HIV Prevention Interventions in Trinidad and Tobago

Mapping of Work Conducted in HIV Prevention from 2004 - 2010
FOREWARD

This report was commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS) with support from the United Nations (UN) Joint Team on AIDS and led and owned by the National AIDS Coordinating Committee (NACC). The UN Joint Team on AIDS is comprised of UN officers who work in the area of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) from the following organizations: United Nations Children’s Fund (UNICEF); Food and Agriculture Organization (FAO) of the United Nations; United Nations Development Programme (UNDP); Pan American Health Organization (PAHO); International Labour Organisation (ILO); United Nations Educational, Scientific and Cultural Organisation (UNESCO); United Nations Population Fund (UNFPA); the United Nations Economic Commission for Latin America and the Caribbean (ECLAC); and the United Nations Fund for Women (UNIFEM). The group is convened by the UNAIDS Country Coordinator for Trinidad and Tobago. The UN Joint Team on AIDS was established to coordinate the UN’s support to the national AIDS response based on a division of labour and deliver their support through an integrated Joint Programme of Support developed in collaboration with national stakeholders.

A mapping and review of HIV prevention interventions is timely and complements the current development of the new National Strategic Plan (NSP) on HIV and AIDS, which builds on data emerging from several other related reviews.
# TABLE OF CONTENTS

List of Acronyms  
Executive Summary  
Background  
Country Situation – The Status of HIV Prevention in Trinidad and Tobago  
Findings from Mapping Exercise – Scope and Scale of Prevention  
Analysis of Key Achievements, Gaps and Challenges, and Recommendations  
Recommended Prevention Standards and Guidelines  
Conclusion  

List of Graphs  

List of Tables  

List of Annexes
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
</tr>
<tr>
<td>CRSF</td>
<td>Caribbean Regional Strategic Framework</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>ECLAC</td>
<td>The United Nations Economic Commission for Latin America and the Caribbean</td>
</tr>
<tr>
<td>FAO</td>
<td>The United Nations Food and Agriculture Organization</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV and AIDS</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>HFS</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>ILO</td>
<td>The United Nations International Labour Organization</td>
</tr>
<tr>
<td>KIIS</td>
<td>Key Informant Interview or Survey</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MARPs</td>
<td>Most At Risk Populations</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MNS</td>
<td>Ministry of National Security</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Coordinating Committee</td>
</tr>
<tr>
<td>NASA</td>
<td>National AIDS Spending Assessment</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
</tbody>
</table>
NHSR  National Health Sector Report
NSP   National Strategic Plan
PAHO  Pan American Health Organization
Pat/R Patient Record
PBS   Population Based Survey
PCR   Polymerase Chain Reaction
PLHIV People Living with HIV
PM    Programme Monitoring
PMTCT Prevention of Mother-to-Child Transmission
PR    Programme Records
RHA   Regional Health Authority
STD   Sexually Transmitted Diseases
T&TPS Trinidad and Tobago Police Service
UA    Universal Access
UN    United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNECLAC United Nations Economic Commission for Latin America and the Caribbean
UNDP  United Nations Development Programme
UNESCO The United Nations Educational, Scientific and Cultural Organization
UNFPA The United Nations Population Fund
UNGASS United Nations General Assembly Special Session on HIV and AIDS
UNICEF United Nations Children Fund
UNIFEM United Nations Fund for Women
UWI   University of West Indies
VCT   Voluntary Counselling and Testing
WAD   World AIDS Day
1.0 EXECUTIVE SUMMARY

The Human Immunodeficiency Virus (HIV) continues to be a major public health concern in Trinidad and Tobago. In keeping with the UNAIDS global thrust of examining HIV prevention in order to halt HIV transmission and “Scale-Up” the response, Trinidad and Tobago has conducted a review of its HIV prevention efforts for the period 2004-2010 to guide the way forward in HIV prevention.

In 2004, stigma and discrimination, of anything associated with HIV or AIDS, were highly prevalent with limited knowledge amongst the general population on HIV. As one stakeholder noted, “most people did not want to be seen wearing a red ribbon as they were afraid people would think that they have AIDS”. Today, several proudly adorn the Red Ribbon and have indicated their support to those infected.

Despite an increase in awareness, there has been little change noted in behaviour with a steady number of new infections each year and with only an estimated 1.89% of the population ever having an HIV test. In reviewing prevention efforts since 2004, significant momentum was built around HIV prevention with the “What’s Your Position” campaign during the period 2004-2006. However, this momentum slowed down, with limitations in accessing government funds; changes in staff at the National AIDS Coordinating Committee (NACC) Secretariat; a decline in funding for the national HIV response; and a lack of political will to address key issues that impact on HIV amongst those considered most at risk. As a result, there has been a major and steady drop in HIV prevention activities implemented between 2007-2010.

The mapping of HIV prevention reveals the need for the following changes in order to halt the spread of HIV:

- A need for better and standardized reporting by those implementing HIV prevention interventions with compilation, good record keeping and monitoring by the NACC;
- The need to define: the size, knowledge, attitudes, practices, behaviour, HIV prevalence, and behaviour risk factors amongst most at risk populations
- Increase knowledge and access to the female condom, particularly in rural areas and amongst sexually active youth
- Greater outreach to FBOs including discussions on issues with MARPs
- Increase support to HIV coordinators including building capacity within the NACC to provide sustained technical support
- The need for more behaviour change interventions including targeting those most at risk and utilizing key public figures;
- Enhance the roll-out of the National HIV and AIDS Workplace policy in both the public and private sectors;
- Ensure further outreach is conducted in rural areas;

\[\text{NACC 2010}\]
- VCT needs to be expanded, particularly in Tobago and rural areas of Trinidad utilising PLHIVs and with consideration given to convenient hours of operation.
- All persons visiting a public STI clinic should routinely be tested for HIV on an "opt out " basis while private practitioners should be encouraged to offer HIV testing to their STI patients. HIV testing should be routinely offered to all persons being admitted to hospital.
- VCT should be offered to persons entering the prison system and being released.
- HIV education amongst youth is primarily taking place through the Ministry of Sport and Youth Affairs. The comprehensive health and family life Education (HFLE) curriculum needs to be implemented in all schools.
- Special focus is needed on out of school youth and MARPs.
- Stigma and discrimination in the health sector must be addressed particularly in respect to the right to pregnancy of HIV positive women.
- The need for adherence counselling and positive prevention to reduce HIV re-infections amongst PLHIV and to reduce transmission of HIV to uninfected persons through increased condom use.
- Address structural and cultural issues, through policies and programmes which serve as obstacles to Universal Access;
- Identify exemplary public figures for public HIV testing to further encourage testing by the general public.
- Support the National Coalition on Women, Girls and AIDS.
- Aggressively address violence in society, particularly gender based violence and violence against children.
- Ensure further collaboration between substance abuse prevention and HIV prevention.
- Develop more gender specific HIV programmes to address specific issues related to males and females.
- Ratify and publicize the draft National Policy on HIV and AIDS.
- Develop and effect an appropriate legislative framework to protect the rights of those living with and affected by HIV.

These issues should be addressed in the development of the new strategic plan on HIV and AIDS as we move forward with universal access to HIV prevention by 2015.
1.0 Background

Despite efforts to improve HIV awareness and change behaviour, over the past four (4) years, there has been an average of 1,400 new HIV infections each year in Trinidad and Tobago with women representing more than 50% of the new infections. While recent reports indicate an increase in awareness of the modes of transmission in 77% of the general population, this knowledge has not yet transferred to personal behaviour and practices, as there are more new infections each year.

As Trinidad and Tobago responds to the call of scaling up access to HIV prevention, care, treatment and support, assesses its progress in meeting its international commitments of halting the spread of HIV by 2015 as part of the Millennium Development Goals (MDG) and prepares its new strategic plan on HIV and AIDS (NSP), it is crucial that efforts to prevent the further transmission of HIV are examined. In order to reduce the number of new infections and better target those most at risk, as part of the new NSP, the United Nations in Trinidad and Tobago supported a NACC led review of prevention activities undertaken since 2004.

The objectives of this review were:
- To ascertain the scope, scale and intensity of HIV prevention interventions in Trinidad and Tobago; and
- To support the development of an information database, which will assist in identifying gaps in the HIV response as well as support, needed to successfully implement the new National Strategic Plan 2010-2015.

A description of the scope of work of this assignment is provided in the terms of reference at Annex I.

The following approach was used to obtain information for this assignment:
- A review of related literature, reports and statistics (See Bibliography at Annex II) with the NACC quarterly reports serving as the main source of information for mapping prevention interventions
- Administration of a survey amongst stakeholders active in prevention initiatives and a questionnaire amongst government ministries and other government agencies to identify their areas of interest and activity
- Focus group meetings with stakeholders on 13 July in Trinidad and 29 July in Tobago
- Telephone interviews with NGOs

Some of the limitations to this assessment were:
- Few responses by stakeholders to the questionnaire administered
- Inadequacies in data collection instruments to capture prevention work accomplished. The questionnaire did not collect data on the exact nature

2 NACC 2010
3 Ibid
of the interface with the target groups or the packaging and distribution of prevention materials
- A lack of a well-designed and maintained database or family of databases of prevention activities which reflects the weakness in data collection, record keeping and monitoring and evaluation
- A lack of specific data in programme reports from implementers in respect to sex, age, place of residence, actual date of intervention, numbers reached, outputs and outcomes
- The exclusion of quarterly reports for April – June 2007, October – December 2007, 2008, 2009 and 2010. There was just one report for 2008 – 2009, which lacked specific dates for when the interventions were conducted.

Despite these limitations, the review of HIV prevention in Trinidad and Tobago has produced a summary of findings including:

- A listing of HIV prevention interventions for the period 2004 – 2010 in Trinidad and Tobago (See Annex 3)
- A database of organizations working in HIV prevention in Trinidad and Tobago (See Annex 4)
- An analysis of work conducted, gaps and recommendations including draft HIV prevention standards and guidelines

This assessment will help to better target prevention intervention over the next five (5) years.
3.0 COUNTRY SITUATION – THE STATUS OF HIV PREVENTION IN TRINIDAD AND TOBAGO

The twin island Republic of Trinidad and Tobago with a population of approximately 1.3 million is one of the wealthiest countries in the Caribbean with a Gross Domestic Product (GDP) of the equivalent of TT$131,466,188,168\(^4\) or US$21,204,223,898 (2009)\(^5\). The country is rich in natural resources, has a thriving energy sector and also benefits from tourism particularly in Tobago with its pristine beaches and in Trinidad, which has the largest carnival festivities in the English speaking Caribbean.

Despite its wealth, like many other countries in the region, it continues to struggle with controlling the HIV epidemic. The current adult HIV prevalence is 1.5% with increasing numbers of women, particularly between the ages of 15-24, representing those who are newly diagnosed\(^6\). This demonstrates the need for specific HIV interventions amongst young women and young people overall.

**Graph 1: QPCC&C: New HIV Positives by Sex, 2005 - 2007**

![Graph showing new HIV positives by sex from 2005 to 2007](image)

The HIV epidemic in Trinidad and Tobago is characterized as both generalized and concentrated as the prevalence of HIV is greater than 1% in the adult population and higher than 5% in at least one of the most at risk populations (MARPs)\(^7\). In 2004, these MARPs were identified as:

- Young women
- Youth in and out of school

---

\(^4\) Exchange Rate used US$1 = TT$6.2  
\(^5\) World Bank 2010  
\(^6\) NACC 2010  
\(^7\) Ibid.
Men who have Sex with Men (MSM)
- Commercial Sex Workers (CSW)
- Prison population (both inmates and workers)
- Substance abusers

Studies show that there is sexual interaction between the groups considered most at risk and the general population, particularly amongst bisexual males, young women with older male partners and those engaged in multiple partnering. This interaction further illustrates the existence of a mixed epidemic.

Table 1 below provides a listing of data for key Universal Access HIV prevention indicators.

**Table 1: National Universal Access HIV Prevention Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult HIV Prevalence</td>
<td>1.5%(^{10}) (2010)</td>
</tr>
<tr>
<td>HIV prevalence amongst pregnant women aged 15-24 (MDG 6)</td>
<td>.06%(^{11}) (2010)</td>
</tr>
<tr>
<td>% of young women and men aged 15-24 who are HIV infected (UNGASS 22)</td>
<td>.8%(^{12}) (2010)</td>
</tr>
<tr>
<td>% of Men who have Sex with Men (MSM) who are HIV infected</td>
<td>20%(^{13}) (2005)</td>
</tr>
<tr>
<td>% of donated blood units screened for HIV in a quality assured manner (UNGASS 3)</td>
<td>100%(^{14}) (2010)</td>
</tr>
<tr>
<td>% of young women and men who have had sexual intercourse before the age of 15 (UNGASS 15)</td>
<td>26%(^{15})</td>
</tr>
<tr>
<td>% of women and men 15-49 who received an HIV test in the last 12 months and know their results (UNGASS 7)</td>
<td>1.89%(^{16})</td>
</tr>
<tr>
<td>% of health facilities that provide HIV testing and counselling services</td>
<td>88%(^{17})</td>
</tr>
<tr>
<td>% of pregnant women who receive HIV testing and counselling and know their HIV status</td>
<td>96.60%(^{18})</td>
</tr>
<tr>
<td>% of HIV-infected infants born to HIV infected mothers (UNGASS 25)</td>
<td>7.18%(^{19})</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (MDG 6)</td>
<td>42.5(^{20})</td>
</tr>
<tr>
<td>% of adults 15-49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS 16)</td>
<td>85.31% (2007)(^{21})</td>
</tr>
<tr>
<td>% of young people aged 15-24 who had more than one sexual partner in the past 12 months who report the use of a condom during the last intercourse</td>
<td>53.3% (2007)(^{22})</td>
</tr>
<tr>
<td># of men who have sex with men reached by HIV prevention interventions in the last 12 months</td>
<td>3,111(^{23})</td>
</tr>
<tr>
<td># of targeted service delivery points for sex workers where STI services are provided per 1000 sex workers</td>
<td>10%(^{24})</td>
</tr>
<tr>
<td>% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS 13 &amp; MDG 6)</td>
<td>57.5% (2007)(^{25})</td>
</tr>
</tbody>
</table>

---

\(^{8}\) UWI 2010  
\(^{9}\) PSI  
\(^{10}\) NACC 2010  
\(^{11}\) Ibid  
\(^{12}\) Ibid  
\(^{13}\) Lee, RK, Poon-King, CM, Legall, G. Samiel, S. and Trotman C 2005  
\(^{14}\) NACC 2010  
\(^{15}\) MOH, Update of Prevention in the Health Sector, July 2010  
\(^{16}\) NACC NSP Assessment, 2010  
\(^{17}\) MOH, PAHO 1020  
\(^{18}\) Ibid  
\(^{19}\) NACC 2010 (2008 data)  
\(^{20}\) 2007 data, MICS, 2008  
\(^{21}\) UNGASS 2008  
\(^{22}\) Global school-based student health survey (GSHS), 2007  
\(^{23}\) NACC 2010  
\(^{24}\) 2008 data MOH & PAHO 2010  
\(^{25}\) 2007 data, MICS, 2008
This data indicates success in respect to: screening donated blood; health facilities presently providing Voluntary Counselling and Testing (VCT); and the number of pregnant women tested for HIV. However, the data also suggest that improvements are needed in the number of people tested; the use of contraceptives; knowledge of HIV amongst young people; and reaching young people to discourage sex before the age of 15. It further suggests that many people are having sex with more than one partner.

While there is data for these indicators above, there are a number of other Universal Access prevention indicators for which there is no data. There is a particular absence of data on:

- HIV prevalence, testing, condom use, knowledge and the numbers reached by HIV prevention programmes amongst MARPs namely sex workers; substance users (crack cocaine users); and men who have sex with women and men
- Admissions and releases from correctional facilities tested for HIV
- Women who have experienced domestic violence who are HIV positive
- Health facilities with Post-Exposure Prophylaxis (PEP) services available on site
- PLHIV who report disclosing their status to their sexual partner
- The percentage of pregnant women sexual partners who receive VCT and know their status
- The condom use rate of the contraceptive prevalence rate (an MDG indicator)
- Condom use amongst those who had more than one partner in the last 12 months

There is also a need to disaggregate data by sex, age and geographical location given gender, age and location differentials such as in health seeking behaviour.

Recent studies note that some of the key factors contributing and influencing the spread of HIV in Trinidad and Tobago include: high levels of domestic violence (including gender based violence and violence against children), crime, homophobia, stigma and discrimination, and denial of bisexuality amongst males. The policy and legislative environment is also lacking, as a national HIV and AIDS policy has not been formally adopted to guide the response. In addition to these issues, Table 2 lists areas identified by national stakeholders as contributing and/or influencing the spread of HIV in both Trinidad and Tobago.

**Table 2: Factors Influencing the HIV Situation in Trinidad & Tobago**

<table>
<thead>
<tr>
<th>Trinidad</th>
<th>Tobago</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Multiple partnering</td>
<td>✗ Unemployment among the youth;</td>
</tr>
<tr>
<td>✗ High use and abuse of alcohol, drugs and other illegal substances</td>
<td>✗ Increasing substance abuse problems;</td>
</tr>
<tr>
<td>✗ Commercial and transactional sex practices</td>
<td>✗ Commercial and transactional sex practices</td>
</tr>
<tr>
<td>✗ Increased incidence of violence among males and between men and women</td>
<td>✗ Powerlessness among women to change cultural norms around multiple partners and child rearing</td>
</tr>
</tbody>
</table>
The multi-sectoral response to HIV is therefore considered key in addressing the multitude of social, cultural and economic factors that impact on HIV. Furthermore, HIV response needs to ensure that these issues are being addressed through its HIV prevention interventions.
4.0 FINDINGS FROM MAPPING EXERCISE – Scope and Scale of Prevention

The mapping of HIV prevention in Trinidad and Tobago has revealed information on demographic coverage, organizational responses, types of interventions, effectiveness of meeting strategic objectives and the potential economic impact of continued growth in HIV prevalence. This information is examined for both Trinidad and Tobago.

4.1 Demographic Coverage

In order to get a better understanding of the scale and scope of work conducted in HIV prevention the geographic location, age, gender, religion and most at risk classification of the beneficiaries and/or organizations implementing the activities are examined.

**Geographic Location**

Graph 2 below illustrates that the majority of discrete HIV prevention interventions from 2004 – 2010 took place in Tobago (60%). Of all the prevention interventions, 30% were national in focus. As Tobago has a much smaller population (4%) than Trinidad, these findings are surprising and may suggest differences in reporting the number of interventions executed as well as differences in the magnitude of interventions executed in Tobago as opposed to Trinidad.

![Graph 2: Activities Conducted by Geographic Area 2004-2010](image)

In looking at Trinidad alone, as demonstrated in Graph 3, most of the interventions took place in the county of St. George, which includes the Capital city of Port of Spain as well as the area known as the East/West corridor. This data illustrates a clear gap in outreach in respect to reaching persons in rural Trinidad. In fact, there were no interventions implemented in the county of Nariva. This is consistent with the point raised by stakeholders that there is a lack of HIV information in rural areas in Trinidad and the need to ensure more community based interventions throughout the country.
In Trinidad and Tobago, differentials in age coverage were only noted for interventions that specifically targeted youth and fell within Strategic Objective 2 of “promoting safe and healthy sexual behaviour amongst most at risk populations”. Under this objective, 74% of the interventions were targeted towards youth in Trinidad. Similarly, in Tobago, 93% of the interventions under this strategic objective also targeted youth.

**Gender**

Most interventions executed targeted both males and females. Only seven (7) interventions in Trinidad were specifically listed for women and 21 specifically listed for men. In Tobago, only three (3) interventions were listed as being targeted to women and two (2) targeted to men.

**Religion – FBO involvement**

The following faith based organizations participated in HIV prevention efforts in Trinidad.

- Lutheran Church
- IRO
- Rescue Mission – Pentecostal
- Maha Saba – Hindu
- Caribbean Council of Churches
- Islamic Support Committee on HIV and AIDS
- San Juan Presbyterian Church
- Caritas AIDS Ministry
- St. Andrews Anglican Church
FBOs were responsible for implementing 6% of all prevention interventions in Trinidad. Of the FBOs, as demonstrated in Graph 4, AIDS Rescue Mission, which is supported by the Pentecostal church, implemented most of the activities in Trinidad followed by the Maha Saba, which is a Hindu organization and the Caribbean Council of Churches (CCC), which is a regional organization of various denominations.

There were six (6) interventions in Tobago executed by the following faith-based organizations:

- Rescue Mission
- IRO
- Open Bible Church
- Anglican Diocese
- Mt. Grace Men’s Forum
- Caribbean Council on SDA

FBOs executed approximately 5% of all HIV prevention interventions in Tobago.

There is a need for further outreach to religious groups that were responsible for only one activity as well as those prominent groups in Trinidad and Tobago not included, such as Rastafarians, Catholics and Shouter Baptists. This outreach can be extended through the IRO who is a member of the NACC and represents most of these religions.
**Most at Risk Populations (MARPs)**

Of the total interventions executed in Trinidad, the majority fell within Strategic Objective 2, which sought to promote healthy sexual behaviour amongst MARPs.

![Graph 5: Total # of Interventions by Strategic Area in Trinidad](image)

However, within the MARPs, most of the interventions were directed at youth.

Table 3 below reflects the number of activities conducted within MARPs in Trinidad.

**Table 3: Coverage of MARPs in Trinidad**

<table>
<thead>
<tr>
<th>Target Group</th>
<th># of Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Women</td>
<td>Information not clearly indicated</td>
</tr>
<tr>
<td>Youth</td>
<td>254</td>
</tr>
<tr>
<td>MSM</td>
<td>12</td>
</tr>
<tr>
<td>CSW</td>
<td>66</td>
</tr>
<tr>
<td>Prison Population &amp; Other Uniformed Services</td>
<td>3</td>
</tr>
<tr>
<td>Substance Users</td>
<td>2</td>
</tr>
<tr>
<td>Migrants</td>
<td>3</td>
</tr>
<tr>
<td>STD Clinic attendees</td>
<td>1</td>
</tr>
<tr>
<td>Tourism Sector</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
</tr>
</tbody>
</table>

After youth, the largest number of interventions was targeted towards sex workers. This can largely be contributed to the work of the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) sex work project, which includes some of the outreach work conducted by Population Services International (PSI). It should also be further noted that while PSI works with sex workers, most of these sex workers are migrants, which is not reflected in the table above.
In Tobago, while the majority of interventions were geared at the general population, interventions that promoted safe and healthy sexual behaviour amongst MARPs were the second largest interventions executed.

Within the MARPs, interventions were only documented for those that reached young women, youth in general and members of the MSM community.

<table>
<thead>
<tr>
<th>Target Group</th>
<th># of Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Women (also included under youth)</td>
<td>1</td>
</tr>
<tr>
<td>Youth</td>
<td>25</td>
</tr>
<tr>
<td>MSM</td>
<td>2</td>
</tr>
<tr>
<td>CSW</td>
<td>0</td>
</tr>
<tr>
<td>Prison Population &amp; Other Uniformed Services</td>
<td>0</td>
</tr>
<tr>
<td>Substance Users</td>
<td>0</td>
</tr>
<tr>
<td>Migrants</td>
<td>0</td>
</tr>
<tr>
<td>STD Clinic attendees</td>
<td>0</td>
</tr>
<tr>
<td>Tourism Sector</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
</tr>
</tbody>
</table>

Like Trinidad, as displayed in Table 4 above, within MARPs most interventions targeted youth.

According to the NACC spending assessment, ___ has been spent on MARPs over the strategic period within the prevention budget.

According to stakeholders, the lack of interventions to address MAPRs can be contributed to the stigma associated with these groups. As the sexual behaviour and practices of members of the MSM and CSW communities in particular, are viewed as illegal and immoral” in the society, there has also been a lack of political will to address HIV prevention amongst these groups. Similarly, many of the decision makers deny sex in prisons, which is also illegal, and have
therefore delayed HIV prevention interventions amongst this group, although treatment for prisoners with HIV is available.

4.2 Organizational Response

The national response to HIV is coordinated through one national coordinating body, the NACC. This committee is comprised of a number of national stakeholders and is administered through a Secretariat, based in the Office of the Prime Minister, and sub-committees.

HIV prevention is coordinated through a prevention sub-committee, which was established in 2004. This committee is chaired by the Executive Director of the Family Planning Association of Trinidad and Tobago (FPATT), vice chaired by the Network of Non-Governmental Organizations of Trinidad and Tobago for the Advancement of Women and comprises the following other representatives:

- Ministry of Youth and Sport Affairs
- Ministry of Community Development, Culture and Gender Affairs
- Ministry of Education
- Tobago Youth Council
- Co-operative Credit Union League of Trinidad and Tobago
- Federation of Independent Unions and Non-Government Organization
- UNAIDS

This committee’s mandate is to oversee the implementation of the prevention strategy in keeping with the national strategic plan on HIV/AIDS 2004 – 2008 (NSP). Within the Prevention Sub-Committee, an Information, Education and Communication Committee was established to provide further guidance to the development and monitoring of an information, education and communication plan.

There are a number of organizations that have been involved in HIV prevention since 2004. From the mapping exercise, a total of __ organizations have been identified (See Annex __). For the purposes of this analysis these organizations have been grouped into the following categories:

UN: Member organizations of the United Nations
NACC: The National AIDS Coordinating Committee Secretariat
Other Gov: Government ministries and programmes other than the NACC
Private Sector: Private companies
CBOs: Community Based Organizations, generally small organizations that focus on a particular community
PLHIV: Comprised of management and staff who are HIV positive
FBO: Faith Based Organizations
Media: Media houses
Other NGO: Larger non-governmental organizations not included in the other categories
Trade Union: Trade Unions
Table _ below provides an overall demographic profile of the organizations engaged in HIV prevention in both Trinidad and Tobago

<table>
<thead>
<tr>
<th></th>
<th>Trinidad</th>
<th>Tobago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information on geographic coverage and # of staff is provided in Annex___.

Most of the HIV prevention interventions in Trinidad executed during 2004 – 2010 were by the NACC Secretariat and other government entities as illustrated in Graph 7.

In Tobago, there is a similar pattern, whereby the THACC Secretariat and other government entities have implemented most of the HIV prevention activities over the same period (See Graph 8).
From 2006-2008, the NACC made available funds to NGOs to implement a number of activities. This along with steady flows of funds for HIV prevention largely contributed to the number of activities implemented in 2006 as illustrated below in Graph 9 and 10.
CSOs involvement in HIV prevention has been acknowledged, particularly the role of organizations of people living with HIV (PLHIV) in providing peer counselling and VCT. Recognizing the importance of CSOs, the NACC commissioned a 2005 study on capacity needs of NGOs in Trinidad and Tobago. The report notes the existence of 28 CSOs who reported working in the area of HIV prevention (See Annex __). However, from the 2008 – 2010 reports, only 11 organizations in Trinidad and nine (9) in Tobago have been recorded as having executed HIV prevention interventions. These are:

<table>
<thead>
<tr>
<th>Trinidad</th>
<th>Tobago</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Family Planning Association of Trinidad and</td>
<td>Tobago Oasis Foundation</td>
</tr>
<tr>
<td>Tobago (FPATT)</td>
<td></td>
</tr>
<tr>
<td>2 Red Initiatives</td>
<td>Friends of Tobago AIDS Society</td>
</tr>
<tr>
<td></td>
<td>(FOTAS)</td>
</tr>
<tr>
<td>3 South AIDS Support (SAS)</td>
<td>Eastern Dynamic Achievers Cultural Club</td>
</tr>
<tr>
<td>4 AIDS Rescue Mission</td>
<td>Pan Groups</td>
</tr>
<tr>
<td>5 Loveuntil Foundation</td>
<td>Population Services International (PSI)</td>
</tr>
<tr>
<td>6 IDAKEDA</td>
<td>Mt. Grace Men’s Forum</td>
</tr>
<tr>
<td>7 Trinidad and Tobago Red Cross Society</td>
<td>Soroptimist International</td>
</tr>
<tr>
<td>8 Population Services International (PSI)</td>
<td>Fisher Folks and Trade</td>
</tr>
<tr>
<td>9 San Juan Boys Scouts</td>
<td>TIBS</td>
</tr>
<tr>
<td>10 Friends for Life (FFL)</td>
<td></td>
</tr>
<tr>
<td>11 Positive Youth Vibes</td>
<td></td>
</tr>
</tbody>
</table>

Amongst the CSOs, as demonstrated in the database at Annex ___ most have limited human resource capacity given the number of full-time paid staff. Despite these limitations, as previously indicated CSOs have been responsible for implementing most of the activities with most at risk populations, other than youth, and therefore have a potential to play a key role in HIV prevention and should be further supported.

### 4.3 Economic Implications

The NSP indicates that “the impact of HIV and AIDS lies in its ability to undermine economic growth through its effect on human, physical, and social capital. As there is the potential to decreases the labour supply, there is also potential for the Gross National Product (GNP) of Trinidad and Tobago to also decline.

HIV estimates, which have been supported by the UN, project that HIV prevalence will grow by .6% between 2009 and 2010 resulting in a 2% prevalence rate by 2015 (See Graph __)
With the rise in HIV prevalence and the estimated number of new HIV infections, the estimate need for Anti-retroviral Therapy is projected to rise from just over 3,500 people in 2009 to close to 5,500 people in 2015.

This means that more funds will be required for HIV treatment, care and support, putting a further financial burden on the national community.

In examining Graph__, while expenditure peaked on HIV prevention in 2006, other than 2007, with the decline in expenditure on prevention, greater resources have been required for treatment.
With less resources allocated to prevention, we note a decrease in the number of prevention interventions in both Trinidad (Chart __) and Tobago (Chart ___).
If greater emphasis is put on prevention, this should result in fewer costs in HIV treatment and care to the national economy. Furthermore, by focusing on early education amongst youth, this should help to prevent further transmission.
5.0 Analysis of Key Achievements, Gaps and Challenges, and Recommendations

In addition to reviewing the activities conducted from 2004 – 2010 an assessment of what was proposed in the NSP in comparison to what has been achieved reveals successes, gaps and challenges. It also provides an opportunity to address the constraints in the new strategic plan. Achievements, gaps and recommendations are examined under each strategic area.

5.1 Strategic Objective 1: Promote safe and healthy sexual behaviours among the general population

The strategies employed to meet the objective of promoting safe and healthy sexual behaviours among the general population were:

a) Heighten HIV Education and Awareness
b) Improve the availability and accessibility of condoms
c) Extend the responsibility for the prevention of HIV to all sectors of government and civil society

5.1.1 Heighten HIV Education and Awareness - Information, Education and Communication (IEC):

Successes:

During the period under consideration, the NACC Secretariat in collaboration with the IEC Sub-committee of the NACC and other partners played a major role in HIV education and awareness. Information materials, video productions, media advertisements, interviews, and messaging using key national figures, were used to create greater awareness of factors contributing to the epidemic.

The "What's Your Position Campaign " was launched during carnival 2005 with a focus of increasing awareness amongst the nation’s youth. The theme sought to actively engage young people to respond to the HIV epidemic by answering this question and in return asking it of others. In response to this question, the NACC promoted the following safer positions: A-Abstain; B-Be Faithful; C-Condoleize; D-Do get tested; and E-Educate yourself. In addition to the “What's Your Position Campaign”, in 2007, the NACC also launched three (3) media campaigns: “Know Your Status”, which was to encourage persons to get tested; “Stigma and Discrimination” to reduce the stigma associated with being HIV positive; and “Champions of Change”, which sought to use public figures as champions to promote responsible behaviour.

According to stakeholders, the “What's Your Position” campaign contributed largely to increasing HIV awareness particularly amongst youth and other members of the general population. Another major information tool, was the “Frequently Asked Questions (FAQs) about HIV”, which have been used by national civil society organizations, government ministries and the private sector in HIV outreach.
Gaps & Recommendations

Despite the success in raising awareness on HIV especially amongst young people, limited information has specifically targeted sex workers, MSM, drug users and prisoners who are also considered most at risk. There has also been limited and inconsistent monitoring of interventions.

In order to improve the spread of HIV information and education to these MARPs, further research is needed on the size, knowledge, attitudes and practices, HIV prevalence and behaviour risk factors in order to develop targeted evidence base information products for these communities.

5.1.2 Improve the availability and accessibility of condoms

Successes and Achievements

The availability and access to condoms has improved with support from UNFPA who since 2008 has distributed ___ of female and male condoms, which are both currently available for free in health centres throughout the country.

Prior to UNFPA’s support, the NACC contracted Population Services International (PSI) to conduct a condom social marketing campaign, which established over 800 non-traditional condom distribution outlets. As these outlets primarily target members of MARPs, this outcome is also reflected under strategic objective 2, which seeks to promote safe and healthy sexual behaviours amongst MARPs.

In addition to condom distribution and the establishment of non-traditional condom outlets, a draft national condom strategy and action plan was also developed.

Gaps and Recommendations

Culturally, there is still not enough support for condom use in the general population as noted that only “53.3% of young people aged 15-24 who had more than one sexual partner in the past 12 months report the use of a condom during their last intercourse. There is also still a denial in society that youth are sexually active resulting in limited opportunities for accessing condoms amongst this group. The condom brands that are made available for free in the public sector are generic in nature (not coloured, don’t offer special enhancements) and not popular amongst this population. There is therefore a need to market diverse types of condoms to improve the demand and use. This can be done using key national figures as spoke persons to promote its use. Furthermore, condoms also need to be made available in “Youth-friendly” spaces.

5.1.3 Extend the responsibility for the prevention of HIV to all sectors of government and civil society

Successes
The United Nations has promoted a multi-sector response to HIV given that the epidemic impacts all sectors of society. A multi-sector response has been implemented amongst government, CSOs and the private sector. In government, 10 HIV Coordinators were appointed in key government ministries to coordinate the response in their Ministry. Cabinet has also approved an additional 22 positions for HIV and AIDS Coordinators.

In addition to the HIV/AIDS Coordinators, CSOs and the private sector have also played key roles in HIV prevention. CSOs role in addressing HIV prevention amongst MARPs is acknowledged and as such CSOs were supported by the NACC to implement various HIV prevention initiatives. The NACC also provided support for capacity building of these CSOs. As culture and politics are largely influenced by FBOs, FBOs were identified as a strategic group to spread HIV information. As such, FBOs were trained to develop their HIV education and counselling skills and were funded to implement HIV awareness as well as care and support projects.

Through the ILO and US-DOL HIV and AIDS Workplace project (supported by the Ministry of Labour, Small and Micro Enterprise Development, trade unions and employer associations) 10 companies from the Banking and Finance Sector, Manufacturing and Retail, Energy, Tourism, Telecommunications, Sea Port and the informal economy have implemented HIV workplace initiatives. This project reached 15,000 workers. In addition to the Workplace project, the Ministry of Labour in collaboration with the ILO, trade unions and employer associations, developed a HIV and AIDS Workplace policy, which has since reached over 100 companies.

**Gaps and recommendations**

While government has indicated their commitment to support HIV/Coordinators in some 33 positions, the appointment of these coordinators with a budget to implement HIV activities has been slow. There are presently only __ HIV/AIDS Coordinators with vacant positions in the Ministry of Education and Ministry of Local Government for over a year. There is also a lack of dedicated technical and support staff for these coordinators. Increase support is therefore needed to HIV/AIDS Coordinators in their ministries so that they can better coordinate their ministry’s response with other initiatives, particularly that of the private sector, for greater impact.

Increase support is also needed to HIV Coordinators in their respective ministries both in terms of budget to implement activities as well as human resources. The work of the HIV Coordinators also needs to be coordinated with private sector initiatives for greater impact. Furthermore, capacity should be built in the NACC to provide sustained technical support to focal points and their team to design, implement, monitor and evaluate behaviour change interventions in the sectors.

The HIV and AIDS Workplace project has identified gaps between worker knowledge of modes of transmission and respect for the human and sexual rights of others. As such, the following is recommended:
- the worker has to become active in the management of his own workplace HIV programme.
- Greater focus is needed on sources of greatest income – tourism and energy
- Greater emphasis is needed on the informal economy as it involves transactional sex and escort services

FBOs have been engaged at the level of project execution and have thus provided support to HIV awareness, promotion of testing and care and support. They have not been formally or effectively engaged in policy discussions with most at risk populations. Given the influence FBOs have particularly on the political directorate, it is important that these discussions take place. Furthermore, not all FBOs are being reached and there are reports of misinformation being communicated by some to their respective congregations. Therefore, greater outreach is needed to all FBOs in Trinidad and Tobago so that they can be sensitized and made aware of their role in HIV advocacy.

As previously indicated, most of the CSOs have minimal staff and lack skills in proposal and report writing, financial management, fundraising and monitoring and evaluation. Despite these challenges, these CSOs are able to reach and implement effective HIV prevention strategies amongst MARPs that government is unable to reach. Further capacity building and utilization of CSOs are needed. Particular use of PLHIV organizations to conduct peer education and VCT is also recommended.

5.2 Strategic Objective 2: Promote safe and healthy sexual attitudes, behaviours and practices among vulnerable/high risk groups

5.2.1 Introduce behaviour change interventions amongst young women and youth in and out of school

Successes

The Health and Family Life Education (HFLE) curriculum has been revised to incorporate HIV and AIDS issues. An education policy on HIV education in schools has also been drafted.

Young women have been targeted through FPATT's creation of “Friendly youth spaces” and through their peer education programme. The Programme for Adolescent Mothers (PAM) in Tobago and the PMTCT programme also effect behaviour change interventions amongst young women. Recently, from 2008 to present, the Ministry of Sport and Youth Affairs has become active in promoting HIV information amongst young people in schools, including females, and is responsible for __% of interventions under this strategic objective for the period.

There have not been many interventions to address out of school youth.

Gaps and Recommendations

The mapping exercise revealed that there were few interventions (__%) specifically targeting young women. A gender approach is needed to HIV prevention to address the particular vulnerabilities of men and women in this context.
society. With support for the National Coalition on Women, Girls and AIDS, further support to interventions addressing this population should be forthcoming.

HFLE implementation has often been left to the discretion of the school principal. There is a major gap between the need for sex education and discomfort with its execution resulting with little or no education. As a result, sexuality education in both primary and secondary schools through the comprehensive Health and Family Life Education (HFLE) curriculum along with other relevant programmes needs to be implemented immediately. To do this, advocacy for a coordinated approach to the rights of the child is needed. Health promoting schools also need to work closely with those agencies, which represent children’s rights.

There are also few (%) interventions targeting out of school youth. Special focus is needed for out of school youth outreach. Condoms need to be accessible and made available to sexually active youths particularly females engaging in transactional relationships by positioning the condoms at the youth drop in centres and locations frequented by youths.

5.2.2 Introduce behaviour change interventions amongst MSM and CSWs

Successes

MSMNPA has issued a quarterly magazine with support from the NACC since 2005, which has served as an instrument of HIV information to the MSM community. Friends for Life has also implemented support groups and chat rooms to build self-esteem and promote behaviour change amongst the MSM and trans community. Red Initiatives has also conducted outreach amongst the MSM Latino community to promote behaviour change.

Gaps and Recommendations

Given the presence of homophobia in society and laws and policies that criminalize male to male sexual relations and indirectly the sale of sex, there is a lack of political will to support initiatives aimed at these populations. There is a denial of bisexuality amongst many men and the denial of sex work activities (particularly transactional sex) resulting in few coming forward to seek support and many not being reached by most interventions. The last HIV prevalence figures amongst the MSM population were 20%. While HIV prevalence figures for sex workers are not available, studies reveal that many young women, in particular, are engaged in transactional sex, multiple partnering and serial monogamy and do not relate or understand that their behaviour is consistent with that of sex workers and are therefore at greater risk. This shows the need for much further interventions than what has been previously supported.

Further research is needed to gather evidence in order to design behaviour change programmes for sex workers and MSM. The Priority for Local AIDS Control Efforts (PLACE) methodology is one of the approaches that should be pursued in order to identify sex worker sites and men who are having sex with women and men in order to guide site based risk reduction interventions.
Interventions should continue to focus on access to condoms with emphasis on site based HIV testing and counselling, as well as referral for the management of other STIs. Condom use and condom negotiation skills should be specifically promoted among sex workers and their clients.

5.2.3 Introduce behaviour change interventions amongst prison population (employees and staff)

Successes

Sensitizations sessions have been held amongst prison staff and an HIV and AIDS prison policy has been developed.

Gaps and Recommendations

While treatment is being provided for prisoners, condoms and periodic testing are not being provided. VCT is recommended for new admissions and at release.

5.2.6 Introduce behaviour change interventions amongst substance users

Successes

Partnerships have been established with National Alcohol and Drug Abuse Prevention Programme (NADAPP) has implemented HIV prevention as part of their behaviour change interventions amongst substance users.

Gaps and Recommendations

As noted in the activity listing, no work with substance users was documented between 2008 – 2010. Studies show direct links between substance use and HIV vulnerability. Further sensitization and outreach is therefore needed.

5.3 Strategic Objective 3: Reduce the rate of Mother-to-Child-Transmission

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Achievement</th>
<th>Gaps</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT at all public sector clinics</td>
<td>VCT is available at all public clinics providing antenatal care 97% of mothers 71.2% adhere to all components for the Anti-Retroviral prophylaxis. In 2008, 170 children received ARV Therapy with 7 subsequently testing positive.</td>
<td>Only 73% stay the full course of treatment; There are adherence issues and the adherence advocates have not been fully brought to the public’s attention Stigma and discrimination continues to</td>
<td>Address stigma and discrimination in the health sector, particularly the right of to pregnancy of HIV positive women, not all that participate in the programme complete the full course of treatment. There are adherence issues also due to</td>
</tr>
</tbody>
</table>
Drug therapy to HIV positive mothers and babies and during child birth | ARVs provided free to all who need. | VCT counselling should include adherence counselling

Testing of babies born to HIV positive mothers | Health personnel have been trained to guide HIV positive mothers on nutritional replacement therapy | See to engender positive prevention to reduce HIV re-infection among PLHIV and to reduce transmission of HIV to uninfected person through increased condom use as well as to reduce stigma and discrimination experienced by PLHIV in health care settings. This strategy should focus on the need for adherence to medication and encourage the reduction of risky sexual behaviour

Standardized care based on protocols

Expansion of programme to private clinics

### 5.4 Strategic Objective 4: Increase Population’s Knowledge of Serostatus

#### 5.4.1 Develop a comprehensive national VCT programme

#### 5.4.2 Promote VCT services

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Achievement</th>
<th>Gaps</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT at all public sector clinics</td>
<td>In 2004, only QPCC&amp;C were testing 3 times</td>
<td>Women are testing 3 times</td>
<td>Provide VCT via mobile sites in</td>
</tr>
<tr>
<td>Offering VCT. A comprehensive VCT programme has been implemented with the introduction of rapid tests at 28 sites.</td>
<td>More than men, which can partially be explained by the efforts of the PMTCT programme which has tested a little over than 50% of the women who have had a HIV test. There is also a gap in VCT for Tobago. The mobile testing clinic is particularly needed in Tobago.</td>
<td>More locations throughout the country. Ensure outreach and provide VCT to men and MARPs.</td>
<td>Expand testing sites with consideration given to convenient hours of operation to increase reach to persons outside of the regular working hours. All persons visiting a public STI clinic should routinely be tested for HIV and on an opt out” basis while private practitioners should be encouraged to offer HIV to their STI patients. HIV testing should be routinely offered to all persons being admitted to hospital using the provider initiated testing and counselling model.</td>
</tr>
</tbody>
</table>
### 5.5 Strategic Objective 5: Reduce the Probability of Post Exposure Infection

The overall strategy is to ensure the availability of adequate post exposure services through:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Achievement</th>
<th>Gaps</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A national policy for all public staff</td>
<td>National post exposure prophylaxis policy developed and implemented for health personnel with the availability of adequate post exposure services</td>
<td>Information is not explained to the general population about how PEP applies to the health sector and to private individuals.</td>
<td></td>
</tr>
<tr>
<td>Ensure constant availability of drugs for PEP management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integration of occupational exposure to HIV with PSBO Occupational Health and Safety Codes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5.6 Strategic Objective 6: Improve the management and control of Conventional Sexually Transmitted Infections (CSTI)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Achievement</th>
<th>Gaps</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase knowledge and awareness of the symptoms of CSTIs through a public awareness campaign</td>
<td>National policy on the decentralization and integration of sexually transmitted infection services developed and implemented to ensure effective syndromic management of conventional sexually transmitted infections</td>
<td>Decentralization remains on paper only; with one polyclinic operating in Tobago</td>
<td>Coordinate training of HIV treatment advocates in PEP making such training integral to HIV response planning</td>
</tr>
<tr>
<td>Ensure effective syndromic management of CSTIs through treatment and counselling delivered by the RHAs; capacity build in the public laboratories; training of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide “youth friendly” sexual and reproductive health services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.0 **Recommended Standards and Guidelines for HIV Prevention**

Based on discussions with key stakeholders and partners in Tobago and Trinidad, a basic set of standards and guidelines have been recommended for developing a comprehensive HIV prevention programme. These standards and guidelines are presented below.

**Health Service Provision**

- Confidentiality
- Non-discrimination
- Equal access to health services

**HIV and AIDS related Programming must:**

- Be evidence based
- Sensitive to the target population (be age, gender and culturally specific and incorporate different modalities of engagement e.g. computer and other multimedia based learning resources)
- Involve multi-sectoral collaboration
- Build in effective monitoring and evaluation mechanisms
- Incorporate a strategic planning approach
- Maintain good governance and accountability
- Incorporate adequate human and material resources.
- Utilize and build upon community resources and capacities
- Emphasize participation and partnerships
- Focus on reducing risk factors and on promoting protective factors.
- Be on-going.
7.0 Conclusion (Assumptions and Mitigating Factors needed to ensure the way forward)

The mapping of HIV prevention in Trinidad and Tobago has provided an overview of the scope and nature of HIV prevention interventions. It has also revealed key achievements and gaps in the national HIV response. Some of the key achievements include:

- Heightened awareness of the modes of transmission of HIV by the general population through information, education and communication products;
- The availability of the female condom and opening of new non-traditional outlets for condoms;
- Partnerships amongst FBOs, PLHIV organizations and other CSOs in educating the population on HIV;
- The sensitization of employers and employees on HIV and Cabinet approval of the National Workplace policy;
- The appointment of ten (10) HIV and AIDS Coordinators in government ministries;
- VCT amongst pregnant mothers;
- The introduction of rapid testing and decentralization of STI and VCT primarily in Trinidad

With these achievements, there are also a number of gaps that need to be addressed. The draft standards for HIV prevention will serve as guidelines in addressing these gaps. Two of the priority gaps that need to be addressed are the mapping of the size and scale of the MARPs; and systematic reporting amongst all partners involved in the HIV response.

While there has been a down turn in the number of prevention initiatives supported as well as funding for prevention, this trend should not be sustained. Greater resources need to be placed on HIV prevention in order to reduce the economic burden on the society and halt the spread of HIV by 2015.
Annexes

CSOs working in HIV Prevention in 2005

1) AIDS Rescue Mission
2) Artists against AIDS
3) ASPIRE
4) Community Action Resource (CARe)
5) Caribbean Conference of Churches
6) CARITAS AIDS Ministry
7) Families in Action
8) Family Planning Association of T&T
9) Friends for Life
10) Heart to Heart
11) Islamic Support Committee
12) Logos Research Institute and Counselling Institute
13) Mariama Teen Turf and Children’s Museum
14) Peer Educators in Sexual Health
15) Rape Crisis Society
16) Red Initiatives
17) South AIDS Support
18) Trinidad and Tobago Association of Midwives
19) Trinidad and Tobago Red Cross Society
20) Tobago AIDS Society
21) Tobago Oasis Foundation
22) Trinidad Youth Council\textsuperscript{26}
23) Tobago Youth Council\textsuperscript{27}
24) Toco Foundation
25) Voice of One Overcomers Club
26) Women Working for Social Progress
27) Young Men’s Christian Association
28) YTEPP

\textsuperscript{26} Trinidad Youth Council defines youth as persons up to 30 years of age.
\textsuperscript{27} Tobago Youth Council defines youth as persons up to 35 years of age.