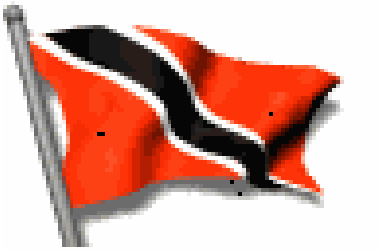
THE REPUBLIC OF TRINIDAD AND TOBAGO



FIVE-YEAR NATIONAL HIV/AIDS STRATEGIC PLAN

January, 2004 – December, 2008

Office of the Prime Minister
Republic of Trinidad and Tobago

December, 2003

EXECUTIVE SUMMARY

The HIV/AIDS pandemic is among the worst health crises that the Caribbean region and by extension, the world has had to face. Since its emergence in Trinidad and Tobago in 1983, the disease has already laid claim to many lives, threatens economic devastation and harbours the potential to reverse the nation's development gains. The complex nature of the disease calls for national commitment to a response that goes beyond the health sector, to incorporate all other sectors of society including key organizations and all stakeholders.

The citizens of Trinidad and Tobago, like the citizens of other nations, have arrived at a major crossroad where critical decisions have to be made with respect to HIV/AIDS and the future of the country. We have in our possession the facts concerning the tremendous human suffering and death that the disease inflicts upon all age groups. We know that if we continue with "business as usual" the outcome can only be a worsening of the situation.

This *Strategic Plan* is the ***instrument*** for initiating the required expanded response. It presents the intentions of the nation as a whole, while taking full cognizance of the fact that there are already many programmes and initiatives currently underway in many sectors throughout the country. The Plan therefore builds upon these initiatives so that a truly **comprehensive, expanded national response** can be achieved, where ***ongoing efforts are strengthened, new partners are mobilized and where all activities are well coordinated and prioritised***. The *Plan* therefore sets out the fundamental principles, the broad tactical approach, as well as the detailed strategic activities necessary to move the country from its current situation to the desired position.

OVERARCHING GOALS OF THE FIVE-YEAR NATIONAL STRATEGIC PLAN

The two (2) overarching goals of the National Strategic Plan are:

- ***To reduce the incidence of HIV infections in Trinidad and Tobago; and***
- ***To mitigate the negative impact of HIV/AIDS on persons infected and affected in Trinidad and Tobago.***

In order to achieve these goals the process will be guided by the main principles presented in the following sub-section.

GUIDING PRINCIPLES OF THE NSP

This *Five-year National HIV/AIDS Strategic Plan for Trinidad and Tobago* is founded upon the following four ***principles***:

- ***Inclusion:*** the strategic response will reflect the voices of all major sectors and interest groups, in particular **PLWHA**, **youth** and **women**;
- ***Sustainability:*** the method and supply of financing for the expanded response will be in keeping with the resources required to reduce and eliminate the disease;
- ***Accountability:*** there will be continuous monitoring, evaluation and reporting to civil society; and
- ***Respect for Human Rights:*** basic human rights for all HIV positive persons will be protected.

ORGANISATIONAL STRUCTURE

An organizational structure for providing leadership and coordination of the expanded response is proposed. The Trinidad and Tobago National AIDS Co-ordinating Committee (NACC) is being established under the aegis of the Office of the Prime Minister to perform a coordinating, monitoring and advisory role in respect to the national expanded response to HIV/AIDS. The NACC will be supported by a small Secretariat. The key areas of focus for the NACC is on ***policy formulation***, ***programme management***, ***coordination***, ***monitoring and evaluation*** and ***finance.*** NACC's key areas of responsibility will include:

- *Definition of national policies;*
- *Setting of national targets;*
- *Establishment of national standards; and*
- *Evaluation and monitoring of the programme at the national level.*

With respect to Tobago, the organisational structure for the expanded response gives recognition to the power conferred on the Tobago House of Assembly (THA). Accordingly, it is accepted that the THA must ensure that the implementation of the expanded response in Tobago is consistent with the national policies, sectoral plans and

standards set out by NACC. This requires a synergistic relationship between the THA and NACC; hence the THA will be represented on NACC.

PRIORITY AREAS AND COST OF THE NSP

Trinidad and Tobago's strategic response to HIV/AIDS will be executed under ***Five Priority Areas*** with corresponding cost as shown in the following table.

TABLE ES I
NSP IMPLEMENTATION COSTS PER YEAR
US$ millions

Priority Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Priority Area I: **Prevention**	4.00	4.32	4.25	4.36	4.13	**21.06**
Priority Area II: **Treatment, Care and Support**	9.62	11.25	10.86	12.34	14.60	**58.67**
Priority Area III: **Advocacy and Human Rights**	0.10	0.10	0.10	0.10	0.10	**0.51**
Priority Area IV: **Surveillance and Research**	0.77	1.67	0.59	0.51	0.59	**4.13**
Priority Area V: **Programme Management, Coordination and Evaluation**	1.12	1.21	1.21	1.21	1.21	**5.96**
TOTAL	**15.61**	**18.55**	**17.01**	**18.52**	**20.64**	**90.33**

The total cost of the NSP is an estimated US$90.33 million over five years. Placing the NSP within the economic context of the country, the first year's implementation cost of US$15.61 million represents 0.20% of the country's income, which was provisionally estimated at US$7,985.85 million in 2000. This also translates into a per capita cost of US$12.20. The cost of implementation in the first year is lower than that of subsequent years. This indicates some measure of gradual capacity building since one of the emphases is on the training of existing and/or newly recruited human resources. The issue of capacity building is essential to the discussion since the experience of other large programmes undertaken prior to this, shows that without the capacity to utilise available resources, they lie idle for several years and ultimately prove to be very expensive to the country.

GAINS AND BENEFITS OF THE NSP

The prevention component of the *Strategic Plan* is expected to avert **3,864** new infections over the period 2004 – 2008. This projection is made upon the assumption that the

prevention programme contained in the NSP will be effective in decreasing the incidence rate to 30% of its 2003 value at the end of the *Plan's* period.

In purely financial terms the prevention component of the NSP can be expected to yield an absolute gain of more than **US$271** million. This is without regard to the non-quantifiable benefits that the investment will undoubtedly yield. Table ES 2 illustrates:

TABLE ES 2
GAINS FROM INVESTING IN THE NSP

Infections Averted	Years of Life Saved	Productivity Losses (US$)	Averted Cost of Care (US$)	Total Financial Benefits (US$)
3,864	38,640	$240,509,270.40	$31,020,192.00	$271,529,462.40

CONCLUDING REMARKS

This S*trategic Plan* is the pathway to a comprehensive and decisive response to the impending disaster. This plan demands *"all hands on deck"* working together in a coordinated fashion with common goals and objectives. For success, the Strategic Plan also calls for a captain of the ship who is committed, strong and compassionate both in statement and behaviour, in leading all sectors and the national community in the fight against the virus.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AZT	Azidothymidine
CARe	Community Action Resource
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community Based Organization
CDC	Centers for Disease Control
CHRC	Caribbean Health Research Council
COHSOD	Council of Human and Social Development
CSTI	Conventional Sexually Transmitted Infection
CSW	Commercial Sex Worker
EAP	Employee Assistance Programme
ECA	Employers Consultative Association
EWMSC	Eric Williams Medical Sciences Complex
FBO	Faith Based Organization
FPA	Family Planning Association
GOTT	Government of Trinidad and Tobago
HAART	Highly Active Antiretroviral Therapy
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Use
IEC	Information, Education and Communication
ILO	International Labour Organization
IRO	Inter-Religious Organization
MoE	Ministry of Education
MoF	Ministry of Finance
MoGender	Ministry of Community Development and Gender Affairs

MoH	Ministry of Health
MoL	Ministry of Labour
MoLA	Ministry of the Office of the Attorney General and Legal Affairs
MoNS	Ministry of National Security
MoP&D	Ministry of Planning and Development
MoSD	Ministry of Social Development
MoSYA	Ministry of Sport and Youth Affairs
MRC	Medical Research Centre
MRF	Medical Research Foundation
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission
YMCA	Young Men's Christian Association
NAC	National AIDS Committee
NACC	National AIDS Coordinating Committee
NAP	National AIDS Programme
NADAPP	National Alcohol and Drug Abuse and Prevention Programme
NAPCU	National AIDS Programme Coordination Unit
NATCU	National AIDS Technical Coordination Unit
NBTU	National Blood Transfusion Unit
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NSU	National Surveillance Unit
NWRHA	North West Regional Health Authority
NYC	National Youth Council
OHS	Occupational Health and Safety
OI	Opportunistic Infection
PAHO	Pan-American Health Organization
PANCAP	Pan American Partnership
PEP	Post Exposure Prophylaxis

PLWHA	People Living With HIV/AIDS
PSBO	Private Sector Business Organization
POSGH	Port of Spain General Hospital
QPCC&C	Queens Park Counselling Centre and Clinic
RHA	Regional Health Authority
SARA	Situation and Response Analysis
SFGH	San Fernando General Hospital
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAS	Tobago AIDS Society
THA	Tobago House of Assembly
TPHL	Trinidad and Tobago Public Health Laboratory
UN	United Nations
UNAIDS	United Nations Joint HIV/AIDS Programme
UNDP	United Nations Development Programme
UWI	The University of the West Indies
VCT	Voluntary Counselling and Testing
YCBO	Youth Community Based Organization
YNGO	Youth Non-Governmental Organization

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SECTION I

INTRODUCTION AND BACKGROUND

THE EPIDEMIOLOGY OF HIV/AIDS IN TRINIDAD AND TOBAGO

Since HIV/AIDS was first diagnosed in Trinidad & Tobago in 1983, over 9,000 cases of HIV have been reported to the National Surveillance Unit (Table 1.1), with roughly 3,500 of these being reported cases of AIDS.

TABLE 1.1
CONFIRMED HIV CASES BY SEX 1983 TO 2000
TRINIDAD & TOBAGO

Year	Male	Female	Unknown	Total	Male/Female Ratio	Total number of persons diagnosed with HIV (cumulative)
1983	8	0	0	8	1:0	8
1984	27	0	0	27	1:0	35
1985	94	17	2	113	1: 0.18	148
1986	104	31	1	136	1:0.30	284
1987	136	40	4	180	1:0.29	464
1988	172	57	12	241	1:0.33	705
1989	142	79	13	234	1:0.56	939
1990	181	92	5	278	1:0.51	1217
1991	269	146	7	422	1:0.54	1639
1992	369	193	18	607	1:0.52	2246
1993	439	177	8	624	1:0.40	2870
1994	381	219	23	623	1:0.57	3493
1995	424	229	31	684	1:0.54	4177
1996	508	311	51	870	1:0.61	5047
1997	573	392	36	1001	1:0.68	6048
1998	552	385	28	965	1:0.70	7013
1999	630	476	35	1141	1:0.76	8154
2000	542	334	40	916	1:0.62	9070

Note: Data presented as at 04/20/2001
Source: National Surveillance Unit Trinidad & Tobago

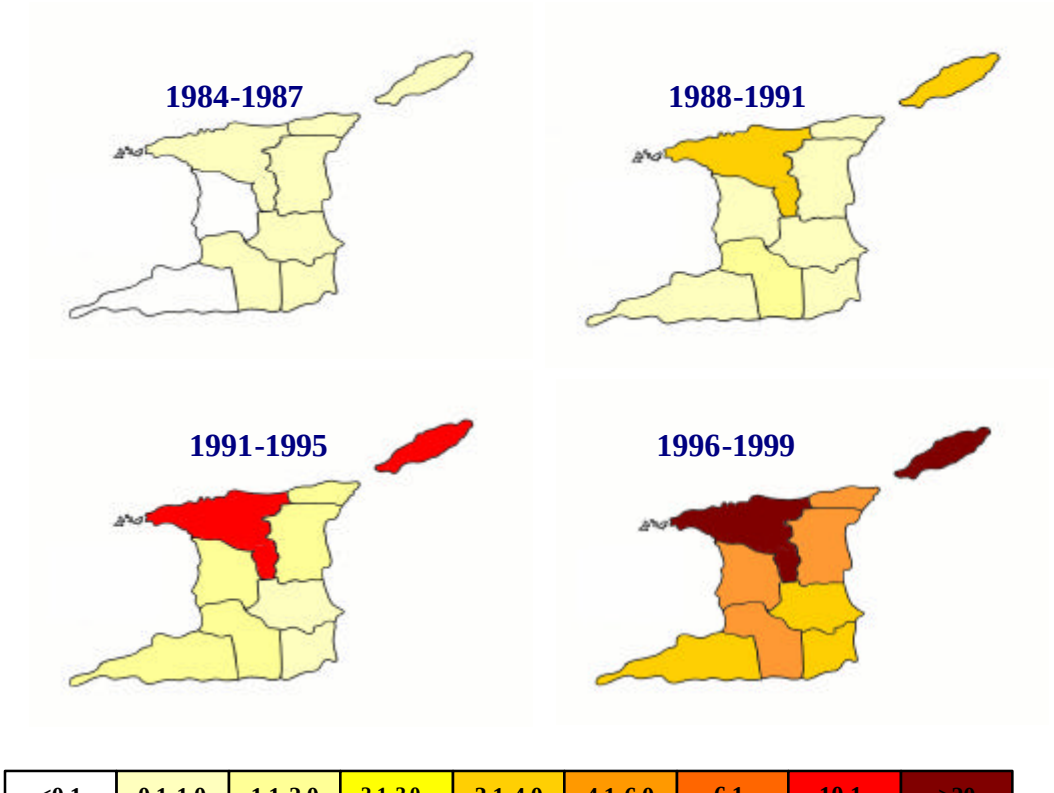
Reports of HIV cases reveal that the demographic profile of the disease is such that there is no geographical region in Trinidad and Tobago unaffected by HIV/AIDS.

TABLE 1.2
REPORTED HIV CASES BY COUNTY
1984 – 2001 (as at March 28th 2001)

Year	St. George (W)	St. George (C)	St. George (E)	Caroni	St. Andrew/ St. David	Nariva/ Mayaro	Victoria	St. Patrick	Tobago	Missing
1984	0	0	0	0	0	0	0	0	0	4
1986	4	4	1	0	1	0	2	1	5	2
1988	13	2	3	0	0	1	3	3	0	40
1990	25	10	6	1	1	1		8	3	25
1992	72	28	12	5	2	0	6	0	7	68
1994	105	49	23	10	2	0	7	2	15	80
1996	84	37	19	9	4	1	9	5	21	145
1998	159	105	89	34	6	4	43	12	44	112
1999	199	101	101	32	11	5	36	11	35	78
2000	105	82	82	12	13	4	46	8	30	90
2001	45	9	9	2	1	1	6	2	4	39

Source: National Surveillance Unit

FIGURE 1.1
HIV POSITIVE CASES (per 10,000 population)
1984 – 1999



Source:

1990 Population and Housing Census, Trinidad Public Health Lab Data (unpublished)

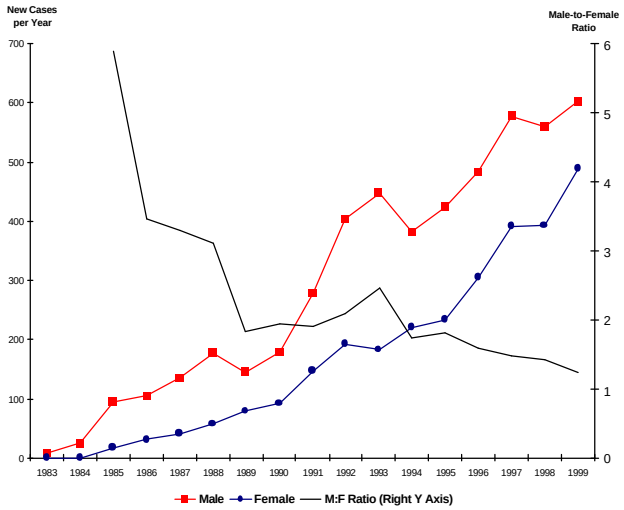
The geographical spread of the epidemic since its inception is depicted in Figure 1.1. All regions in both Trinidad and Tobago have been **progressively** affected. This is also clear from the number of reported cases received by county per year as is illustrated in Table 1.2. The reader is referred to the Situational and Response Analysis (SARA, 2001), for a fuller discussion of these data.

Beyond the information about reported cases, it is estimated that the **actual** number of persons living with HIV is much higher. CAREC (2002) for example estimated the prevalence rate for 2001 at 1.2% of the population or a total of 16,217 HIV positive persons. This estimate is in keeping with unpublished data from NSU/MoH (2000) that estimated an HIV prevalence rate among pregnant women in 1999 at 2.5% in Trinidad and 2.7% in Tobago. If this estimated prevalence rate of 2.5%, is used as a proxy for the adult prevalence rate, it is estimated that more than 17,000 persons are actually living with HIV/AIDS in this country[1].

The percentage of women infected has increased significantly moving from 0% in 1983 to 37% in 2000, with some 82% of reported HIV infected women falling within the age group 15 to 45 years (Figures 1.2 and 1.3 refer). The high female to male ratio of infections among the younger age group (Figure 1.2), seems to suggest that younger girls may be having relations with older men. This however, needs closer examination as the phenomenon could perhaps be indicative of younger males not presenting themselves at health facilities until much later in the epidemic.

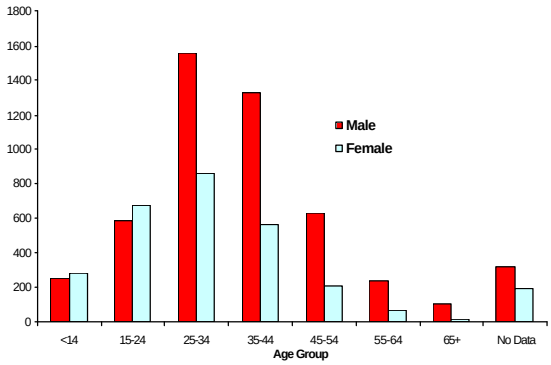
[1] *Adults 15 to 49 years account for 56% of the total population of Trinidad and Tobago. Applying a factor of 0.025 to this population for 2001 will yield: (0.56 x 1,268,000) x 0.025.=17,752.*

FIGURE 1.2
NEW REPORTED HIV/AIDS CASES
BY YEAR AND GENDER
TRINIDAD AND TOBAGO
1983 to 1999



Source: Ministry of Health, National Surveillance Unit

FIGURE 1.3
AGE AND SEX DISTRIBUTION OF
REPORTED HIV/AIDS CASES
TRINIDAD AND TOBAGO
1989 to 1999



Higher HIV/AIDS prevalence rates are also recorded from among the high-risk groups such as Men who have Sex with Men (MSMs), Commercial Sex Workers (CSWs), drug users and Sexually Transmitted Infection (STI) clinic attendees. The most recent quantitative study on HIV prevalence among the MSM group was done in 1983 (Bartholomew, 1987) in which HIV prevalence was estimated at 40%. Prevalence rates from among STI attendees ranged from as high as 13.6% in Port of Spain to 5.8% in San Fernando (Table 1.3). HIV prevalence rates for these key high-risk groups are summarized in the table below.

TABLE 1.3
SELECTED HIV SEROPOSITIVITY ESTIMATES

Year	Population	Sample size	Number positive	Percentage positive (%)
1983-84	Homosexual Men [1]	100	40	40.0
1987-88	STD Clinic Attendees, Port of Spain [2]	2019	61	3.0
1990-91	STD Clinic Attendees, Port of Spain [2]	1606	219	13.6
1994	STD Clinic Attendees, San Fernando	251	8	3.2
1995	STD Clinic Attendees, San Fernando	302	18	6.0
1996	STD Clinic Attendees, San Fernando	479	28	5.8
1990-91	Antenatal clinic attendees	1055	3	0.3
1991-92	Antenatal clinic attendees	1914	11	0.6
1995-96	Antenatal clinic attendees	2041	20	1.0
1985-95	Inpatient drug users, Caura Hospital	1200	35	2.9
1993	Male prisoners	182	9	4.9
1996	TB Patients	276	58	21.0
1996	Blood Donors [3]	15525	101	0.6

Notes
[1] .Bartholomew (1987)
[2]. Cleghorn et al (1995)
[3] Sample excluded persons with risk factors (self administered questionnaire).
Except where footnoted, data were provided during the course of the evaluation exercise
Source: National Surveillance Unit/ Ministry of Health / CAREC Evaluation of the HIV/AIDS/STD Surveillance, March 24-27, 1997

REVIEW OF THE SITUATION AND RESPONSE ANALYSIS

Situation Analysis

A Situational and Response Analysis (SARA) was conducted for the island of Tobago in 1999 and for Trinidad in 2001. These reports both highlight the fact that the HIV/AIDS epidemic is firmly rooted among the youth in the country, while continuing to impact significantly on the older age cohorts (25-39 years). They also confirm the epidemiological data which demonstrates that women are particularly affected. The respective SARAs identify specific sociocultural and behavioural factors that act as driving forces behind the spread of the epidemic in both islands. These factors are highlighted in the following boxes.

BOX 1
Factors Influencing the HIV/AIDS Situation in Tobago

- Unemployment among the youth;
- Increasing substance abuse problems;
- Commercial sex practices;
- High stigma and discrimination of PLWHAs;
- Powerlessness among women to change cultural norms around multiple partners and child rearing;
- Increasing expatriate population; and
- Absence of an organised, coordinated intervention programme based on Tobago's situation and norms.

Source: The University of the West Indies, Health Economics Unit, Report of Consultations for the National Strategic Plan on HIV/AIDS for Trinidad and Tobago: Rapporteur Report, 2002

BOX 2
Factors Influencing the HIV/AIDS Situation in Trinidad

- Multiple partnering;
- High use and abuse of alcohol, drugs and other illegal substances;
- Increased incidence of violence among males and between men and women;
- Inconsistent use of condoms among the sexually active population;
- Gender inequalities among poorer groups;
- Regional and extra regional migration particularly around the festive seasons;
- An environment in where men having sex with men remains illegal; Discrimination and stigmatisation against PLWHAs; and
- Commercial sex practices.

Source: Health Economics Unit, The University of the West Indies (2001). Situation and Response Analysis of HIV/AIDS in Trinidad.

RESPONSE ANALYSIS

The National Surveillance System

Since 1983, the public health sector of Trinidad and Tobago was given the responsibility of monitoring and then responding to the HIV/AIDS epidemic. The National Surveillance Unit (NSU) of the Public Health Laboratory provided limited but important data to policy makers within the Ministry of Health (MoH) on the morbidity and mortality trends as the disease progressed. Although an evaluation of the surveillance system was conducted which led to computerisation of the registry, limitations of the datasets persist. Importantly, analysis of data needs to be improved as well as the reporting by all provider units to the national surveillance body.

Though not all data requirements are present *"…there is sufficiency of information available to allow for a sustained national strategy to reduce HIV/AIDS in Trinidad and Tobago. A part of that strategy will also involve upgrading and expanding the surveillance system. A significant aspect of the data problems at the NSU stems from problems at the collection phase"* (SARA, 2001). Practitioners at both public and private levels therefore need to be sensitised to the benefits to be derived from a fuller dataset.

HIV/AIDS Policy Development

"In 1987, the Cabinet of Trinidad and Tobago created the National AIDS Committee chaired by the Chief Medical Officer and composed mainly of health experts. This committee had the responsibility for policy formulation, programme monitoring and evaluation. Cabinet also created the structure of the National AIDS Programme (NAP) with a fully assigned government officer as the Co-ordinator" (SARA, 2001 p. 39). Starting in 1991, the NAC developed a number of national policies covering several issues. However, a number of these priority policies are yet to be implemented (SARA, 2001 p. viii).

Ministry of Health/RHA Response

It is interesting to note that the responsibility for responding to the HIV/AIDS epidemic during the early 1980s and 1990s was that of the MoH. At that time the MoH was a centralised organisation in charge of financing as well as delivery of services. Since 1994 however, the delivery of health care services has been decentralized with this responsibility handed over to four Regional Health Authorities (RHAs). The health services' response to HIV/AIDS seems to have been fragmented as a result of the decentralisation process. Not much integration at the regional level has taken place with vertical services such as the Queens Park Counselling Centre and Clinic (QPCC&C), public health laboratories and NSU - which remained within the central MoH. Ironically, these units have the major task of HIV/AIDS surveillance, diagnostic, screening, counselling and care requirements on behalf of the entire public health system.

Business Community and Trade Union Response

"*It is noteworthy that after almost two decades into the epidemic, two of the most critical stakeholder groups, businesses and unions, continue to be largely absent from efforts at the national level. While the business sector's response has typically taken the form of an individual firm responding, no real position has, to date, been taken by the umbrella bodies representing the business sector*" (SARA, 2001 p. ix). There is also a critical role for the private health sector as a complementary partner to the public health sector in the delivery of services. While this sector has been quite active in the areas of laboratory testing and the treating of opportunistic infections, there is little or no co-ordinated effort from private health professionals and institutions that may be described as a global private sector position.

Attempts to woo the business sector have, over the years, resulted in their provision of some financial assistance and related support. *"Such efforts at "partnering by pocket", have historically not led to the sustainable involvement by this stakeholder group"* (SARA, 2001). The required emphasis however, should be on "partnering by participation." This will allow the sector to bring their skills to bear in such areas as information dissemination and communication and marketing etc.

Two structures under which HIV/AIDS can be addressed in the context of the work environment are Occupational Health and Safety (OHS) and Employee Assistance Programmes (EAP). With respect to the first structure, the degree of success through which a viable response can be formulated will depend upon a delicate balance being struck between the allocation of resources between the safety component and the health component of OHS programmes. In the latter case, some evaluation will be required to determine the appropriateness for application across all sectors. Individual company responses can also be initiated via the companies' human resource structures, centring on counselling and advocacy via training seminars and other mechanisms.

The trade unions have also been lethargic in responding, perhaps being hindered by lack of internal capacity. Further, there has not been a dedicated programme response by the various agencies/ministries comprising the social sectors. In cases where these programmes do exist, they are plagued by shortages of human and financial resources, and the absence of a comprehensive strategy.

Regional and International Agencies

The Pan American Health Organization (PAHO/WHO) and the Caribbean Epidemiology Centre (CAREC/PAHO) have led the regional and international agencies' response from the very early stages of the epidemic, with the other organisations under the United Nations banner joining the fight within the last 5 to 8 years. With the apparent slow response by the national programmes and national community in general, the international agencies have assumed key roles as initiators behind a number of the interventions. For example, the development of the UNAIDS Theme Group's National AIDS Programme Co-ordinating Unit (NAPCU) bears a striking resemblance to the proposal for a National AIDS Technical Co-ordination Unit (NATCU) which came out of the findings of the technical working group to inform the Inter-Ministerial Committee on HIV/AIDS in 1998.

According to the SARA, the response of the non-health sector can be described as sporadic at best and inadequate on the whole. A critical ingredient needed for driving

such a response is essentially a structure which identifies the role and task of each of these stakeholders as part of a larger macro-plan under the national programme. As a prerequisite, the existing programme responses from the non-health sector, which indirectly address the epidemic, will need to be targeted and upgraded.

Comparison of Trinidad and Tobago's Response with International Experience

International experience has shown that the key ingredients for a successful strategy involve:

- Evidence-based planning led by intensified surveillance and research;
- Enhanced political commitment;
- The development of strong leadership;
- Strengthening public health infrastructure;
- Heightened and expanded community-level responses;
- Building and sustaining partnerships for multisectoral action;
- Reducing vulnerability of the poor and marginalised;
- Creating enabling environments for safe behaviour; and
- Ensuring access to HIV/AIDS care and support.

It would be fair to say that Trinidad and Tobago's response is yet to attain a level that adequately meets the criteria listed above. In fact the (SARA, 2001) identified the following deficiencies of the response to date, namely:

- There has been a lack of leadership to drive the HIV/AIDS response;
- There is a lack of integration of purpose, and action;
- There is a lack of resource commitment;
- The public sector's health services delivery for HIV/AIDS has been fragmented as a result of the decentralization process;
- Regional Health Authorities (RHAs) have not responded except for the provision of basic care for opportunistic infections;
- The role and functioning of the National AIDS Committee (NAC) and the National AIDS Programme (NAP) needs to be revisited;
- The national surveillance system needs to be expanded and upgraded;

- There has been little coordinated effort from private sector health professionals and institutions;
- Trade unions and employers have been absent in response efforts on behalf of their membership/employees;
- There has been no dedicated programme response by agencies/ ministries comprising the social sectors;
- Together the non-health sector response has been sporadic and inadequate;
- Special legislation to protect persons living with HIV/AIDS is absent.

Recommendations of the SARA and KPMG Reports

In light of quality of the response to date, a number of critical recommendations for effectively addressing the current situation have been put forward in the *Situational and Response Analysis (SARA*), and in another recently completed study- *Audit of the National Programmes and Laboratories* (KPMG, 2001). The main recommendations put forth in these two documents are detailed in Boxes 3 and 4 below.

BOX 3
Broad Recommendations of the SARA

- Enhancement of the HIV/AIDS surveillance system to ensure epidemiology monitoring, identification of risk groups, effective programme planning and evaluation;
- Incorporation of Tobago's surveillance into the national picture.
- Development of an agreed policy on reporting between all private labs, TPHL, NAC, CAREC, MRC;
- Initiate training for health care professionals in the area of HIV testing, diagnosis, treatment, counselling, and psychological support to patients and families as well as in the area of STD management;
- Decentralise access to Voluntary Counselling and Testing and psychological support at each RHA;
- Implement targeted behavioural change intervention for specific groups

Source: Health Economics Unit, The University of the West Indies (2001). Situation and Response Analysis of HIV/AIDS in Trinidad.

BOX 4

Broad Recommendations from the Audit of National Programmes and Laboratories

- Establish a National HIV/AIDS Coordination Office with responsibility for Treatment, Care and Support, Education and Prevention, Surveillance, Social Justice, Liaising with International Agencies and NGOs;
- Enact Policy and Legislation that currently exist in drafts and develop a framework to protect the rights of individuals and families from discriminatory practices;
- Rebuild the public health and hospital laboratory systems.
- Increase the number of trained physicians willing to work with PLWHA;
- Production of epidemiological studies to provide reliable estimates of the incidence and prevalence of HIV infection and AIDS in Trinidad & Tobago;
- HIV counselling and testing must be decentralized and made available to all communities in Trinidad & Tobago;
- The MTCT programme should be expanded into a national programme;
- A sustainable health promotion and education strategy dealing with HIV/AIDS is required, focusing on both the general public as well as those groups most at risk; and
- Provision of adequate funding to stem the increasing incidence of HIV and provide care and support for those infected.

Source: KPMG Consulting (2001). Audit of National Programmes and Laboratories, Trinidad and Tobago: National HIV/AIDS/STI Programme, Draft Final Report.

Implications for Development

HIV/AIDS is an infectious chronic disease with heavy social, economic and developmental costs. The mortality structure of the disease is such that it strikes the most productive members of society -over 50% of new infections occur in youths aged 15-24 years and about 70% of all HIV/AIDS cases fall between the age group 15-44[2]. The impact of the disease lies in its ability to undermine economic growth through its effect on human, physical, and social capital. At the macroeconomic level, there is the immediate impact which will be felt in terms of productivity losses due to decreases in labour supply. According to Nicholls et al. (1997), by the year 2005 the Gross National Product (GNP) of Trinidad and Tobago will be at least 4.2% lower than it would have been in the absence of HIV/AIDS, with a consequential fall in employment in key sectors

such as agriculture and manufacturing by 20% if the disease is left unchecked. This study also estimates that in the absence of a national response, national savings stand to fall by as much as 10.3%. HIV/AIDS therefore harbours the real potential to cripple the level of national investment, which is a key variable in the determination of long term economic growth.

At the level of the household, one of the more direct costs of HIV/AIDS is the cost of medical treatment. The financial impact of AIDS on households has been shown to be almost 30% higher than deaths from other diseases[3]. These costs may also reduce the household's ability to pay for necessities such as food, housing and utilities and to invest in children's education, thus reducing the household's general standard of living and driving poorer households deeper into poverty.

Precisely because of these reasons an appropriate response to HIV/AIDS that is both *comprehensive* and *sustainable* is required. Since what we face is no longer a threat that is restricted to the nation's health, but a threat that extends to the nation's developmental goals, this response must draw on stakeholders in both the private and public sectors so that an all embracing strategy to address this crisis may be effected. Some commitment to undertaking such a response has already been displayed by the government of Trinidad and Tobago as is evidenced by its ratification of various regional and international agreements on HIV/AIDS among these being the *Pan-Caribbean Partnership against HIV/AIDS* and the *UNGASS Declaration of Commitment on HIV/AIDS*.

The Pan Caribbean Partnership was officially launched at the 12th CARICOM Intersessional Heads of Government meeting in Bridgetown, Barbados on February 14th 2001. Its membership consists of all countries of the region and is coordinated by CARICOM with the objective of increasing the response to HIV/AIDS in the Caribbean. Regional and global targets set by the Partnership include increased access to information, education and services as well as a reduction of HIV prevalence in young people between ages 15-24. A regional strategic framework that outlines *Priority Areas* for guiding the development of national strategic plans was also developed by the CARICOM.

[2] Rafeeq, Hamza (2001). Statement to the 26th Special Session of the UN General Assembly. June 2001.
[3] South African Health Review 2000, Facts, Figures and the Future.

Trinidad and Tobago is also part of the Declaration of Commitment on HIV/AIDS issued during the United Nations General Assembly Special Session, June 25th to 27th, 2001. This Declaration, which describes the extent of the epidemic and strategies to reverse its effect, is essentially a statement of agreement by Governments on what should be done to respond to the HIV/AIDS situation- independently, and with international and regional support. Additionally, targets and strategies were identified under the headings of *Prevention, Care, Support & Treatment, and HIV/AIDS & Human Rights*.

THE APPROACH TO THE DEVELOPMENT OF THE STRATEGIC PLAN

The formulation of this document was based upon a ***participatory process*** at all levels. Following the SARA, various government and non-government agencies continued to engage in dialogue. In particular, the MoH held consultations with youth organizations, PLWHA, the business community, and trade unions over the period September to December, 2001. A similar consultation was held with the local media in April, 2002[4]. In addition to these discussions, three (3) major consultations were staged immediately preceding the preparation of the Plan. These consultations were deemed necessary to ensure comprehensive representation from all sectors of society and the inclusion of the views of as many stakeholders as possible in the formulation of ***Priority Areas*** and ***Strategic Objectives***.

The first consultation was held in Tobago over June 26th and 27th, 2002. The objective of this session was to ensure that the issues and concerns pertinent to Tobago were well incorporated into the national process. This was particularly necessary in light of the fact that Tobago had already begun the process of articulating a Strategic Framework for itself. The second consultation was held with the business community on June 28th, 2002. In addition to sensitizing this sector to HIV/AIDS issues, this sitting also focused on the identification of an appropriate private sector response. Finally, a two-day National Consultation was held between July 2nd and July 3rd, 2002. All major sectors and stakeholders were brought together at this session during which, attention was paid to the identification of strategic priorities for national action as well as to the enumeration of activities necessary to support these strategic areas.

[4] Media Workshop facilitated by The University of the West Indies, Health Economics Unit.

In addition to these discussions, it was also necessary to meet directly with some key stakeholders to further refine and bring to life concepts and visions that had emerged during the wider level consultations. A list of the additional interviews that were conducted is presented in Appendix IV, while the output of the three (3) major consultations were compiled in a single volume entitled: *Report of Consultations for the National Strategic Plan on HIV/AIDS for Trinidad and Tobago: Rapporteur Report*.

SECTION II

FIVE-YEAR NATIONAL HIV/AIDS STRATEGIC PLAN FOR TRINIDAD AND TOBAGO

PURPOSE OF THE STRATEGIC PLAN

The NSP for Trinidad and Tobago will yield considerable benefits to the people of the Republic as the *Strategic Plan*:

- **Provides the structure** for guiding agents desirous of taking action;
- **Supplies guidelines** for organizing and scheduling activities;
- **Serves as a benchmark** for measuring the country's achievements in its fight against the pandemic; and
- **Is the main vehicle** for assisting in the procurement of financing for identified programmes and projects.

This strategic plan is therefore the guide to Trinidad and Tobago's expanded national response to HIV/AIDS. It sets out the fundamental principles, the broad tactical approach as well as the detailed strategies necessary to move the country from the current situation to its desired position.

OVERARCHING GOALS OF THE FIVE-YEAR NATIONAL STRATEGIC PLAN

Trinidad and Tobago's NSP has two (2) *all-embracing goals*:

- ***To reduce the incidence of HIV infections in Trinidad and Tobago; and***
- ***To mitigate the negative impact of HIV/AIDS on persons infected and affected in Trinidad and Tobago.***

This strategic plan is multi-sectoral in nature as it is well recognized that an effective response to HIV/AIDS does not rest with individual ministries, organizations, or subsets of stakeholders. In addition, full cognizance is taken of the fact that there are currently many programmes and initiatives already underway in many sectors throughout the

country. For example in 1999, the government of Trinidad and Tobago developed a plan of action for mounting an intensified response to HIV/AIDS in the public sector (Refer to "*Proceedings Report on the Technical Working Group Sensitization HIV/AIDS Workshop: July 20-30, September 01, 1999").* The intention of this *Strategic Plan* is ***not*** to replace these ongoing initiatives, but rather to build upon them so as to achieve a truly ***comprehensive, national expanded response*** where new partners are mobilized and where activities are well co-ordinated and prioritised. In the case of the public sector, therefore, the strategies and obligations identified in the *Proceedings Report on the Technical Working Group Sensitization HIV/AIDS Workshop: July 20-30, September 01, 1999* will need to be updated in the first year of the implementation of the NSP.

GUIDING PRINCIPLES OF THE NSP

This *Five-year National HIV/AIDS Strategic Plan for Trinidad and Tobago* is founded upon the following ***principles***:

- ***Inclusion:*** The strategic response will reflect the voices of all major sectors and interest groups, in particular **PLWHA**, **youth** and **women**;
- ***Sustainability:*** The method and supply of financing for the expanded response will be in keeping with the resources required to reduce and eliminate the disease;
- ***Accountability:*** There will be continuous monitoring, evaluation and reporting to civil society.
- ***Respect for Human Rights:*** Basic human rights for all HIV positive persons will be protected.

SWOT ANALYSIS

The following are identified as factors that may facilitate or impede the success of the *Strategic Plan.*

STRENGTHS

- Strong Economy;
- Some organisations have already initiated activities;
- There are well-defined and active PLWHA support groups;
- Political commitment to the NSP process has been displayed;
- A network of regional public health facilities and private health facilities;
- There is an internationally recognized HIV/AIDS research and treatment institution resident locally;
- Presence and support of international agencies.

WEAKNESSES

- Weak surveillance data;
- Weak diagnostic capability;
- Limited capacity and infrastructure especially human resources;
- Lack of coordination among stakeholders;
- Few health care practitioners with specialities in HIV/AIDS;
- A negative perception of the quality and capability of the public and to some extent the private health system.

OPPORTUNITIES

- To coordinate all response efforts in Trinidad and Tobago;
- To partner with the private sector and NGOs and other members of civil society;
- Maximise human and other resources through a coordinated response;
- To effect cost savings to the economy;
- To provide a strong contribution to the regional effort at reducing the developmental impact of HIV/AIDS.

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THREATS

- Tenuous political climate;
- Interpretation of HIV/AIDS as an ethnic or geographical problem which may continue the fragmentation of the response;
- Inadequate earmarked financial resources;
- Possible lack of cooperation by some stakeholders;
- Possible negative reaction by the religious community;
- PLWHA's distrust and dissatisfaction with the current diagnostic and treatment services available to them due to confidentiality issues.

The challenge of implementation is therefore to build upon the strengths, overcome the weaknesses and to convert threats into opportunities.

PRIORITY AREAS

Trinidad and Tobago's strategic response to HIV/AIDS will be executed under the following ***Five Priority Areas***:

Priority Area I:	*Prevention*
Priority Area II:	*Treatment, Care and Support*
Priority Area III:	*Advocacy and Human Rights*
Priority Area IV:	*Surveillance and Research*
Priority Area V:	*Programme Management, Coordination and Evaluation*

The Strategic Objectives and Activities for each Priority Area are discussed below and presented in matrix format on pages forty-two (42) through sixty-eight (68) of this document.

PRIORITY AREA I: PREVENTION

Interventions within this Priority Area are geared towards suppression of the spread of the epidemic. The overall goal of the Prevention Priority is therefore ***to reduce the susceptibility of the population of Trinidad and Tobago to HIV****. To achieve this goal,* ***six (6) Strategic Objectives*** *for the nation are identified with specific strategies and strategic activities for achieving each objective as follows:*

OBJECTIVE 1: TO PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOURS AMONG THE GENERAL POPULATION

Target/Expected Outcome: Increasing percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (90% by 2005 and 95% by 2007)

Strategy A: Heighten education and awareness

To promote healthy sexual behaviours, emphasis will be placed on intensifying HIV/AIDS education and awareness programmes. These programmes will use multiple communication channels to target messages to different audiences. In particular, interventions will focus on encouraging delayed sexual activity for those who have not yet started and on encouraging the sexually active population to adopt safe sexual practices. Both the electronic and print media as well as internet technology will be utilised in these effort, with messages incorporating the use of music, drama and national personalities to make them culturally relevant. The communications programme will also focus on fostering sexual behaviour change during major national and cultural festivals.

The responsibility for arrangements pertaining to the production and dissemination of education/awareness material will reside with the *National AIDS Coordinating Committee* (NACC)[5], and as such, this organization is identified as the lead agency for implementing this strategy. For effectiveness, however, it is also critical to incorporate the experience and expertise of PLWHA, educators, health professionals, NGOs as well as faith-based organizations (FBOs), in the design and delivery of these messages. In the case of FBOs, one can draw on the critical role played by these organizations in Bahamas. The church in Bahamas has high visibility in HIV/AIDS prevention and has played a pivotal role in the success of the programme through the Samaritan programme. In the Trinidad & Tobago context, the church can play an effective role in identifying certain services to assist PLWHAs, families and persons impacted by HIV/AIDS. They can also leverage the influence they have on their congregants through the design and implementation of programmes promoting risk reduction behaviours.

In addition, the importance of the private sector, which possesses economies of scale in media advertising, is also recognized and this sector is therefore also identified as a strategic partner. [Refer to **1: A1- A3** of matrix for further details]

Strategy B: Improve the availability and accessible of condoms

The effectiveness of messages disseminated during the communications campaign will be supported by means of a Condom Social Marketing programme. Attention is drawn to the recommendation in the *Audit of National Programmes and Laboratories, Trinidad and Tobago* (hereinafter referred to as the *Audit of National Programmes and Laboratories*)[6]:

> *"Currently, male and female condoms are the only barrier methods that prevent the transmission of sexually transmitted infections, including HIV, during sexual intercourse. Promoting and supporting the use of condoms must be one of the core, basic preventive strategies for HIV/AIDS programmes. In Trinidad and Tobago, there is a need to destigmatise and normalise condom usage by promoting condoms as part of a positive and healthy lifestyle." KPMG* Consulting *(2001 p. 75).*

This Condom Social Marketing programme will provide education on condom use and will serve to desensitise the issue of condom use by increasing accessibility and availability. Since the existing commercial distribution network, along with promotional techniques will be used as the medium for this programme, the role of the corporate sector is again identified as critical to the success of this intervention. In addition, the strategic approach will also include exploration of the feasibility of introducing condom vending machines at designated sites. [Refer to **1: B1- B4** of matrix.]

Strategy C: Extend the responsibility for the prevention of HIV to all sectors of government and civil society

Emphasis will also be placed on extending the responsibility for prevention activities beyond the health sector, which has traditionally been the key player for the entire nation. While this will necessitate collaboration with the media and other PSBOs to intensify HIV/AIDS awareness, the responsibility of other sectors such as the religious community for the delivery of education and counselling services to their respective audiences is recognized. The strategic plan therefore includes avenues for the provision of training to FBOs and Local Government Councillors to develop their HIV/AIDS education and counselling skills.

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[5] Refer to Priority Area V and Section III for further discussion.
[6] KPMG Consulting (2001). *Audit of National Programmes and Laboratories, Trinidad and Tobago: National HIV/AIDS/ STI Programme*.

The government of Trinidad and Tobago established an inter-ministerial committee in 1998 which had the responsibility for developing a plan to pull together skills and expertise for mounting an intensified national response to HIV/AIDS. A major outcome of this inter-ministerial committee was the formation of a Technical Advisory Group, which was charged with the ***development of a public sector plan of action*** for the coordination of all public sector activities. The agreed public sector plan of action, inclusive of strategies and obligations for each Ministry is contained in a document entitled *"Proceedings Report on the Technical Working Group Sensitization HIV/AIDS Workshop: July 20-30, September 01, 1999"*. The activities contained in this plan are in keeping with the broad strategies of this *Five-year Strategic Plan* and will therefore be considered as the public sector's position in facilitating the expanded national response. An early activity is therefore for the public sector to revisit and revise this document and commence earnest initiation of the activities contained therein. [Refer to **1:C1-C7** of matrix].

OBJECTIVE 2: TO PROMOTE HEALTHY SEXUAL ATTITUDES, BEHAVIOUR AND PRACTICES AMONG VULNERABLE/ HIGH-RISK POPULATIONS

Target/Expected Outcome: At least 50% increase in number of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner; At least 75% increase in the proportion of CSW and MSM reporting use of condoms in last sex experience and in all sex experiences with non regular sex partners in a week's recall period.

Strategies A–D: Introduce behaviour change interventions for young women, youths, MSM and CSWs

This Strategic Plan recognizes the necessity for tailoring interventions to suit the needs of specific groups and to include Strategic Activities aimed at reducing the rate of transmission among groups identified as high-risk or vulnerable within the Trinidad and Tobago context. Young females, men who have sex with men (MSM), commercial sex workers (CSWs), prisoners, youths in-and out-of-school and substance abusers are therefore singled out for special attention. In each case, the strategy is to introduce behaviour change interventions or risk reduction programmes for each target group. The overall national information and education programme will include components specially designed to reach them. In addition, strategies for reducing the incidence rate within each high-risk/vulnerable group are identified.

A: Young Women

Given that the epidemiological profile of HIV/AIDS in Trinidad and Tobago depicts a trend that seems to suggest that young girls engage in sexual relationships with older men, it is felt that young girls should be identified as a vulnerable group and singled out for attention. It is also believed that this pattern may largely be the result of the exchange of sex for economic gain (refer to SARA), and so to address this situation, *Health and Family Life Education* (HFLE) programmes and other projects aimed at building the self-esteem of the nation's young women will be implemented. Young females will also benefit from the upgrading of programmes that support teenage parents. **[2: A1- A3].**

B: Youths In-and Out-of-School

Peer education will be used as the primary vehicle for initiating behaviour change among young people. Youths will benefit from the scaling up of peer-education programmes available at drop-in-centres. Some emphasis will also be placed upon facilitating the gay, bisexual youth at these facilities. Collaboration with the Ministry of Education, Ministry of Sports and Youth, the National Youth Council and other agencies will facilitate the expansion of youth abstinence programmes and the incorporation of HFLE and HIV/AIDS education into youth sporting and other activities. These interventions must, however be accentuated by the formal incorporation of HFLE into the primary and secondary school curriculum and therefore the nation's teachers will receive the requisite training to empower them to deliver these modules.

For out-of-school youth, the strategic approach will include education messages to reach them as well as the hosting of national workshops for the upgrading of skills. It will be necessary to undertake regular surveys on youth sexuality to monitor and evaluate the extent to which programmes achieve the desired behaviour modification. **[2: B1-B9].**

C: MSM

In the case of MSM, the *Strategic Plan* makes provision for institutional strengthening of NGOs that provide support to this group. The *MSM Chat Room* and *Friends for Life* will benefit from this initiative. **[2: C1-C2].**

D: CSWs

The potential of the tourism industry to fuel the spread of the epidemic is recognized and given due consideration (Refer to the SARA, 1999, 2001). In particular, the *Plan* makes

provisions for the introduction of skill-building programmes for youths in Tobago in an attempt to steer them away from the necessity to engage in commercial sex practices. Targeted IEC material for the CSW community in general and for Tobago's "Beach Boys" and "Beach Girls" will be developed in an effort to promote safer sex practices and influence behaviour change. **[2: D1-D2].**

Strategy E: Provide comprehensive support for prison employees and prisoners

Preventive treatment and care for prisoners and prison officers will be provided in addition to the required training of prison Medical Orderlies. Group counseling on HIV and related issues will be provided to the incarcerated population as part of the strategy for reducing the risk of infection among this group. **[2: E1-E6].**

Strategy F: Reduce the impact of substance abuse on HIV transmission

Although intravenous drug use (IDU) as a mode of HIV transmission is very uncommon in Trinidad and Tobago, ***the strategic plan recognizes the relationship between substance abuse and risky sexual behaviour***. The Plan will therefore target this specific issue through collaboration with the *National Alcohol and Drug Abuse Programme* (NADAP) and other NGOs to incorporate HIV/AIDS related education into their programmes. **[2:F1].**

OBJECTIVE 3: TO REDUCE THE RATE OF MOTHER-TO-CHILD TRANSMISSION

Target/Expected Outcome: A 50% increase in the amount of HIV-free babies born to HIV infected mothers.

Strategy A: Implement a nationwide MTCT programme

The third main Strategic Objective under *Priority Area I* is to reduce the rate of mother–to-child transmission (MTCT). The government of Trinidad and Tobago (GOTT) through the MoH is already showing commitment in this area since an MTCT programme is in operation in public health facilities. This programme offers counselling and testing to pregnant women and provides a six (6) week regimen of antiretroviral therapy to mothers testing HIV positive. Babies born to HIV positive mothers are also treated for six weeks. Nutritional replacement therapy is provided to nursing mothers. As part of the strategic response, the *Five-year Plan* will seek the continuation and expansion of these activities to bring about the implementation of a nationwide MTCT programme. The MoH is expected to lead this intervention with critical support from the

RHAs, CAREC and the MRF. Some of the key strategic activities for this programme will include:

- Voluntary counselling and HIV testing of women attending all public sector antenatal clinics (all hospitals and health centres);
- Identification (and upgrade where necessary), of a network of reference laboratories to facilitate timely receipt of results;
- Administering of drug therapy to HIV positive mothers and newborns;
- Administering of drugs during childbirth;
- Testing of babies born to HIV positive mothers;
- Provision of six months of nutritional replacement therapy to all HIV nursing mothers;
- Appropriate training of health care staff;
- Standardized care based on guidelines and protocols; and
- Expansion of the programme to the private health sector.
  [**3.A1-A11** of matrix]

OBJECTIVE 4: INCREASE THE POPULATION'S KNOWLEDGE OF ITS SEROSTATUS

Target/Expected Outcome: At least 40% of the 15-49 aged population accessing VCT services at the end of 2007.

Strategy A: Develop a comprehensive national VCT programme

Voluntary counselling and testing (VCT) is an effective aspect of HIV prevention since an individual's knowledge of his/her serostatus stimulates early health-seeking behaviour and allows for the adoption of actions to prevent the spread of the disease. A fourth Objective of *Priority Area I* is therefore to increase the population's knowledge of its HIV status and to achieve this, the *Five-year Plan* outlines a strategy for intensifying voluntary counselling and testing activities.

At present, access to pre- and post-test counselling is not available nationwide. Within the public system, there is one main Voluntary Counselling and Testing (VCT) centre located at the Queens Park Counselling Centre and Clinic (QPCC&C). HIV testing is

available at private laboratories and under such situations, counselling services are, for the most part, notably absent. This means that a significant amount of persons who test positive do so only upon the display of symptoms - which often is quite late in the progression of the disease. Quite a few persons also become aware of their status due to the testing requirements of insurance companies and some employers.

VCT at Public Health Facilities

Under the new arrangement, the strengthened VCT programme will be more reflective of a national voluntary and testing programme and will allow access to VCT services to all communities. This programme will use as its delivery system, the network of public health facilities strategically located throughout the country – in the five main hospitals, all District Health facilities and at least fifteen (15) health centres. To ensure the effectiveness of this strategy, a national policy with guidelines for confidentiality will be designed, implemented and closely monitored. This is necessary especially in light of reports of breeches of confidentiality within the current system. Further, training for a cadre of counsellors will be provided.

Youth Counselling Services

Given that youths tend to utilize public health centres infrequently, and given the need to provide services that are "friendly" to them, counselling for youths will be provided at specific *Youth Drop-in-centres*. Seven (7) such centres will be provided in the following locations: one each in *Port of Spain; San Fernando; Arima; Point Fortin; Chaguanas*; and two in *Tobago*. ***It is recommended that a project aimed at introducing testing at these sites be piloted***.

Blood Transfusion Services

The *National Blood Transfusion Unit* (NBTU) is entrusted with the task of maintaining a safe blood transfusion service. Since 1985, the blood supply for Trinidad and Tobago has been routinely screened for HIV and it can safely be said that the national blood transfusion system is comparable to international standards. Despite this, the expanded strategic response must continue to address issues relating to blood transfusion and HIV. In this regard ***the national guidelines on screening and transfusion will be constantly monitored and revised as it becomes necessary. In addition, counselling will be extended to donors who test positive.*** This will be accomplished through the

establishment of a ***referral system*** between the NBTU and the network of regional VCT sites that will be established.

Private VCT Sites

There is also the need to establish private VCT sites. In this regard, the private health sector professionals, institutions and laboratories services need to play a lead role in developing a programme with the insurance sector and private sector business organisations to provide health and counselling services to their clients. The NGOs offering HIV/AIDS counselling and care services must also be included in the partnership.

Standards and Procedures

Expansion of VCT will require the development of standardized protocols and training in these procedures. The incorporation of the necessary best practice associated with VCT will be a key pre-requisite for a successful programme. To this end, there will need to be close liaison between those responsible for the development of such protocols and the regional partners at the level of PANCAP for technical support in this initiative.

Strategy B: Promote VCT services

In order for persons to utilise VCT services, they must first want to access it. As a result, a national promotional campaign via print and electronic media will be launched to advance the benefits of VCT and to educate the nation about the availability of free access to these services. This strategy is especially critical for the "*Youth Drop-in centres"*, to ensure that young people understand the uniqueness of these facilities to their needs. **[4:B1].**

OBJECTIVE 5: TO REDUCE THE PROBABILITY OF POST EXPOSURE INFECTION

Target/Expected Outcome: A 90% increase in the proportion of health facilities reporting adequate availability of drugs for Post Exposure Prophylaxis for health personnel in both the public and private sectors.

Strategy A: Ensure the availability of adequate post-exposure services

To achieve this strategy the following strategic activities will be undertaken:

- The development and implementation of national policies for post exposure prophylaxis for all public sector staff;

- Ensuing the continuous availability of drugs for management of post-exposure prophylaxis;

- Ensuring that policies for occupational exposure to HIV are integrated into PSBO's Occupational Health and Safety codes. PSBOs will be encouraged to offer post-exposure prophylaxis to their employees. **[5: A1-A3].**

OBJECTIVE 6: TO IMPROVE THE MANAGEMENT AND CONTROL OF CSTIs

Target/Expected Outcome: At least a 60% increase in the amount of CSTI cases reported, counselled, managed, and monitored.

Strategy A: Increase knowledge and awareness of the symptoms of CSTIs

The management and control of Conventional Sexually Transmitted Infections (CSTIs) is integral to reducing the HIV incidence rate, as is the introduction of post-exposure prophylaxis (PEP). The S*trategic Plan* therefore promotes a strategy to increase the population's knowledge and awareness of these diseases and to promote the availability and accessibility of CSTIs treatment and counselling at various facilities. Towards this end, a public awareness campaign will be launched which will provide information on the symptoms and ill-effects of untreated CSTIs. **[6: A1-A2].**

Strategy B: Ensure effective syndromic management of CSTIs

Under this strategic initiative diagnosis, treatment and counselling of STIs will be provided on a decentralized basis and delivered by the *Regional Health Authorities* (RHAs) through health centres and hospitals. The QPCC&C will provide these services to the *North West Regional Health Authority's* (NWRHA) catchment population and will also play a role as the central unit with responsibility for providing health care practitioners with education and training in CSTI management and control. National protocols for diagnosis and treatment will be effected.

Under this new system, it will be necessary to ensure that the required laboratory testing services are in place to support the delivery of CSTI services across all regions. According to the KPMG Consulting (2001), funding and training of staff should be

provided to the Trinidad and Tobago Public Health Laboratory (TPHL) and regional hospital laboratories to enable them to execute these functions. **[6: B1-B5].**

Strategy C: Provide "youth friendly" sexual and reproductive health services

In recognition of the fact that 50% of new infections occur between the age group 15-24 years, a deliberate strategy aimed at making sexual health services friendly to youths will be initiated. The experience is that presently young people are often dissatisfied with the services they receive at public health facilities and as a result rarely access these services. Apart from sensitising health practitioners about this issue, a full *Youth Clinical Service Centre* will be made available to the youths of Tobago as the need for such a facility was identified by Tobagonian stakeholders. In addition to this, the ongoing efforts of the Ministry of Sport and Youth Affairs (MoS&YA), youth NGOs (YNGOs), CBOs (YCBOs) and the Family Planning Association (FPA) will be acknowledged and supported. **[6: C1-C3].**

PRIORITY AREA II: TREATMENT, CARE AND SUPPORT

This Priority Area focuses on providing HIV/AIDS treatment and care to the PLWHA community inclusive of the administering of anti-retroviral drug therapy - and on the provision of required socio-economic support to the infected and affected population. Two broad Treatment, Care & Support Strategic Objectives are identified for the nation as follows:

OBJECTIVE 1: TO IMPROVE ACCESS TO TREATMENT AND CARE FOR HIV/AIDS

Target/Expected Outcome: At least 6,000 PLWHAs receiving free ARV therapy and HIV/AIDS care over the period 2003-2007 at identified treatment centres; A quality reporting system for care of HIV patients fully established and operational; At least a 50% increase in the number of health practitioners trained in HIV/AIDS treatment and care at primary, secondary and tertiary levels; At least 90% increase in the number of health facilities with adequate availability of drugs for treating Opportunistic Infections.

Strategy A: Implement a national system for the clinical management and treatment of HIV/AIDS

A full clinical management and treatment system for HIV/AIDS will be developed and implemented. Currently, treatment is provided free of charge by the government at the *Medical Research Foundation* (MRF), the *Eric Williams Medical Sciences Complex* (EWMSC) Paediatrics, the *San Fernando General Hospital* (SFGH) and the Cyril Ross Home. Under the new system, PLWHAs will also have access to treatment services at

additional sites including the *Port of Spain General Hospital* (POSGH), *Scarborough Hospital*, the *Eric Williams Medical Sciences Complex* (EWMSC), and at the *Sangre Grande Hospital.* It will also be available on an outpatient basis at health centres and at District health facilities and continued at the Cyril Ross Home.

Appropriate training is essential to the operation of a clinical management and treatment system. In fact, the *Audit of National Programmes and Laboratories* recommends that*:*

> *"…the training of the treating physicians in the use of combination antiretroviral therapy be a prerequisite and a priority to introducing these drugs..."* KPMG Consulting (2001, p.81).

In keeping with this recommendation, the strategic approach will focus on the training and development of a core of health professionals to work in HIV/AIDS care and treatment. These persons who would be allowed to "self select" or opt into the programme, would be the main vehicle/resource for transferring knowledge throughout the rest of the health sector. The strategic approach will also involve the contracting of experts to provide in-service training at commissioned sites over the medium term. In the immediate period, the MRF, which currently administers treatment for the public sector, will continue to be the main agency for training and introducing ARV therapy at the identified sites. It is also envisaged that the University of the West Indies (UWI) would also play a role in developing this faculty locally, through such initiatives as the Institutional Strengthening Project by the European Union. The local programme will also draw on support from the Caribbean HIV/AIDS Regional Training Network (CHART), which is a PANCAP initiative geared towards the use of support from international agencies, regional expertise and centres of excellence. A system for the continuous training of health professionals in ARV management will also be implemented in addition to the provision of psychosocial support for caregivers within the health system.

Laboratory Support

Laboratory support for administering of antiretroviral therapy is another essential element of the treatment and care component of *Priority Area II.* CD4 counts will be available at five major hospitals where dedicated HIV/AIDS wards will be established – the POSGH, SFGH, Sangre Grande, EWMSC and the Scarborough Hospital. Viral load testing will be provided by the TPHL and the three hospital laboratories. Expansion of capacity at

these institutions is necessary if they are to deliver this support. This would necessitate full training in CD4 and viral load testing as well as thorough reviews of the TPHL's testing protocols. It is proposed that a new National Public Health Laboratory be constructed to replace the existing TPHL.

Given that all these facilities will not be available to support the full volume of tests at the outset, a phased approach to the introduction of Highly Active Antiretroviral Therapy (HAART) is recommended where priority is given in the first case to AIDS patients and PLWHA with very low CD4 and extremely high viral load. As the nation gains experience in the use of triple therapy and as the necessary diagnostic and laboratory support becomes available, the programme can be extended to provide full coverage to all PLWHA who require medication. [Refer to **1:A1-A11** of matrix for fuller details].

Strategy B: Improve access to medication, treatment and care for persons with opportunistic infections

Opportunistic infections are the cause of death in many HIV/AIDS patients. As a result, protocols for palliative care and clinical management of OIs will be implemented and monitored. The private sector will be encouraged to adopt the national clinical management and treatment protocols. To ensure the continued adherence to these protocols, HIV/AIDS and OI clinical management modules will be integrated in the curriculum of all nurses, doctors, pharmacists, nutritionists, and social workers with ongoing training of practitioners**. [1:B1-B3].**

OBJECTIVE 2: TO REDUCE THE INCIDENCE OF HIV/AIDS AND TUBERCULOSIS CO-INFECTION

Target/Expected Outcome: To reduce the incidence of HIV/AIDS-Tuberculosis co-infection by 30% over the period 2004-2008

Strategy A: Improve the surveillance, treatment, care and management of HIV/AIDS-Tuberculosis co-infection

Tuberculosis is a leading killer of persons affected with HIV/AIDS. At least 1:3 persons infected with HIV/AIDS will develop tuberculosis in their lifetime. Persons infected with HIV/AIDS have a 10% chance per year of developing active tuberculosis if not treated with treated with antiretroviral drugs. In the context of Trinidad and Tobago,

HIV/AIDS-Tuberculosis co-infection rates increased from 32.5% in 1995 to 42% in 1999.

OBJECTIVE 3: TO CREATE AN ENVIRONMENT THAT SUPPORTS THE INFECTED AND THE AFFECTED

Target/Expected Outcome: An increase in the number of HIV/AIDS service organizations with enhanced ability to respond to the needs of their clients; A referral system between HIV/AIDS service organizations, public and non-governmental organizations for the provision of social support fully developed and operational; At least 75% of PLWHAs and 50% of persons affected by HIV/AIDS receive supportive counselling.

Strategy A: Provide appropriate economic and social support to the PLWHA and to the affected

According to the *Universal Declaration of Human Rights*[7], each individual *"has the right to a standard of living adequate for the health and well being of himself and of his family, including medical care and the right to security in the event of sickness or disability."*

It is therefore necessary to provide support beyond medical care to those that are infected and directly affected by HIV. This support must extend to include the provision of economic and social support to those who require it. As part of *Priority Area II*, research programmes that assess the socio-economic needs of disadvantaged PLWHA and their affected families will be undertaken. This will provide the necessary data upon which a referral system between government agencies, NGOs and CBOs to provide required social and economic support services will be developed.

To deliver the increased demand for services, the capacity of NGOs and CBOs will be improved by providing assistance with training, information systems and other resource needs. In particular, this will facilitate the improvement of home-based care for persons with HIV/AIDS as well as the provision of support services for HIV orphans. The programmes of HIV/AIDS service organisations such as CARe, Cyril Ross Home, OASIS, CARITAS and TAS will receive the required strengthening to lead these processes. **[2: A1-A8].** Consideration will also have to be given to provision of economic and social support to the increasing number of uninfected orphans who are affected by the death of their HIV positive parent (s).

[7] UNESCO (2001). UNESCO's Strategy for HIV/AIDS Preventive Education.

PRIORITY AREA III: ADVOCACY AND HUMAN RIGHTS

The overall goal of this Priority Area is to heighten national interest in HIV/AIDS issues and to ensure the upholding of human rights principles as they relate to PLWHA, CSW, MSM, families of PLWHA and other affected groups. Two Strategic Objectives are identified as follows.

OBJECTIVE 1: TO REDUCE STIGMA AND DISCRIMINATION AGAINST PLWHA

Target/Expected Outcome: At least a 90% increase in the proportion of health care providers with positive attitudes towards HIV positive persons; At least 50% of the general population having an accepting attitude towards HIV+ persons; At least 50% reduction in the number of cases of human rights abuses against PLWHAs; At least 50% of all public and private sector organizations have implemented workplace policies; Enactment of legislation to prevent HIV/AIDS discrimination.

Strategy A: Promote openness and acceptance of PLWHA in the workplace and in the wider community

In an attempt to reduce the level of stigma and discrimination facing the PLWHA community, the Plan identifies a strategy for promoting openness and acceptance of PLWHA. Keen focus will be given to the development of a national workplace policy with the business sector taking a lead role in this initiative. The effectiveness of these policies will be monitored through annual surveys. In addition, companies will be encouraged to include provisions for HIV/AIDS in their *Employee Assistance Programmes* (EAP) with emphasis on counselling, care and support for infected employees. Further, capacity will be built in NGOs that serve PLWHA. **[1:A1-A8].**

OBJECTIVE 2: ENSURE HUMAN RIGHTS FOR PLWHA AND OTHER GROUPS AFFECTED BY HIV/AIDS

Target/Expected Outcome: Enactment of legislation to prevent human rights abuses against PLWHA and other groups affected by HIV/AIDS.

Priority Area III includes three strategies for achieving the objective of ensuring the human rights of PLWHA and for monitoring abuses against them. These are accomplished through separate programmes directed to legislative reform and human rights.

Strategy A: Creation of a legal framework that protects the rights of the PLWHA and those affected by HIV/AIDS

This strategy incorporates strategic activities that will culminate in the enactment of anti-discriminatory legislation in the workplace and in the wider community. Initiatives in these areas will include the continuation of discussions at the Caribbean level relating to human rights education programmes, establishment of appropriate legislation on HIV/AIDS discrimination in the workplace and the inclusion of HIV/AIDS in the Equal Opportunity Act that protects all citizens. These discussions will also focus on the rights of other vulnerable groups such as CSW, MSM, families of PLWHA and Youth. **[2: A1-A3].**

Strategy B: Monitor human rights abuses and implement avenues for redress

Measures for monitoring and highlighting human rights abuses are implemented here. The media is identified as an important strategic partner to work along with the Ministry of Legal Affairs in this regard. The establishment of a dedicated HIV/AIDS desk at the Ombudsman's office and the publication of human rights abuses in the media will be encouraged in order to monitor human rights abuses and provide an avenue for redress. **[2: B1-B3].**

Strategy C: Mobilize opinion leaders on HIV/AIDS and related human rights issues.

Influential public personalities including political figures will be used to advance the cause of HIV/AIDS. **[2: C1-C2].**

PRIORITY AREA IV: SURVEILLANCE AND RESEARCH

Interventions aimed at improving the surveillance system and undertaking applied research into HIV/AIDS and related issues are presented hereunder. The Surveillance and Research Strategic Objectives are identified as:

OBJECTIVE 1: TO STRENGTHEN THE SURVEILLANCE SYSTEMS FOR CSTI/HIV/AIDS

Target/Expected Outcome: Accurate and timely epidemiological data for the entire health sector produced and disseminated to key stakeholders every quarter from 2004.

Strategy A: Improve existing surveillance systems

The surveillance system is an essential element in the success of the treatment and care component, as well as in the evaluation of the National Strategic Plan. As such, the existing surveillance mechanism will require evaluation and improvements where necessary. Enhancements such as the incorporation of private sector reporting and the reconstruction of the TPHL's system inclusive of an examination of its HIV testing protocol will be critical. There will also be the need to provide appropriate training and staffing to the *National Surveillance Unit* (NSU). Regular surveys will be conducted to monitor the progress of activities. **[1: A1-A7]**.

Strategy B: Strengthen national laboratory systems

The robustness of Trinidad and Tobago's national laboratory system is perhaps one of the most important factors that will determine the success of the treatment component of the HIV/AIDS *Strategic Plan*. This will no doubt affect the capacity of the RHAs to respond to demands for ARV treatment. A full evaluation and upgrade of the existing system must be undertaken as a precursor to the expansion of ARV treatment beyond the current capacity. This strategic activity is therefore identified as part of *Priority Area II* (1: A6). The evaluation would require a thorough review of TPHL's protocols on HIV testing and the identification and execution of strategies for strengthening. **[1:B1-B2].**

In Section III, recommendations for public/private sector partnership in the area of laboratory and other support is discussed as a means of expanding capacity in the short to medium term (Refer to page 78).

OBJECTIVE 2: TO UNDERTAKE AND PARTICIPATE IN EFFECTIVE CLINICAL AND BEHAVIOURAL RESEARCH ON HIV/AIDS AND RELATED ISSUES

Target/Expected Outcome: Evidence of a national policy driven research agenda and the dissemination of results from these projects; Improved ability to develop targeted HIV/AIDS education messages and other intervention strategies.

Strategy A: Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS

Behavioural studies which will assess the relationship between poverty and HIV/AIDS, drug abuse and HIV/AIDS and domestic violence and HIV/AIDS and other relevant issues, will be conducted. The results of these research activities will be used to inform the design and focus of intervention programmes, as they will serve to pinpoint the driving forces behind the spread of the epidemic**. [2: A1].**

Strategy B: Conduct effective epidemiological research and clinical trials

Epidemiological research and clinical trials are also important to the success of HIV/AIDS interventions. *Priority Area IV* therefore also makes provisions for the conduct of clinical and epidemiological research on HIV/AIDS in Trinidad and Tobago. **[2: B1-B2].**

PRIORITY AREA V: PROGRAMME MANAGEMENT, COORDINATION AND EVALUATION

All activities related to the management, implementation and evaluation of the nation's expanded response is incorporated under this Priority. The three Programme Management/Coordination and Evaluation Strategic Objectives identified for the nation are as follows.

OBJECTIVE 1: TO ACHIEVE NATIONAL COMMITMENT, SUPPORT AND OWNERSHIP OF THE EXPANDED STRATEGIC RESPONSE TO HIV/AIDS

Target/Expected Outcome: Enactment of legislation for the operationalizing of NACC; Annual budgetary allocation to the NACC from 2003; Individual sectors developing and implementing sector specific HIV/AIDS workplans.

Strategy A: Develop an appropriate management structure for the national expanded response.

The success of Trinidad and Tobago's overall response to HIV/AIDS will be determined by the extent to which the strategies, as laid out in this document can be successfully implemented and effectively monitored. These strategic activities however, cut across all sectors; therefore creating a vital role for coordination and management of the multiplicity of programmes that will be implemented over the five-year period. In fact, one may reasonably argue that ***the single most important ingredient to achieving success of the strategic plan is the creation and empowerment of a structural arrangement with the capacity to manage and coordinate the expanded response***.

The consensus at the close of the stakeholder consultations was that:

- An independent body should be created to provide the necessary coordinating function required to harmonize all national strategies relevant to the expanded response;
- This body should be charged with the responsibility for policy formulation, coordination and monitoring at the national level;
- The voices of the main interest groups: the PLWHA community, youths, business, labour, NGOs, government ministries and faith based organizations should be heard at the level of the independent agency;
- This independent body should fall within the *Office of the Prime Minister*, but should ultimately be accountable to the people of Trinidad and Tobago;
- There should be a separation of the managerial and implementation functions; and
- Tobago should be empowered with an individual institution to implement its programme.

In keeping with these guiding principles, a structure for the management and execution of the expanded response is proposed. This arrangement is discussed in detail in Section III. **[1: A1-A2].**

Strategy B: Gain wide support for the National Strategic Plan

For success, there must also be commitment to and support for the national *Strategic Plan*. The NSP must also become a policy document before it can be effectively considered the official national response of Trinidad and Tobago. As such the *Plan* must be marketed and appropriate steps undertaken to ensure that the legal instruments necessary for execution of the key areas of the document are in place. **[1: B1-B2].**

Strategy C: Mobilise adequate and sustained resources to support implementation of the strategic plan

Successful implementation of the plan requires financial and technical resources. There is the need to identify continuous and dedicated funding to support each identified *Priority Area* over the *Plan* period. The most prudent approach to financing the HIV/AIDS *Strategic Plan* in Trinidad and Tobago would involve a combined strategy of partnerships between domestic, regional, and international stakeholders. Given that HIV/AIDS is a costly chronic disease, a sustained fight requires strong domestic mobilisation of resources over time. The GOTT will need to commit to this fight through meaningful resource allocation from the public purse. Private sector partnership in the

identification and mobilization of resources will also be critical. There is also a role for grant and loan funding to meet some of the needs of the *Plan*. It is also important to note here that the some of the resource requirements necessary to upgrade facilities, and procure equipment have already been identified as part of the Health Sector Reform programme. **[1: C1-C2].**

OBJECTIVE 2: TO MONITOR THE IMPLEMENTATION OF THE EXPANDED RESPONSE

Target/Expected Outcome: Development of NSP monitoring indicators; Annual evaluation reports delivered to the national community.

Strategy A: Monitor the implementation of policies and programs as outlined in the NSP

The NACC, the body charged with the responsibility for management and coordination will also be accountable for monitoring and evaluation functions. This agency will need to develop appropriate indicators to facilitate consistent and periodic monitoring of the implementation of the *Plan*. Reporting to civil society will take place annually during a Health Week. The format of reporting should be nationally, regionally and at the level of sectors.

It should also be noted that NACC will develop standardised training modules for each aspect of the NSP, which will incorporate the training needs of the various agencies and strategic partners. NACC will again be liable for the quality assurance of these programmes. **[2: A1-A5]**

OBJECTIVE 3: TO BUILD CAPACITY AMONG CRITICAL STAKEHOLDERS IN THE EXPANDED NATIONAL RESPONSE

Target/expected outcome: All members of NACC are fully trained to perform their functions effectively and efficiently; Critical sectors are empowered to effectively administer programmes and activities at the level of the community; A coordinated capacity is established at NACC for Human Resource Development; Ongoing training is provided to community based stakeholders.

Strategy A: Strengthen the key constituents of NACC

To effectively discharge its functions in the management and coordination of the national response, it is essential that staff of NACC Secretariat is exposed to the necessary

training and orientation around HIV/AIDS, and be able to access the relevant tools to maximize the expected outcome of the activities for which they are responsible. **[3: A1-A2].**

Strategy B: Strengthen support groups for PLWHAs and increase the number of these support groups

Presently there exist a limited number of support groups for PLWHAs throughout Trinidad and Tobago. In the expanded programme, these groups are expected to accelerate their activities in response to their new roles. It is critical therefore, that these support groups be strengthened to better prepare them for their role in the expanded response. It is also recognized that there is a need to expand the number of such support groups, encouraging an input from other civil society stakeholders. This effort will involve such strategic activities as:

- Conducting sensitization workshops for community based groups; and
- Conducting Training of Trainers workshops for stakeholders at the level of the community.

It is required that baseline indicators be developed in the first year of the programme. These indicators will benchmark such measures as:

- the number of PLWHAs trained in conducting advocacy and sensitisation sessions;
- the number of PLWHAs trained and absorbed into the workplace; and
- the number of local/community-based support groups for PLWHAs.

Pertaining to the efficiency of the programs being administered and the gaps being identified, more detailed monitoring will be conducted. This will in turn provide the basis for development of further or new training modules to address these goals as they arise. The NACC will again assume the lead in this effort. **[3: B1-B3].**

ENSURING REACH OF THE NSP TO TOBAGO

It is well recognized that the island of Tobago has socio-cultural peculiarities distinct to that of Trinidad and that it has a constitutional self-governing structure. ***To be truly***

effective, this National Strategic Plan recognizes and takes into account the heterogeneity of the twin-islands. Despite the fact that there is **a single overall strategic framework** for guiding Trinidad and Tobago's expanded response, Tobago will within this framework, position its response in a manner that will be most efficient and cost effective to the island. For this reason, issues such as travel cost to Trinidad for counselling and testing services are given due consideration when identifying the location of facilities. In addition, Tobago will develop a unique ***sub-structure*** to coordinate and implement its ***Strategic objectives*** and ***activities.*** Details of this arrangement are presented in Section III.

During the consultations held with Tobagonian stakeholders, two major strategic areas for action and some detailed activities for the island that fall neatly into the wider national framework, were identified. It was agreed that Tobago will implement its strategic response under the two identified broad strategic action areas.

1. EDUCATION, PREVENTION AND ADVOCACY

The following programmes were identified for implementation under this S*trategic Area*:

- Communication programmes to increase Tobagonian knowledge and awareness of HIV/AIDS;
- Risk assessment and risk reduction strategies for specific target groups;
- Programmes for the promotion of safer sexual practices to populations at risk;
- Activities for reducing stigma and discrimination of those already infected and affected by HIV/AIDS; and
- Initiatives for addressing human rights issues.

2. TREATMENT, CARE AND SUPPORT

Activities for implementation were identified as:

- Programmes for the prevention of MTCT;
- A clinical management system for HIV/AIDS;

- Treatment programmes for CSTI;
- Provision of social support for PLWHA;
- Development of the Tobago Network for PLWHA; and
- Support to AIDS service organizations.

Strategic Objectives and Activities associated with these *Strategic Areas* are incorporated within the general *National Strategic Planning Matrix* that now immediately follow in the pages 42 to pg. 68. In the majority of cases strategies are cross cutting for both islands. In some instances however, when specific items are targeted to Tobago they are clearly identified.

THE NATIONAL STRATEGIC PLAN MATRIX

PRIORITY AREA I: PREVENTION			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
1. To promote safe and healthy sexual behaviours among the general population.	A. Heighten HIV/AIDS education and awareness.	A1. Continuous dissemination of comprehensive IEC material and messages to the national community via electronic and print media and the production and distribution of posters and pamphlets	NACC, MoH, MOE, Media, Business sector, PLWHA, FBOs
		A2. Dissemination of online education material via a website.	NACC
		A3. Heighten the dissemination of targeted education messages around and during all major national festivals. *Embark upon radio, television and newspaper campaigns*	NACC, Media, Entertainment sector.

PRIORITY AREA I: PREVENTION Cont'd

Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To promote safe and healthy sexual behaviours among the general population. Cont'd	B. Improve the availability and accessibility of condoms.	B1. Embark upon condom social marketing programme.	NACC, MoH, FBOs, Business sector
		B2. Lobby for the sale of condoms at gas stations, supermarkets, "rum-shops," bars/ nightclubs, carnival booths and other non-traditional outlets.	NACC, MoH, Business sector
		B3. Procure and install condom vending machines at identified locations.	NACC
		B4. Strengthen and expand the Family Planning Association's (FPA) mobile clinic.	NACC, MoH FPA
	C. Extend the responsibility for the prevention of HIV to all sectors of government and civil society.	C1. Partner with the media and other PSBOs to intensify dissemination of HIV/AIDS information.	NACC, Media sector, Business sector.
		C2. Train FBOs to develop their HIV/AIDS education and counselling skills.	NACC, FBOs.
		C3. Empower Local Government Councillors to deliver HIV/AIDS information to their constituents.	NACC, Local Government
		C4. Encourage each PSBO to conduct at least one training session over the plan period to educate employees and management re: HIV/AIDS.	Business sector, Trade unions.
		C5. Offer tax incentives to employers who provide HIV/AIDS support in their Employee Assistance Programmes.	MoF,

PRIORITY AREA I: PREVENTION Cont'd

Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To promote safe and healthy sexual behaviours among the general population. Cont'd	*C. Extend the responsibility for the prevention of HIV to all sectors of government and civil society.* ***Cont'd.***	C6.Revisit and review strategies/ activities in the public sector plan contained in "*Proceedings Report on the Technical Working Group Sensitization HIV/AIDS Workshop. July 29-30, September 01, 1999*".	NACC, all other public sector agencies
		C7 Each Ministry/ public sector agency to initiate strategies as identified in revised public sector plan.	MoH, Public sector
2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations.	A. Introduce behaviour change intervention programmes targeted to young females.	A1. Produce and disseminate information and education material for the target population.	NACC
		A2. Introduce comprehensive national self esteem programmes for the empowering young women.	NACC, NGOs, CBOs, MoSYA, MoGender, other sectors
		A3. Revise the HFLE curriculum to incorporate HIV/AIDS issues	NACC, MoE
	B. Introduce behaviour change interventions targeted to youths in and out of school	B1. Develop targeted IEC aimed at youths.	NACC
		B2. Expand peer- education through Youth Drop-in-Centres. Some specific emphasis should be placed on facilitating the gay, bisexual youth.	NACC, MoSYA
		B3. Assist programmes that support teenage parents.	NACC, MoH-Choices, NGOs
PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**

2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations. Cont'd	*B. Introduce behaviour change interventions targeted to youths in and out of school.* ***Cont'd***	B4. Collaborate with National Youth Council on expansion of youth abstinence programs.	NACC, NYC
		B5. Collaborate with Ministry of Sports and Youth, National Youth Council and other agencies to integrate HFLE and HIV/AIDS education into youth sporting and other activities.	NACC, NGOs, CBOs, government sectors.
		B6. Host skills and motivational workshops for out-of- school youths.	All sectors
		B7. Incorporate HFLE into the formal primary and secondary school curriculum	NACC, MoE, FBOs
		B8. Embark upon a national teacher-training programme to provide teachers with the necessary skills.	NACC, MoE
		B9. Undertake regular surveys on youth sexuality to monitor behaviour modification.	NACC, all sectors
	C. Support behaviour change programmes targeted to MSM.	C1. Provide capacity building support to Friends for Life and the MSM Chat Room.	NACC, Friends for Life and MSM Chat Room.
		C2. Develop and disseminate targeted behaviour change communication material.	NACC

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**

2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations. Cont'd	D. Introduce behaviour change/ risk reduction programmes for CSWs.	D1. Develop targeted education material for the CSW community.	NACC
		D2. Encourage the development of skill-building programmes to provide employment other than transactional sex for youths in Tobago.	NACC, THA
	E. Provide comprehensive support programmes for prison employees and prisoners.	E1. Develop an HIV/AIDS in the workplace policy for prison officers and their families.	MoNS, NACC
		E2. Provide group counselling for inmates.	MoNS
		E3. Provide comprehensive preventive, treatment and care to prison officers.	MoNS, MoH
		E4. Provide comprehensive preventive, treatment and care to inmates.	MoNS MoH
		E5. Provide training for prison Medical Orderlies	MoNS MoH
		E6. Lobby for effective prison reform.	All sectors, MoNS
	F. Reduce impact of substance abuse on HIV transmission.	F1. Collaborate with agencies dealing with drug abuse for the integration of HIV/AIDS education.	NACC, NADAP, NGOs

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
3. To reduce mother to child transmission	A. Implement a nationwide MTCT programme.	A1. Develop a national policy on HIV counselling and testing as a routine part of all antenatal programmes. [Include guidelines for confidentiality, collection, storage and transportation of samples.]	MoH
		A2. Train a cadre of counsellors for health centres and clinics.	MoH/RHA
		A3. Provide comprehensive voluntary counselling and testing services as part of all public sector antenatal health programmes.	MoH/RHA
		A4. Monitor and update protocols for ARV treatment during pregnancy.	NACC, MoH
		A5. Identify reference laboratories to conduct re-testing of children born to HIV positive mothers.	MoH/RHA, CAREC
		A6. Upgrade reference labs where necessary.	MoH/RHA, CAREC
		A7. Offer ARV treatment to all HIV positive mothers attending public facilities and babies born to these mothers.	MoH/RHA

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
3. To reduce mother to child transmission. Cont'd	*A. Implement a nationwide MTCT programme.* ***Cont'd***	A8. Provide free nutritional replacement therapy to all HIV exposed infants from birth up to six months.	MoH/RHA
		A9. Testing of children of HIV positive mothers	MoH/RHA, CAREC
		A10. Develop and implement clinical guidelines to reduce MTCT during childbirth	MoH
		A11. Train all public sector staff who undertake deliveries.	MoH, CAREC, PAHO
		A12. Lobby private sector practitioners to encourage them to provide voluntary counselling and testing to their antenatal patients.	NACC, MoH, Medical Association
		A13. Host training/ sensitization sessions for Private General Practitioners, Gynaecologists and Paediatrician.	NACC, MoH/RHA
4. To increase the population's knowledge of its serostatus	A. Develop a comprehensive national Voluntary Counselling and Testing Programme.	A1. Develop a national policy on VCT. [Policy must include protocols for confidentiality, collection, storage and transportation of samples; Mandatory pre and post testing for clients of the insurance industry and anyone who is required to submit to voluntary HIV testing.]	NACC, MoH

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
4. To increase the population's knowledge of its Serostatus. Cont'd	*A. Develop a comprehensive national Voluntary Counselling and Testing Programme.* ***Cont'd***	A2. Provide VCT services at the 5major hospitals, 5 District health facilities, at 15 health centres (3 health centres per region) and at the QPCC&C.	MoH/RHA
		A3. Provide VCT at 5 health centres in Tobago.	MoH, RHA
		A4. Establish 7 Youth Drop-In-Centres [Centres will provide peer education and counselling. Pilot test HIV testing at one of these sites.]	NACC, MoH, MoSYA
		A5. Create a referral system between the NBTU and regional VCT sites.	NBTU, MoH/RHA
		A6. Train a cadre of counsellors for VCT sites and for VCT services at health centres.	MoH/RHA, CAREC, PAHO
		A7. Develop quality standards for VCT services.	NACC, MoH
		A8. Monitor the adherence to standards	NACC
		A9. Lobby the private sector.	NACC, Private Insurance Industry, private labs, Medical Association.
	B. Promotion of VCT services	B1. Promote the accessibility and benefits of VCT.	NACC

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
5. To reduce the probability of post exposure infection	A. Ensure the availability of adequate post exposure services	A1. Develop and implement policies for post exposure prophylaxis for all public sector staff.	NACC, all government sectors
		A2. Ensure the continuous availability of drugs for management of post exposure prophylaxis.	MoH
		A3. Ensure policies for occupational exposure are integrated into PSBO's Occupational Health and Safety codes.	NACC, Business sector, MoL
6. To improve the management and control of Conventional Sexually Transmitted Infections	A. Increase knowledge and awareness of the symptoms of CSTIs	A1. Launch public awareness campaign re: symptoms of STIs and the ill-effects of untreated STIs..	NACC, MoH/RHA
		A2. Promote the availability of free services for STI treatment at public facilities.	NACC, MoH
	B. Ensure effective syndromic management of CSTIs	B1. Develop guidelines and protocols for diagnosis, treatment and counselling for CSTIs.	MoH
		B2. Improve training of public and private sector health practitioners.	MoH/RHA
		B3. Provide training for QPCC&C staff and for lab staff.	MoH
		B4. Provide decentralized CSTI diagnosis, treatment and counselling at health centres and regional hospitals.	MoH/RHA

PRIORITY AREA I: PREVENTION Cont'd			
Goal: To reduce the susceptibility of the population of Trinidad and Tobago to HIV infection. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
6. To improve the management and control of Conventional Sexually Transmitted Infections. Cont'd	*B. Ensure effective syndromic management of CSTIs.* ***Cont'd***	B5. Establish the QPCC&C as a central unit to provide education and training relevant to CSTIs to health providers	MoH, QPCC&C
	C. Provide "youth friendly" sexual and reproductive health services	C1. Sensitise health practitioners about the need to provide youth friendly services.	NACC, MoH,
		C2. Develop a Youth Clinical Service Centre in Tobago	NACC, THA
		C3. Work with YNGOs ,YCBOs and FPA to provide youth health services.	NACC, MoH, MSYA, YNGOs, YCBOs

PRIORITY AREA II: TREATMENT, CARE AND SUPPORT			
Goal: To provide adequate treatment, care and support services for the infected and the affected.			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To improve access to treatment and care for HIV/AIDS	A. Implement a national system for the clinical management and treatment of HIV/AIDS	A1. Identify a core of health care personnel to receive training in clinical treatment and care of HIV/AIDS and in the use of anti-retroviral therapies. [Clinicians and physicians will be allowed to self-select into this program and would be used as the main resource for the transfer of knowledge.]	MoH/RHA
		A2. Train the core team. [Training programme to include visiting expert(s) to provide "in-service" training.]	MoH/RHA, MRF
		A3. Design/ adapt and implement national treatment and care protocols.	NACC, MoH
		A4. Develop a quality reporting system.	
		A5. Expand/ upgrade the following facilities to provide inpatient HIV/AIDS care: SFGH, POSGH, Scarborough Hospital, Sangre Grande Hospital, Caura Chest, EWMSC, Cyril Ross Home.	MoH/RHA
		A6. Develop laboratory capacity at sites to support viral load and CD4 cell count. [TPHL, and labs at the POSGH, SFGH, Scarborough Hospital]	CAREC, MoH/RHA

PRIORITY AREA II: TREATMENT, CARE AND SUPPORT Cont'd			
Goal: To provide adequate treatment, care and support services for the infected and the affected. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To improve access to treatment and care for HIV/AIDS. Cont'd	A. Implement a national system for the clinical management and treatment of HIV/AIDS. ***Cont'd***	A7. Procure and administer HAART at the designated treatment centres. [ARV therapy will be introduced using a phased approach based upon need. Priority will be given to cases identified as AIDS and to PLWHA with very low CD4 and high viral load. As experience in the use of triple therapy is gained and as the required diagnostic and laboratory capacity is improved, the programme will gradually be extended to all PLWHA who require it.]	MoH/RHA MRF
		A8. Monitor and evaluate adherence to and suitability of treatment protocol.	NACC, MoH
		A9. Undertake quality evaluation.	NACC, MoH
		A10. Introduce a system for the continuous training of health professionals in ARV management.	NACC, MoH,/RHA, UWI, NIHERST
		A11. Provide psychosocial support for caregivers within the health system.	MoH/RHA
	B. Improve access to medication, treatment and care for persons with opportunistic infections.	B1. Improve palliative care and clinical management of OIs.	MoH/RHA
		B2. Integrate HIV/AIDS and OI clinical management in curriculum of all nurses, doctors, pharmacists, nutritionists, and social workers.	MoH,/RHA, UWI
		B3. Host sensitisation workshops to train practitioners	MoH

PRIORITY AREA II: TREATMENT, CARE AND SUPPORT Cont'd			
Goal: To provide adequate treatment, care and support services for the infected and the affected. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
2. To create an environment that supports the infected and the affected	A. Provide appropriate economic and social support to the PLWHA and to the affected. ***Cont'd***	A1. Undertake research to determine whether there are special socio-economic requirements of PLWHA and their affected families.	All sectors
		A2. Develop a referral system between government agencies, NGOs and CBOs to provide required social and economic support services.	NACC, Government Ministries, NGOs, CBOs
		A3. Improve the capacity of NGOs and CBOs to respond by providing training, information systems development and other resource needs.	NACC, MoF
		A4. Strengthen the National AIDS Hotline.	NACC, AIDS Hotline
		A5. Intensify training programmes for community-based care.	NACA
		A6. Provide capacity building to NGOs for home based care	NACC, CARITAS, other NGOs
		A7. Provide support for HIV/AIDS orphans.	NACC, Cyril Ross Home, NGOs, MoF
		A8. Support and encourage HIV/AIDS service organizations.	NACC, MoF, CARe, TAS OASIS

PRIORITY AREA III: ADVOCACY AND HUMAN RIGHTS			
Goal: To heighten national interest in HIV/AIDS issues and to ensure the upholding of human rights principles as they relate to PLWHA, CSW, MSM, families of PLWHA and other affected groups.			
Strategic Objectives	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
1. To reduce stigma and discrimination against PLWHA	A. Promote openness and acceptance of PLWHA in the workplace and in the wider community.	A1. Using ILO's code of Practice, develop guidelines/ recommendations for employers for the creation of HIV/AIDS in the workplace policies.	NACC, Business, trade unions, MoL, ILO
		A2. Based upon the guidelines provided by the ECA, design and implement appropriate HIV/AIDS in the workplace policies.	Business, trade unions, MoL
		A3. Monitor the implementation and effectiveness of these policies via annual surveys.	ECA, Media sector
		A4. Intensify HIV/AIDS in the workplace seminars.	NACC, ECA,
		A5. Re-emphasise the issue of HIV/AIDS at committee meetings.	Chambers of Commerce, trade unions
		A6. Encourage the inclusion of provisions for HIV/AIDS in collective agreements. (Based on ILO'S code of practice).	Business sector, Trade unions, MoL, ECA
		A7. Encourage company EAP providers to include counselling, care and support for PLWHA in the workplace.	Business sector, Trade unions, MoL

PRIORITY AREA III: ADVOCACY AND HUMAN RIGHTS Cont'd			
Goal: To heighten national interest in HIV/AIDS issues and to ensure the upholding of human rights principles as they relate to PLWHA, CSW, MSM, families of PLWHA and other affected groups. Cont'd			
Strategic Objectives	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
1. To reduce stigma and discrimination against PLWHA. *Cont'd*	A. Promote openness and acceptance of PLWHA in the workplace and in the wider community. *Cont'd*	A8. Develop and introduce nationwide employers' HIV/AIDS education programmes.	NACC, ECA
		A9. Build capacity in NGOs for PLWHA	NACC, CARe OASIS TAS, MoF
2. Ensure human rights for PLWHA and other groups affected by HIV/AIDS	A. Creation of a legal framework that protects the rights of the PLWHA and other groups affected by HIV/AIDS.	A1. Continue discussions at the Caribbean level re: HIV/AIDS human rights issues.	Ministry of Legal Affairs
		A2. Enact appropriate legislation on HIV/AIDS discrimination in the workplace.	Ministry of Legal Affairs
		A3. Lobby for the inclusion of HIV/AIDS in an Equal Opportunity Act that protects all citizens.	Ministry of Legal Affairs
	B. Monitor human rights abuses and implement avenues for redress	B1. Establish a dedicated HIV/AIDS arbitration desk at the Ombudsman Office to handle disputes.	Ministry of Legal Affairs
		B2. Highlight human rights abuses in media.	Media sector
		B3. Undertake annual surveys to ensure effectiveness of workplace policies.	ECA

PRIORITY AREA III: ADVOCACY AND HUMAN RIGHTS Cont'd			
Goal: To heighten national interest in HIV/AIDS issues and to ensure the upholding of human rights principles as they relate to PLWHA, CSW, MSM, families of PLWHA and other affected groups. Cont'd			
Strategic Objectives	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
2. Ensure human rights for PLWHA and other groups affected by HIV/AIDS. *Cont'd*	C. Mobilize opinion leaders on HIV/AIDS and related human rights issues	C1. Use Cabinet Ministers and Members of Parliament, to speak out on HIV/AIDS human rights issues.	All sectors
		C2. Use other influential community icons to champion the cause of the PLWHA community.	All sectors

PRIORITY AREA IV: SURVEILLANCE AND RESEARCH			
Goal: To provide effective data reporting and monitoring			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To strengthen the surveillance systems for CSTI/HIV/AIDS	A. Improving existing surveillance systems.	A1. Revisit evaluation of existing surveillance systems, identify gaps and develop strategies for improvement.	NACC, CAREC, MoH/RHA
		A2. Training staff at the NSU.	CAREC, MoH
		A3. Host sensitisation workshops for lab staff and other users of forms etc.	-do-
		A4. Conduct follow up surveys to monitor activities.	-do-
		A5. Ensure quality assurance for upgraded systems.	-do-
		A6. Data on HIV testing from private labs reported to the NSU on a monthly basis.	MoH, Private labs
		A7. Implement a system for systematic dissemination of reports to all stakeholders.	-do-
	B. Strengthen national laboratory systems	B1. Evaluate laboratory systems. [Implement a thorough review of TPHL's protocols on HIV testing (and confirmatory testing)]	-do-
		B2. Strengthen lab capacity. [See *Priority Area II*, objective 1:A5]	-do-

PRIORITY AREA IV: SURVEILLANCE AND RESEARCH Cont'd			
Goal: To provide effective data reporting and monitoring Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
2. To undertake and participate in effective clinical and behavioural research on HIV/AIDS and related issues	A. Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS.	A1. Undertake research into the relationship between HIV/AIDS and social issues such as: Poverty and HIV/AIDS; Drug abuse and HIV/AIDS; Domestic violence and HIV/AIDS Other social issues and HIV/AIDS	UWI, relevant research agencies.
	B. Conduct effective epidemiological research and clinical trials.	B1. Provide meaningful financial and other support to the research agenda of institutions that undertake epidemiological and clinical HIV/AIDS research.	MRF, UWI, all relevant research agencies.
		B2. Undertake other epidemiological and clinical research.	UWI, MRF, all relevant research agencies

PRIORITY AREA V: PROGRAMME MANAGEMENT, COORDINATION AND EVALUATION			
Goal: To ensure successful implementation of Trinidad and Tobago's National Strategic Plan			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS	A. Develop an appropriate management structure for the national expanded response.	A1. Commission the National AIDS Coordinating Committee (NACC).	Office of the Prime Minister
		A2. Nominate representatives for the NACC	Office of the Prime Minister
	B. Gain wide support for the National Strategic Plan	B1. Enact all legalisation pertinent to the Strategic Plan	MoLA, NACC
		B2. Undertake national marketing and promotion of the Strategic Plan.	NACC
	C. Mobilise adequate and sustained resources to support implementation of the strategic plan	C1. Collaborate with regional and international partners and the international donor community, technical and support agencies on the way forward.	NACC. MoF, private sector, MoH
		C2. Identify "ring fence" funding to support each identified priority area over the plan period.	Office of the Prime Minister, MoF, NACC

PRIORITY AREA V: PROGRAMME MANAGEMENT, COORDINATION AND EVALUATION Cont'd			
Goal: To ensure successful implementation of Trinidad and Tobago's National Strategic Plan. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies / Strategic Partners**
2. To monitor the implementation of the expanded response.	A. Monitor the implementation of policies and programmes as outlined in the NSP.	A1. Develop standardized modules for all major training requirements of the NSP.	NACC
		A2. Develop NSP monitoring indicators.	NACC, CHRC
		A3. Conduct consistent and periodic monitoring of the implementation process. [Linked to the surveillance reporting system. See *Priority Area IV*; objective 1:A7.]	NACC, CAREC
		A4. Conduct outcome and process research and evaluation. [Use Five-year targets and NSP indicators as guides.]	NACC
		A5. Report annually to civil society. [Reporting to take place annually during a Health Week. The format of reporting should be nationally, regionally and at the level of sectors].	NACC, MoH, Business sector, Media

PRIORITY AREA V: PROGRAMME MANAGEMENT, COORDINATION AND EVALUATION Cont'd			
Goal: To ensure successful implementation of Trinidad and Tobago's National Strategic Plan. Cont'd			
Strategic Objective	**Strategies**	**Strategy Activities**	**Lead Agencies/ Strategic Partners**
3. To Build Capacity among key stakeholders in the expanded response	A. Strengthen the key constituents of NACC.	A1. Conduct sensitisation workshops to all members of NACC.	UN Theme Group, CRN+, UWI
		A2. Conduct extensive training relevant to programme management, coordination and evaluation.	UWI, UN Theme Group
	B. Strengthen support group for PLWHA to better respond to the epidemic and increase the number of these support group.	B1. Develop training modules targeting the public and private NGOs, CBOs, FBOs at the community level.	NACC, Un Theme group, UWI, Network of NGO, CRN+
		B2.Conduct sensitisation workshops to community-based NGOs, CBOs, FBOs, public and private sector interests	NACC, Un Theme group, UWI, Network of NGO, CRN+
		B3. Conduct training of trainer workshops for NGOs, CBOs, FBOs, public and private sector interests	NACC, Un Theme group, UWI, Network of NGO, CRN+

FIVE YEAR-NATIONAL STRATEGIC PLAN TARGETS/EXPECTED OUTCOMES

STRATEGIC OBJECTIVES	FIVE-YEAR TARGETS/EXPECTED OUTCOMES	MEANS of VERIFICATION
To promote safe and healthy sexual behaviours among the general population.	Increasing % of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (90% by 2005 and 95% by 2007).	Population based surveys and related studies from public sector and civil society stakeholders
To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations.	At least 50% increase in number of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner At least 75% increase in the proportion of CSW and MSM reporting use of condoms in last sex experience and in all sex experiences with non regular sex partners in a week's recall period A 50% reduction in the reported HIV incidence rate among prisoners and substance abusers.	Behavioural Surveillance Surveys at base line, mid term and end of five years Behavioural Surveillance Surveys at base line, mid term and end of five years Behavioural Surveillance Reports.

STRATEGIC OBJECTIVES	FIVE-YEAR TARGETS/EXPECTED OUTCOMES	MEANS of VERIFICATION
To reduce mother-to-child transmission	A 50% increase in the amount of HIV free babies born to HIV infected mothers.	Health facility survey and programme monitoring.
To increase the population's knowledge of its Serostatus.	At least 40% of the 15-49 aged population accessing VCT services at the end of 2007. An increase in the number of persons presenting themselves for early HIV/AIDS treatment at health facilities	Facility survey Facility survey
	An increase in the number of persons presenting themselves for early HIV/AIDS treatment at health facilities.	Facility survey
To reduce the probability of post-exposure infection	A 90% increase in the proportion of health facilities reporting adequate availability of drugs for Post Exposure Prophylaxis for health personnel in both the public and private sectors.	Facility survey

STRATEGIC OBJECTIVES Cont'd	FIVE-YEAR TARGETS/EXPECTED OUTCOMES Cont'd	MEANS of VERIFICATION Cont'd
To improve the management and control of CSTIs	At least a 60% increase in the amount of CSTIs cases reported, counselled, managed, and monitored.	Facility Survey

To improve access to treatment and care for HIV/AIDS	At least 6,000 PLWHAs receiving free ARV therapy and HIV/AIDS care over the period 2003-2007 at identified treatment centres.	Facility Survey
	Quality reporting system for care of HIV patients fully established and operational.	Facility Survey
	At least a 50% increase in the number of health practitioners trained in HIV/AIDS treatment and care at primary, secondary and tertiary levels.	Facility Survey
	At least 90% increase in the number of health facilities with adequate availability of drugs for treating Opportunistic Infections.	Facility Survey
To create an environment that supports the infected and the affected.	An increase in the number of HIV/AIDS service organizations with enhanced ability to respond to the needs of their clients.	Health facility survey and programme monitoring
	A referral system between HIV/AIDS service organizations, public and non-governmental organizations for the provision of social support fully developed and operational	Programme monitoring at start, middle and end of planning period.
	At least 75% of PLWHAs and 50% of persons affected by HIV/AIDS receive supportive counselling.	Special Facility surveys

STRATEGIC OBJECTIVES Cont'd	**FIVE-YEAR TARGETS/EXPECTED OUTCOMES Cont'd**	**MEANS of VERIFICATION Cont'd**
To reduce stigma and discrimination against PLWHA	At least 50% reduction in the number of cases of human rights abuses against PLWHAs.	Qualitative assessments and desk reviews and special surveys

	At least a 90% increase in the proportion of health care providers with positive attitudes towards HIV positive persons.	Special surveys and Facility surveys.
	At least 50% of the general population having an accepting attitude towards HIV+ persons.	Qualitative assessments and desk reviews and special surveys
	At least 50% of all public and private sector organizations have implemented workplace policies.	Workplace surveys.
	Enactment of legislation to prevent HIV/AIDS discrimination.	
To ensure human rights for PLWHA and other groups affected by HIV/AIDS.	Enactment of legislation to prevent human rights abuses against PLWHAs and other groups affected by HIV/AIDS.	
To strengthen the surveillance systems for CSTI/HIV/AIDS	Accurate and timely epidemiological data for the entire health sector produced and disseminated to key stakeholders every quarter from 2004.	Quarterly Reports
To undertake and participate in effective clinical and behavioural research on HIV/AIDS and related issues.	Evidence of a national policy driven research agenda and the dissemination of results from these projects.	
	Improved ability to develop targeted HIV/AIDS education messages and other intervention strategies.	Ad recall surveys

STRATEGIC OBJECTIVES Cont'd	FIVE-YEAR TARGETS/EXPECTED OUTCOMES Cont'd
To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS.	Enactment, of legislation for the operationalizing of the NACC.

	Annual budgetary allocation to the NACC from 2003.
	Individual sectors developing and implementing sector specific HIV/AIDS work plans.
To monitor the implementation of the expanded response.	Development of NSP monitoring indicators.
	Annual evaluation reports delivered to the national community.
To Build capacity among key stakeholders in the expanded response	All members of NACC fully trained to perform their functions effectively and efficiently
	Critical sectors empowered to effectively administer programmes .and activities at the level of the community
	Capacity established at NACC for coordinated Human Resource Development
	Ongoing training provided to community based stakeholders

SECTION III

PROPOSED STRUCTURE OF THE HIV/AIDS EXPANDED RESPONSE

THE NATIONAL EXPANDED RESPONSE TO HIV/AIDS

The expanded response to HIV/AIDS is centred around broad-based involvement; encompassing those from the highest political levels, as well as all other sectors, including communities and individuals. Justification for this approach is based upon:

- Recognition of the limited success of previous strategies that were centred in large part on a health response;
- Recognition of the complexities of the driving factors behind the epidemic and its devastating impact on developmental goals; and
- The success of countries that have incorporated a broader-based, multi-sectored approach to addressing the epidemic.

As such, the proposed structure for managing and coordinating the expanded national response is intended:

- To empower and guide all sectors to join the response to the HIV/AIDS epidemic;
- To act as a catalyst of change; and
- To provide facilitation and coordination for the overall programme.

THE ORGANISATIONAL STRUCTURE

An organisational structure that will provide a framework to facilitate the leadership and coordination required to execute the expanded response, while facilitating the effective delivery of services at the community level is proposed for Trinidad & Tobago.

The Office of the Prime Minister

The expanded response will be led by the Office of the Prime Minister. This office will be responsible for increasing the awareness of the expanded response at the national level and as such, will be accountable to the people of Trinidad and Tobago through the Parliament. It will also create linkages with regional and international organizations involved in the fight against the HIV/AIDS pandemic.

The National AIDS Coordinating Committee

A *National AIDS Coordinating Committee* (NACC) is positioned at the centre of this proposed structure. Based on the feedback from the National Consultations, it is proposed that the NACC report directly to the ***Office of the Prime Minister***. This will give the programme the authority necessary to ensure a sustained and broad-based response.

This committee will interact with the national, regional and international community in directing and coordinating the expanded national response. It is proposed that key areas of focus of the NACC will be in ***policy formulation***, ***programme management***, ***coordination***, ***monitoring and evaluation*** and ***finance.***

Composition of the NACC

NACC will comprise representatives from all key stakeholder groups i.e. PLWHA, Business, Youth, other NGOs/FBOs/CBOs, Ministry of Health, Ministry of Legal Affairs, Ministry of Finance, Ministry of Education, Ministry of Planning & Development, Tobago House of Assembly, Labour and the Media.

The core responsibilities of the NACC will include:

- *Building partnerships - public, private, non governmental;*
- *Defining national policies;*
- *Setting of national targets;*
- *Approving sectoral plans;*
- *Approving budgets;*
- *Establishing of national standards; and*
- *Evaluating and monitoring of the programme at the national level.*

The Committee will also have the flexibility to appoint sub-committees.

Coordinating Role of the NACC Secretariat

The Secretariat of the NACC will be established to support the work of NACC. The NACC Secretariat will be under the Office of the Prime Minister. The NACC Secretariat will be responsible for performing a coordinating, monitoring and advisory role in respect to the implementation of the national expanded response according to the key priority areas identified in the National Strategic Plan, reporting to the NACC.

The NACC Secretariat, which is operational arm of the NACC will be expected to:

- Take a lead role in policy development, strategic planning and management of the national response to the epidemic, ensuring that said response is effective and efficient and in keeping with national, regional and international HIV/AIDS and development goals and/or indicators.

- Within the framework of the national HIV/AIDS strategic plan, facilitate a coordinated and effective response to the epidemic across and within all sectors and disciplines and at all levels of the society, from high-level government and administrative leadership to effective community involvement.

- Mobilize financial and technical resources for the national HIV/AIDS response.

- Monitor the allocation and utilization of all resources assigned to the HIV/AIDS response.

- Monitor and evaluate the implementation of national HIV/AIDS strategies and programmes to ensure that they are effective in reducing the epidemic and its impact on Trinidad and Tobago.

- Keep the NACC abreast of current and relevant information so as to facilitate informed, effective decision-making and actions vis-à-vis the management of HIV/AIDS in Trinidad and Tobago. Such information will encompass but not necessarily be limited to:
    - The status of national HIV/AIDS planning and implementation activities.
    - The progress of the epidemic within the country and worldwide.
    - The impact of the national response on the progress of the epidemic, with attention to its strengths and areas for improvement
    - Information on international best practices, development and cutting edge information vis-à-vis successful management of the HIV/AIDS epidemic.

Very importantly, the Secretariat would not itself be engaged in the implementation of the response. There are other organizations and bodies charged with implementation. Its role is to empower those implementing units and to ensure that, together, they mount a coordinated and effective response to the epidemic.

Composition of the NACC Secretariat

The Secretariat of the NACC will comprise a Technical Director, Deputy Technical Director, Programme Officer (Strategic Planning and Management), Programme Officer (Monitoring and Evaluation), Information and Communication Management Officer, Financial Manager and an Executive Administrative Officer and other support staff. These specialists will be charged with the implementation of the area of the national response that is related to their area of technical expertise.

Technical Director

Responsibilities

- Maintains oversight of the strategic management of the national HIV/AIDS response and its impact on the progress of the epidemic;
- Facilitates informed decision making by the NACC by ensuring that it is:
  - Kept reliably informed on epidemiological data tracking the progress of the epidemic in Trinidad and Tobago;
  - Kept up-to-date through programmatic data on the progress and impact of the national response to the epidemic;
- Facilitates and ensures effective coordination of the national expanded response;
- Enables the mainstreaming of HIV/AIDS considerations into the planning and programming for government ministries, as well as private sector and non-governmental organizations;
- Maintains up-to-date contact with lead national and international partners ensuring that their input is well-coordinated and falls within the parameters of the national HIV/AIDS strategic framework and plan;
- Advises on and facilitate the development of policies, legal instruments pertaining to HIV/AIDS and on the integration of HIV/AIDS issues into national development plans;
- Provides advocacy, including lobbying with all stakeholders to ensure that the response to HIV/AIDS in Trinidad and Tobago is congruent with the national strategic plan/policies of Trinidad and Tobago, (including the reduction of stigma associated with PLWHA).

Deputy Director

Responsibilities

- Assists the Technical Director by assuming responsibility for the daily

running of the NACC Secretariat and supervision of staff;

- Facilitates an effective team approach among NACC Secretariat staff thus enabling a coordinated interface with the many and varied HIV/AIDS stakeholder organizations;
- Advises the NACC and stakeholders, as applicable, on progress, priorities, and gaps vis-à-vis the national HIV/AIDS response and remedial actions to be taken;
- Ensures knowledge-sharing among Ministries, implementing agencies and international organisations in respect of research activities and best/worst practices in combating HIV/AIDS;
- Provides advocacy, including social marketing and lobbying with all stakeholders to ensure that the response to HIV/AIDS in Trinidad and Tobago is congruent with the national strategic plan/policies of Trinidad and Tobago, (including the reduction of stigma associated with PLWHA);
- Assumes the responsibilities of the Technical Director in that individual's absence.

Programme Officer for Strategic Planning and Management

Responsibilities

- Assumes a lead role in the development of national HIV/AIDS strategic plan;
- Provides technical guidance for the integration of HIV/AIDS considerations into national development and planning instruments;
- Provides advisory support and monitor the strategic HIV/AIDS plans of Government Ministries/Departments and other implementing agencies (including NGOs, CBOs, FBOs);
- Ensures that the NACC, through the Technical Director, is kept abreast of the status of the development and implementation of the National HIV/AIDS Strategic Plan;
- Maintains a strategic oversight of the implementation status of the NSP and of the results of the monitoring and evaluation of same and uses such information to guide adjustments to the NSP as needed.

Programme Officer for Monitoring and Evaluation

Responsibilities

- Monitors and evaluates the country's multisectoral, multilevel response

to the epidemic;

- Utilises available and up-to-date epidemiological data on the profile and progress of HIV/AIDS in this country, monitos and evaluates the impact of national, sectoral and multilevel efforts on the epidemic;
- Ensures that the NACC, through the Technical Director, always has up-todate information on the performance of the country's HIV/AIDS response;
- Ensures that the Strategic Planning Officer is kept abreast of detailed information on the effectiveness, strengths, weaknesses and gaps in the country's response to the epidemic, thus providing key information for strategic planning to combat the epidemic;
- Facilitates capacity building for implementation partners to enable them to monitor and evaluate their efforts and to utilise the resulting information to improve their HIV/AIDS programming inputs and outputs.

Information & Communication Management Officer

Responsibilities

- Designs and maintains a comprehensive national information system that will be a repository for national information on HIV/AIDS and that will facilitate:
    - The development and maintenance of a data base of programmes being undertaken by stakeholders with a view to maximizing the synergies between the various programmes;
    - Knowledge-sharing among Ministries, implementing agencies and international organisations in respect of research, activities and best practices in combating HIV/AIDS;
    - Its functioning as a clearinghouse for information, including national and international updates, Best Practices and cutting edge information as these become available.
- Ensures that the NACC, its Secretariat and key leading figures are kept abreast of HIV/AIDS developments, Best Practices and cutting edge information (both local and international) in order to facilitate informed decision making.

Financial Officer

Responsibilities

- Mobilises financial and technical resources as necessary;

- Devises and maintains a system that would facilitate up-to-date tracking of the allocation and utilization of all resources, including those generated by and through external agencies and partners;
- Prepare quarterly reports for the Technical Director/Coordinator on the allocation and utilization of financial and technical resources;
- Facilitates coordination and information sharing among all key national and international partners who provide technical and financial resources for the national HIV/AIDS response.

Executive Administrative Officer

Responsibilities

The Executive Administrative Officer will be required to provide overall support for the NACC and PCU and would be expected to:

- Manage and supervise the general operations of the administration and personnel/human resources of the NACC and PCU including the procurement of office supplies.
- Supervise and monitor specifically the work of the support staff of the NACC.
- Oversee mail flows.
- Ensure that meetings for the organisation are properly organized and coordinated.
- Assist in the overall financial management of the office.
- In collaboration with Information and Communication Management Officer, ensure that all IT systems are properly maintained and functional.
- Execute all human resource matters with regards to recruitment, training and administering of staff entitlements.
- Assist in financial and other reporting required of the PCU and the NACC to lending agencies and Government respectively.
- Build partnerships with key government line-Ministers and other stakeholders.
- Other related duties as assigned.

Sector Level Implementation

At the level of programme delivery and implementation, the community's response will be informed by input from the following key stakeholders:

- *NGOs/CBOs;*
- *Government/Public Sector;*
- *PLWHA;*
- *Media;*
- *Labour;*
- *Business Sector;*
- *Regional Health Authority; and*
- *Local Government.*

Support will be provided by NACC and the local, regional and international technical agencies in the implementation phase of the programme. The composition of the sectors to be represented at the local/community level reflects, in large part, the importance of their role in the expanded response. ***It is imperative that Youth, Education and Faith Based Organizations in particular be represented at this level.*** The role of these sectors is critical given the support base and reach of their representing organisations. This proposed structure therefore provides an opportunity for those sectors/sub-sectors that have traditionally responded to the epidemic- for example Health- together with those that are poised to respond to integrate their activities under one coordinated strategic plan.

HIV/AIDS RESPONSE PROGRAMME - TOBAGO

The organisational structure for the expanded response must give recognition to the power conferred on the Tobago House of Assembly (THA) by virtue of the THA Act. Accordingly, it is accepted that the THA through a HIV/AIDS Substance Abuse Commission, must ensure that the implementation of the expanded response in Tobago is consistent with the national policies, sectoral plans and standards set out by NACC. This requires a synergistic relationship between the THA and NACC; hence the THA will be represented on the NACC thereby providing a critical two-way feedback loop between the NACC Secretariat and the THA.

It will however be necessary for the THA to identify a coordinating body for the Tobago response with the following specific areas of responsibility:

- *Setting targets for the island's Programme;*

- *Developing annual budgets;*
- *Identifying available funding;*
- *Capacity building at all levels on the island;*
- *Monitoring and evaluation of the Programme at the sector and community levels; and*
- *Providing updates to the THA.*

The specifics of the Tobago environment coupled with the requirement that Tobago's response be centred at the local level, point to the need for a Tobago Secretariat that will coordinate the work of community and sectoral groups involved in the response on the island. The Tobago Secretariat should be supported by technical and administrative staff.

The Tobago Secretariat will ensure effective implementation of the HIV/AIDS response in Tobago through the following mix of activities:

- *Facilitating the implementation of sectoral plans by groups on the island;*
- *Facilitating capacity building at the level of the community groups involved in the response on the island including acting as the interface with regional and international agencies that provide technical assistance at the community level;*
- *Facilitating the accessibility of vertical funding on behalf of community groups; and*
- *Supervising the disbursement of horizontal funding to community groups on the island.*

The Tobago Secretariat will have a primary reporting relationship with the Tobago House of Assembly through the HIV/AIDS Substance Abuse Commission and a secondary reporting relationship with the NACC Secretariat.

COMMENTS ON THE GENERAL STRUCTURE

The structure detailed above is represented diagrammatically in Figures 3.1 to 3.3. The first diagram identifies the coordination structure by areas of responsibility, the second diagram details the organizational structure of NACC and the third diagram

details the stakeholder participation by the five broad Priority Areas identified in the *Plan*.

The critical role of Programme Management, Coordination and Evaluation must be noted, both in terms of the key role played by other regional and international technical agencies, as well as the acknowledgement that the initiating of activities under the *Plan* depends upon the efficiency with which the roles identified under this Priority Area are carried out. This underscores the importance of this priority area to the ultimate successful implementation of all other Priority Areas.

In the above proposed structure, the National AIDS Coordinating Committee can assume the role of the Country Coordinating Mechanism for Trinidad and Tobago. This structure will also allow Trinidad and Tobago the opportunity to independently apply to the Global Fund for financial support. The above structure is one that is consistent with international requirements and one that will facilitate an expanded response by all sectors to the HIV/AIDS epidemic.

FIGURE 3.1
NATIONAL STRATEGIC RESPONSE TO HIV/AIDS (COORDINATION STRUCTURE)

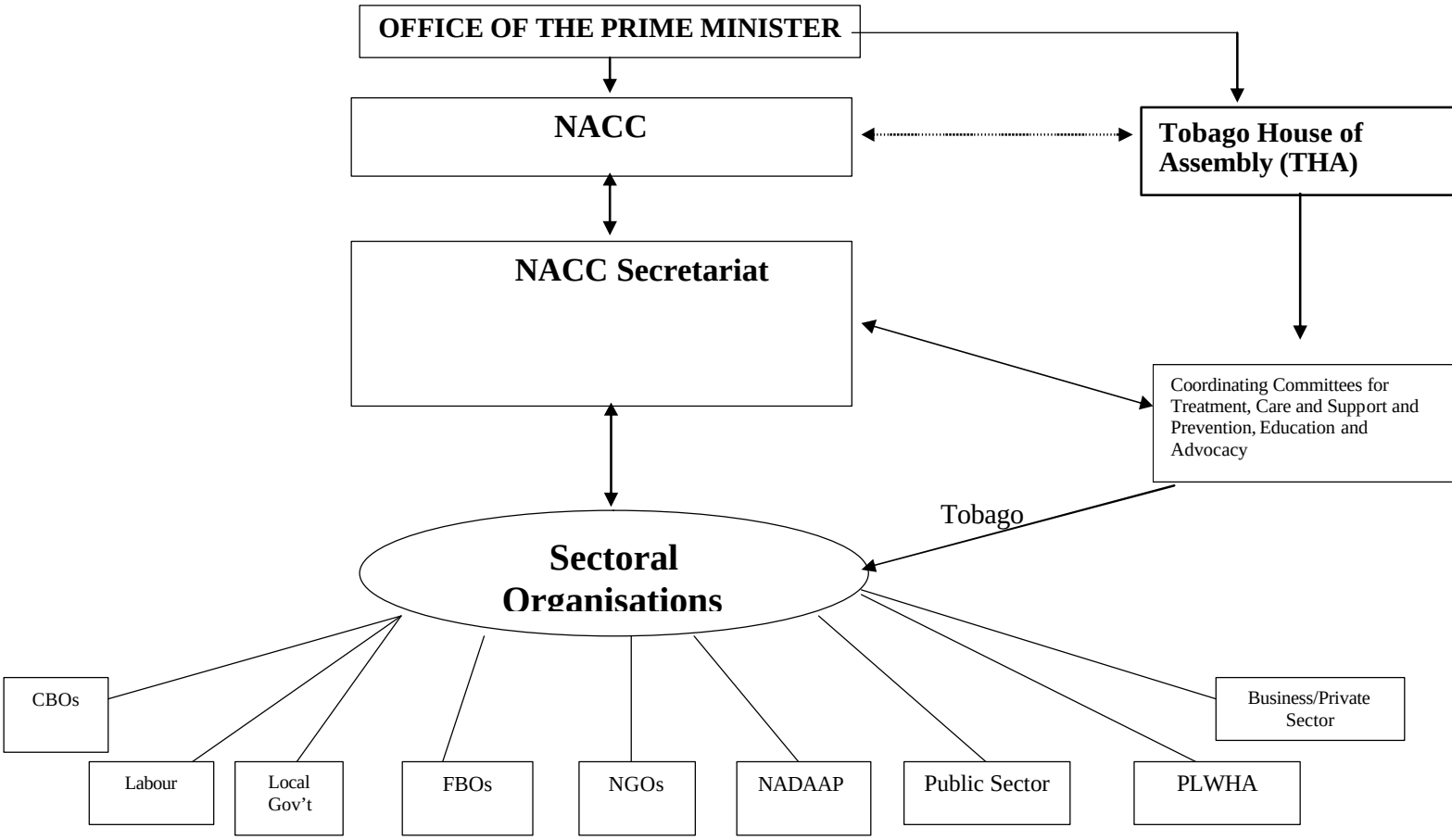


FIGURE 3.2
Governance Structure

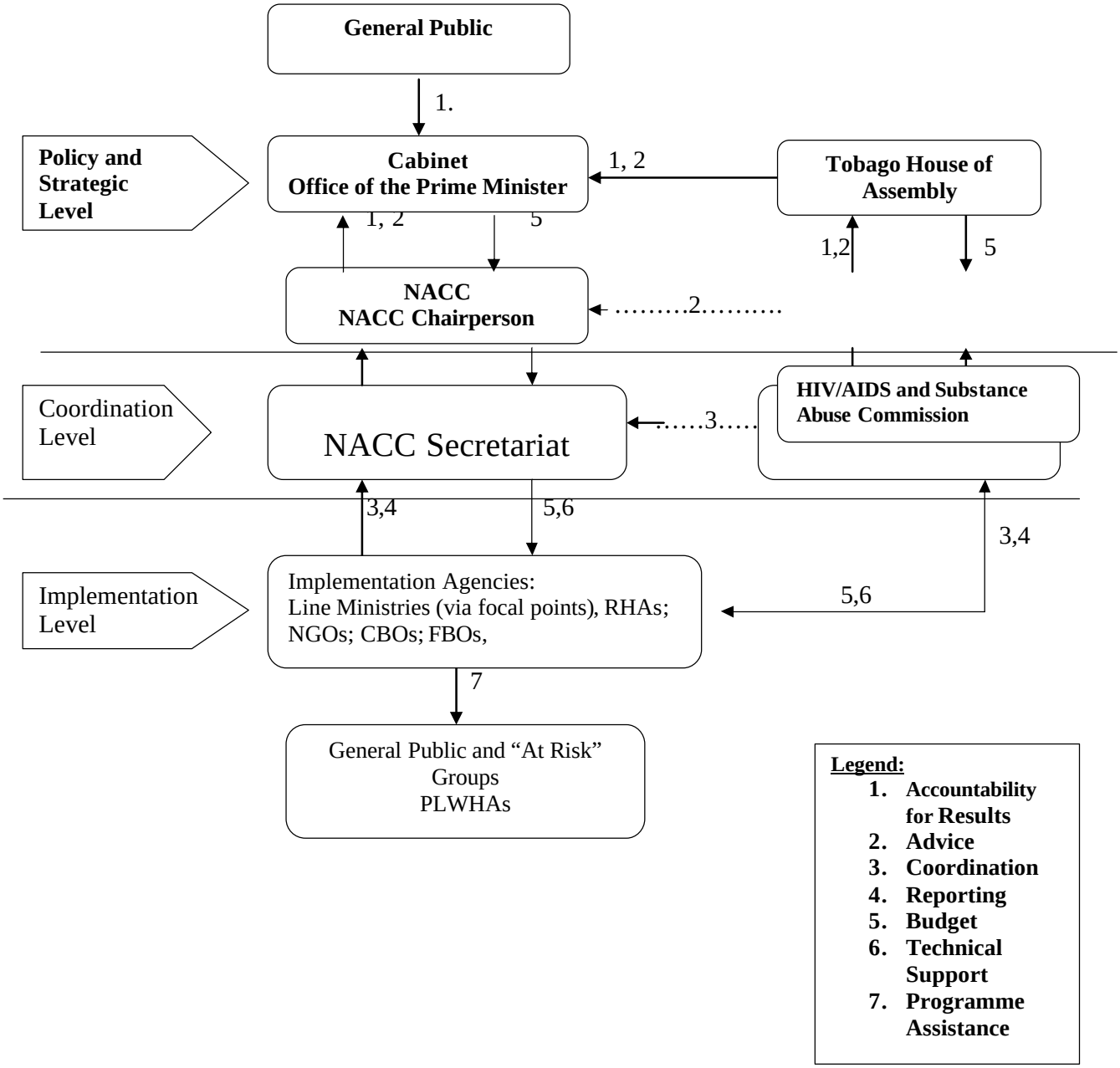
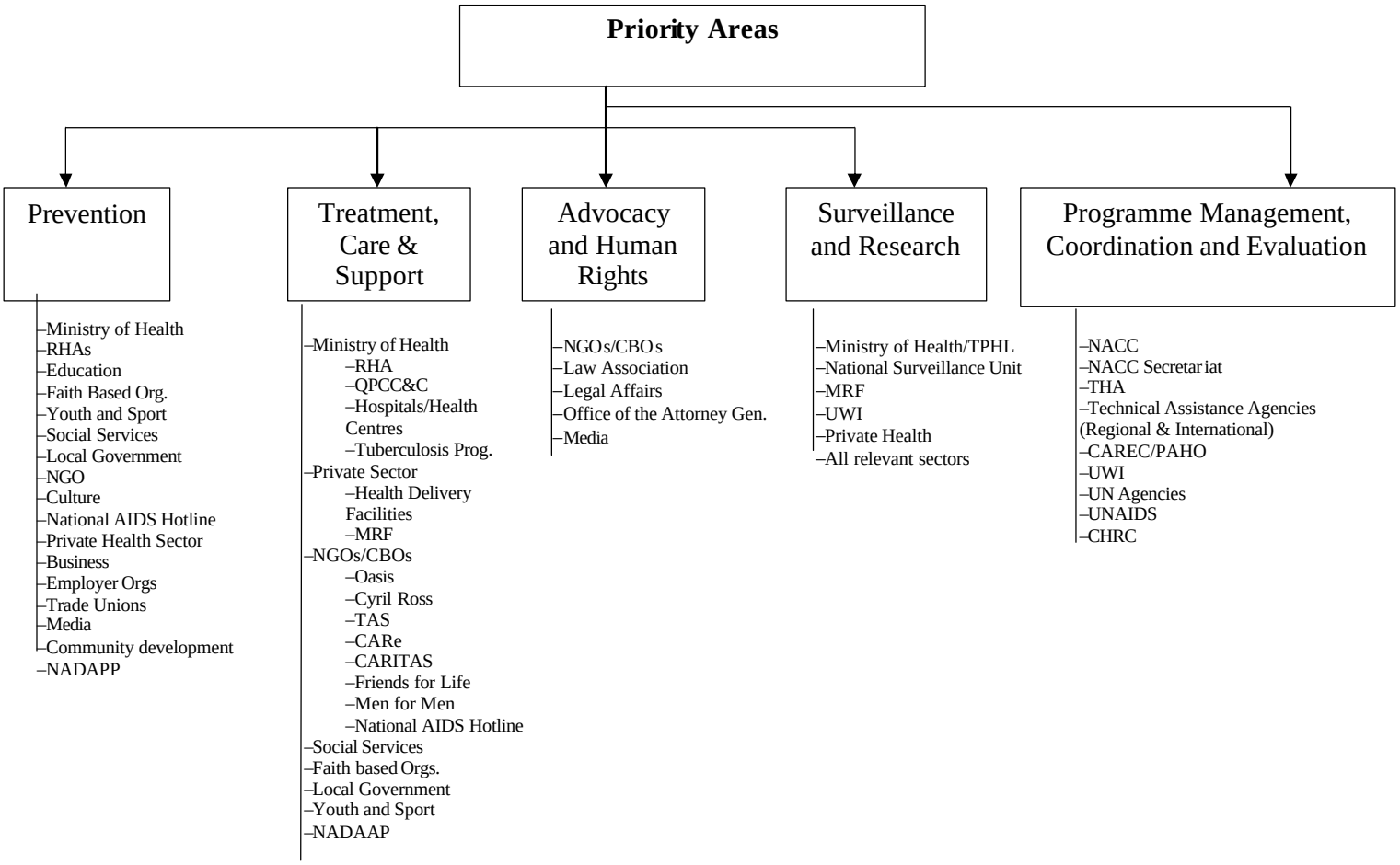


FIGURE 3.3

NATIONAL STRATEGIC RESPONSE TO HIV/AIDS: STAKEHOLDER PARTICIPATION BY PRIORITY AREA FOR PROGRAMME DELIVERY



CHALLENGES OF COORDINATION AND IMPLEMENTATION

Capacity Improvement

The establishment of the National AIDS Coordinating Committee for the response to HIV/AIDS will occur in an environment in which several agencies, including the MoH, have been already responding to the epidemic. In the case of the MoH, this response has been ongoing via the National AIDS Programme (NAP) and the Ministry's service delivery agents- the RHA's. At present, the Ministry of Health is also presently engaged in Health Sector Reform activities that will directly impact on the expanded response to HIV/AIDS. In fact, this *Strategic Plan* expects and assumes that a number of critical outputs of the health sector reform will provide the foundation pillars of the epidemiological, clinical, care and treatment components of the national expanded response.

The following are some of the main expected improvements and expansions upon which the success of the *Five–year National Strategic Plan* is pegged. These are identified in the KPMG Consulting (2001) recommendations that were accepted by the Ministry of Health, and are detailed as follows:

- The National Surveillance Unit will be expanded and improved;
- The QPCC&C will be repositioned and retooled to improve CSTI management;
- Treatment sites for HAART will be established at specified locations;
- Public health laboratory services will be upgraded and expanded to support HAART and MTCT programmes;
- Training of medical, nursing, counselling and other support staff to provide expert HIV treatment and care at the centres and laboratories will be made available; and
- Systems to monitor quality and standards of care for HIV/AIDS patients in the public and private health sector will be established.

The challenge of coordinating the MoH/RHA response within the national expanded strategic response will require agreement between the coordinating agency-NACC- and the Ministry of Health on budgetary and programme responsibilities to ensure maximization of resource utilization, elimination of duplication and effective and efficient health services delivery.

The Role of NAP

The future role of the National AIDS Programme of the Ministry of Health will have to be revisited by the Ministry since much of its present functions will be subsumed by NACC. Although it is not being recommended that the present NAP be expanded into NACC Secretariat, the experience and institutional memory of the NAP will nevertheless prove to be invaluable to the NACC's deliverables.

The Role of the Private Health Sector

For effective execution of the strategic activities identified for *Treatment, Care and Support*, the role of the private health sector must be one of partnership with the MoH/RHAs, as well as the NGOs that provide health care services to HIV/AIDS patients. This partnership must be informed by the national responsibilities of the MoH for the development of policy, standards and quality monitoring for all health care services in Trinidad and Tobago.

Professional associations such as the Medical Association, Dental Council, Nursing Council, Pharmacy Council and allied health professionals are therefore critical strategic partners and must meet with the Ministry of Health and Regional Health Authorities to seek agreement on protocols, levels of care, referral systems, roles, responsibilities and expectations with respect to the expanded national response. Similar meetings must be held with the private hospitals, nursing homes, hospices, diagnostic centres, laboratories, pharmacies, RHAs and the Ministry of Health to define and agree upon:

- The epidemiological database and reporting requirements required to monitor the epidemic;
- Quality assurance systems to be implemented;
- The referral system for patient transfers; and
- The cost of care and subsidy to the private sector with respect to HIV counselling, diagnostics and treatment & care.

The output of this complementary approach between the public and private health sector will lead to a standardized, non-duplication of health services to patients in a streamlined fashion at expert centres of care for HIV/AIDS. One or a combination of models will inform these centres of care:

(a) Private delivery of services;
(b) RHA and private delivery of services;
(c) Private and NGO delivery of services;

(d) RHA and NGO delivery of services;
(e) RHA delivery of service; and
(f) NGO delivery of service.

The models of care will be regionally coordinated and provide service in the areas of VCT, MTCT, pharmacy, diagnostics, laboratory, out-patient and in-patient care, hospice care and counselling services etc. Private health institutions and professionals will also be encouraged to do research in collaboration with established researchers and the NACC secretariat.

Other Public Sector Agencies

Similar issues for agreement and coordination with NACC in the implementation of the expanded response will arise with various public sector agencies, for example:

- MoE and its HFLE programmes;
- MoSD and the requirement of social and economic support to the infected and affected;
- MoNS and its programmes for officers and inmates; and
- Regional corporations, boroughs and cities' plans and programmes for HIV/AIDS response.

SECTION IV

THE COST OF THE NATIONAL STRATEGIC PLAN

COST OF TRINIDAD AND TOBAGO'S NSP

The cost estimates of the NSP are presented along the identified *Priority Areas*, highlighting the costs associated with the strategic activities of the specified objective. In order for an expanded response to the HIV/AIDS epidemic in Trinidad and Tobago to be implemented, approximately US$90.33 million is required over the medium term (five years).

ANNUAL COSTS OF IMPLEMENTATION

Based on the phased implementation of the NSP (see accompanying Implementation Plan), the annual costs from year 1 to 5 are as follows.

TABLE 4.1
IMPLEMENTATION COSTS PER YEAR
US$ millions

Priority Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Prevention	4.00	4.32	4.25	4.36	4.13	**21.06**
Treatment, Care and Support	9.62	11.25	10.86	12.34	14.60	**58.67**
Advocacy and Human Rights	0.10	0.10	0.10	0.10	0.10	**0.51**
Surveillance and Research	0.77	1.67	0.59	0.51	0.59	**4.13**
Programme Management, Coordination and Evaluation	1.12	1.21	1.21	1.21	1.21	**5.96**
TOTAL	**15.61**	**18.55**	**17.01**	**18.52**	**20.64**	**90.33**

It is of note that the implementation cost in year one amounts to US$15.61 million, which is lower than that of subsequent years. This indicates some measure of gradual capacity building since one of the emphases is on the training of existing and/ or newly recruited human resources. Although some programme areas are implemented during the first year, more of the utilisation of other resources occur later in the first year, as well as in the subsequent years. Further, there are some pre-implementation costs that are not catered for under the NSP since the activities to which they are attached, while critical, fall outside the ambit of the NSP. The issue of capacity building is essential to the discussion since the experience of other large programmes undertaken prior to this shows

that without the capacity to utilise available resources, they lie idle for several years and ultimately prove to be very expensive to the country.

Additionally, the estimated cost for the first year of activities is of particular importance since significant emphasis will be placed on the development of NACC and the efficient on-streaming of activities. This is to ensure the efficient and effective use of the resources in the years to follow. It is also recognised that some treatment and care activities will be activated in the first year.

Although annual implementation costs are presented here, it is pertinent at this juncture to indicate that periodic evaluations of the programme by NACC will determine:

- The rate of expansion of the response;
- The programmes to be adjusted; and
- The funds to be expended for subsequent years.

Suffice it to say however, that the cost of the NSP here articulated, does not represent the total amount required to treat with HIV/AIDS in Trinidad and Tobago since expenditures that are currently being undertaken in several sectors must of necessity continue.

Placing the NSP within the economic context of the country, the first year implementation cost of US$15.61 million represents 0.20% of the country's income which was provisionally estimated at US$7,985.85 million in 2000. This also translates into a per capita cost of US$12.20.

The following table provides a detailed overview of the five-year cost for each *Priority Area*.

TABLE 4.2
COST OF TRINIDAD AND TOBAGO'S FIVE-YEAR NSP BY PRIORITY AREA

Priority Area	Costs (5 Year) (US$ million)	% Share of Programme
Prevention	21.06	23.31
Treatment, Care & Support	58.67	64.95
Advocacy & Human Rights	0.51	0.56
Surveillance, Epidemiology & Research	4.13	4.57
Programme Management Coordination & Evaluation	5.96	6.61
TOTAL	**90.33**	**100**

To deliver the strategic activities outlined under the *Treatment, Care & Support Priority Area* US$58.67 million will be required, of which HAART constitutes approximately US$23.19 million and Palliative Care & Clinical Management of Opportunistic Infections approximately US$20.1 million. Together, these represent 73.8% of the cost of Treatment, Care & Support.

Prevention is the second largest cost component of the NSP. It amounts to 23.31% of the overall Plan and includes the VCT (US$9.0 million) and MTCT (US$3.83 million), as well as programmes targeted to risk groups, which amount to US$1.06 million.

The remaining components of the NSP, namely Programme Management, Coordination & Evaluation, Surveillance & Research and Advocacy & Human Rights together constitute 11.74% of the overall cost of the NSP or US$10.61 million.

Details of the cost of the NSP as they relate to each *Priority Area* follow.

PRIORITY AREA I – PREVENTION US$21.06Mn

Priority Area I consists of programmes and activities that are focused primarily on Prevention and which amounts to a total cost of US$ 21.06 million. The following table provides a breakdown of the major programmes as presented in this Priority Area.

TABLE 4.3
BREAKDOWN OF COST STRUCTURE OF PRIORITY AREA I

Strategic Objective	Cost (US$ million)	% of Cost of Objective
To Promote Safe and Healthy Sexual Behaviours among the General Population	3.93	18.66
To Promote Healthy Sexual Attitudes, Behaviour and Practices among Vulnerable/High Risk Populations	1.07	5.08
To Reduce the Rate of Mother to Child Transmission	3.83	18.19
To Increase the Population's Knowledge of its Serostatus	8.99	42.69
Improve the Management & Control of CSTIs	3.24	15.39
TOTAL	**21.06**	**100**

The strategic objective *Promote Safe and Healthy Sexual Behaviours among the General Population* includes programmes aimed at *Heightening HIV/AIDS Education and Awareness,* which attract a cost of close to US$2.02 million to produce and disseminate IEC material specifically targeted to different audiences. Other strategies under this objective include an expanded condom marketing programme (US$1.86 million), which is expected to make condoms more accessible to the sexually active population. The extension of the responsibility for HIV prevention to all sectors costs approximately US$0.05million.

To Promote Healthy Sexual Attitudes, Behaviour and Practices among Vulnerable/High-risk Populations, strategic objective 2, is one of the critical programmes of the NSP and involves targeted interventions for specific groups. In addition to a large IEC component (the costs of which are subsumed under objective 1), behaviour change interventions targeted at young females amount to US$0.13 million, while interventions targeted at

youths in-and out-of-school total US$0.52 million. Capacity building and support for MSMs amounts to US$0.08 million, skill-building programmes for CSWs approximate US$0.23 million, and support programmes for prisoners/prison personnel and drug impact reduction programmes are US$0.05 million each. The total cost of the objective is US$1.06 million.

US$3.83 million is required over the five-year period for the continued expansion of the *Mother to Child Transmission* programme. Approximately 46% of this cost is allocated to capacity building in this area, which is manifested in comprehensive training of health staff at antenatal centres. *It is important to note here that the training of personnel under the general* Voluntary Testing and Counselling *objective will occur simultaneously with the training carried out under the MTCT programme, since it is also a critical component of the MTCT programme. As a result, training costs are combined and savings are realised.* The costs of the corresponding upgrade of reference laboratories to support the MTCT programme fall under the Ministry of Health's laboratory upgrade programme and have not been estimated under the NSP.

The provision of comprehensive testing and counselling for mothers is estimated at US$1.4 million or 36% of the costs of the strategic objective, while ARV treatment for both mothers and babies is estimated to cost US$0.62 million over the five year period. *Developing and Implementing Guidelines* with respect to clinical procedures, as well as the *Lobbying of Private Sector* practitioners to encourage them to provide counselling and testing to their antenatal patients are also activities included under this Strategic Objective.

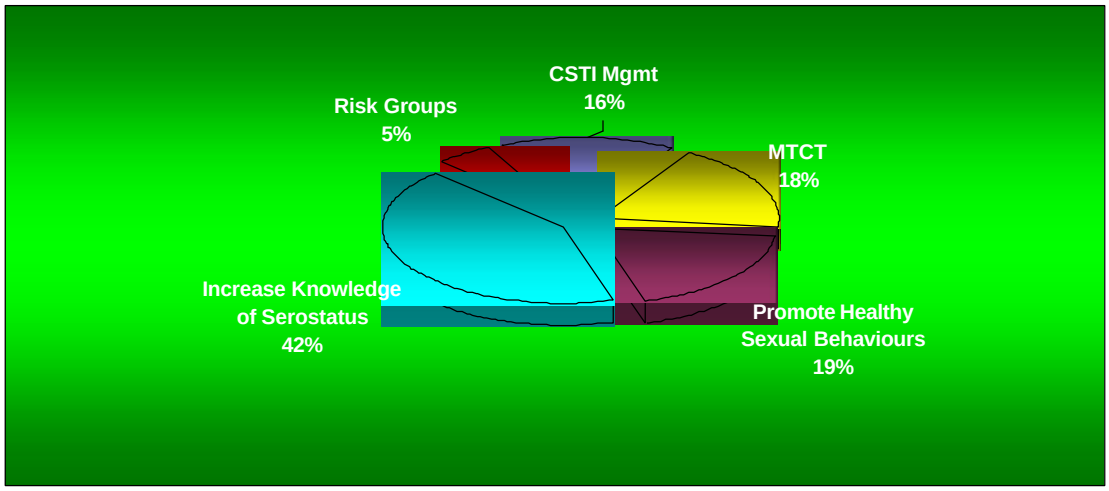
A comprehensive VCT programme, which is the main component of the objective *To Increase the Population's Knowledge of its Serostatus*, will cost approximately US$9.0 million. The actual counselling and testing service is estimated at 82% (US$7.35 million), of the cost of the VCT programme costs, while support services, including equipment, account for the remaining costs. (*See note on training and capacity building*

under MTCT, above). These services will augment those services already being offered in both the public and private sectors.

With respect to youth as a vulnerable group, the provision of youth friendly sexual and reproductive health services are identified for Trinidad, as well as the establishment of two youth centres in Tobago. These facilities will cost approximately US$2.39 million. Also included are activities that support teenaged parents and the expansion of youth abstinence programmes. Additionally, allocations are made to host motivational workshops for out-of-school youth, to train teachers in order to incorporate HFLE in the school curriculum and to undertake regular surveys on youth sexuality to monitor behaviour modification.

The following figure further illustrates the percentage distribution of the programmes/activities in this Priority Area.

FIGURE 4.1
% BREAKDOWN OF PROGRAMMES UNDER PREVENTION



PRIORITY AREA II – TREATMENT, CARE AND SUPPORT US$58.67 Mn

The following table provides a breakdown of the cost structure as detailed in *Priority Area II*.

TABLE 4.4
BREAKDOWN OF COST STRUCTURE OF PRIORITY AREA II

Strategic Objective	Cost (US$ million)	% of Cost of Objective
To improve Access to Treatment and Care for HIV/AIDS	57.13	97.37
To create an environment that supports the infected and affected	1.54	2.63
TOTAL	**58.67**	**100**

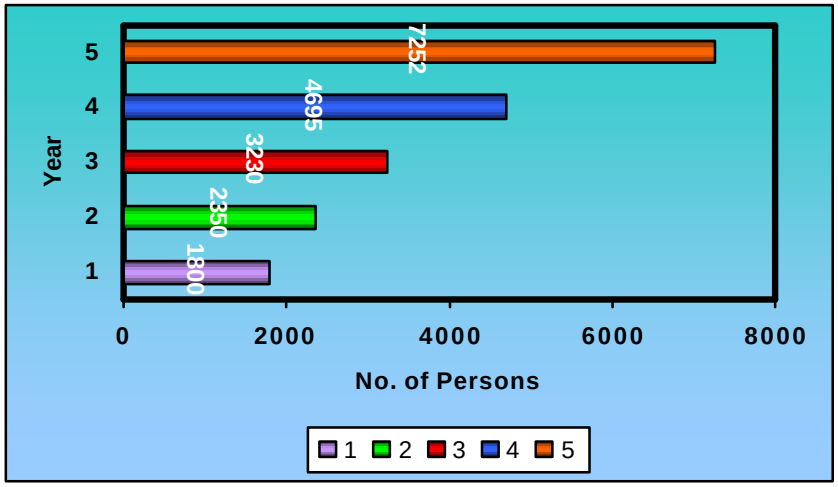
The cost of providing treatment, care and support for persons infected and affected with HIV/AIDS approximates US$57.13 million. This figure includes the expansion and upgrade of existing facilities (US$2.0 million), as well as training of personnel (US$1.27 million. The provision of access to ARV treatment to persons who require it is estimated at US$23.19 million, while the provision of medication, treatment and care for OIs rounds out to US$20.10 million. It is estimated that in the first year of the programme 1,500 persons will be treated with ARV in Trinidad while 300 will be treated in Tobago. From year 2 through 5, a phased approach to HAART is required to facilitate the building and strengthening of capacity. Based on this, increases of 30% to 60% are estimated in Trinidad, while in Tobago, an increase of 100 persons is expected in each year of the programme culminating with 700 persons being treated in year 5. Table 4.5 and Figure 4.2 provide details.

While it may be anticipated that the costs associated with the provision of OIs will fall over time, because of the step-wise phased approach to the introduction of ARVs, the impact of any fall in the costs associated with OIs is not immediately felt over the five year period. Additionally, given concerns raised about the level of under-reporting, some measure of excess capacity has been built in to cater for those persons, who by virtue of being infected but unidentified, may seek treatment for OIs.

TABLE 4.5
ANNUAL COST OF ARV TREATMENT

ARV Treatment	No. of Persons Treated (Projected)	Cost (US$ million)
Year 1	1,800	2.16
Year 2	2,350	2.82
Year 3	3,230	3.88
Year 4	4,695	5.63
Year 5	7,252	8.7

FIGURE 4.2
NUMBER OF PERSONS RECEIVING HAART ANNUALLY



In recognition of the need for appropriate laboratory support to complement the management and treatment of HIV/AIDS, US$8.45 million has been allocated. It must be said at this juncture that this represents enhancing laboratory capacity to allow for two (2) CD4 counts and one (1) viral load test per year, at minimum, to be done for each HIV/AIDS patient who requires monitoring. It is expected that the necessary capital upgrade of the laboratory services will be undertaken through a separate funding stream.

With respect to Tobago, a core Treatment, Care & Support team was identified with cost estimates for this team approaching US$2.12 million or 4% of the programme. Further, initial estimates for the on-streaming of the Tobago Treatment Facility at Scarborough are US$9.23 million over five years or an average of US$1.85 million per year. These costs include ARV treatment, as well as treatment and care of OIs, in addition to the

necessary laboratory support and the costs of the treatment team previously mentioned. The cost of implementing treatment in Tobago therefore represents 10.22% of the cost of the NSP.

PRIORITY AREA III – ADVOCACY AND HUMAN RIGHTS US$0.51Mn

This *Priority Area* entails activities and programmes for the reduction of stigma and discrimination against PLWHAs estimated at US$0.38 million, as well as programmes for ensuring human rights for PLWHAs (US$0.13 million). The following table refers.

TABLE 4.6
BREAKDOWN OF COST STRUCTURE OF PRIORITY AREA III

Strategic Objective	Cost (US$ million)	% of Cost of Objective
To Reduce Stigma and Discrimination against PLWHAs	0.38	74.5
Ensure Human Rights for PLWHA and other groups affected by HIV/AIDS	0.13	25.5
TOTAL ADVOCACY COSTS	**0.51**	**100.00**

The overall thrust of this Priority Area is the ensuring of the creation of a legal framework that protects the rights of PLWHAs and those affected by HIV/AIDS. This includes legislation, which deals with workplace policies and human rights issues. Segments of the overall objective include the annual conduct of surveys, which will aid in monitoring the effectiveness of policies (US$0.7 million), in addition to workshops/seminars and building NGO capacity representing 86% of the costs.

PRIORITY AREA IV - SURVEILLANCE & RESEARCH US$4.13Mn

Estimated to cost US$4.13 million, this *Priority Area* includes the strategic objectives of *Strengthening the Surveillance Systems for CSTI/HIV/AIDS* and *Improving and Participating in Effective Clinical and Behavioural Research on HIV/AIDS.* These include strengthening the National Surveillance Unit in the area of training and provision of additional staff (US$0.95 million). Additionally, there is the undertaking of activities aimed at enhancing laboratory capacity (US$1.45 million), as well as research in clinical and socio-behavioural areas for which the amount of US$1.5 million will be injected over the five year period.

PRIORITY AREA V - PROGRAMME MANAGEMENT, COORDINATION AND EVALUATION US$5.96Mn

The strategic activities that fall under *Programme Management, Coordination and Evaluation* account for US$5.96 million, which represents 6.61% of the overall cost. The programme/activity that attracts a cost element in this *Priority Area* involves the start-up and subsequent operational costs of NACC and its various arms of responsibility. This body will be responsible for the effective coordination, management and timely monitoring and evaluation of the implementation of the NSP. Appendix II provides a more detailed presentation of the NSP costs.

CROSS-PRIORITY COST COMPONENTS OF THE NSP

The cost of several components that span the range of Priority Areas are identified for further analysis since they are critical to an understanding of how the activities are somewhat intertwined. For example, when the training component of the NSP is examined, the estimate is an amount of US$4.52 million, which incorporates training for medical, laboratory and surveillance personnel, as well as FBOs, PLWHAs, teachers and other NGOs. This component represents 5% of the overall cost of the five-year NSP. This speaks to the need for effective coordination of the training programmes since, in some cases, the assumption is made that there will be cross fertilisation across different categories of personnel which would result in shared training costs.

Personnel costs account for 13.73% of the cost of the NSP which translates to a cost of US$12.40 million. As a subset of this, personnel requirements for Tobago amount to US$4.51 million, which facilitates the implementation of the treatment, youth health education and surveillance programmes. The cost also includes the secretariat of the NSP coordinating unit in Tobago. With respect to Trinidad, the personnel costs include the NACC secretariat as well as staff for the National Surveillance Unit. Together these amount to US$7.89 million. The complementary office equipment for these activities (both Trinidad and Tobago) costs an estimated US$0.55 million or 0.61% of the overall cost of the NSP.

The cost of a comprehensive IEC programme is estimated to amount to US$2.02 million over five years. This programme is aimed at behaviour modification in all identified

vulnerable and risk groups, for example, in- and out-of-school youth, CSWs, MSM, prisoners, young females. It will consist of targeted messages to these groups through all forms of media and theatre. In addition, it forms part of the advocacy campaign and also reaches non-risk groups.

Capacity building for NGOs straddles the Prevention, Treatment, Care & Support and Advocacy *Priority Areas* of the Plan. Overall, this amounts to US$2.24 million, with capacity building for homed- and community- based care accounting for the lion's share (US$1.44 million). Together, this component accounts for 2.48% of the NSP.

KEY ISSUES AND ASSUMPTIONS

It is important to note that the infrastructure and development costs of the laboratory system, as well as key health facilities have already been allocated under the Health Sector Reform Programme. As such, they are not picked up here as costs specific to the NSP for HIV/AIDS. What is accounted for here is the required support and strengthening that are needed to ensure the effective implementation. As such, laboratory support for the carrying out of CD4 counts and viral load tests have been estimated at US$8.45 million (9.36% of the NSP). Additionally, support for a portion of the laboratory IT system, namely software and hardware costs and the training of end users has also been allocated to the tune of US$1.45 million.

With respect to the care and support of orphans, the cost of treatment has been subsumed under the overall Treatment, Care & Support programme. Other costs with respect to the upkeep of orphans are catered for under the existing Social Welfare programme. As such, these costs are not reflected in the estimate of the NSP.

SECTION V
EVALUATION OF THE NATIONAL STRATEGIC PLAN

INTRODUCTION

This section evaluates the cost of the *Five-Year National Strategic Plan* within the context of the gains to be derived from effecting an expanded response to HIV/AIDS in Trinidad and Tobago. A cost-benefit approach to measure and evaluate the monetary advantages that the investment will yield is employed. Beyond financial terms, however, suppressing the growth of HIV/AIDS will produce large qualitative returns that are not directly measurable. Such gains include the ***social***, ***psychological*** and ***developmental*** rewards that will emerge as more and more individuals and households are spared the pain and suffering that accompany the epidemic. These issues are discussed at the close of this section.

COST BENEFIT ANALYSIS OF THE NATIONAL INVESTMENT IN HIV/AIDS

The ***primary*** goal of the *Five-year HIV/AIDS Strategic Plan* is to restrict the growth of the HIV pandemic in Trinidad and Tobago. The principal benefit to be derived from the US$90.33 million investment is therefore a ***reduction in the HIV incidence rate***. To assess the efficiency of the use of these resources, we will compare the cost of the *Strategic Plan* versus the cost to the nation if the pandemic is left unbridled. This analysis is performed below and illustrated in Table 5.1 toTable 5.3.

According to *CAREC/CDC- Estimates of People Living with HIV/AIDS in the CAREC Member Countries at the end of 2001,* there were approximately **16,217** persons living with HIV in Trinidad and Tobago. This estimate was based on an overall HIV/AIDS prevalence rate of 1.2%. Data provided by the National Surveillance Unit over the five-year period 1996 to 2000, also reveal that the average annual rate of growth of new reported HIV cases was 7.43% (Refer to Table 1.1). If we assume that this growth rate is an indication of the expansion of the epidemic[8], and if we apply this increase to CAREC/CDC's 2001 estimate while correcting for deaths of those infected with

[8] It is recognized that fluctuations in the number of confirmed cases as picked up by the Surveillance Unit is to some extent a function of the quality of the surveillance effort and may not entirely be indicative of increases in incidence. For the purposes of this exercise however, we assume that the reported and actual rates are equal.

HIV/AIDS, we can comfortably arrive at a projection of the prevalence of HIV in Trinidad and Tobago. This information up to 2007 is depicted in Table 5.1.

TABLE 5.1
PROJECTED NUMBER OF HIV/AIDS CASES IN TRINIDAD AND TOBAGO
WITHOUT NSP IMPLEMENTATION
2001 – 2007

Year	Population (millions) (P_{op})	Incidence rate (per million) (I_r)	Incidence (I)	Deaths (D)	Prevalence (P)
2001	1.268	---	---	---	**16,217**[a]
2002	1.275	945	1,205	324.34	17,098
2003	1.281	1,010	1,294	341.95	18,050
2004	1.287	1,080	1,391	361.00	19,080
2005	1.294	1,155	1,494	381.59	20,192
2006	1.300	1,234	1,605	403.84	21,393
2007	1.307	1,319	1,724	427.86	**22,690**

[a] ***CAREC/CDC, 2001 estimate***.

Assumptions:
(a) P_{op} increases by an annual rate of growth 0.5% per annum. (www.cia.gov)
*(b) HIV incidence (I) is assumed to grow by 7.43% annually. (Based upon the average annual growth of new **confirmed** cases over 1996- 2000 as supplied by NSU data).*
(c) Deaths(D) in any year are 2% of prevalence in the previous year. Thus $D = 0.02 \times P_{t-1}$
(d) HIV prevalence (P) in the current year (t) is equal to the prevalence in year t-1plus incidence in year t, less deaths (D) in year t. Thus $P_t = P_{t-1} + I_t - D_t$.

The data contained in Table 5.1 show that with a current prevalence rate of 1.2%, and adjusting for the mortality rate due to AIDS, ***there are about 17,098 persons currently living with HIV/AIDS in Trinidad and Tobago and that this figure will grow to about 22,690 by 2007 if no strategic response is implemented***.

Using this information, Table 5.2 predicts the behaviour of the pandemic under conditions of non-implementation versus implementation of the *NSP*.

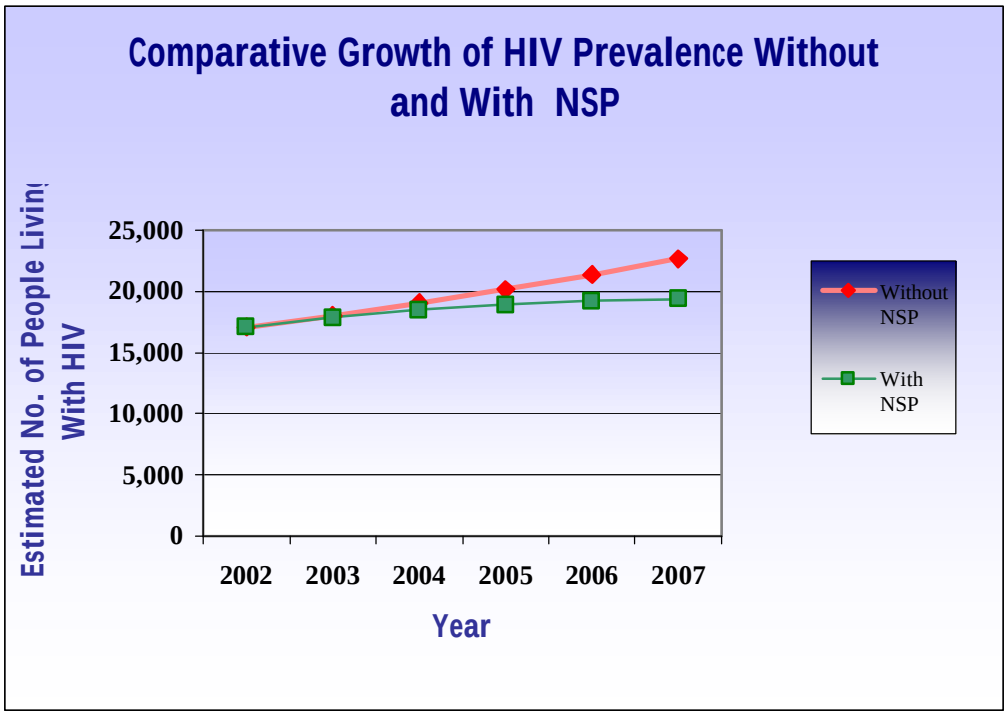
TABLE 5.2
COMPARISON OF GROWTH OF THE HIV/AIDS PANDEMIC IN TRINIDAD AND TOBAGO
WITHOUT VERSUS WITH NSP IMPLEMENTATION

WITHOUT NSP				
Year	**Incidence rate per million**	**Incidence**	**Deaths due to AIDS**	**Prevalence of HIV In the Absence of Strategic Interventions**
2002	945	1,205	324	17,098
2003	1,010	1,294	342	18,050
2004	1,080	1,391	361	19,080
2005	1,155	1,494	382	20,192
2006	1,234	1,605	404	21,393
2007	1,319	1,724	428	***22,690***
WITH NSP				
Year	**Incidence rate per million**	**Incidence ***	**Deaths due to AIDS**	**Prevalence of HIV With Strategic Interventions**
2002	945	1205	324	17,098
2003	869	1113	342	17,869
2004	717	923	312	18,480
2005	565	731	277	18,934
2006	413	536	237	19,233
2007	261	341	193	***19,381***

** Incidence rate decreases linearly to 30% of its 2003 value.*

The top half of the table shows the evolution of the pandemic in the absence of a national *Strategic Plan.* The bottom half of Table 5.2 and Figure 5.1 predict the growth path of HIV when the expanded response is implemented. The National Strategic Plan for Trinidad and Tobago can be expected to restrict the growth in prevalence of the epidemic to **19,381** cases by the year 2007, as opposed to **22,690** cases in the absence of a *Plan*, a reduction of **3,309** cases. Additionally, the *Plan* is expected to avert an estimated **3,864** new infections over the period 2003–2007. This projection is made upon the assumption that the prevention programme of the NSP will be effective in decreasing the incidence rate to 30% of its 2003 value at the end of the *Plan's* period.

FIGURE 5.1



Based upon the forecast contained in Table 5.2 and given the size of the prevention budget- US$21.06 million, the cost to avert one infection is **US $5,450.31**. At this point it must be noted that there is no **predefined formula** or rule of thumb that links one dollar spent on HIV prevention to a specified amount of cases averted. In fact, evidence from several countries shows that the cost to avert an HIV infection can range from as low as US$200 (Zewdie, 2000) to as high as US$13,000 (Kahn, 1992). ***This cost will depend upon the types of interventions contained in the prevention programme, the number of persons targeted and reached, as well as the efficacy of the interventions in actually achieving behaviour change***. The result provided by Kahn (1992) for example, is based on a programme that included counselling and testing in a high-risk North American city while the US$200 estimate (Zewdie, 2000), is based on rudimentary prevention programmes in Sub-Saharan Africa.

In light of these variations, the expectation that the NSP will achieve a 70% reduction in incidence is made in keeping with the ***experience of the cost effectiveness of programmes implemented within the Caribbean region*** where combined condom distribution and peer education programmes in the Dominican Republic and Antigua in the early stages of the epidemic, achieved an infection prevention cost of between US$400 to US$1,000 (Forsythe et al. 1992). These programmes did not include the costs

associated with MTCT programmes, nor did they include the full range of prevention strategies included in Trinidad and Tobago's *Five-year Strategic Plan.* Given this, and in view of the impact of general price inflation, a cost per infection averted of US $5,450.31 for Trinidad and Tobago is quite reasonable.

In purely financial terms, the prevention component of the NSP can be expected to yield an absolute gain of more than **US$271** million. This is without regard to the non-quantifiable benefits that the investment will undoubtedly yield. Table 5.3 illustrates:

TABLE 5.3
GAINS FROM INVESTING IN THE NSP[9]

Infections Averted	Years of Life Saved[1]	Productivity Losses [2] (US$)	Averted Cost of Care[3] (US$)	Total Financial Benefits (US$)
3,864	38,640	$240,509,270.40	$31,020,192.00	$271,529,462.40

Assumptions

[1] *Averting HIV/AIDS buys an individual 10 productive years of life.*

[2] *Annual productivity is measured using 2000 GDP per capita (at current prices).*

[3] *An infected person will live for 10 years with adequate care. Cost of treating OIs is $802.80 as used in the revised FGI model.*

Averting 3,864 HIV infections is tantamount to saving 38,640 years of productive life which in terms of GDP can be equated to a saving of as much as US$240.5 million. Savings are also derived by the economy because of the cost of medical care that is prevented. In addition to these, each case of HIV prevented represents savings to households and communities and reduces intangible costs, such as personal suffering and other derived effects. Although these are difficult to quantify, the impact of the strategic response in reducing or eliminating these costs is now qualitatively discussed.

SOCIO-ECONOMIC IMPACT OF HIV/AIDS

[9] The cost benefit analysis presented in this section will yield similar results under alternative assumptions about HIV prevalence. For example, *UNAIDS/WHO AIDS Epidemic Update, 2001* estimates that the ***adult prevalence rate*** of Trinidad and Tobago is 2.5% which is somewhat confirmed by NSU/MoH (2000) that indicated a prevalence rate of 2.5% among pregnant women in 1999 (Refer to Section I). If this is used as the proxy for the overall prevalence rate, ***the actual number of persons living with HIV in Trinidad and Tobago could be estimated at 17,752 for 2001,*** which is comparable to the CAREC/CDC 2001 estimate. Applying similar assumptions to this estimated prevalence will yield similar cost effectiveness results of the NSP.

Over the past two decades we have seen HIV/AIDS evolve into an epidemic which impacts on almost every aspect of our lives. The impact of HIV is not only on the person infected, but rather, on every institution to which that person is associated, be it the household, private and public sectors or the economy as a whole.

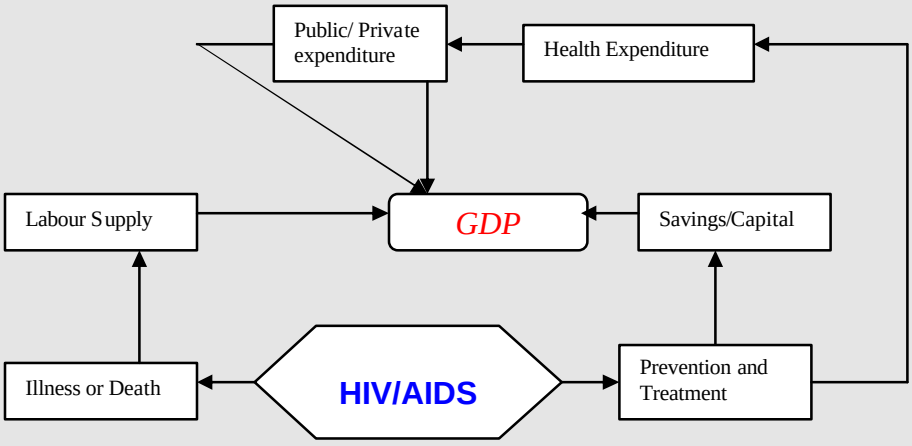
Economic Impact

Erosions in the economic and development gains of the economy will stem from the impact of HIV on human capital and financial resources. HIV/AIDS prevalence is highest among adults 15-49 years of age, the group which is deemed to be the most productive. As a result, HIV/AIDS reduces the pool of skilled labour supply of a country. In a study done by Nicholls et al (1997), HIV/AIDS is estimated to decrease labour supply by 5.2% by 2005. This results in a loss of income for households and a decrease in output for the country. By extension, the level of savings decreases, which has direct implications for the level of investment in the economy. Nicholls et al (1997) in the same study also projected a reduction in the level of savings and investment by 10.3% and 15.6% respectively if present trends continue. This is compounded by the fact that resources to treat HIV/AIDS patients will also be diverted from productive activities into drugs and treatment centres.

The following diagram depicts the relationship between HIV and the economic system.

FIGURE 5.2

HIV/AIDS AND THE ECONOMIC SYSTEM



Source: Adapted from Theodore, Karl (2000b)

However, the impact of HIV on the economy will be reversed by the effective implementation of the NSP, which has the potential to prevent 3,864 persons from becoming HIV victims. This translates into a total of 38,640 years of life saved and productivity gains of over US$240 million.

Social Impact

The loss of a productive member of a household translates into a loss of an income stream, increased costs and changing expenditure patterns. When that loss is due to HIV/AIDS the psycho-social impact is more severe and far-reaching than the loss of financial resources. As the disease progresses, those infected are unable work. As a result, the loss of income to the household results in changing spending patterns. The cost of care for the infected person increases and this shrinks the budget allocations for basic needs such as schooling and nutrition. The financial impact of HIV/AIDS death is seen to be 30% higher than the death of other diseases.[10]

The social impact of an HIV/AIDS death is on the survivor and is measured by indicators such as schooling, nutrition, health poverty and orphanhood, which in itself, can be a

[10] Facts, Figures and the Future. South African Health Review 2000.

long-term effect of HIV. Oftentimes, orphans suffer from a lack of accommodation, income, sexual abuse and exploitation as well as further declines in health status. Resultantly, many may end up in high-risk situations themselves. Further, if relatives or the state do not take responsibility for these orphans, they form child-headed households or become street-children and may eventually turn to crime as an alternative source of income.

It is therefore clear that HIV/AIDS goes beyond being a health issue and affects some of the core issues around which our developmental goals are formulated. An investment in halting the spread of this pandemic therefore, brings with it significant returns, both economic and social. This fact underscores the importance of the health/development nexus. Recognition of this has been registered at the Heads of Government meeting in The Bahamas, which convened in July 2001.

At that meeting, a request was made for a Caribbean Technical Task Force on Health and Development within the Council of Human and Social Development (COHSOD). This Task Force is meant to advocate for, and help propel health, to be at the centre of the development process in the region. This position is also consistent with the 20/20 initiative advocated by the UN agencies, which speaks to the need for greater mainstreaming of health and other social indicators into the development dialogue, backed by a minimum of 20% of expenditures on basic services in these social sectors. The Trinidad & Tobago Strategic Plan with its emphasis on an expended response by all sectors with key roles to be played by Health and Education is well positioned and consistent with goals associated with the 20/20 initiative and those proposed by COHSOD.

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APPENDIX I

MATHEMATICAL FORMULATION OF NSP STLYIZED FGI INTERVENTIONS

The mathematical formulation for the interventions for the NSP is presented in this appendix.

Increasing National Commitment (Including Government Commitment)

Advocacy

1. Advocacy and National Planning

Unit Cost x Total Population

Prevention Activities

Youth Focused Interventions

2. Primary School Students

Unit Cost x Primary School enrolment x 12.17 % x total population x 100% coverage

3. Secondary School Students

Unit Cost x Secondary School enrolment x 11.35% x total population x 100% coverage

4. Out-of School Youth

Unit Cost x 6.52% x total population x 100% coverage

Vulnerable Populations

5. Cost Per Vulnerable Person

Unit cost x (% MSM + %CSW + % Prisoners) x total population x 100% coverage + other programme costs

Voluntary Counselling and Testing

6. Cost per Person Counselled and Tested under VCT Programme

(% population 15-49 x % 15-49 sexually active x total population x unit cost x 5%)+ (% population 15-49 x % 15-49 sexually active x total population x unit cost x 7%)+(% population 15-49 x % 15-49 sexually active x total population x unit cost x 9%)+ (% population 15-49 x % 15-49 sexually active x total population x unit cost x 11%)+ (% population 15-49 x % 15-49 sexually active x total population x unit cost x 13%) +other programme costs

Mother to Child Transmission

7. Cost per Woman Screened

Total Population x population with access to health services x birth rate x unit cost per woman screened x 100% coverage

8. Cost per Woman Testing HIV+ and Receiving Regimen

Total Population x population with access to health services x birth rate x ANC HIV prevalence x unit cost per woman with HIV x 100% coverage

9. Cost per Woman Testing HIV positive of Strengthening Delivery Services in Facilities to Undertake Regimen

Total Population x population with access to health services x birth rate x ANC HIV prevalence x unit cost x 100% coverage + other programme costs

10. Re-testing of 18 month babies of HIV+ Mothers

Total Population x population with access to health services x birth rate x ANC HIV prevalence x unit cost x 100% coverage

11. Cost per Woman of Six Months Formula Milk

Total Population x population with access to health services x birth rate x ANC HIV prevalence x unit cost x 100% coverage

Public Awareness Campaigns

12. Cost of Public Awareness Campaign Per Capita

Unit cost x Total Population

Distribution of IEC Costs Among Target Populations.

The distribution of costs associated with the IEC component of the NSP was spread among the following target groups: Primary School Aged population, Secondary School Aged Population, Out of School Youth Population, Workers in Formal Employment and Vulnerable groups including CSWs, MSMs and Prisoners. Allocations were also made to the Advocacy Intervention. The calculations for the distributions are detailed hereunder and are based on the Estimated Population by Age Group, as at June 2000.

13. Primary School Population (5-11) x Enrolment Rate
= 5-9 Age Group - 108,030
+ 10-14 Age Group x 2/5 – 128,496 x 2/5 = 51,398
= Total Primary School Age Population x 98 % = 159,428 x 98 % = 156,239
Assumption is made that ages 10-11 account for 2/5 of the 10-14 age group.

14. Secondary School Population (12-18) x Enrolment Rate
= 10-14 Age Group x 3/5 – (128,496 x 3/5) = 77,098
+ 15-19 Age Group x 4/5 – (125,851 x 4/5) = 100,681
= Total Secondary School Age Population x 82% = 145,779

Assumption is made that ages 12-14 accounts for 3/5 of the 10-14 Age Group, and ages 15-18 account for 4/5 of the 15-19 Age Group.

15. Out-of-School Youth
= 15-19 Age Group x 1/5 (125,851 x 1/5) = 25,170
+ 20-24 Age Group x 1/5 (116,913 x 1/5) = 23,382
+ 2 % of Primary School Population (2% x 159,428) = 3189
+ 18 % of Secondary School Population (18 % x 177,779) = 32000
= Total Out-of School Youth Population = 83,742

Assumption is made that age 19 accounts for 1/5 of the 15-19 Age Group, and age 20 accounts for 1/5 of the 20-24 Age Group. Additionally, this includes primary and secondary aged youth out of school.

16. Vulnerable Groups

(i) CSWs estimated at 1% of total population

= 1% x 1,283,683= 12,837

(ii) MSMs estimated at 1.5% of total population

= 1.5% x 1,283,683= 19,255

(iii) The number of Prisoners amount to 36,436 or 2.84% of the total population

Total Vulnerable Population = *(i) +(ii) +(iii)* = 68,528

17. Workers in Formal Employment

Formal employment is estimated to be 43% of the population. This percentage was applied to the 1999 population estimates. Coverage target for this group under the IEC component has been put at 50%.

No. of Workers in Formal Employment (50% coverage)

= 43% x 1,283,863 x 50%= 276,031

18. Population Covered by the Advocacy Intervention

= (1,283,863) – (Equations 12+13+14+15+16) = 553,544

TABLE A1
IEC DISTRIBUTION AMONG TARGET GROUPS

Target Group	*No. of Persons*	*% of Total Population*
Primary School Population	**156,239**	**12.17**
Secondary School Population	**145,779**	**11.35**
Out of School Youth	**83,742**	**6.52**
CSW, MSM, Prisoners	**68,528**	**5.33**
Workers in Formal Employment (50%)	**276,031**	**21.50**
Other (Advocacy Programme)	**553,544**	**43.12**
TOTAL	**1,283,863**	**100.00**

The costs of the IEC Programme were appropriated across these groups based on the percentage share of the population.

Condoms Targeted to Commercial Sex Workers; Increased Public Sector Condom Provision and Condom Social Marketing

CSW

19. No. of Male Condoms

(% CSW x total population) x (average no. of sex acts per CSW) x (% coverage of CSWs) x (% coverage of CSW sex acts)= (1% x 1,283,863) x (200) x (75%) x (95%) = *1,829,505 condoms*

20. No. of Female Condoms

(% CSW x total population) x (average no. of sex acts per CSW) x (% coverage of CSWs) x (% coverage of CSW sex acts)= (1% x 1,283,863) x (200) x (25%) x (5%) = *32,097 condoms*

Public Sector

21. Male Condom Distribution

(% of 15-49 age group of total population / 2) x (% 15-49 in non-regular relationship x number of non- regular sex acts) + (% 15-49 in regular relationships x 2% of regular sex acts) x (% coverage) = (57% x (1283863/2)) x (18% x 25) + (82% x (416 x 0.02)) x (25%) = 408,463 condoms

22. Strengthening Male Condom Logistics

(% of 15-49 age group of total population / 2) x (% 15-49 in non-regular relationship x number of non- regular sex acts) + (% 15-49 in regular relationships x 2% of regular sex acts) x (% coverage) = (57% x (1283863/2)) x (18% x 25) + (82% x (416 x 0.02)) x (25%) = 403,138 condoms

Condom Social Marketing

23. No. of Male Condoms Distributed

(% of 15-49 age group of total population / 2) x (% 15-49 in non-regular relationship x number of non- regular sex acts) + (% 15-49 in regular relationships x 2% of regular sex acts) x (% coverage) = (57% x (1283863/2)) x (18% x 25) + (82% x (416 x 0.02)) x (50%) = 816,525 condoms

24. No. of Female Condoms Distributed

(% of 15-49 age group of total population / 2) x (% 15-49 in non-regular relationship x number of non- regular sex acts) + (% 15-49 in regular relationships x 2% of regular sex acts) x (% coverage) = (57% x (1283863/2)) x (18% x 25) + (82% x (416 x 0.02)) x (20%) = 6,537 condoms

TABLE A2
CALCULATION FOR DISTRIBUTION OF COSTS FOR CONDOMS

Programme	*Male Condoms*	*% of Male Condoms*	*Female Condoms*	*% of Female Condoms*	*Total*	*% Total Condoms*
CSW	**1,829,505**	**59.89%**	**32,097**	**83.08%**	**1,861,601**	**60.18%**
Public Sector Distribution	**408,463**	**13.37%**	-		**408,463**	**13.20%**
Social Marketing	**816,925**	**26.74%**	**6,537**	**16.92%**	**823,462**	**26.62%**
Sub-Total	**3,054,893**	**100.00%**	**38,633**	**100.00%**	**3,093,526**	**100.00%**
Add Public Sector Logistics	**408,463**		-		**408,463**	
Total	**3,463,356**				**3,501,989**	

Palliative Care and Care for Opportunistic Infections

25. Cost of Opportunistic Treatment

(HIV Prevalence x Total Population x Unit Cost x 5) + (other programme costs)

26. Home based care for AIDS patients (cost per person with AIDS)

Unit cost x 640 + other programme costs

ARV Treatment

27. HAART

(1800 x Unit Cost) + (2350 x Unit Cost) + (3230 x Unit Cost) + (4695 x Unit Cost) + (7252 x Unit Cost)

Research

28. Sentinel Surveillance & Survey Information & Research

Unit Cost x Total Population

APPENDIX II

DETAILED NSP WORKSHEET

PRIORITY AREA 1: PREVENTION	(US$)
Goal 1: To Reduce the Population of Trinidad and Tobago's Susceptibility to HIV Infection	
To Promote Safe and Healthy Sexual Behaviours among the General Population	
Heighten HIV/AIDS Education and Awareness	2,019,386.11
Improve the Availability and Accessibility of Condoms	1,858,976.58
Extend the Responsibility for HIV Prevention to all Sectors of Government and civil society	50,000.00
PROGRAMME SUB-TOTAL	**3,928,362.68**
To promote healthy sexual attitudes, behaviour and practices among Specific Vulnerable/ High-risk Groups	-
Support behavior change programmes targeted to MSM	75,000.00
Introduce behavior change/risk reduction programmes for CSWs	225,000.00
Provide comprehensive support programmes for prison employees and prisoners	50,000.00
Introduce behavior change intervention targeted to young females	125,000.00
Introduce behavior change intervention targeted to youths in and out of school	515,000.00
Reduce the impact of substance abuse on HIV transmission	75,000.00
PROGRAMME SUB-TOTAL	**1,065,000.00**
To Reduce the Rate of Mother to Child Transmission	-
Implement a nationwide MTCT programme	-
Train a cadre of counsellors, for health centres and clinics.	1,750,000.00
Provide comprehensive counselling and testing services as part of all public sector antenatal health programmes.	1,396,201.01
Offer ARV treatment to all HIV positive mothers attending public facilities and babies born to these mothers.	586,869.83
Provide six months of free infant formula to HIV positive nursing mothers accessing public health services.	66,552.25
Re-test children of HIV positive mothers at eighteen (18) months.	30,251.02
PROGRAMME SUB-TOTAL	**3,829,874.11**

PRIORITY AREA 1: PREVENTION (CONTINUED)	**(US$)**
To Increase the Population's Knowledge of its Serostatus	-
Develop a Comprehensive National Voluntary Counselling and Testing Programme	
Provide VCT support services at key health centres throughout Trinidad and Tobago.	1,542,261.71
Provide VCT treatment	7,352,298.24
To provide quality VCT services.	98,799.75
PROGRAMME SUB-TOTAL	**8,993,359.70**
To Reduce the Probability of Post-exposure Infection.	-
To Improve the Management and Control of Conventional Sexually Transmitted Infections	-
To increase knowledge and awareness of the symptoms of CSTIs	103,900.97
Ensure effective syndromic management of CSTIs	750,000.00
To provide "youth friendly" sexual and reproductive health services	2,387,394.92
PROGRAMME SUB-TOTAL	**3,241,295.89**
TOTAL PREVENTION COSTS	**21,057,892.38**
PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT	-
To Implement a National System for the Clinical Mgt and Treatment of HIV/AIDS	-
To Improve Access to Treatment and Care to all PLWHAs	
Implement a national system for the clinical management and treatment of HIV/AID***S***	31,643,200.00
To Improve access to Medication, Treatment and Care for Persons with OIs	25,485,856.97
PROGRAMME SUB-TOTAL	**57,129,056.97**
To Create an Environment that supports of the Infected and Affected	-
To Provide Appropriate Economic and Social Support to the PLWHA and to the Affected	1,540,710.82
PROGRAMME SUB-TOTAL	**1,540,710.82**
TOTAL TREATMENT, CARE & SUPPORT COSTS	**58,669,767.80**

PRIORITY AREA 3: ADVOCACY & HUMAN RIGHTS	(US$)
To Reduce Stigma and Discrimination against PLWHAs	
Promote Openness and Acceptance of PLWHAs in the Workplace and Wider Community	380,000.00
PROGRAMME SUB-TOTAL	**380,000.00**
To Ensure Human Rights for PLWHAs and other groups affected by HIV/AIDS	-
Create a Legal Framework that Protects the Rights of PLWHAs& those Affected by HIV/AIDS	125,000.00
Monitor Human Rights Abuses and Implement Avenues for Redress	-
To Mobilise Opinion Leaders on HIV/AIDS and Related Human Rights Issues	
PROGRAMME SUB-TOTAL	**125,000.00**
TOTAL ADVOCACY & HUMAN RIGHTS COSTS	**505,000.00**
PRIORITY AREA 4: SURVEILLANCE & RESEARCH	
To provide effective data reporting and monitoring	
To Strengthen Surveillance Systems for CSTI/HIV/AIDS	
Improve existing surveillance systems	1,181,041.26
Strengthen National Laboratory Systems	1,447,802.91
To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues	
Understand the Linkage between Psychosocial issues and Vulnerability to HIV/AIDS	250,000.00
To Conduct Effective Epidemiological Research and Clinical Trials	1,250,000.00
TOTAL SURVEILLANCE & RESEARCH COSTS	**4,128,844.17**

PRIORITY AREA 5: PROGRAMME MANAGEMENT, COORDINATION & EVALUATION	**(US$)**
To ensure successful implementation of Trinidad and Tobago's NSP	
To Achieve National Commitment, Support and Ownership of the Expanded Strategic Response to HIV/AIDS	-
Develop an Appropriate Coordinating Structure for the National Expanded Response	5,969,072.23
To Gain Wide Support for the NSP	-
PROGRAMME SUB-TOTAL	**5,969,072.23**
To Monitor the implementation of the expanded response	-
To Mobilise Adequate and Sustained Resources to Support Implementation of NSP	-
To Monitor the Successful Implementation of Policies and Programmes	-
TOTAL PROGRAMME MGM'T, CO-ORDINATION & EVALUATION COSTS	**5,969,072.23**
	-
TOTAL COST OF STRATEGIC PLAN	**90,330,576.58**

APPENDIX III

THE COST OF THE NSP - FGI MODEL ALLOCATION

METHODOLOGY

The estimation of the cost of the NSP for Trinidad and Tobago involved several phases of in-depth meetings and working sessions with various multisectoral stakeholders. Through this process, the various line items of the NSP were detailed and the required resource needs for the particular activity were determined. As a means of allocating and deriving the costs associated with some of the activities, the Resource Allocation Model developed by the Futures Group International (FGI) was employed and customized for Trinidad and Tobago. In August 2000, a World Bank team in collaboration with Caribbean agencies made adjustments to this module and estimates were derived for several Caribbean countries. Further revisions were made in September 2000 in a collaborative effort between the agencies and the Caribbean Task Force on HIV/AIDS, at which point, the spending capacity of the individual countries and alternative scenarios for the cost and coverage of HAART were considered.

The customized FGI model contains some predetermined specifications that are defined by several formulas and variables. In most cases these were adjusted and refined. The model facilitated the allocation of resources to specific target groups such as Primary and secondary school students, out-of-school youth, as well as workers in formal employment and vulnerable groups. Where actual data was not available to inform this process, assumptions were made based on information obtained during workshops, interviews and focus group discussions with key stakeholders, as well as secondary data sources of experiences of other developing countries. Details of the allocation of the cost of the NSP under the FGI format are presented in the following section. The presentation of the costs of the NSP in this format can provide a basis for comparability across countries, since the model has been widely used.

COST OF THE NSP AS IT APPEARS IN THE FGI COSTING MODEL

The costs of each activity/programme of the NSP were allocated to the appropriate cost centres as detailed by the FGI module. It must be noted that since some of the strategic activities straddle more than one area, allocations under this model differ somewhat to the costs presented under the NSP format. For example, capacity building activities which occurred under various Priority Areas, were all allocated to the Capacity Building category. Although the two formats differ as to allocation across Priority Areas, the cost of the NSP remains the same.

The FGI format presents the cost of the NSP in the following broad categories:

TABLE A3
DISTRIBUTION OF COSTS AS PER THE FGI MODULE

Cost Category	Cost US$ Million	% of Total Cost
Increasing National Commitment (Including Government Commitment)	0.57	0.57
Prevention Activities	20.54	22.74
Treatment and Care	58.57	64.84
Capacity Building	6.32	7.00
Research	4.34	4.80
TOTAL	**90.33**	**100**

Treatment and Care accounts for the largest share of the total cost, approximately 65%. While this may seem to be an exorbitant amount, one should remember that the costs of ARV treatment as well as Palliative Care for Opportunistic Infections are included in this cost. *Prevention* follows with an estimated cost of US$20.54 million and together with Treatment and Care constitute 88% of the overall cost. The remaining 12% is distributed among *Increasing National Commitment (Including Government Commitment), Capacity Building* and *Research.*

Further details on each of these areas follow.

INCREASING NATIONAL COMMITMENT (INCLUDING GOVERNMENT'S COMMITMENT) US$0.57MN

Estimated to cost approximately US$0.57 million, this programme includes *Intensifying AIDS in the Workplace Seminars* (US$60,000). *Ensuring Human Rights for PLWHAs* (US$125,000) also forms part of the strategic activities undertaken in this area. Additionally, included in this cost is 43.12% of the print IEC, which forms part of the Prevention programme as well as programmes aimed at *Broadening the Responsibility of HIV Prevention to all Sectors* (US$50,000).

PREVENTION US$20.54MN

A breakdown of costs for Youth Intervention programmes and activities targeted at high risk groups are provided under this category. Youth intervention strategies include programmes targeted to primary, secondary and out of school youth and represents approximately 15.18% of the Prevention programme.

A condom social marketing programmes is calculated at US$0.48 million and is intended to influence behaviour change by sensitizing the population to issues surrounding condom use and benefits.

Also included are MTCT and VCT programmes, which represent 18.65% and 43.79% of the Prevention cost respectively. A proportion of the VCT as well as the MTCT costs, represents training of staff as well as the provision additional staff and equipment for identified sites.

IEC costs have been allocated among various populations including youth, high risk groups, workers in formal employment and the general public as part of the Advocacy programme. A Public Awareness Campaign which is launched through the electronic media is estimated at US$1.25 million.

The following table and figure provides further details on the programmes and activities as outlined within this cost category.

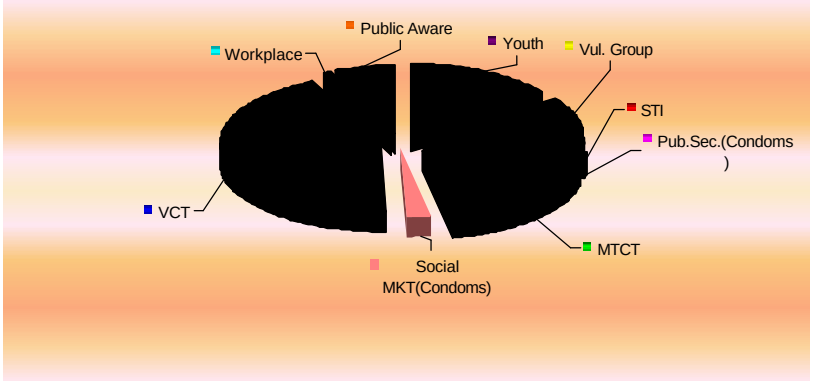
TABLE A4

COSTS DISTRIBUTION OF PROGRAMMES INCLUDED IN PREVENTION

Programme/Activity	Cost US$ Million	% of Total Prevention Cost
Youth Focused Interventions (In and Out of School)	3.11	15.18
Interventions Focusing on Commercial Sex Workers and Their Clients & Other Vulnerable Groups	1.61	7.83
Increased Public Sector Condom Provision	0.23	1.13
Condom Social Marketing	0.49	2.36
Improving STI Management	0.85	4.16
Voluntary Counselling and Testing	9.00	43.79
Workplace Interventions	0.17	0.80
Prevention MTCT	3.83	18.65
Public Awareness Campaigns	1.25	6.10
TOTAL	**20.54**	**100**

FIGURE A1

% DISTRIBUTION OF PROGRAMMES



TREATMENT AND CARE US$58.57MN

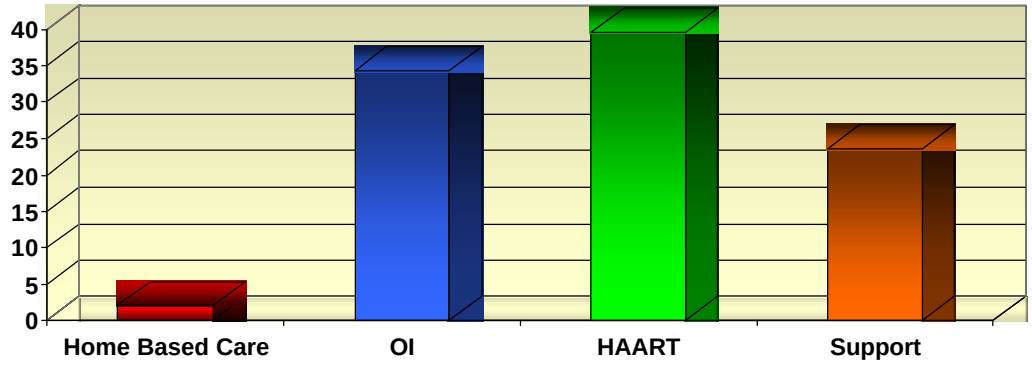
Treatment and care accounts for almost 65% of the overall cost. This category includes allocations for ARV Treatment and Palliative Care and Care of OIs, which totals approximately US$43.31 million. Recognizing the need for upgrading the current facilities and retraining of staff, close to US$13.82 million was so allocated.

Allocations to Home Based Care for AIDS patients amounted to US$1.44 million, representing approximately 2.12% of the overall cost of Treatment and Care. This includes capacity building, support and training for NGOs and CBOs that are involved with providing care to PLWHAs. Further details of these programme cost follows.

TABLE A5
PROGRAMME COST DISTRIBUTION FOR TREATMENT AND CARE

Programme/Activity	Cost US$ Million	% of Treatment and Care
Palliative Care and Care for OIs	20.12	34.32
Home Based Care	1.44	2.12
HAART	23.19	39.60
Treatment, Care and Support	13.82	23.59
TOTAL	**58.57**	**100**

FIGURE A2
% COST DISTRIBUTION OF PROGRAMMES/ACTIVITIES



CAPACITY BUILDING US$6.32MN

Priority Area V of the NSP as well as other capacity building components have been allocated to this cost category. This amounts to 7% of the total cost and includes the costs incurred in the establishment of the NACC as well as the Tobago Secretariat. Other programmes included in this area are aimed at *Achieving National Commitment, Support and Ownership of the Expanded Response, Monitoring the Successful Implementation of Policies and Programmes* and *Ensuring Sustained and Effective Implementation of HIV/AIDS Programmes.*

RESEARCH US$4.34MN

Research accounts for 4.8% of the total cost and includes Priority Area IV, *Surveillance and Research* of the NSP, in addition to other research components of the Plan. Included are activities/programmes that *Strengthen Existing Surveillance Systems, Strengthen National Laboratory Systems*. This is achieved by an evaluation of the current system to identify weaknesses, upgrade of facilities and funding the provision and training of staff. This facilitates the implementation of a system to provide timely reports to stakeholders as required.

To *Understand the Linkage between Psychosocial issues and Vulnerability to HIV/AIDS,* behavioral research will be conducted and is estimated at approximately US$0.25 million. *Conducting Effective Epidemiological Research and Clinical Trials* is also significant and as a result, US$1.25 million is so allocated.

APPENDIX IV

LIST OF INTERVIEWS

NAMES	REPRESENTING AGENCY	DATE
Ann Marie Libert, Communications Coordinator	National Aids Programme	15/07/02
Patricia Hinds, Youth Officer I	Min. Of Sport & Youth Affairs	16/07/02
Wilton John, Director ofYouth Affairs	Min. Of Sport & Youth Affairs	16/07/02
Catherine Williams Programme Coordinator	CARe	16/07/02
Dr. Ian Popplewell, Acting Principal Medical Officer (Epidemiology)	Ministry of Health	19/07/02
Courtney Phillips Asst. Resident Representative	UNDP	22/07/02
Dr. Maria Dillon-Remy, Hospital Medical Director	Tobago RHA	23/07/02
Lyndon Wilson, Youth Field Supervisor	Youth Department, THA	23/07/02
Virginia Alexander Wright, Health Education Officer	THA	23/07/02
Zelia Scott De Gannes, Youth Coordinator	Tobago Integrated Youth Health Promotion Project, FPATT	23/07/02
Suzanne Yeates, Chairperson, Peer Educator / Counsellor	Tobago Oasis Foundation	23/07/02
Mona Dillon, Medical Social Worker	Tobago	23/07/02
Vida Romeo Guy Project Execution Officer	Social Services, ADAPP	23/07/02
Joanne Cruickshank, Nutritionist	Tobago	23/07/02
Jason Caesar	Tobago Youth Council	23/07/02
Dr. Mentor Melville, Tobago County Medical Officer	Ministry of Health	23/07/02
Barbara Steele	Div. Health Social Services	23/07/02
Dr. Helen Crooks, Psychiatrist	Tobago	23/07/02
Clinton Ross, Laboratory Manager	Tobago	23/07/02

GLOSSARY

Affected Person: Person whose life is changed in any way by HIV/AIDS due to the broader impact of this epidemic.

Antenatal Clinic: A health facility that pregnant mothers visit before birth.

Antiviral: A substance or process that destroys or weakens a virus or interferes with its ability to replicate.

Antiretroviral Therapy: Therapy that uses drugs to suppress HIV replication.

Acquired Immunodeficiency Syndrome (AIDS): A human viral disease that ravages the immune system, undermining the body's ability to defend itself from infection and disease.

Azidothymidine (AZT): The first drug approved by the Food and Drug Administration to treat AIDS. It became available in 1987 and it slows HIV growth in the body, permitting an increase in the number of CD4 cells, which boosts the immune system. AZT also prevents transmission of HIV from an infected mother to her newborn.

Benchmark: The measure against which performance can be compared and find ways to improve.

Capacity Building: An element of operations management that determines an organization's capability to produce the products/services/resources to meet demand.

CD4 Count: A test to evaluate the immune system by measuring the number of immune system cells that have CD4 receptors. The count is determined by a blood test and measured by the number of CD4 per cubic millimetre of blood. Normal CD4 counts range from 800-1500 cells/mm^3. A CD4 count at or below 200 cells/ mm^3 ia an AIDS defining condition.

Clinical Management: This involves comprehensive care for individuals affected by the disease. In order to meet the total needs of persons affected by the infection there are other facets of care like nursing care, counselling and social support that have to be taken into consideration. To help meet these varied needs the concept of comprehensive HIV/AIDS care across a continuum is advocated. This is the pooling together of medical and social services within the community, and the creation of linkages between the community care initiatives and all levels of the health care system.

Clinical Research: As scientists gain more knowledge in a particular area, they begin studies on humans. These studies often take place in hospitals and are called clinical research.

Clinical Trials: Trials to evaluate the effectiveness and safety of medications or medical devices by monitoring their effects on large groups of people.

Commercial Sex Worker (CSW): One who exchanges in sexual activities for commercial gains.

Conventional Sexually Transmitted Infection: Also called venereal disease or VD (an older public health term). Sexually transmitted infections are spread by the transfer of organisms from person to person during sexual contact. In addition to the "traditional" STIs (syphilis and gonorrhea), the spectrum of STIs now includes HIV infection, which causes AIDS; *Chlamydia trachomatis* infections; human papilloma virus (HPV) infection; genital herpes; chancroid; genital mycoplasmas; hepatitis B; trichomoniasis; enteric infections; and ectoparasitic diseases (ie, diseases caused by organisms that live on the outside of the host's body).

Enzyme Linked Immunosorbent Assay (ELISA): A type of enzyme immunoassay to determine the presence of antibodies to HIV in the blood or oral fluids. Repeated reactive ELISA tests results should be validated with an independent supplemental test. In the US the validation test most often used is the Western Blot test.

Epidemic: Outbreak of contagious disease affecting an unusually large number of people or involving an extensive geographical area.

Epidemiology: (1) The study of the distribution and determinants of health-related states and events in populations and the control of health problems. (2) The study of epidemic disease. (3) The study of the incidence of disease in large populations.

Epidemiological Research: Studies designed to examine associations, commonly hypothesized causal relations. They are usually concerned with identifying or measuring the effects of risk factors or exposures.

Expanded Response: The response that incorporates, not only the Health sector, but that of all sectors of society since the impacts of HIV/AIDS has gone beyond being a health issue to one of a developmental issue.

Healthcare Service Delivery: The concept concerned with all aspects of providing and distributing health services to a patient population.

Human Immunodeficiency Virus (HIV): HIV belongs to a unique group of viruses known as retroviruses – these viruses reverse the usual flow of genetic information within an infected cell. It is a virus that weakens the body’s immune system, ultimately causing AIDS.

Incidence Rate: The rate at which new events occur in a population. The numerator is the number of new events occurring in a defined period. The denominator is the population at risk of experiencing the event during this period.

Indicators: Indicators are the means by which the attainment of strategic objectives will be measured. The indicators provided in this document present for each strategic objective the gauge that will signal when the objective has been successfully met. These indicators should not be confused with *national strategic plan implementation indicators* that must be developed to monitor and evaluate the overall Five-Year Strategic Plan. In the final document, an illustration of such indicators adapted from UNAIDS 2001 (Item in the AIDS Programme Effort Index) will be included as an example for those who will have the responsibility for monitoring and evaluation.

Infected Person: A person who has been diagnosed with the HIV virus or AIDS.

Lead Agency / Strategic Partner: The lead agency is the main organization(s) responsible for undertaking strategic objectives while strategic partners are sectors that will work along with the lead agency to undertake these activities.

Local Government: The government of a specific local area constituting a subdivision of a major political unit.

Matrix Structure: A tight organizational structure characterized by rigidly defined tasks, formalization, many rules and regulations, and centralized decision-making.

Men Who Have Sex With Men (MSM): A man who has sexual intercourse with a person of the same sex, that is, a man.

Mother-To-Child Transmission: HIV transmission from an infected mother to her baby while the baby is still in the woman's uterus or, more commonly, during childbirth. The virus can also be transmitted through the mother's breast milk during breastfeeding.

Multi-Sectoral: Comprising of a multitude of sectors across all levels and boundaries.

National Work Policy: The code of practice, used by employers and employees, that specifies the rules and regulations for dealing with HIV/AIDS in the workplace.

Opportunistic Infection: Infection by organisms that usually only cause disease in people with weakened immune systems. Persons living with advanced HIV infection suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic infections common in persons diagnosed with AIDS include *Pneumocystis carinii* pneumonia; Kaposi's sarcoma; cryptosporidiosis; histoplasmosis; other parasitic, viral, and fungal infections; and some types of cancer.

Outpatient: Patient who does not require an overnight hospital stay.

Palliative Care: Palliative care is an approach to life-threatening chronic illnesses, especially at the end of life. Palliative care combines active and compassionate therapies to comfort and support patients and their families who are living with life-ending illness.

Palliative care strives to meet physical needs through pain relief and maintaining quality of life while emphasizing the patient's and family's rights to participate in informed discussion and to make choices. This patient- and family-centered approach uses the skills of interdisciplinary team members to provide a comprehensive continuum of care including spiritual and emotional needs.

Pandemic: An epidemic of widespread proportions is referred to as pandemic.

Policy Formulation: Preparation of a broad guide for organizational members to follow when dealing with important and recurring areas of decision-making. They set limits and provide boundaries for decision makers.

Polyclinic: A clinic in which diseases of many sorts are treated, especially, an institution in which clinical instruction is given in all kinds of disease.

Postponement: To put off or delay sexual intercourse for a future period, for example, until marriage.

Post Exposure Prophylaxis: The prevention of disease, preventive treatment after exposure to HIV/AIDS by taking antiretrovirals immediately (within 72 hours) after exposure to HIV.

Principles: The basic idea or rule that explains or controls how something happens or works.

Priority Area: The key agenda items for which tactical interventions are required. They are determined by identifying for Trinidad and Tobago, the epidemic's most important determinants and potential impact. The Priority Areas identified in this plan fall within the framework for action for the region as proposed by the Caribbean Task Force on HIV/AIDS.

Prevalence: A measure of the proportion of people in a population affected with a particular disease at a given time.

Private Sector Ownership: The adoption of the HIV/AIDS issue as "*I own this, it belongs to me"* by the private sector.

Protocol: A protocol consists of agreed upon guidelines for which there is consensus.

Ring-Fenced Funding: Funding that is allocated to the HIV/AIDS programme and is to be used specifically for that purpose. It is protected from being reallocated to other projects / programmes.

Safe Sexual Practices: Sexual practices that do not involve the exchange of bodily fluids, including blood, sperm, vaginal secretions and saliva to avoid AIDS and other sexually transmitted diseases**.**

Serostatus: The condition of having or not having detectable anti bodies to a microbe in the blood as a result of infection. One may have either a positive or negative serostatus.

Sexually Active Population: That part of the population that is engaging in sexual intercourse.

Sexually Transmitted Disease (STD): *See CSTIs*

Socio-Cultural Peculiarities: The influences and contributions from diverse groups outside an organization.

Stakeholder: Those persons, groups, organizations, ministries that have contributed to and have interests and involvement in the HIV/AIDS expanded response.

Stigma: Personal characteristics that others treat as deviant.

Strategy: The broad tactical approach that will be used to achieve strategic objectives.

Strategic Activities: These are action steps that describe specific tasks that will advance a strategic objective. They answer the questions, what specifically will be done, how and where it will be accomplished. Strategic activities can only be successfully achieved through work plans that carefully delineate who will have the responsibility for what and by when. The *Implementation Plan* that accompanies the Five-Year Strategic Plan for Trinidad and Tobago provides a comprehensive work plan for the agency charged with the overall coordination of the expanded response. Each individual sector, however, will need to develop its sector specific work or implementation plan that will enumerate its list of strategic activities.

Strategic Objective: Strategic Objectives are statements of what each Priority Area hopes to achieve. They are essentially statements of what needs to be done to move the nation from its current state to the desired future state at the end of five years.

Strategic Plan: A plan that contains the answers to what, where, when, how, and how much for achieving strategic goals – the long-term, countrywide goals established by government and stakeholders.

Support Mechanisms: These help people deal with the emotional repercussions, as well as the practical considerations of living with a disabling, fatal disease.

Surveillance System: A system or process that is implemented to closely observe the functioning of a programme.

Symptom: A signal that something is wrong and draws attention to finding the cause – that is, the problem.

Symptomatic Treatment: Therapy that eases the symptoms without addressing the basic cause of the disease. Symptomatic treatment is also called palliative treatment.

Syndromic Management: The planning and delivery of health care programmes for the treatment of a set of signs or a series of events occurring together that often point to a single disease or condition as the cause.

Tactical Approach: A course of action designed to achieve a short-term goal.

Transactional Sex: Engaging in sexual-economic exchanges usually for a specified sum of money.

Transmission Rate: The rate at which HIV/AIDS is transferred within a population over a specified time period.

Treatment Protocol: The standardization of the quality and delivery of treatment to HIV/AIDS persons.

Triple Therapy: Employing a combination of three drugs taken together to halt HIV replication. Triple therapy maximizes potency while reducing the chance of drug resistance. The combination of three drugs is often referred to as an AIDS cocktail. Triple therapy was introduced in the United States in 1996.

Viral Load: The amount of the HIV virus in the blood. The viral load helps doctors estimate an infected person's survival time. A viral load test measures the quantity of HIV RNA in the blood. Measures of viral load CD4 cells are used to determine when to initiate therapy.

Vulnerable (High Risk) Group: Groups that are at greater risk of being exposed to HIV/AIDS.

VCT Site: A place that a person attends to receive voluntary counselling and HIV testing.

ACKNOWLEDGEMENTS

The University of the West Indies, Health Economics Unit, acknowledges all those whose sterling efforts went into the production of this document. Our thanks are extended to the sponsor of the project - the United Nations Development Programme (UNDP). We thank Mr. Neil Pierre and his staff, especially Mrs. Maylene Leu-Bent, for the invaluable input of the UNDP throughout the project, particularly in organising the three major consultations.

Additionally, we acknowledge the input of the Ministry of Health, the Caribbean Epidemiology Centre, and the Tobago Regional Health Authority.

Thanks are also due to Ms. Claudette Francis, HIV/AIDS Programme Specialist and Mr. Martin Franklyn, Lecturer, UWI.

Special recognition and thanks go out to the Staff, Associates and Resource Persons attached to the Health Economics Unit, whose various important contributions made this assignment possible:
Vyjanti Beharry, Dr. Anton Cumberbatch – Advisor, Abigail Dean, Kimberly-Ann Gittens, Dr. Althea La Foucade, Christine Laptiste, Roger McLean, Charmaine Metivier, Donna-Lisa Peña and Andrea Yearwood.

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