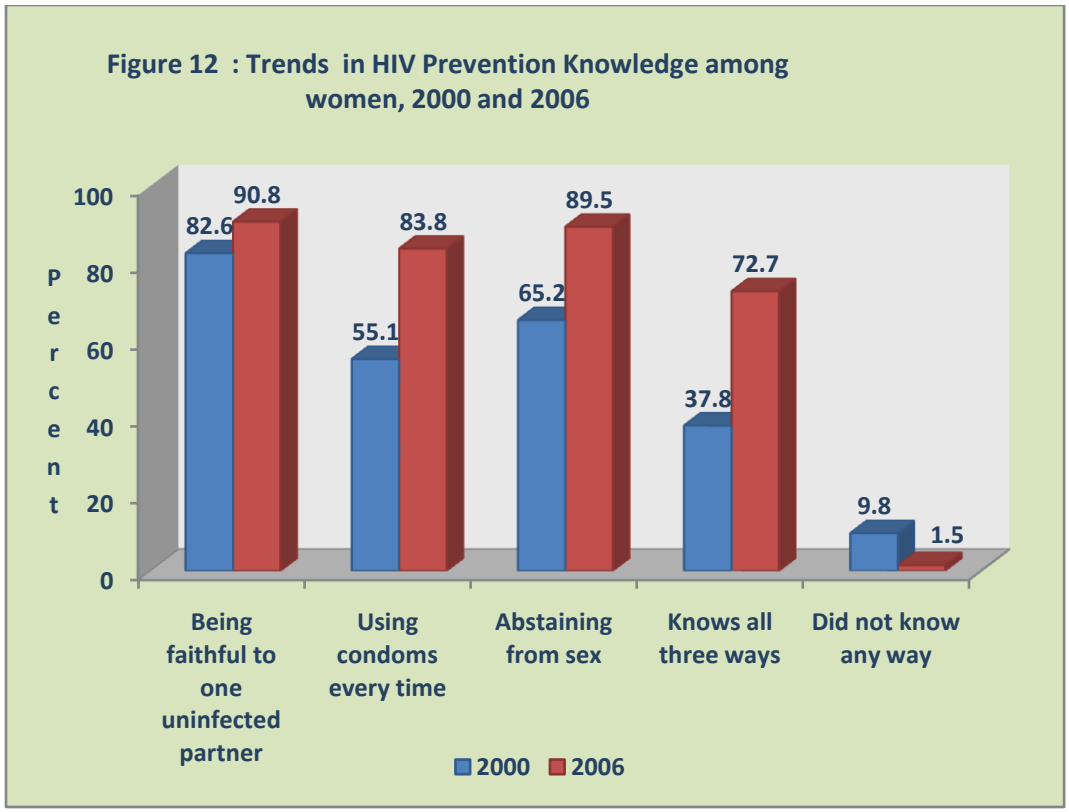
The treat at CD4 < 500 cells/$mm^3$ and test and treat all options need to be informed by the NASA and the undertaking of the Investment Case. In addition, a mid-term review of the Strategic plan is a necessity in order to guide the future strategic direction to reset targets. Guidelines would also necessitate the need for increased psychosocial support mechanisms. The USAID and FHI 360 in collaboration with the MOH involved CSOs across Trinidad and Tobago to also contribute to the strengthening of Positive Connections programme contributing to curriculum development and linkages for the Adolescent PLHIV. The need for a strong multisectoral mechanism such as the NACC would be a fundamental prerequisite for the implementation of these guidelines as well as increased community involvement.

## c. Knowledge and Behaviour Change

HIV in Trinidad and Tobago is driven by factors such as early sexual debut, multiple partnerships, transactional and commercial sex, intergenerational sex, low condom use, poverty and gender inequalities. The principal source of data on trends in knowledge and behaviour change is nationally representative surveys such as the KABP and the MICS Survey. The last KABP survey was conducted around 2006 and aspects of the findings would have been reported on in previous Country Progress Reports. The MICS Survey was last conducted in 2011 but the results have not yet been released. The MICS survey only provides data on females aged 15-49 years.

### Trends in HIV Knowledge

Two rounds of data are available from the MIC Survey (2000 and 2006) and the data indicate that there was substantial improvement in HIV Prevention knowledge since the proportion of women which knew all three ways of preventing HIV increased from 38% in 2000 to 73% in 2006 suggesting that sensitization efforts were being successful. Whether the increased knowledge contributed to behavioural change is yet to be measured. According to 2006 data just over half (57.5%) of the women had comprehensive knowledge of HIV with adolescents aged 15-19 years showing the lowest levels of knowledge (49%) and young women aged 25-29 years showing the highest levels (63%). The results of the 2011 survey are needed to ascertain the trends in this indicator.




## Behaviour Change Communication

During 2014 and 2015 there were BCC campaigns mainly coinciding with the main seasonal festivals and events for example for Carnival, Regional Testing Day and World AIDS Day. For Carnival season 2014 a '***Caption This Competition'*** was launched on social media Facebook to promote responsible sexual behaviour and health and reduce the spread of HIV.

The 2015 Carnival campaign featured taglines encouraging persons to adopt risk reduction behaviours by using condoms or abstaining, and getting tested. During this time ads were placed in the print and visual media to reach the different audiences.

World AIDS Day Commemorations featured broadcasting of messages by the Honourable Prime Minister and other senior country officials including the Honourable Ministers of Health, Social Development and Family Services and Labour and Small Enterprises. The commemoration emphasised the promotion of health seeking behaviours through testing and counselling and NCD Screening, a film festival, and Red Ribbon Formation.

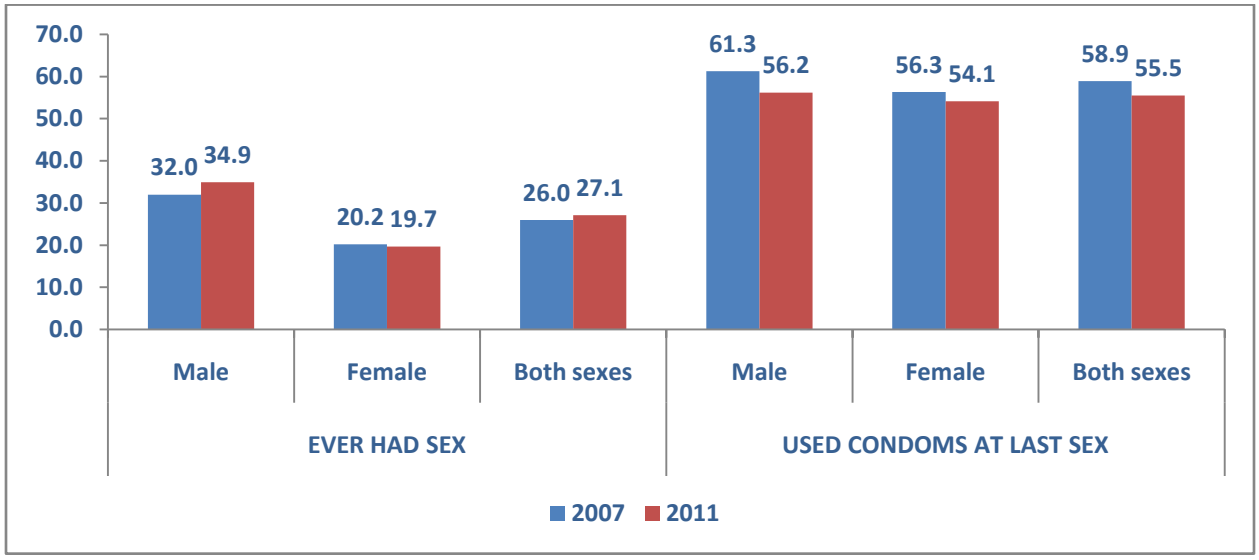
IEC Materials including brochures, posters, booklets etc were developed in the reporting period targeting different groups and addressing several issues such as STIs, safe sex, positively living with HIV. These included materials on Abstinence and Youth which targeted adolescents and youth to delay sexual initiation. One FBO developed PSAs addressing the issues of Living Positively with HIV, Care and Support, Making Informed Choices targeting young people 11-35years and as well as parents.

A Poster Campaign was developed related to each Division of the Ministry of National Security. It aims to educate employees within the various Divisions by presenting specific taglines and imagery relevant to their respective Divisions. Posters are considered an efficient tool to influence the opinion of employees about HIV and AIDS because their eye-catching and strong visualisations promote discussion among specific audiences. Posters are also accessible to persons who may not be interested in reading a brochure. These posters have been successfully distributed to the T&T Air Guard and are strategically placed in the brochure stands at the Head Office in Temple Court I and II. Distribution will continue in each division.

## Evidence of behaviour change among adolescents and the general population: sexual activity and condom use

The global school health survey (GSHS) was conducted in 2007 and 2011 among in school students aged 13-15 years. A number of questions on sexual and other risk behaviours were asked. There was slight increase in reported sexual activity among students over the period of the two surveys. The proportion of male students reporting that they ever had sex increased from one third in 2006 to 35% in 2011. The proportion remained stable among females at 20% in both years. However there were significant declines in the proportion of males reporting that they used condoms at last sex from 61% to 56%. Overall this declined from 60% to 56% among both sexes.

**Figure 13- Trends in Self-Reported Sexual Activity and Condom Use among in school youth 13-15 years, GSHS, 2007 and 2011**




**Source: Global School Health Survey, 2007 and 2011**

Delaying sexual activity is a key driver in reducing HIV transmission. Among students who ever had sex 70% reported that they had sex before the age of 14 years while 15% had 2 or more partners in their lifetime in 2011.

## Promoting Healthy Lifestyles and HIV Knowledge among Adolescents and Youth:

### *Youth Health Campaigns*

The Ministry of Health targets adolescents and youth through its Youth health Campaign entitled- ***'Like Yuhself...Live in Knowledge and Empowerment'*** which is aimed at promoting knowledge, awareness, behavioural change and empowerment among the nation's youth. The themes which are identified as critical and which are discussed in the programme include obesity and early development of risk factors for chronic diseases, managing sexuality, teen parenting and HIV/AIDS, drug use/abuse, mental health issues, management of self, anger and coping skills. This is in keeping with the national strategic objective of promoting healthy sexual health attitudes and practices in youth aged 15 to 24 years. During the reporting period the first phase of the ***"Like Yuhself"*** Campaign was implemented in secondary and tertiary institutions as well as police youth clubs and youth focused NGOs. The Health Education unit leads this programme and collaborates with NGOs, and other MOH units such as Rapport. The techniques used a varied and multifaceted and include quizzes, demonstrations, DVDs, edu-theatre, spoken word poetry.

### *School EDUVANs and Youth Health Caravans*

The Eduvan (Educational Caravan) and Youth Health Caravan are innovative, school intervention projects which address health issues that are affecting young people in schools. The Eduvan represents a partnership between the District Youth Offices and the schools in the catchment area. This initiative is spearheaded by the Ministry of Sport and Youth Affairs.The intent of the Eduvan is to empower students to acknowledge and take personal responsibility for the issues that impact their health, safety and well-being.

The Eduvans focus on issues such as peer pressure, child/teen abuse, the harmful aspects of social media, alcohol and drug use, teenage sexuality, HIV and AIDS, teenage pregnancy, teen promiscuity, gambling, bulling including cyber-bulling, depression, attempted suicide, school gangs and violence and other risks. These issues are identified, within the school system, by the students, Student Councils, Sixth Form Associations and other student bodies, the School Administration, Deans, School Social Workers, Guidance Officers, Safety Officers, Teachers etc. and Parents/Guardians (PTA). Representatives from these entities usually comprise the Committees that plan and implement the Eduvan Project with assistance and guidance from the Youth Officers or Youth Development Officers.

A wide range of participatory methodologies are also used to reach the students. These include games, testimonies, spoken word, quizzes, competitions, mime, drama, music, photovoice, videography, etc.

Beyond the one-day intervention, students pledge to become active charge agents and champions for youth health (theirs and their peers). They are also encouraged to form Student Health Committees, Action or Advocacy Groups to address sustainability of the programme. This venture is supported by the national co-ordinating mechanism through the provision of IEC materials, resource personnel to deliver lectures and other technical assistance. During the period 2011-2015, twenty (20) schools benefited from the programme

## Promoting HIV Education and Awareness in the Workplace

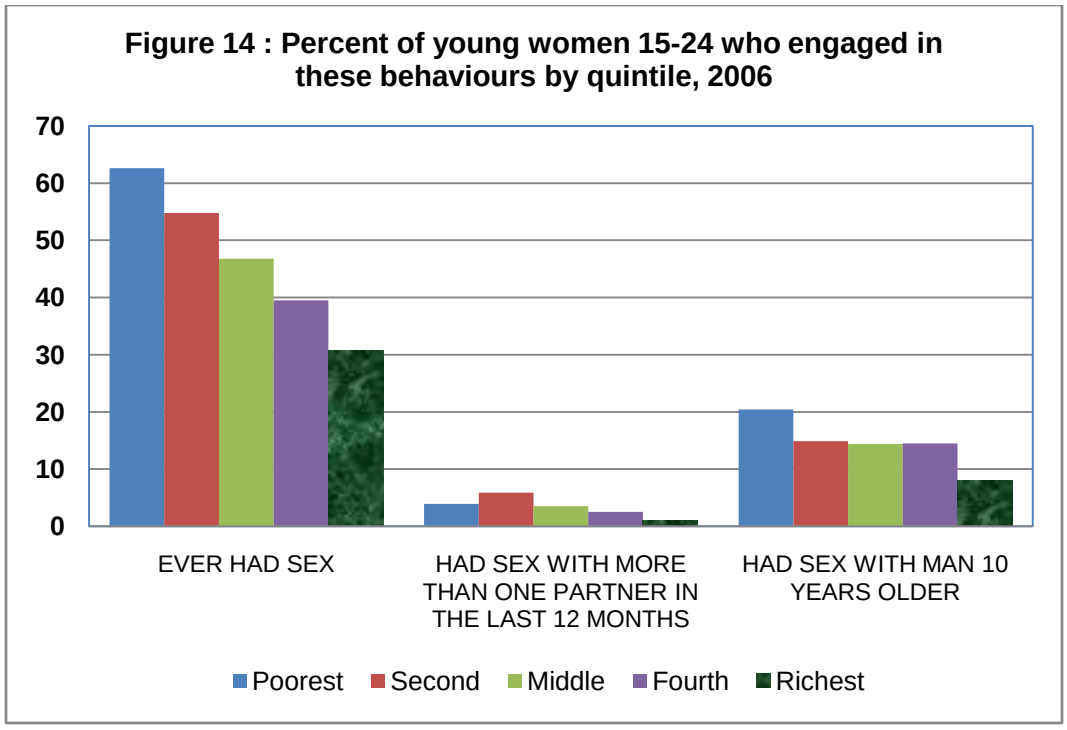
In the workplace for the calendar year 2015, the HASC led workplace interventions aimed at increasing knowledge about HIV transmission, prevention, treatment and care etc. They provided the following information and services:

- a total of **three thousand, one hundred and fifty eight (3,158)** Information Education and Communication (IEC) materials were distributed.
- a total of **seven hundred and ninety-two (792)** persons were sensitised on HIV and AIDS as a workplace issue.
- a total of **twelve (12)** copies of ILO Recommendation 200 concerning HIV and AIDS and the World of Work, 2010 were distributed.
- a total of **six (6)** copies of ILO code of practice on HIV/AIDS and the world of work were distributed.
- a total of **seven (7)** copies of the National Workplace Policy on HIV and AIDS were distributed, not including e-copies made available on the Ministry's website for the policy revision consultations.
- Worked with small businesses, to include modules on Basic HIV education, HIV prevention and interaction between providers and clients where an individual is living with HIV. These modules were included in the cohort training for a diploma in Massage Therapy in August 2015.
- Collaborated with the ILO and PANCAP to provide training to a cohort of students pursuing the Masters in Human Resource Management at the Arthur Lok Jack Graduate School of Business in Oct-Nov 2015. Basic HIV education was included as well as a session on managing HIV in the workplace from Legal, Ethical and Occupational Safety and Health perspectives.

## Risk behaviours and economic vulnerability

Poverty has been identified as one of the drivers of the HIV epidemic in Trinidad and Tobago. Some insights into the relationship between risk behaviours and economic disadvantage can be gleaned from the chart below where it is observed that women from poorer backgrounds show a higher level of risk behaviours. For example, the proportion of young women who reported ever having sex was 63% in the poorest quintile compared to only 31% in the richest quintile or economic strata.

Similarly a higher percentage of women from the poorest economic strata were more likely to have had sex with a man 10 years or more, older than themselves compared to women from the richest quintile (See Figure 7). However, analytical and correlational studies are required to establish the relationship between vulnerability and risk behaviours.




## d. Impact alleviation

Peer support programmes are led by the MoH in collaboration with RHA, other Ministries and NGOs. The goal of this programme is to address the psychological needs of newly diagnosed HIV positive clients and their partners through strengthening referral linkages and access to HIV care and treatment services. The expected outcome is to improve adherence and optimise their long term status and quality of life.

Public sector ministries such as The MSDFS-HIV Unit have expanded the national prevention thrust to include at risk and vulnerable groups such as disabled youth. Sensitization Workshops were also done with staff members on issues which contribute to HIV vulnerability. Capacity building workshops targeting social workers, welfare officers, family case workers, intake officers equip and enable these categories of personnel to provide nutritional and social support to clients living with HIV and AIDS, and assist clients to adhere to treatment.

Cyril Ross Home is the only one being operated for children living with HIV and is supported by the Ministry of Social Development and Family Services. It is estimated that there are less than 500 Orphan and Vulnerable Children in T&T according to UNAIDS estimates

The Positive Connections Programme is designed to reach and support adolescents living with HIV. During 2015 USAID and FHI 360 in collaboration with the MoH engaged CSOs in the strengthening of the Positive Connections programme through workshops held in Trinidad as well as Tobago with focus on improving the programme's curriculum design with emphasis on linkage to care; care transition from Paediatric to Adult; Prevention with positive for adolescents; retention in care and psychosocial support.

Other Ministries such as the Ministry of Agriculture and Community Development reach communities through community health and empowerment fairs. The Ministry of Community Development, Culture and the Arts provides support and capacity development for community enhancement, empowerment, growth and renewal. Many NGOs involved in HIV response are able to secure funding from these mechanisms for impact mitigation initiatives.

NGOs such as Com Talk support persons living with or affected by HIV through facilitation and provision of income generating projects which reduces the dependence of these groups on donor support. Despite these commendable efforts there is still a great need to provide NGOs with adequate funding in a sustainable manner

Faith based organisations also support homes for children living with HIV as well as provide counselling for substance users and PLHIV and newly diagnosed PLHIV

Community based organisations provide support to the homeless many of whom are substance users and HIV positive. They are tested, provided with referrals for treatment and psychosocial support.

Key populations such as incarcerated persons are reached and supported by CSOs such as Vision on Mission, Com Talk and the Ministry of Social Development and Family Services.

## e. Enabling and Policy environment

An enabling social, economic and legal environment is a pre-requisite for ensuring universal access to HIV prevention, treatment and care and support. A number of policy documents were initiated or reviewed during the reporting period or are currently in the process of being reviewed including:

- HIV in the Workplace policy being reviewed. Several consultations were held with stakeholders across the country
- HIV testing and counselling policy being reviewed
- Sexual and Reproductive Health Policy several consultations were held with stakeholders
- National Strategic Plan on Gender based and Sexual Violence
- Draft Situational Analysis for the National Policy on HIV and AIDS

Ministries which have finalised or have draft HIV Workplace Policies include:

- Ministry of Agriculture (final)
- Ministry of Social Development and Family Services (draft)
- Ministry of Tourism (final)
- Ministry of Community Development, Culture and the Arts (draft)
- Ministry of National Security (draft)

Consultations were held to revise the national HIV counselling and testing policy, and a national sexual and reproductive health policy has been drafted.

In 2016-2017, there are also plans to review certain laws, regulations, and policies and propose amendments to protect key populations from discrimination such as the Equal Opportunity Act to include HIV status discrimination, and to review and re-establish the Human rights desk.

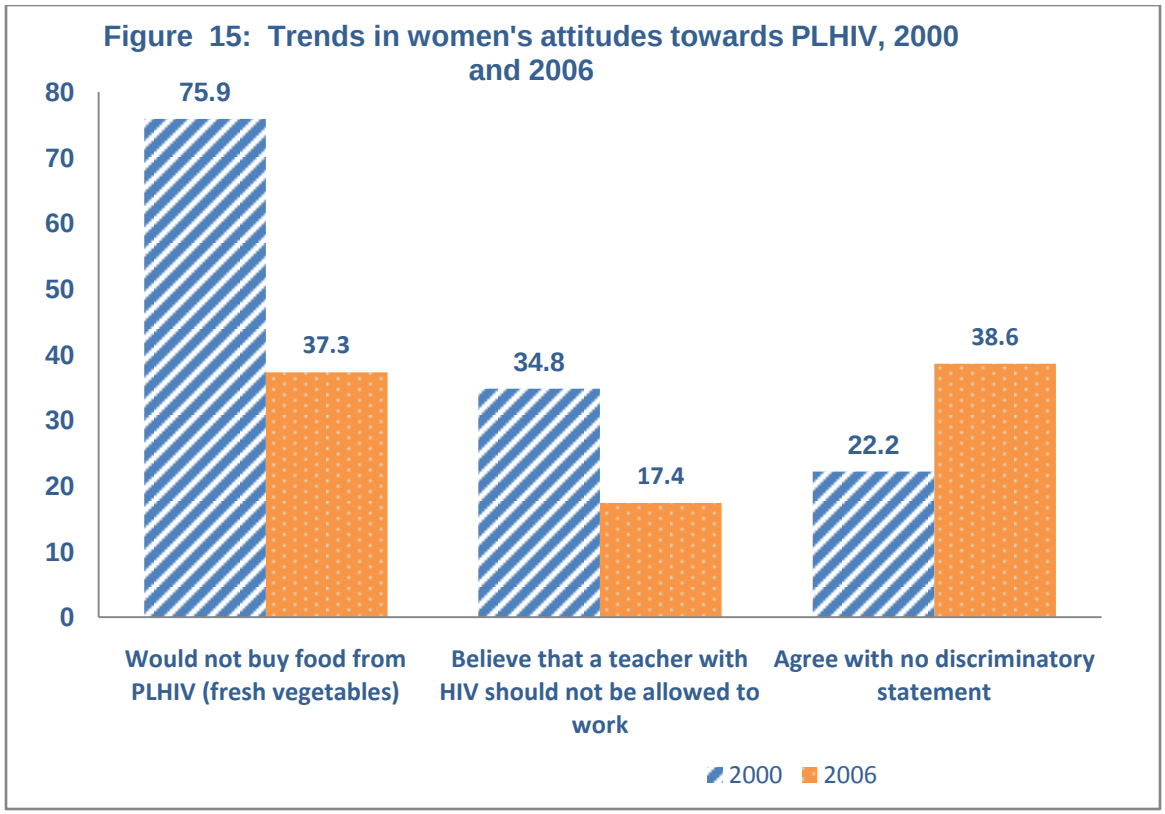
Civil society also facilitated a number of initiatives to implement the national HIV response in 2014 and 2015 through peer education training, outreaches, training and sensitizations workshops, provision of HIV counselling and testing services, HIV treatment and care, strategic information activities, and HIV advocacy and human rights activities.

## Eliminating Stigma and Discriminatory attitudes towards PLHIV

One of the targets of the 2011 UN Political Declaration is the elimination of stigma and discrimination against people living with and affected by HIV by promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms. Evidence from the MICS survey suggests that there are some decline in stigma towards PLHIVs. Women in the surveys seem to be displaying more accepting attitudes towards PLHIVs. For example three-quarters of women stated that they would not buy food/fresh vegetables from a PLHIV in 2000 but in 2006 this had declined substantially to 37.3%. Similarly 35% of women believed that a teacher with HIV should not be allowed to teach whereas in 2006 this proportion had reduced by half. A survey undertaken under the ageis of UNAIDS in 29 locations T&T in 2013 found that 56% of respondents were accepting and tolerant of homosexuals and 78% felt that persons should not be treated differently because of their sexual orientation (UNAIDS, A Mandate to Act, 2013). These poll results are consistent with the decline in discriminatory attitudes observed among women from the MICS survey.

With regard to fostering an enabling environment, the Ministry of Health involved members of CSOs to train health workers to support the creation of an enabling environment to reduce stigma and discrimination towards KP in 2015.

The improvements in attitudes towards PLHIV are in part the result of interventions such as mass media campaigns of previous years. However there is still more to be done to reduce stigma and discrimination against PLHIV as well as key populations. Moreover there is need to re-establish the Human Rights Desk and enact legislation which prohibits discrimination against someone on the basis of their HIV status or their sexual orientation. There is also need to address data gaps on attitudes towards key populations and PLHIVs among health workers as well as in the general population.




**Source: MICS 2000 and 2006**

## Social Justice and Human Rights: Justice for all Mandate

The Justice for All programme comprise a number of activities aimed at eliminating stigma and discrimination against persons living with HIV. It is carried out by PANCAP in collaboration with UNAIDS and features a series of community and stakeholder consultations with a cross-section of stakeholders or clusters including parliamentarians, the judiciary, civil society, private sector, faith organisations, youth, media workers. The consultations would gather information on the factors which perpetuate stigma and discrimination and solutions to eliminate it. In Trinidad cluster consultations with Parliamentarians were conducted in 2015.

## Elimination of Gender inequalities and Gender based violence

One of the targets of the 2011 Political Declaration is to eliminate gender inequalities and gender based violence and abuse and increase the capacity of women and girls to protect themselves against HIV. Gender inequalities and greater biological susceptibility place women and girls at higher risk for HIV infection (UNAIDS, 2010).

Women who have experienced violence are up to three times more likely to be infected with HIV than women who have not (UNAIDS, 2010). Younger women are more likely to experience

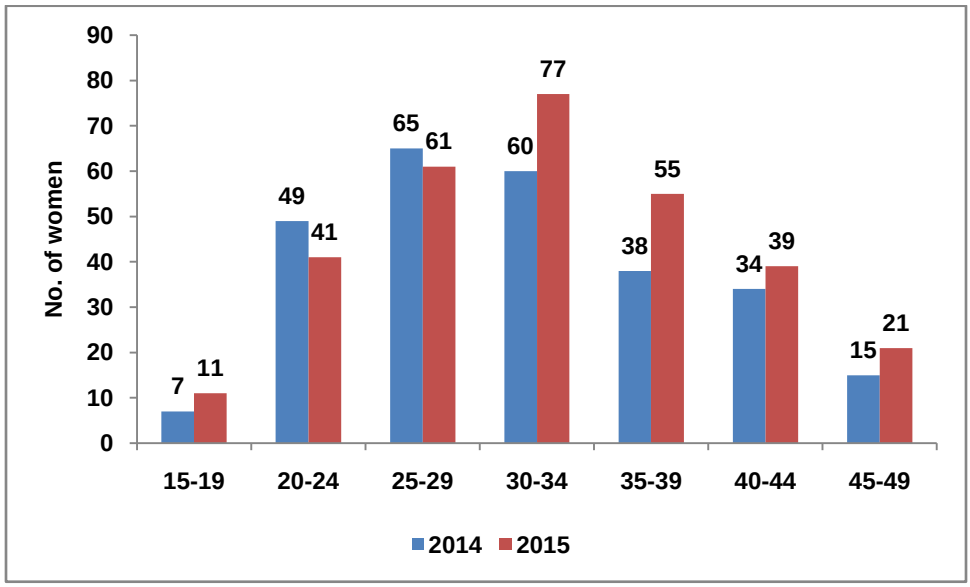
physical or sexual violence than older women usually at the hands of an intimate partner. This is seen in the data emanating from CAPA, TTPS.

Biologically, women are susceptible to infection and forced sex further increases the risk of HIV infection transmission due to tears and lacerations especially in adolescent girls. The threat of violence can also have a negative effect since women fearing violence are less able to protect themselves. They have reduced power to negotiate safe sex, or refuse unwanted sex, they do not get tested and fail to seek treatment after infection. The fear of violence, rejection and discrimination also affects women's disclosure of their status. These gender issues have not received adequate attention from the national response.

## Intimate partner violence in Trinidad and Tobago, 2014-2015

Statistics on intimate partner violence were sourced from the Crime and Problem Analysis Branch of the TTPS. In 2014 there were 268 reported cases of IPV. This increased by 14% to 305 in 2015. The majority of cases comprised assaults and beatings (97%) and the remainder were murders and sexual offences. The prevalence of IPV peaked in the 30-34 age group in 2015 however 62% of women who experienced IPV were under the age of 35.

**Figure 16 : Women aged 15-49 years who experience physical and sexual violence from an Intimate partner, 2014 and 2015**




**Source: CAPA, TTPS**

**Table 10: Trends in Sexual Violence, 2005-2015**

| Sexual Offences | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Rapes** | 334 | 259 | 317 | 236 | 247 | 217 | 200 | 286 | 212 | 198 | 180 |
| **Incest** | 56 | 43 | 46 | 63 | 71 | 22 | 30 | 104 | 17 | 35 | 38 |
| **Grevious Sexual Assault** | 87 | 145 | 135 | 168 | 134 | 168 | 150 | 202 | 109 | 206 | 136 |
| **Sexual intercourse with Female 16 years or under** | 255 | 445 | 314 | 245 | 296 | 285 | 252 | 325 | 203 | 373 | 252 |
| **Buggery (Female victim)** | 14 | 31 | 15 | 22 | 11 | 17 | 13 | 23 | 25 | 17 | 13 |
| **Buggery (Male victim)** | 16 | 7 | 16 | 3 | 8 | 7 | 8 | 19 | 7 | 10 | 15 |
| ***TOTAL (ALL REPORTED OFFENCES)*** | ***803*** | ***984*** | ***901*** | ***779*** | ***804*** | ***767*** | ***709*** | ***1028*** | ***621*** | ***909*** | ***695*** |

**Source: CAPA, TTPS**

**NB-Statistics refer to year the offence was reported not the year of occurrence. In 2012 one station district reported 62 offences in one month which occurred in previous periods.**

## Government response to ending GBV and sexual violence

Children and Youth especially young girls and women are vulnerable to HIV through sexual violence such as child sexual abuse, coerced sex and intimate partner violence. Empirical research conducted in North America shows that young people who have experienced sexual abuse are more likely to engage in sexual or drug related risk behaviours (CDC, Dec 2011, HIV Among Youth). Fear of violence can also be a barrier to disclosing one's status as well as seeking counselling and testing and getting treatment. Data from CAPA for 2015 showed that reported sexual offences against females under the age of 16 fluctuated during the period but declined by 32% from 373 in 2014 to 252 in 2015. Females and males who are the victims of sexual violence and child abuse are at risk for STI and HIV infection since in some instances the perpetrators may be HIV positive.

Ending Gender based violence is the mandate of the Ministry of Gender and Child Affairs who embarked on the development of the National Strategic Plan on Gender based and Sexual Violence for Trinidad and Tobago. Some of the strategic actions for ending GBV and domestic violence and child abuse included enacting legislation and policies such as the development of the national strategic plan on Gender based and sexual violence, re-establishment and staffing of the Domestic Violence Unit, gender training awareness and sensitization, completion of additional safe houses for victims of domestic violence and abuse, training of community lay responders, and the plan to establish the central registry on domestic violence for Trinidad and Tobago and use of post exposure pro. There is also a multifaceted multimedia campaign comprising different modalities of delivery including use of television and radio Ads, print Ads,

social media, IEC brochures, media interviews. Other agencies of government include the victim and support unit and the Children's Authority.

Additionally persons can acquire HIV if they are exposed to infected bodily fluids through sexual violence and assaults. For these emergency cases Post exposure Prophylaxis (PEP) is available through the Ministry of Health at emergency rooms, health centres and treatment clinics throughout T&T. Exposed persons should access Post exposure Prophylaxis within 72 hours of the incident to reduce the risk of post exposure infection. PEP is available to reduce the risk of HIV transmission and must be taken for 28 days.

**NGO response to eliminating Gender based, sexual violence and intimate partner violence**

One NGO, PSI Caribbean launched gender based violence prevention pilot in 2015- 'Make It Stop' which aims to reduce the prevalence of IPV and ensure the health and safety of women and girls experiencing IPV. This would be done by increasing access to quality, comprehensive gender based violence services and support for women and girls experiencing violence, transforming negative gender norms among youth and their families, cultivate community based approaches to preventing GBV and increasing public awareness and advocacy for a concerted national response to GBV.

Despite the tireless work of NGOs and the government sector much more is required from the national response in the elimination of gender based and sexual violence. For example, mainstreaming gender issues into the development and delivery of HIV prevention interventions and increased programming to address GBV. This is being addressed in the SRH policy and The newly established NACC will engage in actions to sensitize stakeholders and implementing partners about gender related issues and how they impact HIV and intersect with other socio-economic and demographic issues, equip stakeholders with the tools required to develop gender sensitive HIV programmes and services and provide support in developing an action plan to improve the integration of gender into HIV programming.

## Capacity building of CSOs and Stakeholders involved in national HIV response

In 2015 a number of capacity building sessions were undertaken with key partners including:

**1)** The Ministry of Social Development and Family Services in collaboration with the HIV Secretariat hosted a workshop entitled: *Understanding Adherence and the Effects of Treatment and Promoting Nutrition and Health Eating Habits for PLHIV* in September 2015**.**The workshop was fully subscribed with 35 social workers, liaison officers, family case workers and intake officers being in attendance, Two members of the HIV Secretariat and one HIV Co-ordinator also attended the workshop.

2) Training in Provider Initiated Testing was provided for NGOs and CSOs and Rapid HIV testing offered by the Ministry of Health HIV Coordinating Unit increasing access to HIV screening services.

3) Strengthening the capacity of stakeholders and implementing partners in the SWIT Methodology

4) Training of SRH and HIV Peer Educators attached to the Rapport Youth Programme. The training strengthened the capacity of the trainees to implement prevention strategies for youth and key populations. A total of 15 persons were certified as Peer Educators and 13 as Peer Instructors. The UNFPA provided technical support for this training and provided guidance to the MOH on the curriculum for Peer Educators and Key populations

5) As a good example of South –South co-operation 63 teachers and administrators and 3 CSOs involved in HIV response were trained in HFLE as Master Trainers. Six teachers from Jamaica facilitated this training under the auspices of UNFPA, UNICEF and UNESCO and the Ministries of Education of Jamaica and Trinidad and Tobago

6) Sensitization and capacity building workshop for FBOs on Sexual and Reproductive health rights of Adolescents. Thirty-five FBO representatives were trained including 4 from Tobago under the auspices of UNFPA in collaboration with the HIV Secretariat, MOH.

7) Training of 26 first responders in MISP (Minimum Initial Service Package) to deliver GBV prevention and comprehensive integrated SRH services in emergency settings

8) Training of 29 health professionals (doctors, nurses and midwives) to create friendly environments for adolescents requesting SRH services and commodities

9) One FBO conducted facilitator training for regional and international participants on HIV and AIDS. The main topics included
   - HIV, AIDS and Me,
   - Living with HIV:
   - A Christian response
   - What does it mean to be a compassionate, HIV competent community?
   - Conducting workshops and adult learning

10) The Ministry of National Security HACU conducted an in-house Train-the-trainer's workshop in February 2015 for the newly contracted programme officers and included the TTPS' Welfare Officers to build capacity among MNS personnel to facilitate the MNS' Sensitisation Workshops. The workshop was held at the MPA's Training Facility.

11) The Ministry of National Security HACU conducted HIV Sensitization Workshops in January 2014 for personnel of the Trinidad and Tobago Regiment who were attached to the 2nd Bn. In January 2015 the HACU was programmed to conduct an Impact Survey on the participants of those workshops. However, although access was granted for the survey, tracking of these personnel was negatively impacted because of redeployment of most of the workshops participants and the incorrect contact data for a significant number of them. Nonetheless the survey was conducted with a reduced population size. As a result the HACU undertook

to verify and update its contact information for all workshop participants beginning in Fiscal 2015 – 2016.

12) Three HIV Sensitisation Workshops for the personnel of the TTAG during November and December 2015. Seventy (70) personnel from the rank of Corporal benefited from the training. This training is scheduled to resume from the 25 January 2016.

13) CrossRoads Teacher Training was conducted by FBOs in August 2015. Cross Roads is a strategy that provides educational, health and spiritual solutions to communities affected by social crises brought about by risky behavior such as teen pregnancy, violence, drugs, and HIV and AIDS. The programme is founded on an interactive, 28-lesson character education curriculum, which involves students, parents, teachers and the community. This curriculum is ideal for secondary schools and has been embraced by education officials in more than 70 countries across 3 continents, supported by ministries of education, NGO's and concerned corporate citizens. In Trinidad and Tobago, CrossRoads is in all the secondary schools of Tobago and in approximately eleven schools in Trinidad. The Training was carried out among participants. The HIV Secretariat collaborated with Family Life T&T in training 35 persons 9 of which were from Tobago.

14) Basic Monitoring and Evaluation for MoH staff

15) The HIV Secretariat (Ministry of Health/OPM) in conjunction with the University of the West Indies, embarked on the rapid mapping and NGO database project conducting a rapid mapping exercise. In 2015 three capacity building workshops were held. This project will identify all NGOs, CBOs and FBOs that are actively involved in HIV/AIDS prevention, treatment, care and support, advocacy, human rights and research in Trinidad and Tobago. One of the objectives of the rapid mapping project is to create an interactive database that would permit online registration and updating of information of all stakeholders.

    The outcome of such a database has several benefits: the HIV AIDS Online System (HANOS) would be the central repository of basic data on NGOs, CBOs, and FBOs and would facilitate the ministry and other stakeholders in receiving access to various levels of information. Additionally, the creation of HANOS will assist the NACC in identifying civil society organizations, the current work of these organizations in the field of HIV/AIDS and it will as well, strengthen the NACC and other stakeholders' response to HIV and AIDS while improving the use of resources. The HANOS system also includes communication tools that would enhance M&E reporting and capacity as well as a proposal builder which will facilitate the online completion of funding proposals to the NACC. The GIS Maps and NGO capacity assessment tool are also integral features of the HANOS system. HANOS would also provide a forum for NGOs to communicate and collaborate with each other

**Laboratory Strengthening**

The improvement to the laboratory network is critical to the HIV response. Implementation of a directed national laboratory plan will benefit country in the area of HIV /STI, new emerging infection and chronic disease. In addition it will improve time to diagnosis of disease which can also have an effect on decreased hospital admissions and decreased repeat testing. Trinidad and Tobago has benefited from CDC PEPFAR activity in the support of some laboratories, the development of the draft strategic plan for the laboratory sector and Development of draft laboratory policies. Caribbean Med Labs Foundation and Trinidad and Tobago Lab Accreditation Service are also critical partners in this activity.

**Funding for the Expanded National Response and closing the resource gap**

Funding for the national response to HIV and AIDS is primarily provided by the Government of Trinidad and Tobago. Other agencies provide support for specific activities and initiatives and include local, regional and international partners. Line Ministries with HIV co-ordinators also receiving funding from their respective ministries for approved sectoral activities. Civil society organisations receive limited funding through requests for proposals usually for the Carnival season and for World AIDS commemoration. Currently T&T is working towards producing the NASA (National AIDS Spending Assessment) for the period 2010-2015. This initiative would be led by the NACC and undertaken in collaboration with and technical assistance from UNAIDS and UNDP. These entities are also providing assistance in the production of the HIV Investment case. All sectors involved in national HIV work would be included in these projects.

## IV. Best Practices

1) South–South Co-operation in the training of teachers in HFLE by Jamaican counterparts. This was an example of an effective approach to ensuring that there are competent professionals to support the successful implementation of HFLE. Both teachers and a limited number of NGOs involved in HIV/SRH response were trained who can serve as trainers. This encouraged a high level of engagement and commitment among stakeholders. It was also a multI-organisation collaborative approach between the Ministry of Education Trinidad and Tobago, Jamaica, UNFPA, UNICEF and UNESCO
2) Wider engagement of RHA stakeholders inclusive of training units to scale up HIV rapid testing.
3) Integration of HIV testing with wellness testing and counselling in the WVCT Campaign. The Wellness approach to increasing HIV testing uptake is commonly advocated. This campaign was completed through a strong multi-collaborative approach between the HASC, line ministries, MOH/RHAs, CSOs, the UN and the private sector which was one of its main features.
4) Completion of the first BBSS and drug users study required rapport and trust with Community stakeholders. This study was characterised by a high level of multi-sectoral multi partner collaboration with the community without which the survey would not have been completed. The successful conduct of the study required securing external buy-in to the process from the community. The Ministry of Health provided leadership and

direction in collaboration with NASTAD who provided technical assistance. Technical support, oversight and funding were provided by the US Centers for Disease Control and Prevention.

## V. Major Challenges and Remedial Actions

**Table 11: Challenges and Remedial Actions**

| Key Challenges | Remedial actions taken/needed |
|---|---|
| **Lack of country co-ordinating mechanism** | NACC was re-established in the Office of the Prime Minister |
| **Inadequate human resources at national and sectoral levels** | Recruit competent staff with correct skill mix |
| **Improvement of M&E System** | Need to finalise M&E plan and improve M&E across all sectors with clear data flow plan. Need for ongoing capacity building in M&E across public sector as well as among CSOs |
| **Inadequate funding** | Complete HIV investment case to provide the required evidence for decision making to determine the funding required for the national response |
| **Centralised treatment and care centres** | Need to establish additional treatment sites and multidisciplinary treatment and care teams |
| **Key populations and marginalised groups** | Training of health care providers in addressing issues of stigma and discrimination, empowerment of peer educators to reach key populations |
| **Lack of integration of HIV and other programmes such as SRH and** | Establish more centres in Trinidad patterned after the Health Promotion Clinic model of Tobago |
| **Procurement of drugs** | |
| **Lab issues** | |

## VI. Support from the Country's Development Partners

While the government of Trinidad and Tobago funds the national HIV programme, the Government partnered with a number of regional, bilateral and international partners which provided greatly needed technical and financial assistance and support for several activities in 2015. The government is appreciative of the support received from its partners which included:

**Table 12: Support from Partners**

| AGENCY/PARTNER | TYPE OF SUPPORT |
|---|---|
| UNFPA | SRH Policy, SRH for Faith based Organisation, and Technical Support for training of RHA based Rapport , support adolescent friendly care protocols;<br>HFLE Training of Teachers and NGOs |
| PEPFAR agencies in country : | Department of Defense working with ministry of National Security.<br><br>HRSA working with UWI .<br><br>CDC – Co-operative agreement with MOH 2010 - 2015 ( extenstion 2016 ): focus areas:<br>Strategic Information :(MSM,Sex worker survey), Case base surveillance; Prevention, Laboratory Strengthening.; Pilot of stigma & discrimination training., Review of PITC curriculum, Quality management<br><br>USAID- LCI Capacity building Project with CSOs<br>Positive Connections and Guideline Review with respect to Adolescents living with HIV and AIDS |
| PANCAP | Facilitated Parliament Cluster of Justice for All consultations, CLFI initiative |
| UNDP and UNAIDS | NASA, Investment case, technical support for WVCT Campaign by UNAIDS |
| CARPHA( Caribbean Public Health Agency) | Evaluation of Peer Support<br>Training of Health sector staff<br>Evaluation of Treatment sites ability to collect treatment and care data |
| **PAHO** | Treatment 2.0 Mission assessment of country's ability to scale up treatment<br>Surveillance strengthening |
| **FAO** | Preliminary discussions held with the Ministry of Agriculture on initiative targeting HIV Nutrition, Livelihoods and Food Security |
| **ILO** | The HASC received technical and financial support from UNAIDS in the planning and proposal development of the Workplace HIV and Wellness Voluntary Counselling and Testing Campaign (WVCT@Work) 2015. Capacity-building of local implementers was supported by ILO Personnel who facilitated training on the ILO's SOLVE Methodology |

Further Support and technical assistance is needed for the following areas and activities:

- Complete and finalize the M&E Plan and to strengthen the national M&E system at national and sectoral levels,
- Conduct national AIS/KABP/ survey to measure risk behaviours such as sexual activity, condom use, sexual partnerships, HIV knowledge, stigma attitudes among youth and the general population.
- Development and implementation of a BCC plan targeting high risk and marginalised youth and key populations
- Coordinated prisons intervention
- Review and finalisation of the draft national HIV and AIDS Policy
- HFLE Training for CSOs to supplement teachers
- Laboratory strengthening : improvement of TPHl and QPCC&C critical to response (diagnosis is critical to access, prevention and improve diagnosis of OI)
- Pharmacy mission should receive continued support to improve procurement mechanism to support wider treatment .
- Improved investment in social support mechanism in country to support wider access to ARV and reduction in treatment default and implementing multidisciplinary treatment and care teams
- Estimation of PLHIV – guided by data
- Testing access to key populations
- Linkage to care for PLHIV
- Development of programme to support retention in care
- Training of Data Entry Officers in the Basics of M&E;
- Review of NSP to ensure realignment with requirements of the Treatment 2.0 recommendations and other evaluation reports including setting new targets .

## VII. Monitoring and Evaluation Environment

Trinidad and Tobago promotes the principle of one national M&E plan. There was a strategic information sub-committee which led this priority area of the national strategic plan. However there have been challenges at many levels and in many sectors in implementing the M&E plan. One challenge has to do with the governance of the national co-ordinating mechanism which expired in January 2015. Subsequent to the expiration of the IHA the M&E officer also demitted office and the post not filled.

In addition a great challenge is the paucity of human and other resources required for the implementation of an effective and sustained M&E plan. This occurs at the level of the national co-ordinating mechanism as well as at the sectoral and civil society levels. For example our national statistical office has experienced severe operational challenges which has impacted the national statistical system. The impact of this is that there are several data gaps in the indicators required for national and international reporting requirements.

Currently data are collected on key populations such as MSMs using the Respondent Driven Sampling methodology. However these studies are not representative of all MSMs and have limited coverage. These studies however provide benchmark information on key populations.

The health sector based plan is still in draft format. A costed national M&E work plan exists but requires revision at the level of the health sector based on cross-cutting issues. Routine data monitoring occurs via the utilisation of paper-based and electronic data sources. Data are available from the public health sector however; data are not readily available from all private health sector data sources and Central Statistical Office. Moreover there are many standalone unlinked databases.

Second generation HIV surveillance was implemented in 2013 and now operational for 2 years and in the 3rd year of implementation. Bio-behavioural surveillance was conducted with one key population (MSM) and completed in May 2014. A formative assessment with the FSW community was completed in December 2014 and the research protocol is currently being explored for submission to local Ethics.

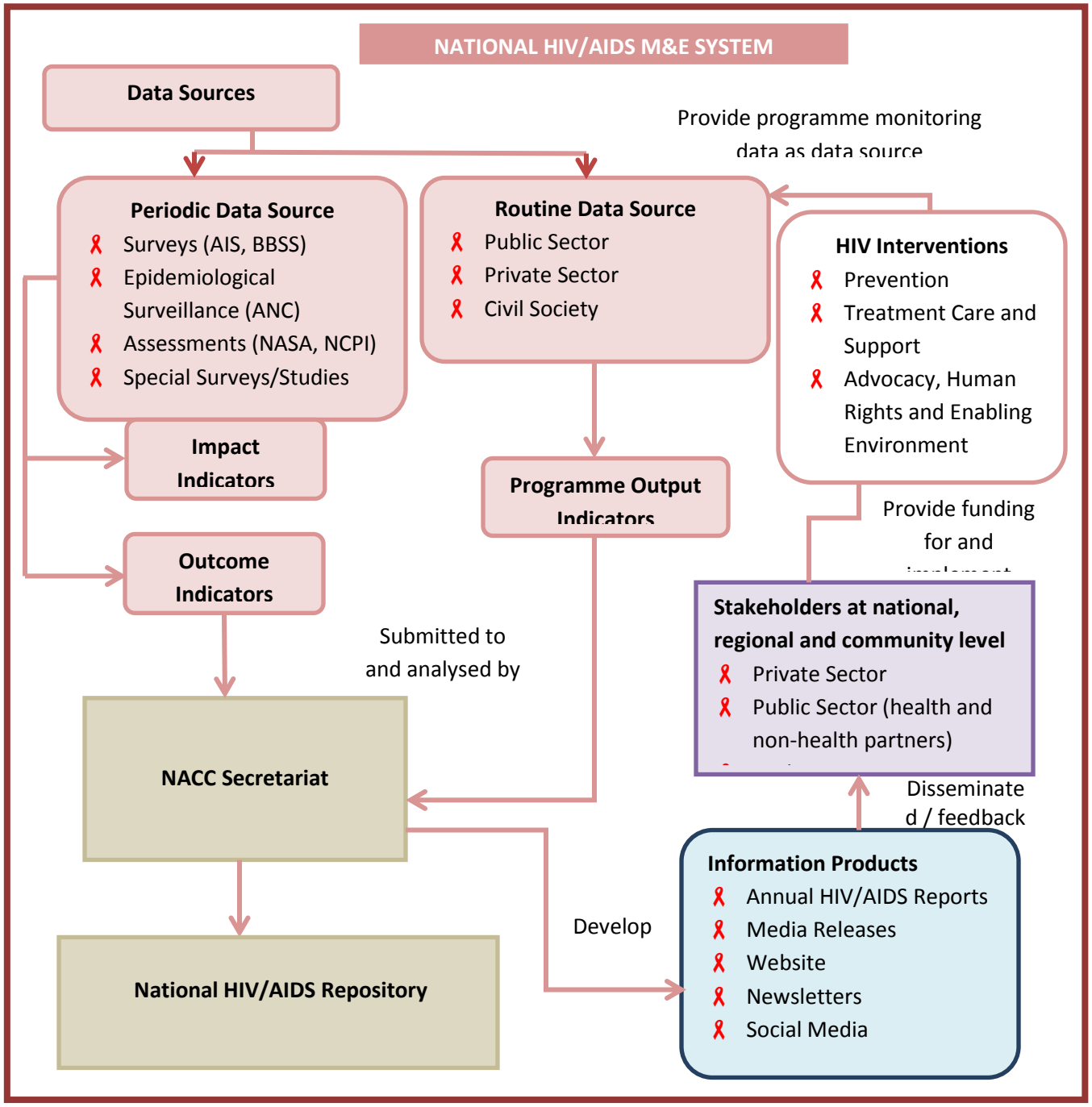
The previous strategic information sub-committee had identified a number of surveys and studies which need to be executed in order to close of the data gaps currently existing. These included a national KABP Survey since the last one was conducted in 2007, modes of transmission study, profiles of PLHIVs and Stigma Index study. However due to staff and other limitations proposals for the conduct of these studies have not been developed. As the new NACC Secretariat commences operations these activities would be undertaken.

Supportive Supervision/data auditing occurs at the national and sub-national level in order to address data quality issues. The health sector related M&E unit of the Ministry of Health worked with teams from the PMTCT of HIV programme and Treatment & Care sits to updated retrospective data for the programme to strengthen data quality and align with an improved line listing reporting format for the programme. Officers audited some entries from sites/ Counties and checked for data inconsistencies in the sub-national programme data. Treatment & Care data checks were intermittent with electronic patient monitoring systems. Inconsistencies with data emanating from paper-based sites were pinpoint and drawn to the attention of the site for resolution. The extent to work with the Treatment & Care Sites was not realised due to the lack of key M&E human resources.

Some Civil society organisations such as Family Planning Association of TT uses the Ministry of Health's and FPATT's data collection forms that require information on age, sex, presenting symptoms, results, basic demographics etc which is sent to the Ministry of Health monthly. FPATT also uses a daily log provided by the Ministry of Health trapping all persons tested and sent to the Ministry at the end of the year. Data collected informs the Association's annual programme and budget activities planned for HIV programmes. However CSO groups expressed the view that The data collection forms are repetitive and tedious to complete making the margin of human error in completing it greater and the HIV screening service longer, limiting the number of person that can be seen.

The necessary human resource with correct skills mix to implement and follow up on data management activity and lack of commitment to data collection are also challenges faced by CSOs. This results in a paucity of data coming from CSOs who are supposed to have greater reach with key populations such MSMs, CSWs prisoners, marginalised youth, substance users etc

**Figure 17: National HIV and AIDS Monitoring and Evaluation System**




**Source: Draft National HIV and AIDS M& E Plan**

**Remedial actions planned to address the aforementioned challenges include**

- Steps are being undertaken to fill posts for the new NACC Secretariat
- Working in collaboration with the M&E divisions within and across Ministries and civil society groups
- Regular data dissemination fora to highlight research being undertaken
- Greater advocacy for M&E activities.
- Working with regional and international bilateral and UN Agencies with the required expertise
- The mechanism within the former national coordinating mechanism needs to be re-introduced.
- Civil society groups are streamlining data collection forms to limit duplication.
- Description of Data gaps and highlighting the necessary HR needed to support this activity. This has been done but requires approval
- Development of a detailed inter-sectoral plan over the next five years to collect data.
- Technical assistance around M&E plan which would also include collection of data from Statistical Office.
- Implementation of the measurement tool to monitor treatment milestones of the PLHIV and assist with the development of Treatment cascades;

There is need for much technical assistance and capacity building. Areas include data entry and compilation, validation, analysis and report preparation.

Strengthening of the capacity of the national statistical office to provide support and data to other ministries

Review of NSP to ensure realignment with requirements of the Treatment 2.0 recommendations.

Revision of the Health sector M&E plan align with the revised NSP for HIV; Creation of a unique identifier to link patient monitoring systems

## VIII. Challenges in preparing this report

There were a number of challenges in preparing this report. The 2016 GARPR guidelines were only made available in February and included the reporting of new indicators and as such, the country was unable to report on many of those indicators. Some of the data usually required for the GARPR were either unavailable such as the data on AIDS spending, or if the data was available there were issues of timeliness, completeness, and representativeness. In addition, some of the assumptions of the spectrum model to derive the estimates related to treatment do not reflect the Caribbean context, and may not reflect the national HIV/AIDS situation. The country intends to meet with relevant stakeholders involved in data collection and compilation process to discuss the challenges they faced and the way forward.

As of time of writing of this report the country co-ordinating mechanism was not yet established. During the reporting period 2015 there was no functioning country co-ordinating mechanism. The staff of the Secretariat comprised a Director and an On the Job Trainee.

One of the grave challenges in preparing this report is the number of data gaps which limits the trend analyses which can be undertaken. The gaps especially with respect to sexual behaviours in the general as well as among key populations can be closed by undertaking population based surveys such as the KABP or AIDS Indicator Survey for both males and females, modes of transmission studies.

# Appendix I: Indicator Table Overview

## HIV PREVENTION IN THE GENERAL POPULATION

| INDICATOR | | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|---|
| | **Last year available** | **2013** | 2014 | 2015 | |
| 1.1 Young people:<br><br>Percentage of young women and men aged 15-24 who correctly identify both ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 2006<br><br>(57.5%) | NA | | | Last data available is from the 2006 MICS for women only. Data for 2011 from the MICS not yet released by Ministry of Social Development and Family Services (SDFS) |
| 1.2 Young people:<br><br>Sex before the age of 15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 | 2006<br><br>(4.7%) | NA | | | Last data available is from the 2006 MICS for women aged 15-19 only. Data for 2011 from the MICS not yet released by Ministry of Social Development and Family Services is for 2006 |
| 1.3 Multiple sexual partnerships *Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months* | 2006<br><br>(3.4%) | NA | | | Last data available is from the 2006 MICS for women 15-24 only. Data for 2011 from the MICS not yet released by SDFS |
| 1.4 Condom use at last sex among people with multiple sexual partnerships *Percentage of women and men aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse* | NA | | | | |
| 1.5 People living with HIV who know their status* *Percentage of people living with HIV who know their status (including data from case-based* | | | | | NA<br><br>This info not requested |

| INDICATOR | | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|---|
| | **Last year available** | **2013** | 2014 | 2015 | |
| *reporting)* | | | | | due to time of receipt of new GARPR guidelines |
| 1.6 HIV prevalence from antenatal clinics, by age group* *HIV prevalence among women attending antenatal clinics in the general population* | | | | | NA |
| 1.20 HIV incidence rate* *Number of new HIV infections in the reporting period per 1000 uninfected population* | | 0.74 | 0.81 | | Source: Population data 1,324,699 reported in the 2011 Population and Housing census<br>2013 Value: [964/(1,324,699-21948)]x1000<br>2014 Value: [1053/(1,324,699-22900)x1000] |
| 1.22 Male circumcision, prevalence *Percentage of men 15–49 that are circumcised* | | | | | Not relevant to T&T |
| 1.23 Annual number of men voluntarily circumcised *Number of male circumcisions performed according to national standards during the past 12 months* | | | | | Not relevant to T&T |

## KEY POPULATIONS

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 2.1 Size estimations for key populations | | | | NA |
| 2.2 Sex workers: condom use *Percentage of sex workers reporting the use of a condom with their most recent client* | | | | NA |
| 2.3 HIV testing in sex workers *Percentage of sex workers who received an HIV test in the past 12 months and know their results* | | | | NA |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 2.4 HIV prevalence in sex workers *Percentage of sex workers who are living with HIV* | | | | NA |
| 2.5 Men who have sex with men: condom use *Percentage of men reporting the use of a condom the last time they had anal sex with a male partner* | 53.3^ | | | ^Weighted analysis Source: TT MSM BBSS Report 2013-2014 |
| 2.6 HIV testing in men who have sex with men *Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results* | 56.5^ | | | ^Weighted analysis Source: TT MSM BBSS Report 2013-2014 |
| 2.7 HIV prevalence in men who have sex with men *Percentage of men who have sex with men who are living with HIV* | 26.6^ | | | ^Weighted analysis Source: TT MSM BBSS Report 2013-2014 |
| 2.8 Needles and syringes per person who inject drugs *Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes* | | | | NR |
| 2.9 People who inject drugs: condom use *Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse* | | | | NA |
| 2.10 People who inject drugs: safe injecting practices *Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected* | | | | NA |
| 2.11 HIV testing in people who inject drugs *Percentage of people who inject drugs who received an HIV test in the past 12 months and know their* | | | | NA |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| *results* | | | | |
| 2.12 HIV prevalence in people who inject drugs *Percentage of people who inject drugs who are living with HIV* | | | | NA |
| 2.13 Opioid substitution therapy coverage *Percentage of people who inject drugs receiving opioid substitution therapy (OST)* | | | | Not relevant to TNT |
| 2.14 HIV prevalence in inmates/detainees* *Percentage of inmates/detainees who are living with HIV* | | | | NA |
| 2.15 HIV prevalence in transgender people* *Percentage of transgender people who are living with HIV* | | | | NA |

## PREVENTION OF MOTHER TO CHILD TRANSMISSION

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015** | |
| 3.1 Prevention of mother-to-child transmission *Percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) to reduce the risk of mother-to-child transmission ** | 85.8[S] | | | 2015 Denominator value emanates from Spectrum's 2016 model |
| | | 84.5[P] | 82.5[P] (113/137) | [P] Programme data. |
| 3.2 Early infant diagnosis *Percentage of infants born to HIV-positive women receiving a virological test for HIV within two months of* | 51.1[SD] | | | [SD] – Spectrum Denominator |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015** | |
| *birth*** | | | | |
| | | 109.3[P] (176/161) | 109.5[P] (150/137) | [P] Programme data. The definition of the indicator numerator was not clear since infants born in the last 2 months of the previously ending year could have been tested within 2 months of birth during the 1st quarter of the reporting period additionally, there were multiple women with twin births |
| 3.3 Mother-to-child transmission of HIV *Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months*** | | | | [S] Data emanating solely from Spectrum |
| | 0.0[P] | 0.0 [P] (0/177) | NA | [P] Programme data. |
| 3.3a Programme-level mother-to-child transmission of HIV *Registered percentage of child HIV infections from HIV-positive women delivering in the past 12 months* | | | | Data for 2014 are not included |
| 3.4 PMTCT testing coverage *Percentage of pregnant women with known HIV status* | 67.4 | **96.3** (19250/20000) | 65.5 (12976/19800) | Note that measurement of this indicator is different for 2015 value. Denominator value emanates from UNDESA |
| 3.5 Testing coverage of pregnant women's partners *Percentage of pregnant women attending antenatal clinics whose male partners were tested for HIV during pregnancy* | 0.3 | 0.1 | | Partner Testing for HIV at ANC is not currently part of routine surveillance at AN Clinics. Male partners are hypothesized and based on anecdotal evidence to take place separately at clinics not focussed on maternal health. Data only reflect initial assessment of partners at testing sites and do not reflect follow-up testing at treatment and care sites. Data are based on public sector only. |
| 3.7 Coverage of infant ARV | 92.04 | | | [SD] – Spectrum Denominator |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015** | |
| prophylaxis *Percentage of HIV-exposed infants who initiated ARV prophylaxis ** | | 91.9[P] (148/161) | 100.0[P] (137/137) | [P] Programme data. |
| 3.9 Co-trimoxazole (CTX) prophylaxis coverage *Percentage of HIV-exposed infants started on CTX prophylaxis within two months of birth ** | 74.4 | | | |
| | | 65.8[P] (106/161) | 66.4[P] (91/137) | [P] Programme data. |

## TREATMENT

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 4.1 HIV treatment: antiretroviral therapy. *Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV** | 48.0[SD] | | 62.2[SD] (6720/10812) | [SD] – Spectrum Denominator |
| | | 71.2[P] (6399/8987) | 74.5[P] (6720/9023) | [P] MOH Programme data. The denominator value here is different to the definition of the indicator and the data reflect those in care within the national treatment and care programme versus **estimated adults and children living with HIV** which emanates from Spectrum. |
| 4.2 Twelve-month retention on antiretroviral therapy. *Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy* | 93.4 | 95.1[P] | 90.5[P] | [P] MOH Programme data. |
| | 86.5[P] | 86.2[P] | 87.1[P] | [P] MOH Programme data |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 4.2a Twenty-four-month retention on antiretroviral therapy . *Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy in 2013* | | | | |
| 4.2b Sixty-month retention on antiretroviral therapy. *Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy in 2010* | 60.7[P] | 61.4[P] | 59.8[P] | [P] MOH Programme data |
| 4.3 HIV care coverage* *Percentage of people currently receiving HIV care ** * | | | 83.5[SD] (9023/10812) | [SD] – Spectrum Denominator 2015 Denominator value emanates from Spectrum's 2016 model |
| 4.4 Antiretroviral medicines (ARV) stock-outs *Percentage of facilities with stock-outs of antiretroviral medicines* | 0.0 | 0.0 | 83.3 | Treatment Site Pharmacy Reports (5/ 6) |
| 4.5 Late HIV diagnoses *Percentage of HIV-positive persons with first CD4 cell count < 200 cells/µL in 2015* | NA | 34.1[P] (212/622) | 30.2[P] (238/787) | 2014: Data for 7 of 8 treatment sites |
| 4.6 Viral load suppression* *Percentage of adults and children receiving antiretroviral therapy who were virally suppressed in the reporting period (2015)* | | | 77.7[P] | [P] MOH Programme data . Data represent 4 of 8 treatment sites |
| 4.7 AIDS-related deaths* *Total number who have died of AIDS-related illness in 2015* | | | NA | In the CBSS SOP, **Death** is defined as the death of an individual with a confirmed diagnosis of HIV/AIDS. The cause of death does not have to be listed as HIV, AIDS, or HIV/AIDS related illnesses to be entered into the database. |
| | | | | |

## AIDS SPENDING

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 6.1 AIDS Spending *Domestic and international AIDS spending by categories and financing sources* | NA | NA | NA | Last NASA was for period 2003-2009 |

## GENDER

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 7.1 Prevalence of recent intimate partner violence. *Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months* | | | 0.11 | Proxy Data sourced from TTPS/CAPA. |

## STIGMA AND DISCRIMINATION

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | Last year available | 2014 | 2015 | |
| 8.1 Discriminatory attitudes towards people living with HIV *Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV* | 2006<br><br>37.3% | NA | NA | Last data available is from MICS 2006. (37.3%- Would not buy food from PLHIV)<br><br>54% of persons in a UNAIDS poll felt that PLHIV were in need of special protection by the state against discrimination. 41% felt they did not, 5% unsure or won't say. (Source: A Mandate to Act. Findings from a Poll on Public Attitudes to Sexual and Reproductive Health, Abuse, Violence and Discrimination, 2013, UNAIDS Caribbean) |

## HEALTH SYSTEMS INTEGRATION

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 10.2 External economic support to the poorest households *Proportion of the poorest households who received external economic support in the past three months* | NA | NA | NA | Data may be available from Survey of Living Conditions but this is not yet released by Ministry of Social Development and Family Services |

## HIV AND OTHER DISEASES

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| 11.1 Co-management of tuberculosis and HIV treatment *Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV* | NA | NA | | |
| 11.2 Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis (TB) disease | NA | NA | 6.0[P]<br>(39/649) | Numerator: National TB programme<br>Denominator: data available from 6 of 8 sites, data do not represent Tobago Adult sites<br>[p] MOH Programme data |
| 11.3 Proportion of people living with HIV newly enrolled in HIV care started on tuberculosis (TB) preventive therapy *Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period* | NA | NA | 0.2[P] | Numerator: National TB programme<br>Denominator: data available from 5 of 8 sites, data do not represent Tobago Adult sites<br>[p] MOH Programme data |
| 11.4 Hepatitis B testing *Proportion of persons in HIV care who were tested for hepatitis B virus (HBV)** | | | | This info not requested due to time of receipt of 2016 GARPR guidelines |
| 11.5 Proportion of HIV-HBV coinfected persons currently on combined treatment * | | | | |
| 11.6 Hepatitis C testing *Proportion of people in HIV care who were tested for hepatitis C virus (HCV)** | | | | |
| 11.7 Proportion of persons diagnosed with HIV-HCV | | | | |

| INDICATOR | VALUES | | | COMMENTS/NOTES |
|---|---|---|---|---|
| | 2013 | 2014 | 2015 | |
| infection started on HCV treatment during a specified time frame (e.g. 12 months) * | | | | |
| 11.8 Syphilis testing in pregnant women *Percentage of pregnant women accessing antenatal care services who were tested for syphilis* | | | | |
| 11.9 Syphilis rates among antenatal care attendees *Percentage of antenatal care attendees who were positive for syphilis* | | 0.3[Q] (42/15326) | 0.2[Q] (35/15662) | [Q] MOH STI Diagnostic & Treatment Programme data |
| 11.10 Syphilis treatment coverage among syphilis-positive antenatal care attendees *Percentage of antenatal care attendees positive for syphilis who received treatment* | 83.0[Q] (39/47) | 64.3[Q] (27/42) | 85.7[Q] (30/35) | [Q] MOH STI Diagnostic & Treatment Programme data |
| 11.11 Congenital syphilis rate (live births and stillbirth) *Percentage of reported congenital syphilis cases (live births and stillbirths)* | NA | NA | NA | |
| 11.12 Men with urethral discharge *Number of men reporting urethral discharge in the past 12 months* | 763[Q] | 756[Q] | 595 [Q] | [Q] MOH STI Diagnostic & Treatment Programme data<br>Denominator value: WHO will use value from the UNPD (Number of males aged 15 and older) |
| 11.13 Genital ulcer disease in adults *Number of adults reported with genital ulcer disease in the past 12 months* | 229[Q] | 242[Q] | 311 [Q] | [Q] MOH STI Diagnostic & Treatment Programme data<br>Denominator value: WHO will use value from the UNPD (Number of individuals aged 15 and older) |

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