



**OFFICE OF THE PRIME MINISTER**

**GREEN PAPER**

**NATIONAL HIV AND  
AIDS POLICY**

**2020-2030**

**TABLE OF CONTENTS**

EXECUTIVE SUMMARY .....7

1 INTRODUCTION.....9

2 BACKGROUND .....9

    2.1 Methodology.....10

    2.2 The National Policy Environment .....10

        2.2.1 The National Development Strategy.....11

        2.2.2 The National Strategic Plan for HIV and AIDS 2013-2018.....11

        2.2.3 Legislative Context.....13

    2.3 International Commitments and Protocols .....14

    2.4 Situation Analysis.....17

        2.4.1 Epidemiology of HIV and AIDS in Trinidad and Tobago .....17

        2.4.2 Social, Behavioural, Structural Drivers of the HIV Epidemic .....22

    2.5 The National Response .....25

        2.5.1 Achievements and Challenges.....29

3 POLICY FRAMEWORK .....33

    3.1 Conceptual Framework.....33

    3.2 Scope.....33

    3.3 Vision and Mission.....34

    3.4 Underlying Principles .....34

    3.5 Policy Goals .....36

    3.6 Policy Objectives .....36

    3.7 Policy Outcomes.....37

4 POLICY STATEMENTS .....39

5 PRIORITY AREA 1: PREVENTION .....39

    5.1 Rationale .....39

    5.2 Strategic Objectives .....39

    5.3 Policy Statements .....40

        5.3.1 Combination Prevention.....40

        5.3.2 HIV Testing, Counselling and Linkage.....41

        5.3.3 Condoms and Lubricants .....43

        5.3.4 Prevention of Mother to Child Transmission.....44

        5.3.5 Post Exposure Prophylaxis (PEP) .....45

5.3.6	Pre Exposure Prophylaxis (PrEP).....	45
5.3.7	STI Management .....	45
5.3.8	Information, Education and Communication .....	46
5.3.9	Behavioural Interventions .....	47
5.3.10	Behaviour Change Communication.....	48
5.3.11	Use of Technology and Other Creative Methods in Prevention Efforts .....	48
6	PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT.....	50
6.1	Rationale .....	50
6.2	Strategic Objectives .....	50
6.3	Policy Statements .....	51
6.3.1	A Treat All Approach .....	51
6.3.2	Service Delivery.....	51
6.3.3	Client Centred Models of Care .....	52
6.3.4	Anti-Retroviral Therapy and Adherence.....	52
6.3.5	Treatment of Co-Infections.....	53
6.3.6	Treatment Monitoring .....	54
6.3.7	Health Systems Support .....	54
6.3.8	Sexual and Reproductive Health .....	55
6.3.9	Psychosocial Support.....	55
6.3.10	Nutrition and Food Security.....	56
6.3.11	Laboratory Services .....	57
6.3.12	Access to Treatment and Care Services During and After Humanitarian Emergencies and Crises .....	57
7	PROMOTION OF HUMAN RIGHTS AND CREATION OF AN ENABLING AND EMPOWERING ENVIRONMENT FOR PLHIV, KEY POPULATIONS, VULNERABLE GROUPS AND COMMUNITIES .....	59
7.1	Rationale .....	59
7.2	Strategic Objectives .....	60
7.3	Policy Statements .....	60
7.3.1	Enabling Legislative Framework .....	60
7.3.2	Redress System for Reporting Abuses and Discrimination Against PLHIVS and KPs.....	61
7.3.3	Gender Sensitivity .....	61
7.3.4	Protection, Empowerment and Participation of PLHIV, Key and Vulnerable Populations .....	62
7.3.5	Women, Girls and HIV.....	63

7.3.6	Mitigating the Impact of HIV on PLHIV .....	63
7.3.7	Confidentiality.....	63
7.3.8	Partner Notification and Referral .....	64
7.3.9	Migrants.....	64
7.3.10	Prison and Detention Settings .....	65
7.3.11	Gillick Competency.....	65
7.3.12	Community and Civil Society Strengthening.....	65
7.3.13	Workplace Settings .....	66
8	STRATEGIC INFORMATION AND KNOWLEDGE MANAGEMENT.....	67
8.1	Rationale .....	67
8.2	Strategic Objectives .....	67
8.3	Policy Statements .....	68
8.3.1	Resources for Effective and Sustainable Strategic Information .....	68
8.3.2	Monitoring and Evaluation .....	68
8.3.3	Research .....	68
8.3.4	Surveillance .....	69
8.3.5	Data Management System.....	69
8.3.6	Data Use and Dissemination.....	70
9	COORDINATION, IMPLEMENTATION AND MONITORING .....	70
9.1	Rationale .....	70
9.2	Roles and Responsibilities of Implementing Partners .....	71
9.3	Leadership and Knowledge Management .....	80
9.4	Resourcing the National Response .....	80
9.5	Monitoring and Evaluation of the Policy.....	81
	<b>APPENDICES.....</b>	<b>82</b>

**LIST OF TABLES**

- Table 1: International and Regional Commitments
- Table 2: Ratified International Agreements
- Table 3: Reported new HIV Infections by Age and Sex, 2005-2017
- Table 4: Key Achievements and Challenges by Priority Area

**LIST OF BOXES**

- Box 1: Other Key Milestones

**LIST OF FIGURES**

- Figure 1: Priority Areas of the National Strategic Plan for HIV and AIDS 2013-2018
- Figure 2: AIDS Related Mortality Rates per 100,000 Population
- Figure 3: Twelve Month Retention in ART, 2013-2015
- Figure 4: Social Ecological Model

**ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CRSF	Caribbean Regional Strategic Framework
CSO	Civil society organisation
FBO	Faith-based organisation
HACU	HIV and AIDS Coordinating Unit
HFLE	Health and family life education
HIV	Human Immunodeficiency Virus
KP	Key population
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex
MDG	Millennium Development Goal
MOH	Ministry of Health
MSM	Men who have sex with men
NACC	National AIDS Coordinating Committee
NAP	National AIDS Programme
NDS	National Development Strategy
NGO	Non-governmental organisation
NSP	National Strategic Plan
OPM	Office of the Prime Minister
PHC	Primary health care
PITC	Provider initiated testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PPU	Population Programme Unit
PEP	Post exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PWD	People with disabilities
PWUD	People who use drugs
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
TG	Transgender
THA	Tobago Health Authority
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United National General Assembly Special Session
WHO	World Health Organization
VCT	Voluntary counselling and testing



## EXECUTIVE SUMMARY

Persons living with HIV and AIDS are among the most vulnerable in our society. The manner in which we treat our most vulnerable groups in our population is a reflection of who we are as a people. The National HIV and AIDS Policy 2020-2030 seeks to place the focus on vulnerable and key populations who are most at risk of being affected. The Government of Trinidad and Tobago renews and reaffirms its continued commitment to all persons living with HIV and those who are vulnerable to becoming infected. This is the first National HIV and AIDS Policy for this country as it forges on to achieve the goal of ending AIDS by 2030.

The Government's vision is :

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

Our Mission is to challenge and encourage the national community to work in partnership to prevent and treat HIV and to mitigate its negative impacts. This will be achieved by creating an enabling environment for preventing the further transmission of HIV and AIDS in the population, by the optimisation of treatment, care and support and by setting standards to guide, co-ordinate and manage the national response at all levels and in all sectors.

This Policy is grounded in twelve underlying principles- *political leadership and commitment, good governance, transparency and accountability, equity, gender equality, promotion and protection of human rights, collaboration, inclusion, community systems strengthening and participation, evidence based programming, regulatory role of the Ministry of Health, Efficiency and Sustainability.*

The Policy sets out eleven outcomes dependent on eleven Policy Objectives

1. Reduced new infections: By 2030 there would be a 95% reduction in new HIV infections in the general and key populations.
2. Reduced AIDS related deaths- By 2030 AIDS related deaths would be reduced by 95%.
3. Elimination of Mother to child transmission by 2025.
4. Increased knowledge of HIV Status: By 2025.
5. Increased persons on treatment: 95% of persons who know their status would be on treatment.
6. By 2025, 95% of persons on treatment virally suppressed.
7. Decreased stigma and discrimination faced by PLHIV and Key Populations. By 2025, there would be a 95% reduction in stigma and discrimination faced by people living with HIV and by key populations. This would be achieved by everyone's human rights being respected, protected and upheld.



8. Increase by 50% the percentage of PLHIV and KPs engaged in national response programmes.
9. An enabling environment which would promote universal access to services and resources and mitigate the impact of HIV and AIDS.
10. Sustainability of the national response as evidenced by increased national funding and capacity
11. Strengthened evidenced base and robust research agenda which is used for planning, decision-making, policy formulation and programme implementation.

This Policy was revised and drafted by the NACC Secretariat and Policy Research and Planning Unit in the Office of the Prime Minister. The process of developing the Policy was consultative and participatory involving all stakeholders on both islands including government stakeholders, and civil society organisations, private sector, faith based organisations, youth groups. Information gathered from the consultations were used in the development of the Policy. The GoRTT takes this opportunity to thank and acknowledge the valuable contribution of all involved in the development of the Policy and to advocate for the continued support in its implementation.

Vision 2030 National Sustainable Development Strategy 2016-2030 is the cornerstone of the Policy and it is tied to the Sustainable Development Goals. The Policy will be accompanied by a costed Implementation Plan, Monitoring and Evaluation Plan and Communication Strategy.

The Office of the Prime Minister (NACC Secretariat) is responsible for coordinating the implementation and monitoring of this Policy. All Government Ministries, statutory bodies and other state agencies are responsible for delivery and reporting on the implementation of strategies within the Policy. The successful and effective implementation of this Policy demands requires commitment, coordination and partnership among all relevant stakeholders.

## 1 INTRODUCTION

Trinidad and Tobago is at the cusp of a new phase of the HIV and AIDS epidemic. From the first case being reported in 1983 to now, there have been many substantial changes in the national response with many successes along the way. With the adoption of the 90-90-90 targets, there has been a fundamental shift in the approach to responding to the epidemic, especially as it relates to prevention and treatment. Underlying all of these is the need to ensure that a rights based approach is at the foundation of all policies and responses and that all progress made is maintained. To date, there have been several achievements. One milestone that has been reached to date is that more than half of the estimated number of persons living with HIV are now on treatment.

Despite several successes and achievements of the national HIV and AIDS response continues to be plagued by several challenges. The lack of a clear policy framework has contributed to ineffective co-ordination among key partners and stakeholders with little or no collaboration, lack of clarity with respect to roles and functions in service delivery. The draft policy and the National Strategic Plan 2013-2018 do not take into account the Political Declaration of the 2016 UN High Level Meeting, the Sustainable Development Goals, the 2016-2021 Strategy for Ending AIDS by 2030, new national policy directions such as Treat All and the Vision 2030 National Development Strategy and regional agreements such as the Caribbean Regional Strategic Framework.

With this in mind, the Government of Trinidad and Tobago mandated the National AIDS Coordinating Committee (NACC) to develop a National HIV and AIDS Policy that incorporates and responds to the current political, economic and epidemiological context. The NACC, which was established in 2016 in the Office of the Prime Minister has been mandated to define a National HIV and AIDS Policy in Trinidad and Tobago to provide broad guidelines for design, implementation, co-ordination and management of all HIV and AIDS programmes, activities, interventions at national, community, family and individual levels.

## 2 BACKGROUND

The aim of the Policy is to develop a relevant and appropriate policy that considers and aligns with national frameworks such as 2016-2030 National Development Strategy (Vision 2030), the National Strategic Plan for HIV and AIDS and international strategies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 Targets, the Sustainable Development Goals, the WHO Global Health Sector Strategies for HIV, Viral Hepatitis and Sexually Transmitted Infections 2016-2021, the End TB Strategy and the WHO recommendation to Treat All.<sup>1,2</sup>

While achieving its overarching aim, this Policy also provides guidance on programme and intervention design, management and co-ordination in the development of HIV related

---

1 World Health Organization. *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. September, 2015. [www.who.int](http://www.who.int). Accessed, 18 April 2018.

2 Joint United Nations Programme on HIV/AIDS (UNAIDS). *90-90-90 An ambitious treatment target to help end the AIDS epidemic*. 2014.

interventions. Moreover, this Policy provides a framework for leadership and co-ordination of the national multi-sectoral response led by the Office of the Prime Minister in collaboration with all partners and stakeholders to the benefit of all citizens of Trinidad and Tobago, especially those persons infected and affected by HIV and AIDS.

## 2.1 METHODOLOGY

The National HIV and AIDS Policy has been developed under the leadership of the NACC through a consultative process that engaged a broad range of stakeholders throughout Trinidad and Tobago. The policy development process has taken into account the epidemiology of HIV in Trinidad and Tobago, current international guidelines and the changing national context, in order to provide an overarching framework for continued strengthening of a comprehensive national multi-sectoral response to HIV. A comprehensive document review was conducted, with the primary aim of ensuring alignment of the National HIV and AIDS Policy with other sectoral policies, international guidance and Caribbean regional commitments.

A broad-based consultative process engaged government, civil society, faith communities, Key Populations (KPs) and international partner stakeholders throughout Trinidad and Tobago, in determining priorities to be addressed in the National Policy. Consultations conducted with key informants to identify and record the issues, concerns and recommendations from stakeholders included , visits to treatment sites and one-on-one discussions with physicians, other providers and people living with HIV (PLHIV); small group discussions with the NACC, government agency representatives, PLHIV, other KPs and representatives of faith communities; a Policy development workshop was held with forty stakeholders comprising Civil Society Organisations (CSOs), KPs, private sectors, government ministries representatives working in the national response; meetings of key stakeholders, including providers and CSO representatives in the HIV response in Tobago.

## 2.2 THE NATIONAL POLICY ENVIRONMENT

An effective and sustainable response to HIV is critical for achieving Trinidad and Tobago's social and development goals and objectives including poverty reduction. Additionally, there have been significant government policy initiatives in multiple sectors that directly address or otherwise define the context for the national HIV response. The National HIV and AIDS Policy takes cognisance of, is guided by and is aligned with national, regional and international policies, conventions, agreements and political declarations. Some of the main national policies to which this policy is aligned and which bear relevance are Vision 2030, National Policy on Gender and Development, Sexual and Reproductive Health Policy, Mental Health Policy, National Population

Policy. A complete listing of National Policies which are related to the Draft HIV and AIDS Policy can be found in **Appendix I**.

---

### 2.2.1 THE NATIONAL DEVELOPMENT STRATEGY

The National Development Strategy (Vision 2030) establishes a broad, long-term socio-economic development framework for Trinidad and Tobago, towards achievement of the Millennium Development Goals (MDGs) including HIV epidemic control, and the Sustainable Development Goals (SDGs). Vision 2030 defines the priorities and overarching thrust of government policy in support of sustainable economic growth, improved social conditions and quality of life. This strategy explicitly aims for a national dialogue on cultural and behavioural shifts that are required to achieve development goals. A key underpinning principle is the adoption of an integrated whole-of-government approach to pursuing cross-cutting national development objectives.

The National HIV and AIDS Policy will align with and contribute to the achievement of the development goals articulated in the following Thematic Areas of the Vision 2030:

- Theme I - Putting People First: Nurturing Our Greatest Asset, and
- Theme II - Promoting Good Governance and Service Excellence.

Of particular relevance is Theme 1 which is grounded in respect and dignity for all, particularly the most vulnerable, and the creation of a society in which the basic needs of all people are met and without poverty, discrimination, economic and social marginalization, disease and poor health and substandard living conditions. It underpins the Human Rights approach of this policy. Goal 1 also stipulates that in the short-term citizens would be empowered to lead healthy lifestyles.

Thematic Area II aims to ensure excellent governance and service which are critical elements in ensuring a high standard of living and a good quality of life for all citizens of Trinidad and Tobago.

---

### 2.2.2 THE NATIONAL STRATEGIC PLAN FOR HIV AND AIDS 2013-2018

Trinidad and Tobago's national response to HIV is governed by the **2013-2018 National Strategic Plan for HIV and AIDS (NSP)** that articulates three overarching goals as the basis of the national response:

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

In meeting these goals, priority areas were identified; these are outlined in Figure 1.

The NSP supports a national partnership to implement a comprehensive, integrated, multi-sectoral approach that engages the public sector, the private sector, trade unions, civil society, communities, international partners and academic institutions.

**Figure 1: Priority Areas of the National Strategic Plan for HIV and AIDS 2013-2018**



As the 2013-2018 HIV and AIDS National Strategy (NSP) draws to a close, the National HIV and AIDS Policy will provide the overarching framework to guide the development of the next iteration of the national strategy that guides the HIV response in Trinidad and Tobago. To this end, the new national strategy will reflect the Government’s approach to health that recognizes the need to address the underlying social, cultural, structural and psychological dimensions and risk factors

of HIV. The new national strategy will align with the principles and objectives of the National HIV and AIDS Policy, in order to achieve national and international commitments and goals.

---

### 2.2.3 LEGISLATIVE CONTEXT

There are several pieces of legislation and statutes which directly and indirectly impact the environment in which PLHIV and Key Populations live and which affect HIV and AIDS outcomes in Trinidad and Tobago. These laws indicate the extent to which an enabling environment exists within the context of HIV and AIDS in Trinidad and Tobago<sup>3</sup>. Of importance are:

1. Equal Opportunity Act 2000 Chapter 22:03
2. Children's Authority Act 2000 Chapter 46:10
3. Children's Community Residences, Foster Care and Nurseries Act 2000 Chapter 46:04
4. Criminal Offences Act 1844 Chapter 11:01
5. Cohabital Relationships Act 1998 Chapter 45:55
6. Offences Against the Person Act 1925 Chapter 11:08
7. Sexual Offences Act 1986 Chapter 11:28

A review of the legislative landscape in Trinidad and Tobago has identified a number of challenges and gaps which include:

- There is no protection in the law however against discrimination on the grounds of HIV status or suspected HIV status. General anti-discrimination legislation (the *Equal Opportunity Act 2000*) exists, but HIV status or suspected HIV status is not included as a prohibited ground of discrimination.
- The *Children's Act Chapter 46:0* establishes the age of consent as 18 years and over and this requires that minors get parental consent to access treatment and care services. Minors are denied SRH services and deemed legally incapable of consenting to treatment in the absence of a parent or guardian.
- The *Sexual Offences Act* should be reviewed to strengthen the protection of women and children against crimes such as trafficking and internet offences and to bring it in line with current approaches to sexual offences.
- The *Sexual Offences Act Chap.11:28* criminalizes anal intercourse, irrespective of consent, between men and between men and women but is perceived as criminalizing homosexual conduct and reinforces stigma and discrimination against MSM by criminalizing conduct associated with homosexual behaviour. In 2018, the Trinidad and Tobago High Court ruled that Sections 13 and 16 of the Sexual Offences Act are unconstitutional, null and void. The State has announced its decision to appeal the ruling.
- The *Equal Opportunity Act 2000* expressly prohibits discrimination on the grounds of sex but excludes sexual orientation, sexual preference or gender identity. The Equal Opportunity Act section 24 does not provide protection against discrimination within the context of insurance for PLHIV.

---

<sup>3</sup> Myrie, T. *Legal Environment Assessment for the HIV and AIDS Response in Trinidad and Tobago, Final Report*. 2018.

- The *Data Protection Bill 2009* proposes to safeguard the confidentiality of personal information stored in electronic format only. This should be extended to guarantee confidentiality of all medical information and records, irrespective of the format in which they are gathered or stored, and should extend to surveillance procedures. Regulations should specify the categories of health care workers on whom the duty of confidentiality is imposed as well as all other persons who come into contact with medical information, both in the private and public sectors.
- The *Offences against the Person (Amendment) (The HIV Bill) Chap. 11:08, 2004* makes it an offence to intentionally or recklessly expose someone to HIV infection.
- The *Immigration Act of Trinidad and Tobago Chap. 18:01 Act 41 of 1969* prohibits entry to the country of homosexuals and sex workers, as well as “persons afflicted with any infectious or dangerous infectious disease”.
- There is no governing legislation or policy to guide MOH contact tracing efforts.
- There is need for an HIV in the workplace policy for prison officers and their families, group counselling for inmates, comprehensive preventive, treatment and care to prison officers and inmates, training for prison medical orderlies and effective prison reform.
- While a **Public Health Act** exists, it is outdated and inadequate for providing an enabling legislative framework for addressing national public health priorities.

A complete listing of all the Legislation of relevance to HIV and AIDS can be found in **Appendix II**.

### 2.3 INTERNATIONAL COMMITMENTS AND PROTOCOLS

Trinidad and Tobago has committed to numerous regional and international conventions, accords and protocols regarding HIV and AIDS. These include:

*Table 1: International and Regional Commitments*

<b>Beijing Declaration and Platform for Action 1995</b> committed to equality, development and peace of all women.
<b>UN Millennium Declaration, including Goal 6:</b> to halt and begin to reverse the spread of HIV and AIDS.
<b>2011 Political Declaration on HIV and AIDS</b> called for the intensification and scale up of actions with respect to leadership, prevention, treatment and care, reducing stigma and discrimination, resources, health systems strengthening and integration of HIV and AIDS with broader health and development, research development, co-ordination and management.
<b>ILO Recommendation concerning HIV and AIDS and the World of Work (No. 200)</b> called for inter alia the adoption of national policies and programmes on HIV and AIDS and the world of work and on occupational safety and health, where they do not already exist; and the integration of their policies and programmes on HIV and AIDS and the world of work in



development plans and poverty reduction strategies, including decent work, sustainable enterprises and income-generating strategies, as appropriate. These and other recommendations are enshrined in the National Workplace Policy on HIV and AIDS.

**Montevideo Consensus on Population and Development 2013.** The consensus seeks to promote the prevention and timely detection of and guarantee universal access to comprehensive treatment for HIV/AIDS and sexually transmitted infections and eliminate the stigma and discrimination to which persons living with the virus are often subjected. It also calls for strengthening of measures for detection of HIV/AIDS and other sexually transmitted infections in pregnant women and for prevention of the vertical transmission of the virus.

**Post 2015 Agenda 2030 Sustainable Development Goals.** Of particular relevance to HIV and AIDS are :

SDG 1: No Poverty;

SDG 2: End Hunger, achieve food security and improved nutrition and promote sustainable agriculture;

SDG 3: Ensure healthy lives and promote well-being for all at all ages;

SDG 5: Elimination of violence against women and children and the empowerment of women and girls;

SDG 16: Promoting peaceful and inclusive societies for sustainable development, providing access to justice for all and building effective, accountable and inclusive institutions at all levels and

SDG 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

**55<sup>th</sup> Directing Council of PAHO/WHO- Resolution CD 55.R5. Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021**

**Caribbean Regional Strategic Framework on HIV and AIDS (CRSF) 2014-2018,** which sets out a consensus approach to achieving the elimination of AIDS in the Caribbean.

**2016 UNAIDS Fast Track Initiative to end the AIDS epidemic by 2030.** The fast track targets to be reached by 2020 include achieving **90-90-90**: 90% of people living with HIV knowing their HIV status; 90% of people who know their HIV-positive status on treatment; and 90% of people on treatment with suppressed viral loads.

**WHO Recommendation Treat All 2017**



Trinidad and Tobago has ratified the following treaties and agreements which are particularly important within the context of HIV and AIDS and human rights:

**Table 2: Ratified International Agreements**

<i>Agreement/Treaty</i>	<i>Year of Ratification</i>
<b>ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111)</b>	1970
<b>International Covenant on Civil and Political Rights ('ICCPR') 1976 which was ratified by Trinidad and Tobago in 1978. The Optional Protocol to the ICCPR 1976 and Second Optional Protocol to the ICCPR, aiming at the abolition of the death penalty 1991 have not been ratified by Trinidad and Tobago</b>	1976
<b>International Covenant on Economic, Social and Cultural Rights ('ICESCR') 1976 which was ratified by Trinidad and Tobago in 1978</b>	1978
<b>Convention on the Elimination of All Forms of Racial Discrimination ('CERD') 1969</b>	1973
<b>Convention on the Elimination of All Forms of Discrimination against Women ('CEDAW') 1981.</b>	1990
<b>Convention on the Rights of the Child ('CRC') 1990</b>	1991
<b>Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ('Convention of Belem do Para') 1994</b>	1996
<b>Convention on the Rights of Persons with Disabilities ('CRPD') 2008</b>	2015
<b>2030 Agenda for Sustainable Development</b>	2015

## 2.4 SITUATION ANALYSIS

### 2.4.1 EPIDEMIOLOGY OF HIV AND AIDS IN TRINIDAD AND TOBAGO

The first case of HIV was reported in 1983. From then to 2016, a cumulative total of 28,402 new HIV infections were reported. Over the period 1983-2016, 6857 AIDS Cases and 4554 AIDS related deaths were reported.

Trinidad and Tobago has both a generalised and a concentrated epidemic. In 2017, UNAIDS estimated that the prevalence was approximately 1.1% among the general adult population ages 15-49. Prevalence was higher among men at 1.4% as compared with women at 0.8%. UNAIDS also estimates that approximately 11,000 persons were living with HIV in 2017 with 3900 being women 15 years and over and less than 200 being children aged 0-14 years. HIV incidence was estimated to be 0.24 per 1000 of the population in 2017.<sup>4</sup> These estimates are derived from Spectrum modelling software and may under-estimate the true levels of these indicators.

#### 2.4.1.1 MAIN ROUTE OF TRANSMISSION AND RISK CHARACTERISTICS

Data shows that the primary mode of transmission is through unprotected sexual activity. Of the total number of men who reported risk exposures, 24.6% reported having unprotected sex with another male in the last 12 months and 5.7% reported having unprotected sex with both men and women in the last 12 months (2017 HIV Annual Surveillance Report, HACU). More than four out of five women or (83%) reported having unprotected sex with a male while just over 5% reported having sex with a person with known HIV positive status.

#### 2.4.1.2 AGE AND SEX OF NEW INFECTIONS

Trinidad and Tobago has experienced shifts in the socio-demographic profile of the epidemic which are also reflective of broader national demographic trends. From 1983 to 2006, newly diagnosed infections among males outstripped newly diagnosed infections among females. From 2007 to 2009, a higher number of new infections were reported among females than males. However, this trend was reversed over the last few years 2012 to 2017 as more new HIV infections were observed among males compared to females. This is a pattern being observed that while more women than men come forward to be tested, more males than females are testing positive. Women accounted for 40% of new reported infections in 2017 while males represented 58%. However, there are significant age and sex differentials in the new cases of HIV infections. For example, among young adults, females accounted for 60% of all new

<sup>4</sup> Ministry of Health. 2017 Spectrum Estimates for Trinidad and Tobago, unpublished.

infections among adolescents aged 15-19 and just over 50% among young adults 20-24 in 2014. An upward trend among the older population 50 years and over has also been observed over the period 2010- 2012.<sup>5</sup>

**Table 3: Reported new HIV Infections by Age and Sex, 2005-2017**

Year	Under 15		15-24		25-49		50+		Unknown	Not stated	All Ages
	Male	Female	Male	Female	Male	Female	Male	Female	Sex		
2005	58	58	61	167	489	303	121	54	24	118	1453
2006	37	43	62	149	425	365	104	61	32	161	1439
2007	15	23	65	186	419	369	97	51	37	167	1429
2008	5	10	66	194	382	384	109	56	52	190	1448
2009	6	6	57	143	379	388	110	50	64	187	1390
2010	7	8	48	114	348	334	94	37	47	117	1154
2011	6	6	60	119	295	293	109	47	45	97	1077
2012	12	8	80	123	378	342	122	61	47	111	1284
2013	9	3	68	57	290	233	103	50	21	130	964
2014	9	5	58	68	287	251	108	66	8	193	1053
2015	1	4	58	59	218	198	65	29	14	57	703
2016	2	3	41	39	205	160	67	25	9	4	555
2017	1	3	50	33	197	138	54	33	11	4	524

Source of Data: Ministry of Health, HACU, Annual Surveillance Report

### 2.4.1.3 GEOGRAPHIC SPREAD OF THE EPIDEMIC

#### Geographic Spread of the Epidemic

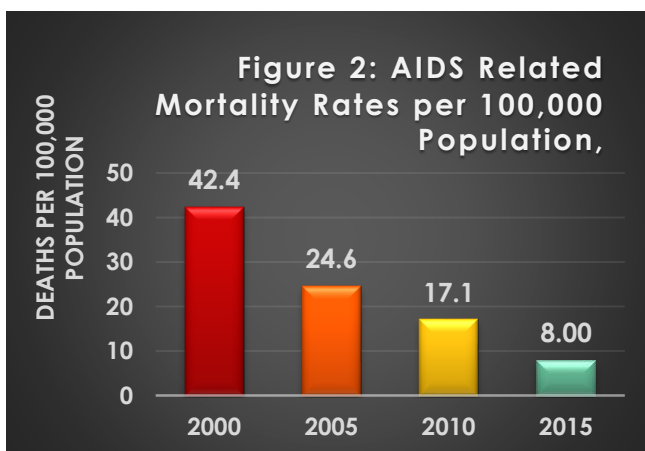
All counties and regions have been affected by the epidemic. Data for 2017 show that the urban centres of St George (53.4%), Caroni (10.9%), Victoria (7.6) and St Patrick (5.9%) accounted for more than 75% of new reported HIV infections. Tobago accounted for 1.3% of new reported

<sup>5</sup> Ministry of Health. National Surveillance Report 2005-2012, unpublished and Ministry of Health, HACU. HIV Surveillance Annual Reports, 2013-2017

infections in 2017. Rates of new HIV Diagnoses disaggregated by Municipality Residence showed that the city of Port-of-Spain (113.3), Borough of Arima (83.3), San Juan /Laventille (59.8), Diego Martin (37.9) and Tunapuna/Piarco (36.3) were the regions with the five highest rates of new infections per 100,000 population in 2017 respectively.<sup>6</sup>

#### 2.4.1.4 AIDS RELATED MORTALITY

AIDS related mortality has declined substantially from 42.4 in 2000 to 8 deaths per 100,000 in 2015. These declines are due to the introduction of HAART in 2003 which is available free of charge to the population and also to the successes in controlling mother to child transmission of HIV.



Source of data: Central Statistical Office and Ministry of Health, HACU

#### 2.4.1.5 HIV TRANSMISSION IN KEY AND VULNERABLE POPULATIONS

**Key populations** are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. **Vulnerable populations** are groups of people who are particularly vulnerable to HIV infection *in certain situations or contexts*.<sup>7</sup>

<sup>6</sup> Ministry of Health, HACU, HIV Surveillance Annual Report, 2017

<sup>7</sup> World Health Organization. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update. Geneva, 2016.

The National HIV and AIDS Strategic Plan of Trinidad and Tobago 2013-2018 defines key populations as comprising men who have sex with men (MSM), sex workers (SW), substance users, youth, infants born to HIV positive mothers, prisoners and migrant workers.

Vulnerable populations include women, adolescents, and the homeless and socially displaced, orphans, street children, people with disabilities, marginalised youth, the elderly and transgender populations.

### ***Men who have sex with Men and LGBTI***

Cross-sectional studies such as the Men's Bio-Behavioural Study completed in 2014 show HIV Prevalence among the respondents in this key population to be approximately 27%. Additional findings from this study revealed that among the 246 participants:

- ✚ 24% were unaware of their HIV status;
- ✚ 91% knew where to access an HIV test but only about four-fifths of MSMs in the survey reported ever being tested;
- ✚ over half did not know the status of their last partner;
- ✚ about two-thirds (65%) preferred to use private facilities;
- ✚ one in four engaged in transactional sex in the previous 12 months; and
- ✚ more than one third (38%) had unprotected anal intercourse with partner of opposite or unknown status in the previous 12 months.

Many members of this population encounter high levels of stigma and discrimination and homophobic attitudes from the general population as well as from health workers which may negatively impact their accessing prevention and treatment services.<sup>8</sup>

Members of the LGBTI community are also vulnerable to HIV and other STIs due to violence, laws criminalizing their behaviours, lack of access to quality and non-discriminatory health care, lack of literacy surrounding treatment and services. These issues were raised as concerns confronting both PLHIVs and Key Populations.<sup>9</sup>

### ***Sex workers***

A recently conducted sex worker survey found that prevalence of HIV among sex workers was approximately 2% <sup>10</sup>. Data on risk exposures and characteristics for 2017 from HACU show that roughly 3% of risk exposures were due to sexual activity with sex workers in the past 12 months.<sup>11</sup>

This population is also known to face stigma and discrimination, violence and other barriers in accessing health services including HIV testing and other reproductive health services. Moreover,

---

<sup>8</sup> Ministry of Health. *Men's Bio-Behavioural Survey, unpublished, 2014*

<sup>9</sup> Myrie, T. *Legal Environment Assessment for the HIV and AIDS Response in Trinidad and Tobago, Final Report. 2018.*

<sup>10</sup> Ministry of Health. *Female Sex Worker Study, unpublished*

<sup>11</sup> Ministry of Health, HACU, *HIV Surveillance Annual Report, 2017, unpublished*

knowledge about HIV and STIs and uptake of services have been found to be low among migrant Hispanic sex workers in Trinidad and Tobago.<sup>12</sup>

Studies have described the vulnerabilities and risks faced by migrant sex workers in this country. In 2012, COIN/CVC published the results of a 2011 survey (assisted by FPATT) that covered 60 migrant Hispanic sex workers in Trinidad and Tobago and found they were mostly from Dominican Republic, Columbia and Venezuela. Their levels of education were low (with less than 30 percent having completed primary school) and they had little knowledge about HIV and how to prevent its spread. Other risks included non-use of female condoms and inconsistent use of male condoms, lack of knowledge of correct male condom use, forced to have sex and physical and verbal abuse, language and communication barriers.<sup>13</sup>

### ***Substance Users***

There is a general paucity of studies on HIV prevalence among drug users in Trinidad and Tobago. However, among this group HIV is also much higher than among the general population. One study conducted in 2006 among female crack-cocaine users found the prevalence to be 19.8% which was about six times higher than in the prevalence in the general population<sup>14</sup>. One community based NGO conducted a pilot study among homeless non-injecting drug users in 2015 in Port-of-Spain's east side, San Juan, Curepe, Tunapuna and Arima found that among the 688 persons participating in the intervention, 6% were HIV positive<sup>15</sup>. There is also the intersection between drug use and sex work which can become a major driver for HIV transmission.<sup>16</sup>

### ***Children and Youth***

For the year 2016, UNAIDS estimated the HIV prevalence among young women and men to be 0.3% and 0.4% respectively<sup>17</sup>. The UNAIDS estimated that in 2017 there was less than 200 children living with HIV in Trinidad and Tobago. Surveillance data for 2017 showed that children under 15 comprised 1.3% of all new reported HIV infections. It is also estimated that 87% of children living with HIV were receiving ART.

---

<sup>12</sup> Hasbún, Julia et al *Diversity and Commonality: A Look at Female and Transgender Sex Workers in Three Caribbean Countries*, Caribbean Vulnerable Communities Coalition/The Center for Integrated Training and Research and the Pan Caribbean Partnership on HIV and AIDS, Dominican Republic. 2012.

<sup>13</sup> CVC/COIN Vulnerabilized Groups Project: Phase One (January 2011 - March 2013) An Independent Evaluation By Stuart Adams. August 201.

<sup>14</sup> Reid, Sandra. "HIV Seroprevalence and risk factors in female substance abusers seeking rehabilitation in Trinidad and Tobago". *West Indian Medical Journal*. vol. 53, no. 3, June 2004, pp. 155-8.

<sup>15</sup> Community Action Resource. *Drug Users Community-based participatory Action Research Project*

<sup>16</sup> Arreola et al. *Substance Abuse and HIV/AIDS in the Caribbean: Current Challenges and the Ongoing Response Journal of the International Association of Providers of AIDS Care*, vol. 16, no.1, 2017, pp. 56-74

<sup>17</sup> Trinidad and Tobago, UNAIDS Country Factsheet, 2016

LGBTQI youth have been found to face specific challenges. A baseline study conducted in six Caribbean Countries including Trinidad and Tobago among marginalized youth found that these youth are subject to stigma and discrimination, and face specific challenges negotiating safe sex owing to power imbalances. Health and social services fail to meet their unique needs. Data from Trinidad and Tobago show that only 23% of LGBT youth reported that someone had spoken to them about HIV in the past 6 months; 16% had been taught how to use a condom correctly; fewer than half reported ever being tested for HIV.<sup>18</sup>

### ***Prisoners***

Anecdotal evidence suggests that HIV prevalence among prisoners may be as high as 15% however this is still to be confirmed (NSP, 2013-2018).<sup>19</sup> Persons in incarcerated settings are not afforded the HIV and SRH prevention and treatment and care services that they need.

---

## 2.4.2 SOCIAL, BEHAVIOURAL, STRUCTURAL DRIVERS OF THE HIV EPIDEMIC

A number of behavioural, social, structural factors have been found to drive the epidemic and influence behaviours and outcomes including early age of sexual debut; insufficient condom use; large number of sexual partners; transactional sex, intergenerational sex/age mixing; gender norms and values, gender based violence, poverty and social vulnerability and pervasive stigma and discrimination.<sup>20</sup>

---

### 2.4.2.1 BEHAVIOURAL DRIVERS

#### ***Early age of sexual debut***

The most recent data from the MICS Survey 2011 show that just over half (52%) of young women 15-24 years ever had sex. Among adolescents 15-29 years 28% more than a quarter ever had sex. Early sex debut was experienced by 4% of women 15-24 years who reported that they had sex before the age of 15.<sup>21</sup>

Adolescents attending school also engage in sexual activity. Results from the 2017 GSHS show that about one in five students aged 13-15 years had ever had sex, with the proportion among males being twice as high that of females (33% vs 16%). Forty percent of students attending school aged 15-17 years reported ever having sex, 54% among males and 27% among females. Among students

---

18 CVC/COIN Vulnerabilized Groups Project - An Independent Evaluation. CVC/COIN Baseline Studies Round 9 Grant

19 National HIV and AIDS Strategic Plan, 2013-2018. Office of the Prime Minister, Trinidad and Tobago. 2013.

20 Andrews, B. Draft Situational Analysis of HIV and AIDS in Trinidad and Tobago. 2019.

21 Ministry of Social Development and Family Services, Central Statistical Office and UNICEF. "Key Findings and Tables" Trinidad and Tobago Multiple Indicator Cluster Survey 2011. Port of Spain, Trinidad and Tobago, 2017.

who ever had sex aged 13-17 years about 56% of them had their first sexual intercourse before the age of 14 years.<sup>22</sup>

### ***Insufficient and inconsistent condom use***

Condoms have been found to be an effective method of reducing one's chances of being infected if used consistently and correctly. According to the 2011 MICS Survey less than half of the women aged 15-49 who had multiple sex partners in the last 12 months used condoms the last time they had sex.

It appears therefore that condom use is not high even with multiple partners. Among adolescents in school aged 13-17 years who have ever had sex, half of them used condoms during their last intercourse. Condom use was much lower among female students (46%) than among male (52%).<sup>23</sup>

### ***Unprotected sex and Large number of sexual partners***

Having a large number of sexual partners is a major risk factor for increasing the epidemic in the population. The last national Knowledge Attitudes Practices and Beliefs (KAPB) survey conducted in 2006-2007 showed that four out of five persons who had sex in the last 12 months had more than one sexual partner.<sup>24</sup>

Population based survey data from the Multiple Indicator Cluster Survey on women shows that 3% of women ages 15-49 reported that they had sex with more than one partner in the last 12 months.

### ***Transactional sex***

New infections were transmitted through transactional sex or exchange of sex for money, drugs or material gain was 3.4 % of risk exposures among men and 2.4% among women.<sup>25</sup>

### ***Intergenerational sex or Age Mixing***

There is the phenomenon of age mixing where young persons, especially girls and women, have sex with older more sexually experienced men. This increases vulnerability of young persons to become infected with HIV and other STIs. The 2006-2007 KAPB showed that four out of five respondents 15-24 years reported having sex in the past year with a partner 10 years older.<sup>26</sup>

---

22 *Global School Health Survey, Trinidad and Tobago, 2017*

23 *Global School Health Survey, Trinidad and Tobago, 2017*

24 Maharaj et al. "Sexual Practices among 15-49 year olds in Trinidad and Tobago 2006-2007." *Caribbean Medical Journal*, vol. 76, no. 2, December 2014, pp. 10-14.

25 *Ministry of Health, HACU, Annual Surveillance Report, 2017*

26 Maharaj et al. "Sexual Practices among 15-49 year olds in Trinidad and Tobago 2006-2007." *Caribbean Medical Journal* vol. 76, no. 2, December 2014, pp. 10-14.



MICS survey results in 2011 showed that there is intergenerational sex among young women with just over one-tenth (13%) of sexually active young women aged 15-24 years reporting that they had sex with a man more than 10 years older than themselves. Intergenerational sex was highest among young women in rural areas (15%) than among women in urban areas (11%) and among young women in the poorest economic group (16%).<sup>27</sup>

---

#### 2.4.2.2 SOCIAL AND CULTURAL DRIVERS

Cultural factors such as attitudes towards sexuality being viewed as taboo, homophobic attitudes, traditional gender roles, discomfort with discussing sex and sexuality, sexual socialization practices and norms have been found to influence behavior which propel the transmission of HIV. For example masculinity norms can foster machismo attitudes which may encourage multiple sexual partners and risk-taking which place men and their partners at risk of HIV infection.

---

#### 2.4.2.3 STRUCTURAL DRIVERS

##### ***Gender inequality, gender based violence, norms and values***

Gender roles and relations powerfully shape the course and impact of the HIV and AIDS epidemic. Gender-related factors influence the extent to which men, women, boys and girls are vulnerable to HIV infection, the ways in which AIDS affects them, and the kinds of responses that are feasible in different communities and societies.<sup>28</sup> Financial disparities and intimate partner violence in relationships often hinder a woman's ability to negotiate condom use and protect herself from HIV. Gender inequality and gender roles may place women at a disadvantage in sexual relationships and increase their vulnerability by reducing their inability to negotiate condom use and their access to sexual health services such as HIV testing and treatment. Gender based violence, for example sexual violence from intimate and non-intimate partners also fuel the spread of the epidemic and is a risk factor for HIV transmission. Fear of violence, violence, trauma and other negative social outcomes act as barriers to women's ability to access HIV prevention tools and services and can lead to lower treatment adherence, lower CD4 counts and higher viral loads <sup>29, 30</sup>

The 2018 Women's Health Survey found that 30% percent of ever-partnered women experienced physical and/or sexual violence by an intimate partner in their lifetime; and 6 % in the 12 months

---

27 Ministry of Social Development and Family Services, Central Statistical Office and UNICEF. *Trinidad and Tobago Multiple Indicator Cluster Survey 2011*. Port of Spain, Trinidad and Tobago, 2017.

28 Joint United Nations Programme on HIV/AIDS (UNAIDS). *Fact sheet – Gender and HIV and AIDS*

29 World Health Organization. *Addressing violence against women in HIV testing and counselling: a meeting report*. Geneva, 2006.

30 Joint United Nations Programme on HIV/AIDS (UNAIDS). *When Women Lead Change Happens*, 2017.

prior to data collection. The prevalence of non-partner sexual violence (NPSV) was reported to be 21.3%.<sup>31</sup>

### ***Poverty and social vulnerability***

Other structural impediments include poverty, factors related to legislation and policy which impede vulnerable populations access to services. With respect to poverty according to Gilbert “Poverty's companions encourage the infection: undernourishment; lack of clean water, sanitation and hygienic living conditions; generally low levels of health, compromised immune systems, high incidence of other infections, including genital infections, and exposure to diseases such as tuberculosis and malaria; inadequate public health services; illiteracy and ignorance; pressures encouraging high-risk behaviour, from labour migration to alcohol abuse and gender violence; an inadequate leadership response to either HIV/AIDS or the problems of the poor; and finally, lack of confidence or hope for the future.”<sup>32</sup>

A 2011 study by **Scott et al**, on Poverty, Employment and HIV/AIDS in Trinidad and Tobago concluded that HIV/AIDS and poverty reinforce each other, with poor, vulnerable women being a significant driver of the disease while also bearing the burden of its impact. They further recommended that Policies are needed to protect the women of Trinidad and Tobago, as well as the rights of all participants in the labour force.<sup>33</sup>

## 2.5 THE NATIONAL RESPONSE

The response to HIV was initially led by the National AIDS Programme in the Ministry of Health. Recognising that HIV and AIDS transcend the health sector and impacts every dimension of the social fabric the National AIDS Co-ordinating Committee was first established in 2003 by Cabinet under the auspices of the Office of the Prime Minister. This multi-sectoral body was tied to a World Bank Project and loan which expired in 2011. With the change in administration in 2010 a new Interim HIV Agency was created to lead the national response to HIV initially under the OPM and then transferred to the Ministry of Health. The term of this Agency expired in January 2015.

In 2016 the national response to HIV was once again re-established under the Office of the Prime Minister. The National AIDS Co-ordinating Committee was created to lead, co-ordinate and guide the national response to HIV and AIDS. It is supported by a Secretariat. The Co-ordinating body adheres to the Three One's Principle. One National Plan, One Co-ordinating, Body and one

<sup>31</sup> Pemberton, C. and Joseph, J. *National Women's Health Survey for Trinidad and Tobago: Final Report*. 2018.

<sup>32</sup> Gilbert, Godfrey 2004, *World Poverty- A Reference Handbook* .p 170

<sup>33</sup> Scott et al. 2011 *Poverty, Employment and HIV/AIDS in Trinidad and Tobago.* " *International Journal of Business and Social Science*, vol. 2, no. 15, August 2011.

Monitoring and Evaluation Plan. There are also four line Ministries with HIV Co-ordinators which implement strategies in the national response related to their particular sector.

The national response is organised along five priority areas:

- Prevention combining biomedical, behavioural, structural and approaches also known as Combination Prevention;
- Treatment and Care;
- Enabling environment;
- Strategic Information; and
- Policy and Programme Management.

### HIV TESTING

Rapid HIV testing is provided free of charge in the public sector. With the expansion of testing sites, same day testing, outreaches etc. testing has been significantly scaled up and is routinely offered. The number of same day testing sites more than doubled from 31 in 2010 to 64 in 2015. There are testing sites throughout the country which include primary health care centres in regions, STI clinics, public hospitals, NGOs sites, private labs. Despite the increase in testing sites the majority of testing occurs in the hospital. The population also can access Testing through community and workplace interventions. HIV testing is performed by trained health care providers and lay testers. The number of persons/clients tested increased by 52% from 39032 in 2010 to 59395 in 2017. Among persons being tested for whom the sex was reported, the majority were female (n= 37407, 63%) and males comprised one-third (n=20,388).<sup>34</sup>

### PREVENTION OF MTCT

Trinidad and Tobago is working towards certification for the elimination of mother to child transmission. There is high percentage of pregnant women who receive ARV for PMTCT. In 2016, 95% of pregnant HIV positive women received ARV. In 2017 this figure was 81%.

### TREATMENT, CARE AND SUPPORT

In 2015, Trinidad and Tobago adopted WHO Treatment Guidelines of Treat All Policy i.e. persons who are diagnosed are offered treatment and care immediately upon diagnosis regardless of their

#### Box 1: Other Key Milestones

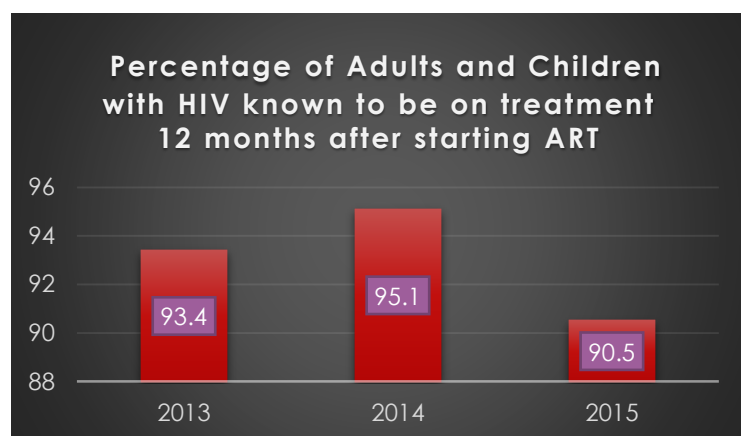
- **In 2011:** the HIV/AIDS Workplace Advocacy and Sustainability Centre was also created and placed in the Ministry of Labour was created to lead the national response in the workplace
- **In 2017:** the National Workplace Policy on HIV and AIDS was approved by Cabinet and is being implemented
- **In 2018:** The Tobago HIV Co-ordinating Committee (TACC) was re-established in 2018 to co-ordinate treatment care and all aspects of the response on the island. The TACC works in tandem with the NACC.

<sup>34</sup> Ministry of Health, HACU. 2017 Annual Data Management Report, 2017.

CD 4 count. This has the effect of reducing transmission as persons who are started on treatment earlier and who adhere are more likely to become undetectable and are at low risk for transmission. ART is provided free of charge at seven treatment sites across the country the largest being the Medical Research Foundation TT.

In 2017, of the 11,000 persons estimated by UNAIDS to be living with HIV roughly 6700 were on treatment representing 62% of estimated PLHIV. A larger proportion of males (51% (n=3416) were on treatment as compared to females (3277). The age distribution of persons on treatment mirrors the age distribution of PLHIV with the highest proportion of persons (65% of persons) receiving treatment belonging to the age group 25-49 years. Persons newly initiated on ART increased slightly from 725 in 2016 to 746 in 2017.<sup>35</sup> Persons known to be on retention on ART 12 months after starting ART increased between 2013 and 2014 and decreased in 2015.

**Figure 3: Twelve Month Retention in ART, 2013-2015**



*Source of data: HIV and Other Diseases Data Driven Health-related Indicators 2018 Reporting Cycle- Ministry of Health, HACU*

Retention in care remain a challenge as only two thirds of persons initiating treatment were still in treatment one year later. Factors affecting treatment include accessibility, stigma and discrimination from health care workers, psychosocial factors e.g. nutritional support. Clients are also challenged by frequent stock outs of medicines as evidenced by five out of six treatment sites experiencing a stock out of one or more ART medicines during 2017.

Consultations coming out of the Legislative Environment Assessment conducted in 2018 revealed that PLHIV and Key Populations expressed concerns about access to health care and quality of health care, stigma and discrimination, challenges regarding privacy and confidentiality, concerns

<sup>35</sup> Ministry of Health, Global AIDS Monitoring (GAM) Indicators, unpublished

about disclosure, contact tracing and HIV testing. There was also insufficient treatment literacy, patient empowerment and communication issues between health care professionals and patients.<sup>36</sup>

### **SERVICE DELIVERY**

HIV services are delivered through a network of providers operating at the public health sector level, private sector, civil society. There are 64 HIV testing sites and seven adult and four paediatric treatment sites.<sup>37</sup> The Ministry of Health is a major service provider in the national response providing HIV and SRH services through RHAs, vertical units such as HACU, Population Programme Unit, QPCC&C, PMTCT Programme, and Antenatal Clinics. There are also NGOs such as FPATT and Medical Research Foundation which are involved in service delivery. FPATT provides integrated HIV/SRH services while MRFTT (an NGO) is the largest treatment site in the country. Key components of service delivery for HIV and AIDS includes: screening/testing, counselling, referrals, education and information and outreach, treatment and care, psychosocial support. There is also a cadre of health care professionals, non-health care professionals, lay and community workers, peer navigators who provide support and are critical in the response. Psychosocial support is provided through a multi-sectoral network comprising government, NGOs and private sector. However there is need for more comprehensive psychosocial support services and mechanisms at each treatment site. There is limited care for HIV provided in the private sector. There is also limited outreach to support clients with poor health seeking behaviour and limited youth and adolescent friendly services.

### **ROLE OF CIVIL SOCIETY AND COLLABORATION WITH PARTNERS**

The NACC is mandated to build and deepen multi-sectoral partnerships to achieve national commitment, support and ownership of the response to HIV and AIDS. Civil Society continues to play a critical role in the national response with respect to operationalising strategies in the NSP and by stakeholder involvement through various mechanisms such as Technical Working groups, NGO Fora, Partnership Forum. To date three NGO Fora and a Partner's Forum have been convened under the auspices of the re-established NACC.

There is a continued strong relationship with our development, bilateral and regional partners who continue to provide technical support and funding to the national response e.g. PEPFAR, UN Agencies –UNFPA, UNDP, ILO, and PAHO/WHO; regional bodies e.g. CARPHA and PANCAP and Caribbean Vulnerable Communities.

---

<sup>36</sup> Myrie, T. *Legal Environment Assessment for the HIV and AIDS Response in Trinidad and Tobago, Final Report. 2018.*

<sup>37</sup> Joint United Nations Program on HIV/AIDS (UNAIDS). *Global AIDS Response Progress Report (GARPR) Country Narrative Report. 2016.*

2.5.1 ACHIEVEMENTS AND CHALLENGES

Since the first case of HIV was reported in 1983 the national response has evolved and there have been some key achievements over the history of the epidemic in this country.

**Table 4: Key Achievements and Challenges by Priority Area**

PRIORITY AREA	KEY ACHIEVEMENTS	CHALLENGES
<b>Prevention</b>	<ul style="list-style-type: none"> <li>• Decrease in new infections among children.</li> <li>• Substantial reduction in mother to child transmission. TNT is going through process to certify elimination of MTCT.</li> <li>• Expansion of Testing and counselling sites and mechanisms for testing.</li> <li>• Increase in the number of schools with HFLE in the curriculum.</li> <li>• Improvement in levels of knowledge and awareness about HIV and AIDS.</li> <li>• Establishment of key population peer navigation and education support system.</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate knowledge of HIV and SRH among some populations, especially rural areas.</li> <li>• Low uptake of HIV testing and adoption of risk reduction behaviours especially among men.</li> <li>• Even though increasing numbers of condoms are being distributed there is insufficient consistent use of condoms and adoption of other risk reduction strategies.</li> <li>• Limited access to SRH information and services for minors and other vulnerable populations.</li> <li>• Stigma and Discrimination impact persons especially key and vulnerable populations’ access to health, SRH services, disclosure of HIV status.</li> <li>• Inefficient HIV testing systems- Labs are challenged which would affect achievement of 90-90-90 targets.</li> <li>• Difficult to reach men with behavioural change interventions e.g. health seeking, risk reduction, which may make men more vulnerable to HIV.</li> <li>• Lack of systematic programme to address SRH issues including HIV</li> </ul>

PRIORITY AREA	KEY ACHIEVEMENTS	CHALLENGES
<p><b>Access to treatment and care for PLHIV and psychosocial support</b></p>	<ul style="list-style-type: none"> <li>• Increased number of persons in treatment and care and retained in care.</li> <li>• Reduced AIDS related mortality due to access to free medication.</li> <li>• Initiatives targeting youth such as youth clinics at major treatment sites</li> </ul>	<p>and STI Management and prevention for the disabled and the elderly.</p> <ul style="list-style-type: none"> <li>• Low retention in care.</li> <li>• Loss to follow up and adherence rates.</li> <li>• Low levels of viral suppression.</li> <li>• More needs to be done to retain persons in care by addressing the social determinants of non-adherence.</li> <li>• Inadequate attention to the psychosocial and behavioural factors which influence aspects of treatment and care for example disclosure</li> <li>• Treatment of OIs and more efficient lab systems needed</li> </ul>
<p><b>Enabling environment:</b></p>	<ul style="list-style-type: none"> <li>• Several laws, plans and policies relevant to HIV have been enacted e.g.:               <ul style="list-style-type: none"> <li>— National HIV and AID Strategic Plans 2004-2008 and 2013-2018;</li> <li>— National Workplace Policy on HIV and AIDS 2017;</li> <li>— National Development Strategy 2020-2030; and</li> <li>— Treatment and Care Guidelines.</li> </ul> </li> <li>• Partnerships with CSOs e.g. Faith-Based Organisations.</li> </ul>	<ul style="list-style-type: none"> <li>• Homophobic attitudes which drives key populations underground and inhibits access to health and other social services.</li> <li>• Inadequate advocacy efforts with respect to calling for amendments for key legislation that would promote equality and social justice e.g. the Equal Opportunity (Amendment) (No.2) Bill, 2011 to include ‘real or perceived HIV status’ and ‘sexual orientation’ as grounds for protection and non-discrimination.</li> <li>• Lack of comprehensive prevention and treatment initiatives for the incarcerated and other institutionalized populations.</li> </ul>



PRIORITY AREA	KEY ACHIEVEMENTS	CHALLENGES
		<ul style="list-style-type: none"> <li>• Lack of a national system for reporting of infringement of human rights and a redress system.</li> <li>• Need for increased uptake of HIV workplace programmes that can contribute towards the achievement of the 90-90-90 targets.</li> </ul>
<b>Strategic Information</b>	Improved surveillance system e.g. Case based surveillance system.	<ul style="list-style-type: none"> <li>• Low data quality due to incomplete reporting of key variables such as place of residence, risk behaviours and due to low sensitivity (high under-reporting) in the case base surveillance system.</li> <li>• Need to improve research on HIV and AIDS.</li> <li>• Lack of capacity to report on HIV in a sustained manner to national, regional and international stakeholders.</li> <li>• No sustained national system for reporting reliable population data on knowledge attitudes and behaviours related to HIV and for reporting on stigma and discrimination.</li> <li>• HIV is still not a notifiable disease.</li> <li>• No system in place for monitoring HIV Drug Resistance.</li> <li>• Inadequate accessibility to information on STIs.</li> </ul>
<b>Policy and Programme Management</b>	<ul style="list-style-type: none"> <li>• The National Coordinating Mechanism established under OPM to lead national response.</li> </ul>	<ul style="list-style-type: none"> <li>• Need to improve the performance monitoring of the national response.</li> <li>• Need to strengthen national capacity for an effective and sustained response.</li> </ul>



PRIORITY AREA	KEY ACHIEVEMENTS	CHALLENGES
	<ul style="list-style-type: none"> <li>• National response mainly funded by domestic resources i.e. 90% of response funded domestically.</li> <li>• Strong linkages with development partners e.g. UN Bodies- ILO, PAHO, UNFPA, UNDP and PEPFAR.</li> <li>• Accreditation of two labs</li> </ul>	<ul style="list-style-type: none"> <li>• Declining domestic and international funding for HIV and AIDS programmes.</li> <li>• Inadequate human and financial resources for the national response.</li> <li>• Contribution from private Labs are largely undocumented implying the need for a national regulatory lab surveillance framework.</li> <li>• Reduction in HIV Coordinators in Public Sector Ministries due to economic and ministerial priorities. This affects commitment and attainment of key HIV goals and targets for Ministries inclusive of the 90-90-90 targets.</li> <li>• Need to improve the use of new media for promoting behavioral change, advocacy, co-ordination and management of the response.</li> <li>• Lack of a Quality framework for the national HIV and AIDS response.</li> <li>• Inadequate responses addressing vulnerable and marginalized groups such as adolescent mothers, persons with disabilities, orphan and other children made vulnerable by HIV, the elderly, migrants, sex worker, persons in institutionalized settings including prisons, youth camps, youth drop outs and out of school youth etc.</li> <li>• Lack of systematically collected data on financing</li> </ul>

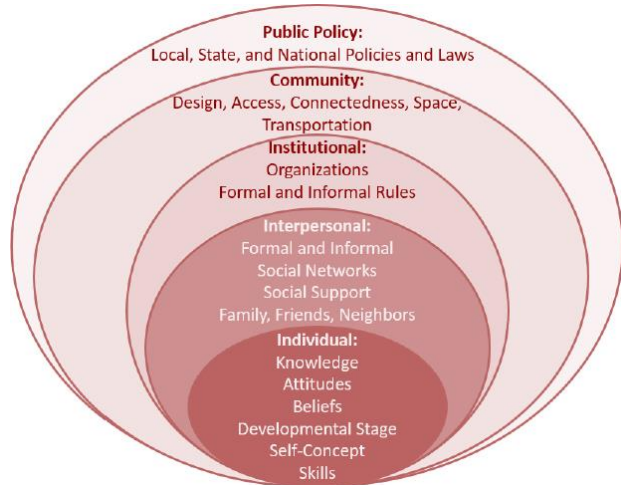
### 3 POLICY FRAMEWORK

This section describes the national Policy Framework for the National HIV and AIDS Policy. It highlights the Conceptual Framework, Scope, Vision and Mission, Underlying Principles Goals, Objectives and Policy Outcomes.

#### 3.1 CONCEPTUAL FRAMEWORK

HIV and its associated risks, outcomes and behaviours are driven by a range of factors that put persons at risk and increase their vulnerability to infection, affect uptake of prevention and adherence, disclosure and related behaviours. The social ecological model describes the interplay of factors operating at individual, relationship, institutional, community, and societal levels.

The model provides a theory-based framework for understanding how the social determinants of health influence and maintain health and health-related issues such as outcomes and behaviours associated with HIV and AIDS. This can help identify promising points of intervention and provide a better understanding of how social problems are produced and sustained within and across the various subsystems (i.e., an individual’s decisions and behaviours result from interactions with his/her social and physical surroundings).<sup>38</sup>



Adapted from McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) 39

**Figure 4: Social Ecological Model**

#### 3.2 SCOPE

The National HIV and AIDS Policy provides the overall vision and direction for the Trinidad and Tobago national HIV response. The HIV response requires full national ownership of a

<sup>38</sup> Texas HIV/STD Prevention Community Planning Group, *Texas HIV/STD Prevention Plan, 2011*

<sup>39</sup> McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.). "The Social Ecology of Health Promotion Interventions." *Health Education Quarterly*, vol 15, no. 4, 1988, pp. 351-377.

coordinated multi-sectoral approach to developing and implementing effective strategies that optimally utilise resources to achieve national targets and goals. The policy provides an overarching framework for the development and implementation of enabling legislation, national strategic plans, sector-specific policies and national standards and protocols.

By outlining specific responsibilities in the areas of **prevention, testing, treatment, care and support, and in coordinating and implementing a multi-sectoral response** the National HIV and AIDS Policy provides guidance to public, private sector and community actors involved in the national HIV response.

### 3.3 VISION AND MISSION

#### **Vision**

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

#### **Mission**

To challenge and encourage the national community to work in partnership to prevent and treat HIV and to mitigate its negative impacts.

### 3.4 UNDERLYING PRINCIPLES

The principles that guide the Trinidad and Tobago National HIV and AIDS Policy are aligned with those upon which Vision 2030 and the NSP are premised. These are:

- ***Political leadership and commitment:*** Strong political leadership and commitment at all levels are critical to an effective, comprehensive and sustained national response.
- ***Good governance, transparency and accountability:*** Human, financial and organisational resources will be mobilized and managed in an effective, transparent and accountable manner. The policy would be widely disseminated and progress assessed against benchmarks and targets on an annual basis.
- ***Equity:*** All persons can access information, prevention, treatment, care and support services regardless of HIV or other health status, sexual orientation, gender identity, age,

disability, religious beliefs, socio-economic status, immigration status, incarceration status, geographic location, level of literacy or vulnerability to exposure.<sup>40</sup>

- **Gender equality.** With HIV and AIDS being a social, cultural and economic phenomenon gender equality is imperative in addressing sexual and reproductive health. Women and girls are particularly vulnerable to HIV infection. Men and boys are also vulnerable and their needs should also be included in all programming and prevention interventions.
- **Promotion and protection of human rights:** All persons infected, perceived as infected or affected by HIV have the right to equality before the law and freedom from discrimination, and to be treated with dignity and respect in all areas of daily life. The National HIV and AIDS Policy draws attention to the compelling public health rationale to overcome stigmatization and discrimination in society, including the impact of gender norms and stereotypes. Reducing stigma and discrimination towards people living with HIV and key populations is critical for an effective national response.
- **Collaboration:** A comprehensive national response utilizes the full range of effective, evidence-based policy and programmatic interventions, and involves all stakeholders in decision-making, planning, implementing and monitoring.
- **Inclusion:** Meaningful participation by all groups in society in decision-making, planning, implementing, monitoring and evaluating the national response to HIV is critical for an effective and sustainable response. It is also critical to understand and meet the needs of PLHIVs, KPs, vulnerable groups and others who face high levels of stigma and discrimination and as a result, may be deterred from accessing health and other services.
- **Community systems strengthening and participation:** Community actors working together with the formal health sector are critical to the long-term sustainability of effective interventions for epidemic control. Programmes designed, led, implemented and supported by the community should be evidence-informed, cost-effective, sustainable, and include support for KPs and vulnerable groups unable or unwilling to access government-provided services. Community networks, linkages and partnerships should be supported and integrated into the national programme.
- **Evidence based programming:** All programmes and interventions are to be designed taking into account the factors driving the epidemic within locations and subpopulations and should be based on the epidemiological, economic, social, and demographic contexts of the country.
- **Regulatory role of the Ministry of Health:** The regulatory framework for the provision of health services provides up-to-date and scientifically sound guidelines for the delivery of HIV and related services.

---

<sup>40</sup> This includes young people, women, orphans, wards of the state, men who have sex with men, transgender people, sex workers, street and working children, people living with disabilities, people who use drugs, migrants and prisoners.

- **Efficiency:** Strategies, resources and inputs for the HIV response are integrated with other national development and health efforts to enhance overall efficiency and potential for sustainability. This includes the equitable and sustainable resourcing of the health sector in alignment with national priorities, policies and strategies.
- **Sustainability:** in light of the changing economic environment, donor landscape and limited available resources emphasis would be placed on value for money, funds must be spent for the greatest impact and in the most efficient way, foster increased and continued country ownership, efficiency and sustainable financing.

### 3.5 POLICY GOALS

The overarching goals of the National HIV and AIDS Policy are to create an enabling environment for preventing the further transmission of HIV and AIDS in the population, for the optimisation of treatment, care and support and to mitigate the impact of HIV and AIDS on individuals, families, communities and society as a whole. The policy sets standard parameters to guide, co-ordinate and manage the national response to HIV and AIDS at all levels and in all sectors. It is expected that this Policy would facilitate the achievement of Vision 2030 and the goal of ending AIDS by 2030 through the achievement of the 90-90-90 Targets.

### 3.6 POLICY OBJECTIVES

The objectives of the National HIV and AIDS Policy are to:

1. Prevent new HIV infections and other STIs among general, key and vulnerable populations.
2. Scale up the provision and delivery of services, commodities, programmes along the prevention to treatment, and care and support continuum.
3. Ensure universal access to prevention, treatment and care services to all persons including Key and Vulnerable Populations.
4. Increase utilization of services along the prevention to treatment, care and support continuum by all.
5. Create an enabling environment for all persons to access and use these services without stigma, discrimination or violence.
6. Define the institutional and legal framework for effective leadership, co-ordination and management of a multi-sectoral response to the HIV epidemic.

7. Increase the active and meaningful participation of PLHIVs, Key and Vulnerable Populations at all levels of the government, private sector actors in and beyond the health sector, and the community.
8. Affirm the protection of the human rights of KPs, Vulnerable Populations and PLHIV as central to the HIV response and as enabling factors for effective service provision without stigma and discrimination.
9. Establish the framework for the development of sustainable financing for the expanded response.
10. Provide guidance for the design, coordination and implementation of HIV and AIDS programmes and interventions in all sectors.
11. Establish and strengthen the framework for effective strategic information in decision-making, planning and policy formulation.

### 3.7 POLICY OUTCOMES

This Policy provides a set of standard guidelines for governing the programmatic, institutional and social responses in key thematic and priority areas and is expected to yield the following outcomes:

12. Reduced new infections: By 2030 there would be a 95% reduction in new HIV infections in the general and key populations.
13. Reduced AIDS related deaths- By 2030 AIDS related deaths would be reduced by 95%.
14. Elimination of Mother to child transmission by 2025.
15. Increased knowledge of HIV Status: By 2025.
16. Increased persons on treatment: 95% of persons who know their status would be on treatment.
17. By 2025, 95% of persons on treatment virally suppressed.
18. Decreased stigma and discrimination faced by PLHIV and Key Populations. By 2025, there would be a 95% reduction in stigma and discrimination faced by people living with HIV and by key populations. This would be achieved by everyone's human rights being respected, protected and upheld.
19. Increase by 50% the percentage of PLHIV and KPs engaged in national response programmes.
20. An enabling environment which would promote universal access to services and resources and mitigate the impact of HIV and AIDS.
21. Sustainability of the national response as evidenced by increased national funding and capacity
22. Strengthened evidenced base and robust research agenda which is used for planning, decision-making, policy formulation and programme implementation.



## 4 POLICY STATEMENTS

This policy is structured around seven priority areas which are required for an effective and sustainable response to HIV and AIDS. These include:

- i) Prevention
- ii) Treatment, care and support
- iii) Enabling Environment and Promotion of Human Rights
- iv) Empowerment, Engagement and Protection of PLHIVs, Key and Vulnerable Populations
- v) Mitigation of the Impact of HIV
- vi) Strategic Information and Knowledge Management and
- vii) Co-ordination, Management and Sustainability

## 5 PRIORITY AREA 1: PREVENTION

### 5.1 RATIONALE

Prevention of HIV and STIs are fundamental to ending AIDS by 2030. Trinidad and Tobago has seen a 28% decline in new HIV infections from 2005 to 2014.<sup>41</sup> It has been estimated that at least 60% of persons in the population have never been tested for HIV. A multiplicity of social, behavioural, cultural, structural and health system factors have been shown to fuel the sexual transmission of HIV and increase vulnerability to HIV in Trinidad and Tobago which would necessitate being addressed in a comprehensive national HIV prevention strategy rooted in combination prevention.

### 5.2 STRATEGIC OBJECTIVES

1. To scale up universal access to comprehensive HIV prevention services, programmes and interventions for all,
2. To increase the proportion of the population and persons living with HIV that know their status,
3. To reduce mother to child transmission,
4. To increase the coverage of HIV, STI and TB testing in general, key, vulnerable populations,
5. To decrease the proportion of the population that engage in risky behaviours and,
6. To increase the use of technology in HIV prevention interventions.

---

<sup>41</sup> Andrews, B. *Draft HIV and AIDS Situation Analysis, Trinidad and Tobago. 2019.*



### 5.3 POLICY STATEMENTS

#### 5.3.1 COMBINATION PREVENTION

This policy will adopt a Combination Prevention approach which will use a mix of biomedical, behavioural and structural interventions. Research has shown that a combination prevention approach that provides high-quality, evidence-informed, culturally appropriate education, behaviour change and biomedical interventions, is critical to reduce HIV transmission.

- The essential Combination Prevention package would include the following elements and interventions :
  - **Biomedical-** including HIV testing and counselling, commodities e.g. condoms (male and female) and lubricants, PMTCT, ART as prevention, PReP for discordant couples, PEP, STI services, blood and tissue safety, universal precautions, HBV and HPV Vaccinations.
  - **Behavioural Interventions-** that encourage safe behaviour e.g. risk reduction counselling, comprehensive sexuality education, peer education programmes, social marketing campaigns, social and behaviour change communication and positive health, dignity and prevention.
  - **Structural interventions** that promote an enabling environment would include interventions, programmes and services which address health and family life education, gender inequality and violence, laws to protect the rights of persons living with HIV and key populations, interventions to reduce stigma and discrimination, psychosocial services, and policy framework.
- The Government through the NACC would encourage the development of interventions that form the basis of prevention programmes which are based on scientific evidence and expert international and national consensus about the optimal ways to implement evidence-based HIV prevention.
- In order to have a significant public health impact, structural, behavioural and biomedical prevention interventions, including condom distribution, structural interventions, treatment as prevention, and pre-exposure prophylaxis (PrEP) must be accessible and appropriate for KPs and vulnerable populations.
- HIV services offered should include the full basket of SRH services
- All prevention and treatment and care services should be trauma informed ie should incorporate knowledge about trauma in all aspects of service delivery

### 5.3.2 HIV TESTING, COUNSELLING AND LINKAGE

Universal HIV testing, counselling and linkage is a core prevention strategy that is critical to control the spread of HIV, and provides the opportunity for persons to become aware of their HIV status, access treatment, prevent transmission and reduce risk.

- 1) All persons, regardless of sexual orientation, gender, gender identity, age, disability, religious beliefs, socio-economic status, immigration status, incarceration status, geographic location, level of literacy or vulnerability to exposure, will have access to HIV testing and counselling and to information that will enable them to make an informed decision about whether to have a test and how to do so.
- 2) HIV testing will be scaled up and promoted to achieve universal access and the 90-90-90 Targets using but not limited to the following modalities:
  - i) voluntary testing and counselling; (client initiated) and partner testing
  - ii) provider initiated testing and counselling;
  - iii) community-based testing including home based testing and self-testing;
  - iv) mobile outreach and testing in various settings (for example churches, schools, workplaces, community centres, key population venues); and
  - v) testing in medical and non-medical settings including walk-in health and clinic based settings.
- 3) The NACC and the Ministry of Health (MOH) will be responsible for developing strategies and actions to ensure that HIV testing is mainstreamed in the health sector and promoted as widely as possible.
- 4) The MOH will facilitate a multifaceted approach by providing or sanctioning training to CSO testers and supporting the provision of testing and referral services at the community level.
- 5) In the public sector, HIV testing will be provided free of charge in health facilities and other settings. Testing services can be provided by private sector or civil society providers who have received training through a programme recognized by the NACC or MOH.
- 6) Providers of testing services, in both the private or public sectors, will comply with national guidelines, standards and protocols, including being fully confidential, reliable, of good quality, accessible and affordable.
- 7) The MOH shall be responsible for regulating public and private laboratories that test for HIV and STIs, including monitoring compliance with national standards and protocols and ensuring that sanctions are applied as appropriate.
- 8) Innovative technologies will be promoted for use of self-tests only after they have been evaluated and licensed by the MOH, and in accordance with any guidelines issued by the MOH.

- 9) In accordance with WHO/UNAIDS guidelines, health care providers should recommend HIV testing (provider-initiated testing), assisted partner notification to all patients who present with conditions that might suggest underlying HIV disease.<sup>42</sup>
- 10) Routine testing is to be recommended for all persons attending healthcare or community facilities by a healthcare provider or equivalent as a standard component of medical care.
- 11) Patients may choose to opt out or to opt in to healthcare provider recommendations to add HIV testing to routine medical testing. KPs that may lack the ability to fully negotiate in healthcare settings should be offered opt in testing to ensure consent and confidentiality.
- 12) No individual shall be compelled to undergo an HIV test. In particular, there should be no obligatory testing of specific groups such as men who have sex with men, sex workers, prisoners, or other key populations.
- 13) Employers should not require candidates for employment or employees to have HIV tests for promotion or otherwise. HIV testing should not be included in routine medical examination of workers neither should they be tested without their knowledge.
- 14) All persons testing positive are to be linked to the national treatment programme via a referral or case navigator system on the same day or at least within seven days.
- 15) The NACC in collaboration with key partners such as the MOH, Ministry of Social Development and Family Services and civil society are responsible for identifying and addressing structural and contextual barriers to Treat All, to ensure that those who test positive are initiated on ART as soon as possible.
- 16) Test results are confidential and are only to be released to the individual who was tested.
- 17) All testing should be voluntary for all populations and must be based on the three C's- informed consent, confidentiality and counselling should be provided.
- 18) Policies and laws which hinder minors from accessing HIV testing and counselling should be reviewed and amended.
- 19) HIV testing and counselling targeting youth should be provided in youth friendly spaces.
- 20) HIV testing and counselling targeting key populations should be provided in key population friendly spaces.

---

<sup>42</sup> World Health Organization. (2018). *Provider-initiated HIV testing and counselling in health facilities*. <http://www.who.int/hiv/topics/vct/PITC/en/>. Accessed, 1 December 2017.

- 21) Strategies to increase uptake of HIV testing and counselling among men should be developed and should involve the participation of men in the design of interventions.
- 22) The MOH will ensure that there are no stock outs of HIV testing kits, reagents etc. and that persons can access HIV testing once they desire to do so.
- 23) All facilities (public and private ) offering HIV testing are required to report HIV positive results on an anonymous basis to the national health information system for the sole purpose of gathering epidemiological data.

---

### 5.3.3 CONDOMS AND LUBRICANTS

The use of condoms and lubricants is a key strategy for the reduced transmission of HIV and sexually transmitted infections (STIs). While there is high knowledge about condoms there are low levels of condom use in the general populations. In the last population based KABP survey<sup>43</sup> (2007) over 80% of respondents had ever used condoms, however only one-third used condoms at their last sexual encounter with a regular partner and 14% used condoms consistently with non-regular partners. Condom use among youth is also not as high as it should be since the NSP targets that 80% of youth 15-24 years should use a condom with their non-marital, non-cohabiting sex partner. Only 60% of young women 15-24 years used condoms with a non-regular partner in the last 12 months and less than half of women 15-49 years who had more than one sexual partner reported condom use. <sup>44</sup>

- 1) All condoms for distribution, sale and use in Trinidad and Tobago must conform to the norms and standards determined by the Ministry of Health and informed by international research, as articulated in the National Condom Strategy.
- 2) Accurate information on the reliability of condoms in protecting against HIV transmission, as well as information on other complementary strategies to prevent transmission, must be made available as part of HIV and sexuality education and awareness efforts.
- 3) Condoms (male and female) and lubricants are to be made affordable and accessible to the public, including key populations. They are to be distributed widely in the public and private sectors at free or low cost, accessible to all sexually active members of the population and to all persons who may choose to use them.

---

43 Maharaj et al. "Sexual Practices among 15-49 year olds in Trinidad and Tobago 2006-2007." *Caribbean Medical Journal*, vol. 76 no. 2, December 2011, pp. 10-14.

44 Ministry of Social Development and Family Services, Central Statistical Office and UNICEF. "Key Findings & Tables." *Trinidad and Tobago Multiple Indicator Cluster Survey 2011. Port of Spain, Trinidad and Tobago, 2017.*

- 4) Condom distribution will occur through various mechanisms, including public sector family planning clinics, government agencies, HIV treatment sites, STI clinics, the private sector, social marketing agencies and CSOs.
- 5) Condom programming will be scaled up to promote the increased use of condoms among key and vulnerable populations and to utilise traditional and non-traditional condom distribution outlets in line with the National Condom Strategy.
- 6) Condom programming should target key and vulnerable populations including sexually active adolescents, youth, MSM, sex workers, transgender
- 7) Targeted condom distribution should occur at all prevention priority sites including all HIV and STI treatment sites and other areas where they can be accessed by vulnerable populations e.g. brothels, disaster management shelters
- 8) Condoms for oral sex and dental dam should be promoted and made widely accessible.
- 9) The MOH and the NACC will ensure that there are no stock outs of condoms and lubricants.

---

#### 5.3.4 PREVENTION OF MOTHER TO CHILD TRANSMISSION

Trinidad and Tobago has achieved significant success in its PMTCT programmes. It is estimated that coverage of pregnant women living with HIV who received ART was 81%. The national response needs to maintain low transmission of Mother to child HIV (less than 5%) and meet other conditions to be certified as having eliminated MTCT.

- 1) The PMTCT programme and associated interventions shall comply with the Ministry of Health Policy on Prevention of Mother to Child Transmission of HIV (PMTCT).
- 2) PMTCT programmes will be accessible for every pregnant woman living with HIV and should be integrated into family planning, sexual and reproductive health, antenatal care (ANC), and maternal and child health programmes in a manner that improves ease of access and reduces potential for stigma and discrimination.
- 3) PMTCT programming will be expanded to facilitate a PMTCT Plus approach and services will include:
  - 1) HIV information and education for all clients, partners and their families on admittance to the programme.
  - 2) HIV testing as part of routine (opt-out) antenatal services.
  - 3) Sexual and reproductive health services, specifically reversible contraception, accessible to all HIV positive women of reproductive age.

- 4) Referral for anti-retroviral therapy (ART) and care for all HIV positive pregnant women, including psychosocial support, follow-up services and nutritional support for mothers and infants.
- 5) PMTCT services should be integrated into maternal and child health and family planning programmes.
- 6) Linkages between primary health care and Community will be strengthened to enhance service delivery.

---

#### 5.3.5 POST EXPOSURE PROPHYLAXIS (PEP)

Post exposure prophylaxis (PEP) is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, through occupational exposure or, sexual assault by a person of unknown or known HIV status

- 1) PEP will be provided as part of a comprehensive combination prevention approach to reduce exposure to infection, and administered in accordance with guidelines issued by the MOH.
- 2) The MOH is responsible for providing guidance to clinicians for administration of PEP.
- 3) Communication and Information on PEP will be developed and disseminated to the public.

---

#### 5.3.6 PRE EXPOSURE PROPHYLAXIS (PREP)

Pre exposure prophylaxis (PrEP), is antiretroviral treatment to prevent HIV infection in persons who are at high risk of transmission.

- 1) PrEP will be provided as part of a comprehensive combination prevention approach to reduce exposure to infection, and administered in accordance with guidelines issued by the MOH. It would be promoted among discordant couples as directed by the MOH
- 2) The MOH is responsible for providing guidance to clinicians for administration of PrEP.

---

#### 5.3.7 STI MANAGEMENT

An increasing trend in some STIs have been observed in the general and among some key populations. The presence of an STI increases the risk of HIV transmission and can increase viral load.

- 1) All national guidelines governing the screening and management of STIs should be adhered to

- 2) All persons should have access to comprehensive, high quality, confidential, client friendly STIs services at all times in line with management protocols and national guidelines
- 3) Integrated HIV and STI services should be promoted and scaled up
- 4) Evidence based programming should be used to inform behaviour change

---

#### 5.3.8 INFORMATION, EDUCATION AND COMMUNICATION

Effective Information, Education and Communication (IEC) materials are an important component of a comprehensive HIV education campaign aimed at raising levels of knowledge about HIV and reducing the spread of HIV and AIDS. However it is recognized that IEC alone is insufficient and should be complemented by BCC, life skills and other SRH services.

- 1) The NACC and its implementing partners will scale up the provision of IEC messages targeting the general and key populations, vulnerable groups, PLHIV, PWD, older persons institutionalised persons, out of school youth
- 2) It is the responsibility of the NACC to monitor the accuracy of disseminated information about HIV, ensuring that it is based on available scientific data and reflects current international guidance. In so doing, the NACC will coordinate partnerships with other ministries, the private sector, religious organisations, non-governmental and community based organisations and inter-governmental agencies in the planning, coordination, implementation and evaluation of information dissemination.
- 3) The NACC will ensure that public and private, traditional and non-traditional channels are utilized in the drive to inform and educate the public about:
  - a) Epidemiology of HIV in Trinidad and Tobago, including modes of transmission and associated risk factors;
  - b) Prevention methods including but not limited to condoms, risk avoidance and harm reduction;
  - c) Social, cultural, behavioural and structural determinants and drivers of the HIV epidemic;
  - d) Availability and efficacy of interventions to prevent transmission and infection, including PrEP and PEP;
  - e) Clinical symptoms and signs of HIV infection and opportunistic infections;
  - f) Diagnostic criteria for HIV infection and AIDS, and laboratory protocols for confirming HIV infection;



- g) ARV treatment and treatment resources, including psychosocial support and laboratory facilities, available to people living with HIV and how to access these;
  - h) Benefits of early or rapid treatment initiation;
  - i) Importance of supportive care to enable treatment adherence and achievement of viral suppression;
  - j) Patient rights and standards of care, including confidentiality, and the rights of PLHIV and KPs;
  - k) Mechanisms and processes in place for reporting human rights violations and receiving redress for these;
  - l) Role of communities in service delivery and in monitoring the quality of services;
  - m) The Impact of Stigma and discrimination on all aspects of the epidemic including but not limited to prevention, treatment and care and monitoring and reporting;
  - n) The right of each person to access culturally acceptable and age-appropriate information on HIV and AIDS, including information on prevention, treatment and care services; and
  - o) Policies and legislation on SRH and HIV.
- 4) All persons including Persons Living with HIV, KPs and vulnerable groups shall have equal access to scientifically sound, evidence-based, accurate and up-to-date HIV information, including prevention and treatment services.
- 5) The NACC, in collaboration with the Ministry of Health, the Ministry of Education and civil society, will ensure the implementation of the HFLE curriculum in all government primary and secondary schools, including the sexuality and sexual health component to empower young people through age and culturally appropriate sexuality education.
- 6) The NACC will encourage collaboration with, actively engage and build the capacity of the media as a key partner to ensure that their programmes and reports are sensitive to HIV, AIDS, SRH and Human Rights issues with the aim of increasing uptake of services and reducing stigma and discrimination related to HIV and AIDS.

---

### 5.3.9 BEHAVIOURAL INTERVENTIONS

Interventions that encourage safe behaviour e.g. risk reduction counselling, comprehensive sexuality education, peer education programmes, social marketing campaigns, social and

behaviour change communication and positive health, dignity and prevention should be gender sensitive and include women and men, boys and girls.

---

#### 5.3.10 BEHAVIOUR CHANGE COMMUNICATION

Reducing the spread of HIV and improving treatment and care outcomes for people living with HIV and AIDS requires addressing social factors and behaviours that put people at risk. Social and behaviour change communication reveals causes of behaviours, the social structures and context that drive the epidemic and the factors that increase risk and vulnerability.

- 1) The NACC will have overall responsibility for ensuring that behaviour change interventions are based on the available scientific data, reflect current international guidance, and serve to protect and promote the rights of all persons.
- 2) The NACC and key partners shall develop a national behavioural change strategy which would focus on the increased adoption of safer sexual and reduction in risk behaviour, increased utilization of HIV prevention, reduction of structural drivers such as gender based violence and poverty and creation of an enabling environment for sustainable behaviour change for all key and vulnerable populations
- 3) Partners in the HIV response will develop and disseminate only behavioural interventions that are evidence-informed, rights-based and effective.
- 4) NACC in collaboration with key partners such as Ministry of Health, OPM Gender Affairs, will develop, promote and implement health seeking strategies in collaboration with men and targeting men
- 5) Sustainable and effective peer education and support programmes will be developed targeting PLHIV, key and vulnerable populations by NGOs in collaboration with MOH, NACC, MOE

---

#### 5.3.11 USE OF TECHNOLOGY AND OTHER CREATIVE METHODS IN PREVENTION EFFORTS

Technology including information and communication technologies (ICTs) such as E- (electronic) and M-health (Mobile) interventions are already being used within the global HIV response, and are increasingly being viewed as an essential factor to ending AIDS as a public health threat. In light of this

- 1) Prevention efforts will be augmented with the optimal use of technology to enhance and scale-up reach, particularly of hard-to-reach, key and vulnerable populations over widespread geographic areas, reaching populations that would otherwise be difficult to access.

- 2) The MOH, in collaboration with the NACC, private sector and other relevant government agencies will consider the range of functions for which technology can be utilized and pursue the use of technological tools as appropriate. In so doing a plan of action for the use of technology in HIV programming will be developed by the NACC and its partners
- 3) The MOH, NACC, Ministry of Education and in collaboration with key stakeholders will explore the use of creative methodologies targeting young Persons Living with HIV as part of rehabilitation efforts at institutions for young PLHIV and others at any local institution.

## 6 PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT

### 6.1 RATIONALE

One of the most integral components of an effective national response to HIV and AIDS is the provision of a suite of interventions that effectively treat, support and care for those infected and affected by the epidemic.

Reducing HIV related morbidity and mortality in infected persons will require tangible and intangible resources that are available, accessible and that people are aware of. With the introduction of HAART available to the population free of charge in 2003, AIDS related mortality has declined substantially from 42.4 in 2000 to 8 deaths per 100,000 in 2015. Moreover, Trinidad and Tobago has committed to the elimination of AIDS as a public health issue by 2030. The second and third 90s of the 90-90-90 targets require that 90% of those who are positive and know their status are on treatment and 90% of those on treatment are virally suppressed.

This policy recognizes that treatment, care and support are integrally linked to prevention. This is because treatment, if implemented effectively, can result in reduced transmission and can lead to a reduction in new infections. With this in mind, a “Treat All” approach has been adopted and is being implemented in Trinidad and Tobago since 2017. Thus, the policy statements within this priority area seek to enable universal access to adequate clinical, and psychosocial support systems, structures and services that will sustain the effective treatment and care outcomes for persons living with HIV and AIDS and those affected by it.

Policy statements will also address underlying socioeconomic deprivations and other structural barriers which impede the provision of quality care and support for PLHIV and Key populations. Of particular concern will be scaling up community and peer to peer level support structures which can aid in addressing challenges such as non-adherence to treatment programmes and low levels of viral suppression.

### 6.2 STRATEGIC OBJECTIVES

1. To establish and strengthen linkages, policies, systems and structures that will enable all persons infected by HIV and AIDS to access free treatment, care and support.
2. To increase the number of persons receiving treatment and retained in care among the population of those living with HIV and AIDS.
3. To improve treatment, care and support services for PLHIV and those affected by HIV and AIDS by incorporating the needs of men and women, boys and girls.
4. To increase the levels of viral suppression among those treated for HIV.
5. To identify and remove barriers to treatment uptake, adherence and retention in care.

### 6.3 POLICY STATEMENTS

#### 6.3.1 A TREAT ALL APPROACH

- 1) Trinidad and Tobago has adopted the Treat All Approach and the MOH, is responsible for ensuring that the public health system can adequately support the implementation of Treat All.
- 2) HIV Treatment and care will be offered free-of-charge in the public sector, to all people testing positive, regardless of sexual orientation, gender, gender identity, age, disability, religious beliefs, socio-economic status, immigration status (documented, undocumented, refugee status), incarceration status, geographic location, level of literacy or vulnerability to exposure without stigma and discrimination.
- 3) All treatment and care sites will have a robust secondary prevention plan targeting their active PLHIV population
- 4) All clients will be adequately evaluated prior to ARV initiation and supported in this process
- 5) Clinicians will adhere to national treatment guidelines for implementation of Treat All, including offering ART to everyone, testing positive for HIV, irrespective of CD4 count.
- 6) Testing programmes that allow for immediate treatment initiation (on-site or via referral), clear service delivery guidelines related to linkage to care will be developed by the MOH
- 7) Clear service delivery guidelines related to linkages to ART care, and a national adherence support policy will be developed and implemented by the MOH to guide facilities and community-based actors in strengthening retention of patients in care.
- 8) In Trinidad and Tobago, Treat All will complement case finding and adherence strategies that are reflected in national policies on testing.
- 9) Barriers to equitable access to treatment, care and support services among all affected and infected populations including PLHIVs, Key and vulnerable populations must be identified and removed. This is the responsibility of the MOH, NACC, Social Development and Family Services, NGO Partners.

#### 6.3.2 SERVICE DELIVERY

- 1) Treatment and care services will be decentralised and evidence informed so as increase accessibility to services with multiple points of access including public sector, private sector and civil society.

- 2) An integrated approach to treatment will be promoted to reduce stigma associated with standalone treatment sites and increase testing and linkage to care.
- 3) Partnerships will be developed within the Government, private sector and civil society organisations to enhance linkages to treatment, care and support services.
- 4) A multi-sectoral network will be developed to monitor and treat PLHIV and to ensure that available services are accessible to them and those who are affected by HIV and AIDS.
- 5) CSO partners providing or supporting treatment services will do so in accordance with national standards and guidelines, including the Trinidad and Tobago Essential Package of HIV Services, the Trinidad and Tobago Linkage to HIV Care Protocol, and regulations of the MOH and shall comply with national referral and reporting systems and protocols.
- 6) Training programmes and service delivery guidelines must emphasize confidentiality and professionalism of service provision, patient empowerment, and the capacity and responsibility to understand and meet the needs of KPs.
- 7) Community systems will be integrated into the national surveillance system to enable improvement of the quality and accessibility of service delivery and to provide feedback to the NACC and MOH in order to improve effectiveness and reach.

---

#### 6.3.3 CLIENT CENTRED MODELS OF CARE

- 1) Client-centered approaches will be utilised in developing and implementing all HIV and AIDS related interventions.
- 2) The MOH, through the HACU, is responsible for developing, sanctioning and overseeing the implementation of differentiated, client-centered strategies, policies and guidelines, including task-shifting, to enable the health sector to manage higher numbers of people on ART, and increase service uptake among KPs.
- 3) The MOH is responsible for informing the public, patients and service providers about the benefits of such strategies, training of providers and educating patients.
- 4) Models such as the differentiated service delivery model and other models will be implemented and scaled up to improve identification and ARV coverage among men and adolescents.

---

#### 6.3.4 ANTI-RETROVIRAL THERAPY AND ADHERENCE

- 1) Only providers who have been fully trained by a programme recognized and sanctioned by the MOH can manage patients who are on ARVs.

- 2) The MOH and the NACC will be responsible for ensuring that Guidelines for treatment are disseminated to CSOs, health facilities and PLHIV networks to ensure that there is accountability in ART.
- 3) Strategies to increase adherence and linkage to care should incorporate the social, cultural, structural, psychosocial factors that influence disclosure, treatment and adherence. Strategies should be relevant across the life course of the individual.
- 4) Measures will be put in place to scale up equitable access to ART, STI and opportunistic infections treatment especially for KPs and vulnerable groups.
- 5) Before any changes to treatment, all patients must be fully informed about these changes in their treatment regimen, the rationale for change and the potential implications.
- 6) Treatment will be administered in accordance with the standard updated WHO, ARV guidelines.
- 7) All Patients have the right to be fully informed about their treatment options; potential side effects of ART or other complications, in order to participate in treatment decisions.
- 8) ART literacy should be promoted among all key populations and vulnerable groups including migrants. A treatment literacy strategy should be developed by the MOH and implemented at each treatment site.

---

#### 6.3.5 TREATMENT OF CO-INFECTIONS

- 1) PLHIV co-infected with TB, hepatitis and other infections will be offered specific treatment regimens in addition to ART, as specified in the Trinidad and Tobago Treatment and Care Guidelines.
- 2) The MOH is responsible for ensuring that healthcare facilities are equipped to offer services for the management of opportunistic infections according to the national guidelines.
- 3) Where possible, healthcare facilities should provide a full range of integrated services, as defined in the Trinidad and Tobago Essential Package of HIV Services. Where services are not directly provided by a particular site, clear and easy referral and coordination mechanisms should be established with relevant providers, following the Trinidad and Tobago Linkage to HIV Care Protocol.



---

#### 6.3.6 TREATMENT MONITORING

- 1) Individuals on ART will be closely monitored through a national health information management system developed by the MOH to ensure treatment efficacy and improved health outcomes for all.
- 2) The MOH, the NACC and other stakeholders and service providers will monitor the uptake of ART to ensure that equitable access exists for all persons living with HIV, including Key Populations and vulnerable groups
- 3) Clinical monitoring of patients will be done according to national clinical guidelines issued by the MOH.
- 4) Use of ARV should be regulated and monitored to reduce the risk of drug resistance.
- 5) The MOH is responsible for ensuring adequate and equitable access to viral load testing for all PLHIV to enable routine virological monitoring of patients on ART.<sup>45</sup>
- 6) CD4 cell counts will be utilized to support initial decisions around an appropriate treatment regimen, including ART initiation and clinical management, particularly for patients presenting late to care.

---

#### 6.3.7 HEALTH SYSTEMS SUPPORT

- 1) The MOH is responsible for developing and implementing a national strategy and guidelines for integration of HIV services into primary health care (PHC) and sexual and reproductive health (SRH) services in order to rationalize resource use.
- 2) The MOH is responsible for ensuring equitable and timely access to essential medical products, medicines and technologies of assured quality, safety and efficacy that are scientifically sound and cost-effective.
- 3) The MOH will ensure that forecasting, procurement and proper supply management of drugs and commodities will be practiced and encouraged at all levels to avoid drug shortages and to facilitate effective implementation of Treat All.
- 4) The NACC and HACU will work with treatment providers to actively address structural barriers, including stigma and discrimination in treatment site settings, to improve uptake of treatment and adherence by PLHIV and key populations.

---

<sup>45</sup> Viral load monitoring was recommended by WHO in 2013 guidelines as the preferred way to monitor people on ART.

---

#### 6.3.8 SEXUAL AND REPRODUCTIVE HEALTH

- 1) HIV and STI care will be provided as part of an integrated package of SRH services which include: family planning; maternal health (antenatal, childbirth, postpartum and post abortion care); HIV and other STIs; treating sexual violence; screening for cancers of the reproductive organs; and addressing infertility management.
- 2) The MOH is responsible for outlining the package of SRH services and ensuring that all persons are educated on these services and where they can be accessed.

---

#### 6.3.9 PSYCHOSOCIAL SUPPORT

- 1) All HIV and AIDS counselling must comply with the WHO 5Cs (consent, confidentiality, counselling, correct test results and connections to care, treatment and prevention services) that are the guiding principles for the conduct of HIV testing and counselling.
- 2) The fullest possible range of psychosocial support services as defined by the UN, is to be accessible to PLHIV, KPs and vulnerable groups, their partners, caregivers and families through approved public, private sector and community health and non-health facilities.
- 3) Psychosocial support will address the ongoing emotional, social, physical and spiritual needs of persons living with HIV and AIDS including children and adolescents
- 4) All organisations that offer any component of psychosocial support for PLHIV and AIDS are required to ensure that its members are appropriately trained to meet the needs of PLHIVs, KPs and vulnerable groups in a rights-promoting and non-discriminatory manner.
- 5) Providers of psychosocial support services will comply with national standards and protocols established by the Ministry of Social Development and Family Services, MOH and other government agencies as appropriate which includes, but is not limited to, the National HIV and AIDS Treatment and Care Guidelines.
- 6) Training on the provision of psychosocial support for PLHIV should be incorporated into the curriculum for all health care providers.
- 7) Guidelines for home care services should be developed and should include the provision of basic psychosocial care by community volunteers and family caregivers.
- 8) Continuous Training and capacity building for community volunteers will be organised and provided by the NACC, the MOH and in collaboration with other key national and regional stakeholders and partners.

- 9) Strategies for providing psychosocial support for specific groups (e.g. women, youth, men who have sex with men, injecting drug users, migrants, incarcerated populations and health care workers) will be developed by the MOH in collaboration with these groups, the NACC and key partners and would be implemented in priority prevention sites through community, institutional, school and workplace interventions
- 10) A comprehensive support system linking and coordinating existing psychosocial services with each other and to health services needs will be established.
- 11) At the hospital or clinic level, support groups for health care workers in higher HIV prevalence areas will be especially important for the support of nurses, physicians, social workers, counsellors and other health care personnel who may be seeing large numbers of HIV infected patients. Supervision of health care workers will be key in assisting health workers to cope with issues related to HIV/AIDS.
- 12) The NACC in collaboration with PLHIV, CSOs, Key populations and other ministries will develop a strategy to promote the creation of peer support groups (whether of health workers working under stressful conditions, PLHIV and AIDS, or family members of people with HIV/AIDS) that will be used as an effective way of providing psychosocial support.
- 13) The NACC will be responsible for developing strategies in collaboration with key Ministries (such as the Ministry of Community Development, Culture and the Arts and the Ministry of Social Development and Family Services) so that existing programmes at the community level can be utilised as platforms for the provision of counselling and support to PLHIV as well as their families. This will build the capacity of community to provide counselling and support and will ensure sustainability, continuity of interventions and community development.
- 14) The NACC will work with Ministry of Health, CBOs and NGOs and FBOs to develop and build the capacity of HIV Competent communities.

---

#### 6.3.10 NUTRITION AND FOOD SECURITY

This policy recognizes that food security and nutrition are intricately linked with HIV and with the potential for increased risk of opportunistic infections. The provision of adequate food and nutrition is a critical need for people living with or affected by HIV for fighting HIV and maintaining the immune system, protecting the body, improving quality of life and managing co-infections.

- 1) In this regard the NACC, Persons living with HIV, Ministry of Health, Ministry of Social Development and Family Services and the Ministry of Agriculture and key stakeholders will ensure that food and nutritional support are integrated into the package of services and into the

response to HIV and AIDS, and other health programmes such as maternal and child health, school health, with the goal that all people at all times, will have access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV/AIDS.

- 2) The MOH will ensure that nutritional assessment, counselling and support that includes food assistance to PLHIV which will help to promote adherence to antiretroviral treatment are promoted and supported.
- 3) Improved care and access to adequate and safe diets will be made accessible to nutritionally vulnerable PLHIV.
- 4) Nutritional support will be integrated into the routine package of psycho-social services available to PLHIV.

---

#### 6.3.11 LABORATORY SERVICES

- 1) A National Laboratory Plan and National Regulatory Policy will be established to guarantee accessibility of quality lab services as part of the HIV continuum of care.
- 2) The MOH, as the regulatory authority, is responsible for ensuring compliance of both public and private laboratories with national protocols, including with regard to the provision of results in a timely and standardized manner, protection of client confidentiality, confidential reporting of HIV positive results and ensuring access for KPs.
- 3) The decentralized laboratory network will be coordinated and monitored by the Central Laboratory of the MOH.
- 4) The MOH is responsible for developing strategies to meet the key challenges related to laboratory services.

---

#### 6.3.12 ACCESS TO TREATMENT AND CARE SERVICES DURING AND AFTER HUMANITARIAN EMERGENCIES AND CRISES

Persons affected by humanitarian emergencies whether natural or man-made may be at increased risk of HIV. Migrants, refugees and other displaced persons are many times not included in national HIV strategies and subsequently may not be reached by prevention and treatment services. These conditions exacerbate existing vulnerabilities and inequalities which work to increase the risk of HIV for key affected and vulnerable populations. This policy therefore asserts that:

- 1) Guidelines will be developed to outline how, prevention and treatment and care services will be made available during humanitarian emergencies. This will be the responsibility of the MOH and will be supported by NACC and other key Ministries, Government Agencies and organisations.
- 2) HIV interventions as part of SRH services should be integrated into planning for emergency situations and disaster risk management to ensure that persons living with HIV can access treatment and care services in these conditions.
- 3) The NACC, MOH, Ministry of Social Development and Family Services, Ministry of Local Government, ODPM and other key partners including PLHIV and KPs will work together to develop an integrated HIV and AIDS emergency risk management plan.
- 4) Refugees, migrants and other displaced persons will have access to the full suite of HIV prevention, and treatment and care services available in the public sector at no cost.
- 5) A plan for treating migrants, refugees and other displaced persons will be developed by NACC to ensure that these vulnerable groups have access to prevention, treatment and care medication, supplies and commodities. This plan will include among others delineation of roles and responsibilities, decentralisation of stocks of medication, community strengthening, data management and patient follow up.

## 7 PROMOTION OF HUMAN RIGHTS AND CREATION OF AN ENABLING AND EMPOWERING ENVIRONMENT FOR PLHIV, KEY POPULATIONS, VULNERABLE GROUPS AND COMMUNITIES

### 7.1 RATIONALE

Effective responses to HIV and AIDS and other STIs must address and recognize the importance of an enabling environment in facilitating behaviour change across the HIV cascade of services. Shifting from punitive laws and their enforcement to actions which promote rights-based principles, harm reduction, and removal of other notable structural barriers, create a better environment for entrance into and retention in the range of HIV Services. Moreover where there are punitive legal and social environments, there is lower awareness of HIV risks, lower access to HIV services, reduced meaningful participation in the design of programmes and overall responses to HIV and AIDS including community led initiatives among key and vulnerable populations. This also can have the effect of undermining national development and public health outcomes.

Thus, a human rights-oriented policy and legal framework is vital to address the securing and advancement of the human rights of PLWAs, key and vulnerable populations, reduction of stigma, discrimination, violence and gender inequality among these group. The reduction of vulnerability to HIV requires that all persons' human rights and fundamental freedoms are realised. A recently completed legal environment scan concluded that whilst Trinidad and Tobago has made significant efforts in addressing and recognising legal and human rights issues in the context of HIV and AIDS, the lived realities of PLHIV and Key Populations signalled that there are major deficiencies in the State's response. One of these deficiencies is Trinidad and Tobago's legal and policy framework. Moreover, barriers such as social norms, cultural factors, gender inequality, domestic and gender-based violence, continue to impede persons in their attempts to seek the HIV continuum of services.

By utilising a human rights approach, this policy will address the structural and sociocultural barriers that prevent the mitigation and elimination of this disease. Addressing these barriers to HIV Services will significantly contribute to the achievement of the 90-90-90 targets and ensure that no one is left behind as we move to end AIDS by 2030.

It is imperative therefore that the Government and key stakeholders ensure compliance with this HIV policy. Compliance will ensure that there are less sociocultural barriers preventing treatment uptake and this will aid in the advancement of the nation's efforts to achieve human development.

## 7.2 STRATEGIC OBJECTIVES

1. To advocate for and increase legislation and policies that will foster an enabling environment that promotes and supports respect for human rights for all persons, regardless of HIV status, sexual orientation, gender, age, disability, religious beliefs, socio-economic status, immigration status, incarceration status, geographic location, level of literacy or vulnerability to exposure.
2. To establish a system of redress for the reporting and addressing human rights violations against PLWHAs.
3. To increase the implementation of strategies that aim to reduce levels of stigma and discrimination.
4. To improve monitoring frameworks that will allow for strategic planning for an effective response to stigma and discrimination.

## 7.3 POLICY STATEMENTS

### 7.3.1 ENABLING LEGISLATIVE FRAMEWORK

1. The Government of Trinidad and Tobago is responsible for providing an enabling environment for an effective public health response to HIV, through the development and enactment of appropriate policy and legislation.
2. The NACC, the Tobago House of Assembly (THA) and MOH shall lead efforts to strengthen the legal and policy framework to support a human rights-based response to HIV, based on the understanding that punitive legislation is counter to the public health response.
3. Responsibilities of the NACC, the THA and MOH will include increasing awareness of the compelling public health rationale for legislative reform and eliminating stigmatization and discrimination, and leading collaborative advocacy policy development and monitoring efforts.
4. The NACC, the THA and the MOH shall lead efforts, in collaboration with CSOs and communities, to educate KPs about their rights and mechanisms to enable reporting and provide redress when rights are abused.
5. Public and private sector partners in the national HIV response should develop sector- specific rights-promoting stigma and discrimination prevention and mitigation strategies.
6. A supportive and enabling environment for KPs and vulnerable groups should be promoted by identifying and confronting underlying prejudices and inequalities through community dialogue, advocacy, policy and legislative formulation and implementation. NACC will work with stakeholders to implement strategies which support empowerment of clients, key and vulnerable populations across the continuum

7. The NACC will develop a surveillance framework that will monitor the levels of stigma and discrimination against PLWHAs.

---

#### 7.3.2 REDRESS SYSTEM FOR REPORTING ABUSES AND DISCRIMINATION AGAINST PLHIVS AND KPS

1. The NACC in collaboration with the PLHIV, KPs, THA, Ministry of Attorney General and Legal Affairs, the MOH and other partners will develop a national redress system which will include, implementation plan, communication strategy and monitoring framework. The national redress system would be able to:
  - Accept, sort and process complaints;
  - Acknowledge and follow up on lodged complaints;
  - Verify and investigate claims;
  - Submit verified complaints to the relevant authorities that will punish human rights violations; and
  - Provide feedback to clients seeking redress.
  - Communicate about its work

---

#### 7.3.3 GENDER SENSITIVITY

In Trinidad and Tobago, HIV transmission is fuelled by gender norms that support cultural, social, economic and legal barriers to the realisation of human rights. Unequal power dynamics, gaps in educational attainment, the reliance of women on male partners for economic support and sexual violence exacerbate the risk of sexual transmission of HIV. These inequalities result in gender and sexual minorities having less information about HIV, having fewer resources to take preventive measures, and diminishing their chances to negotiate safer sex and access to treatment. Thus, this policy will ensure that prevention, treatment and care interventions take gender-based risk and vulnerability, including gender-based violence, into account.

1. A gender-sensitive approach to HIV programming will be promoted nationally. This approach will address issues related to cultural norms that perpetuate gender-based stigma, discrimination and violence.
2. The NACC will work with the Gender Affairs Division to develop strategies that promote gender-sensitive programming that will include:
  - A monitoring and evaluation system that collects and uses sex, gender- and age-disaggregated data and includes gender-sensitive indicators to monitor and evaluate the impact of programmes on men, women and KPs;
  - Planning, design and implementation processes that involve women, men, PLHIV and KPs;



- Strategic partnerships to influence health and non-health policies and strategies to reach people who face gender-related prejudice and to promote norms, attitudes and behaviours that promote gender equity; and
- Information, education and communications campaigns aimed at preventing gender-related prejudice and at promoting norms, attitudes and behaviours to achieve gender equity.
- Men and boys.

---

#### 7.3.4 PROTECTION, EMPOWERMENT AND PARTICIPATION OF PLHIV, KEY AND VULNERABLE POPULATIONS

In accordance with the Equal Opportunities Act (2000) the NACC will support partner agencies to understand, design and implement interventions that protect PLHIVs, vulnerable groups such as persons living with disabilities (PWD), women, persons living in poverty, children, refugees and KPs (as defined in the NSP). This policy will ensure:

1. The rights and dignity of PLHIV, KPs and vulnerable groups are respected, protected and fulfilled.
2. A legal, economic, social and cultural environment is created.
3. Prevention, treatment and care interventions that are tailor made and accessible to vulnerable populations take into account risk and group specific disadvantages so as to ensure equity is achieved.
4. PLHIVs, KP and vulnerable populations will be protected against violence including sexual violence, rape and other coerced sex.
5. Support systems for persons who experience violence, abuse or are removed from their homes on the basis of their perceived status or sexuality will be created.
6. A monitoring and evaluation mechanism that collects and uses disaggregated data and indicators by group will be developed.
7. Planning, design and implement interventions, programmes and processes that facilitate greater and meaningful involvement of PLHIV, KPs and vulnerable populations.
8. Strategic partnerships to influence health and non-health policies and strategies to reach these groups with the aim to promote norms, attitudes and behaviours that promote equity.
9. Information, education and communications campaigns aimed at preventing prejudice and negative norms and behaviours that perpetuate stigma and discrimination, especially for vulnerable and key populations.
10. National communication strategies and policies will take into consideration the needs of differently abled persons, and persons who with low literacy levels and will uses modes that are friendly to these populations
11. Sectoral and national workplace policies shall be implemented and strengthened with legislation to address breaches of these policies.

12. Health care and other service providers, who provide services to minors and other key populations will not be classed as accessories to a criminal offence.

---

#### 7.3.5 WOMEN, GIRLS AND HIV

This policy recognizes specific vulnerabilities of adolescent and young girls and women as a result of unequal power relations between women and men and boys and girls. It also supports the integration of prevention, treatment, care and support into a gender responsive approach.

- 1) This policy calls for an examination of the root causes of new HIV infections among women and adolescent girls whose vulnerability is increased by discrimination and all forms of violence.
- 2) Scale up efforts to achieve greater gender equality and empowerment of women and girls in all spheres of life taking into account structural inequalities which undermine effective responses.
- 3) Intensify efforts to implement laws, policies and strategies which eliminate gender based violence and discrimination against women and girls by removing barriers to their access to health care and services.
- 4) Ensure the dignity, rights and privacy of women and girls living with HIV by addressing gender based violence and stigma and discrimination.
- 5) This policy calls for the strengthening of community level capacity to confront the dual epidemics of HIV and Gender based violence and other socio-structural determinants of HIV

---

#### 7.3.6 MITIGATING THE IMPACT OF HIV ON PLHIV

- 1) A social protection package and strategy should be developed by the NACC and MOH in tandem with the Ministry of Social Development and Family services that will target PLHIV, who require socioeconomic support.
- 2) In order to sustain the improved nutritional status of PLHIV who are phased out of the food assistance programmes due to the improvement in their nutritional status, PLHIV should be linked with economic strengthening opportunities such as income-generation activities.
- 3) A plan for improving the Opportunities for Sustainable livelihoods and employment for all PLHIVs including young adults and those transitioning to adulthood will be developed by NACC, MSDFS, and MOH.
- 4) Persons living with HIV shall be entitled to obtain all types of personal or group health insurance and shall not be debarred because of their status.

---

#### 7.3.7 CONFIDENTIALITY

1. The confidence that clients place in HIV service providers must be respected, and individuals who access services must be guaranteed confidentiality. This means that all discussions

relating to information provided, examinations carried out, and an individual's health status must be discreet and of a strictly confidential nature.

2. An individual's right to privacy must be respected, especially when they are in contact with the health sector, and in the collection and dissemination of information.
3. Access to a person's records shall be on a need-to-know basis among service providers. In particular, information about HIV status may not be disclosed to a third party without the written consent of the person living with HIV.
4. The NACC is responsible for developing national standards and guidelines to ensure confidentiality in service provision to protect the privacy of all clients, including PLHIVs and KPs.
5. The NACC is responsible for establishing, guiding and supporting an effective mechanism to receive, investigate, and act on complaints of breaches of confidentiality.
6. All organisations working in the national HIV response will develop and implement confidentiality statements, policies and guidelines in line with the national standards to ensure that service providers hold personal information concerning PLHIV or KP clients in strictest confidence.
7. Workplace HIV policies which address protecting the confidentiality of employees' HIV status shall be enforced.

---

#### 7.3.8 PARTNER NOTIFICATION AND REFERRAL

1. Partner notification and referral is strongly encouraged along with appropriate counselling and education through the creation of a supportive environment and appropriate services to those affected by this disclosure.
2. The MOH and the NACC will develop standards for partner notification in line with national guidelines and international best practice.
3. The MOH will ensure that all providers offering support for partner notification and referral are trained and supported with the full understanding that disclosure may endanger the safety of people living with HIV.
4. Where service providers support partner notification and referral, information must be made available to partners on the implications of having been exposed to the infection, on confidential HIV testing facilities and pre- and post-test counselling.

---

#### 7.3.9 MIGRANTS

1. An enabling environment including policy, legislation, removal of structural barriers including violence, language and other barriers will be created so that all migrants (documented and undocumented) shall have access to the full range of HIV prevention, treatment and care services in the public sector and their uptake of services is increased.
2. Health services for HIV prevention and treatment in the public sector shall be made available to all migrants at no cost.

3. The NACC in collaboration with implementing partners and stakeholders will develop a Migrants Action Plan to include strategies to address among other issues, the vulnerability of migrants, refugees, and other mobile populations, reduction of barriers such as stigma and discrimination and promote and facilitate health service utilization of these groups.

---

#### 7.3.10 PRISON AND DETENTION SETTINGS

1. The quality and scope of HIV services available to persons in prisons and other closed settings shall be similar to that provided for the broader population.
2. The full range of integrated HIV, STI and SRH services will be provided to infected and non-infected persons who are incarcerated, regardless of health status, sexual orientation, gender, age, disability, religious beliefs, socio-economic status, immigration status, incarceration status, geographic location, level of literacy or vulnerability to exposure.
3. The NACC will support the Trinidad and Tobago Prison Service in the development of clear policy and procedures to enable the level of access to continued treatment, care and support provided in this policy for persons who are in prison or in detention settings and for those who have been released from prison. A programme of information and education for both prisoners and prison staff will be included in these procedures.
4. Mandatory HIV testing shall not be conducted among persons who are incarcerated or detained.

---

#### 7.3.11 GILLICK COMPETENCY

1. HIV service providers will apply Gillick competency standards to determine the ability of minors to consent to service provision in the absence of a parent or guardian.
2. The Children's Authority of Trinidad and Tobago (CATT) along with other key stakeholders such as the Office of the Prime Minister (Gender and Child Affairs) will be responsible for developing national guidelines for application of Gillick competency standards, and for ensuring that the national policy framework enables the full application of such guidelines.
3. The MOH, in collaboration with the CATT, will be responsible for ensuring training of service providers in the application of Gillick competency standards.

---

#### 7.3.12 COMMUNITY AND CIVIL SOCIETY STRENGTHENING

1. Community structures for addressing HIV and AIDS will be strengthened so that all communities will become HIV Competent communities.
2. Government shall ensure that civil society are encouraged and supported with human, technical, material and financial resources to facilitate their effective participation in the national HIV and AIDS response.
3. Relevant capacity building shall be provided to Civil Society Groups and community organisations to facilitate optimal implementation and to ensure compliance with laws,

policies, guidelines, ethical standards, protocols, human rights and reporting requirements. A civil society capacity building plan will be developed in collaboration with these groups.

4. Within the framework of this response civil society partner and implementing organisations will be encouraged to budget, mobilize human, technical and financial resources for the activities in Policy which are under its remit.
5. All non-profit CSOs are required to adhere to all government legislation and regulations such as the Non-Profit Organisations Bill, Procurement and Financial Regulations.

---

#### 7.3.13 WORKPLACE SETTINGS

1. All employers in all sectors shall be guided and adhere to the National Workplace Policy on HIV and AIDS developed by the Ministry of Labour and Small Enterprise Development.
2. The Ministry of Labour and Small Enterprise Development shall work with the Office of the Attorney General to amend existing or develop new legislation to protect workers living with HIV and AIDS, key populations from discrimination, wrongful dismissal. Legislation which contain penalties for the breaches of the Policy shall be enacted and enforced.
3. The Ministry of Labour and Small Enterprise Development will work with all workplaces to develop and implement Workplace Policies and Programmes on HIV and AIDS.

## 8 STRATEGIC INFORMATION AND KNOWLEDGE MANAGEMENT

### 8.1 RATIONALE

Strategic information is the cornerstone of an evidence-based response to HIV and AIDS. Strategic information entails the systematic collection, consolidation, analysis and use of relevant, consistent, accurate, timely and affordable information from multiple sources in support of HIV policy, planning, resource allocation, programme design, management and evaluation, service delivery and accountability. Strategic information goes beyond basic epidemiologic data and seeks to provide a deeper understanding of the context of the epidemic including community and individual vulnerability, exposure to risks, barriers to access, alleviation and mitigation of the impact of HIV. It also assists in understanding and documenting the impact and effectiveness of strategies, interventions and programmes in the national response to HIV and AIDS. The main activities related to strategic information are: a) Monitoring and Evaluation of HIV response; b) Surveillance of HIV and sexually transmitted infections; and c) Research.

Scaling up of the national HIV response requires increased investment in strategic information to guide programme planning and sustain national and international commitment and accountability. Many gaps in the strategic information in Trinidad and Tobago have been observed including the following:

- general paucity of information on research on the sexual behaviours of the general population and vulnerable groups
- Substantial amount of data generated but not much analysis and utilisation in decision-making
- lack of harmonisation between the MOH and other stakeholders in the response,
- need for improved infrastructural and system development for data collection, validation, and analysis of data
- inadequate resources invested into HIV Strategic Information development

### 8.2 STRATEGIC OBJECTIVES

The objectives of this policy are to:

1. Increase existing knowledge about HIV and AIDS through high quality, accurate, reliable and timely Strategic Information and research (including but not limited to biomedical, social science, behavioural, economic, operations).
2. Sustain a well-resourced national HIV and AIDS Strategic Information System inclusive of Monitoring, Evaluation, Surveillance and Research, to facilitate the effective co-ordination, management and dissemination of HIV and AIDS information

3. Increase the conduct of population-based and special surveys to track the HIV and AIDS epidemic and behavioural trends.
4. Develop and implement a national HIV and AIDS research agenda.

### 8.3 POLICY STATEMENTS

#### 8.3.1 RESOURCES FOR EFFECTIVE AND SUSTAINABLE STRATEGIC INFORMATION

1. The Government undertakes to provide adequate investment in strategic information including surveillance, monitoring, evaluation and research to reduce gaps in key priority research areas.
2. The Government will ensure that the NACC is adequately resourced to undertake the tasks of strategic information management.

#### 8.3.2 MONITORING AND EVALUATION

1. The NACC will finalise and implement the national multi-sectoral HIV and AIDS M&E Plan using a participatory and collaborative approach.
3. The NACC in collaboration with stakeholders and key implementing partners will develop a core set of indicators which stakeholders in the response must submit to The Office of the Prime Minister on a regular basis.
4. The NACC in collaboration with national, regional and international partners will build capacity and facilitate and co-ordinate ongoing capacity building in specialised and technical areas of M&E, survey research, behavioural research to ensure that all partners are able to provide the required information for the national M&E System.
5. The NACC will ensure that mid-term and end of term reviews of the NSP are conducted.
6. The NACC will develop a comprehensive data sharing policy detailing the standards for data collection, storage, security, confidentiality, retrieval, sharing, use and release.

#### 8.3.3 RESEARCH

1. The NACC will promote biomedical, social science, behavioural, economic, spatio-temporal and operations research that is priority and relevant to the country's HIV response.
2. The NACC will facilitate the conduct of multidisciplinary research on issues related to the social, economic, and psychological and spatio-temporal antecedents and the impacts of HIV and AIDS on individuals, families, communities, businesses and other sectors.
3. The NACC will identify the national research agenda for HIV and AIDS through a consultative and participatory process and will identify and publish the list of national HIV, AIDS and STI research priorities and widely disseminate to stakeholders.

4. The Ministry of Health and NACC will ensure all research comply with ethical standards and human rights requirements according to national and international guidelines. National norms and cultural sensitivities should also be respected when conducting research.

---

#### 8.3.4 SURVEILLANCE

1. The NACC will work with partners such as MOH, international and regional partners to strengthen the national HIV and AIDS surveillance system.
2. HIV shall be a reportable or notifiable disease in the national HIV and AIDS surveillance system. Both public and private facilities are required to report all new cases to the HACU in the MOH.
3. MOH will engage and work with private facilities to build their capacity to report on HIV testing results.
4. MOH will convene quarterly feedback sessions with data providers to promote the importance of surveillance data, data quality, and the unique identifier and to build capacity.

---

#### 8.3.5 DATA MANAGEMENT SYSTEM

1. The NACC would establish a comprehensive integrated national HIV and AIDS data management information system. An effective system for data management would contain the features of Data security, Confidentiality, Data access and sharing and Use of unique identifiers. The data management system shall assure accessibility, reliability and timeliness of data to satisfy the needs of the data users.
2. The NACC will facilitate the collection, analysis, use and dissemination of relevant, consistent, accurate, timely and affordable information from multiple sources such as surveillance, programmes and service delivery, special and population based surveys, health information management system, geographic information systems (GIS), and stigma index surveys, modes of transmission surveys, operational research and such like. This would be done in collaboration with key implementing partners such as the Central Statistical Office, Ministry of Health, Academic institutions, and private sector.
3. The NACC in collaboration with key partners such as the Ministry of Health will engage the private health and non-health sector and work with them to facilitate their reporting requirements to the Office of The Prime Minister on the national response.
4. Guidelines for the conduct of SI activities will be developed by the NACC including data sharing protocols, tools for measuring data quality assurance.
5. NACC will ensure standard data quality checks/audits are carried out before final reporting to national, regional and international bodies so that high-quality information can be produced.



### 8.3.6 DATA USE AND DISSEMINATION

1. The NACC will be a repository and clearinghouse for all information on HIV and AIDS.
2. The NACC will promote the use of data for decision-making in policy, planning and programming. Data use will be promoted through synthesizing, producing and disseminating several information products based on analysed data. These will include annual reports to the nation, quarterly reports, newsletters, brochures, fact sheets, statistical and epidemiological bulletins and reports, literature reviews, analytical studies, research briefs, infographics, best practices and lessons learned through electronic, social and print media. Similarly, data will be used for global reporting.
3. The NACC will widely disseminate Information products to a wide variety of stakeholders - other than the data providers – using varied formats which would take into account varying levels of literacy and disability. Guidelines to support the analysis, presentation and use of data will be produced. Stakeholders will have access to the data/information products through the official website of NACC.

## 9 COORDINATION, IMPLEMENTATION AND MONITORING

### 9.1 RATIONALE

The HIV and AIDS epidemic is multidimensional and multifaceted and an effective national response requires a multi-sectoral approach which includes institutional arrangements and partnerships between Government and all relevant stakeholders such as NGOs, private sector, faith based organisations, trade unions, international organisations, academia, people living with HIV, Key Populations. An effective response also requires strong coordination, leadership and management that identifies national priorities, provides equitable and sustainable resource allocations for strategic and high impact interventions which enhance the organised participation of all stakeholders in the multi-sectoral response.

This policy adheres to the three Ones Principle- One Strategic Plan, One Co-ordinating Mechanism and One M&E Framework. Ending AIDS by 2030 requires full participation and commitment by all. Key institutional arrangements include identification and allocation of roles and responsibilities, resource mobilization, and monitoring and evaluation. In this regard for an effective and sustainable response, clear roles and responsibilities must be delineated and discharged if the objectives of this policy are to be realised. These include:

- A. Government agencies
- B. Private sector
- C. Civil Society: NGOs/CBOs and FBOs, Trade Unions, Academia, the Media
- D. Regional and international organisations
- E. Office of the Parliament

F. Co-ordination of the response in Tobago

9.2 ROLES AND RESPONSIBILITIES OF IMPLEMENTING PARTNERS

**A. GOVERNMENT AGENCIES**

All government agencies will:

1. Plan for and allocate resources for implementing and monitoring HIV prevention and management.
2. Mainstream HIV into all policies, plans and programmes using a whole of Government approach.
3. Develop sectoral policies and plans, and implement interventions in support of national goals and targets articulated in the National Strategic Plan. This should include non-discriminatory and equitable access to government-provided social security and economic support programmes, for people living with HIV and other key populations.

Responsibilities of specific government ministries with respect to the implementation of this Policy are detailed below.

**OFFICE OF THE PRIME MINISTER: NATIONAL AIDS COORDINATING COMMITTEE (NACC) AND NACC SECRETARIAT**

- a) The NACC is the mechanism to promote and manage collaboration with a wide range of public, private, multilateral and bilateral partners to provide effective, high-quality services that are accessible to all, including key populations.
- b) The NACC should ensure transparency and accountability of key actors through a decision-making, monitoring and oversight function that involves the participation of a wide range of partners, in the best interest of PLHIV and KPs.
- c) All sectors of society, including PLHIV and KPs, should be involved in the design, implementation, monitoring and evaluation of the national response, including through public consultation processes and representation on national bodies such as the NACC.
- d) The NACC should provide leadership that enables accountable and performance-oriented institutions to provide effective, collaborative partnerships within the health sector, the private sector, CSOs and communities.
- e) The NACC shall develop a suitable framework and system for monitoring compliance with the National HIV and AIDS Policy, including leading an annual review of the Policy to respond to scientific and technological advances, and in the international and national context.

**OFFICE OF THE PRIME MINISTER: GENDER AFFAIRS DIVISION**

- a) The NACC Secretariat will collaborate with the Gender Affairs Division to design, implement and strengthen gender-sensitive approaches to decision-making, planning, implementing and monitoring all aspects of the national HIV response.
- b) Promote greater societal understanding and acceptance of gender diversity and gender dimensions of HIV, including the intersection with gender-based violence and culturally-specific manifestations of gender discrimination.
- c) Ensure that treatment, care and support services are available to comprehensively address gender-based violence in a manner that protects and promotes the rights of survivors and gender minorities.
- d) Strengthen gender-disaggregated data collection and analysis to provide an evidence-base for the design and monitoring of effective and appropriate gender-sensitive institutional and other treatment, care and support services for people living with HIV and other key populations. This should include analysis of the impact of socio-cultural and economic factors in perpetuating gender-related stigma and discrimination that act as a barrier to accessing services.

**OFFICE OF THE PRIME MINISTER: CHILD AFFAIRS DIVISION**

- a) Will work with NACC to develop HIV interventions that are child friendly to increase awareness; prevent HIV transmission and if infected increase uptake and adherence to treatment and care.
- b) In collaboration with CATT, NACC, MOH and MSDFS develop a plan of action for adolescents and young people living with HIV to promote life skills for living with HIV and transitioning to adulthood.

**MINISTRY OF HEALTH**

- a) Coordinate the health sector response, as the lead ministry for establishing national standards and for providing comprehensive prevention, treatment and care services for all people that are integrated into primary health care, including sexual and reproductive health and maternal and child health programmes.
- b) Coordinate external multi-national agencies technical and financial support for prevention, treatment, care and support.
- c) Provide technical support to other government, private sector, and civil society and community organisations to develop and implement prevention, treatment and care programmes.
- d) Ensure that PLHIV and other KPs can confidentially access comprehensive, appropriate, high quality, gender-sensitive health services, including combination prevention, anti-retroviral treatment and psychosocial support.

- e) Lead, oversee and implement data collection and research that will inform targeted and effective HIV programming, and monitor progress towards 2020 and 2030 HIV reduction and elimination goals.

### **REGIONAL HEALTH AUTHORITIES**

- a) Ensure that the HIV policy is translated into specific strategies at the level of the RHA.
- b) Mainstream HIV programming into the activities and plans of RHAs.
- c) Build capacity of staff in HIV programming, implementation and monitoring.
- d) Ensure that HIV activities are adequately resourced and sustainable.
- e) Collaborate with key stakeholders e.g. PLHIV, Key Populations and vulnerable groups.
- f) Strengthen data collection and M&E capacity and ensure that data are disaggregated by for example age, sex, region, key population and provide data to key users such as MOH, HACU and NACC on a timely basis.

### **MINISTRY OF LABOUR AND SMALL ENTERPRISE DEVELOPMENT**

- a) Lead, coordinate and oversee the implementation of the National Workplace Policy on HIV and AIDS.
- b) Support other line ministries and departments, the private sector, employers and worker organisations in the formal and informal sectors, to develop, implement and mainstream HIV workplace policies and programmes.
- c) Provide advice and guidance on HIV Workplace policies and programmes.
- d) Work with other Ministries to develop programmes and interventions to mitigate the impact of HIV on PLHIV, Key and Vulnerable Populations and to reduce incidences of stigma and discrimination in the workplace.

### **MINISTRY OF COMMUNICATION**

- a) Play an active role in the implementation of national communication strategies related to HIV and AIDS.
- b) Collaborate with the NACC to Promote HIV messaging aimed at the general population on HIV issues.
- c) Collaborate with the NACC, other Ministries, CSOs and the private sector to build the capacity for effective media involvement in the reduction of stigma and discrimination, prevention and treatment and care.

**MINISTRY OF LOCAL GOVERNMENT**

- a) Local governments in 14 municipalities across the country provide a unique opportunity for the implementation of workplace policies on HIV and AIDS as a response to the adverse effects of the pandemic on the workplace.
- b) Local governments are responsible for sensitizing their staff and workers about HIV risk, transmission and protection mechanisms.
- c) Local governments will have their competency built to plan, implement and monitor appropriate and effective responses to HIV and AIDS in the working environment.
- d) Advocate for the rights of workers infected with and affected by HIV and AIDS.
- e) Ensure compliance with the national HIV and AIDS and National Workplace Policies.

**MINISTRY OF FINANCE**

- a) Provide financial oversight over the national response and ensure timely releases to all Ministries and State Agencies for HIV and AIDS programmes and activities.
- b) Work in collaboration with the NACC and the MOH to define the resource needs of an effective and comprehensive national response, and
- c) Ensure continued adequate domestic resources to sustain the national HIV response, including implementation of Treat All.

**MINISTRY OF PLANNING AND DEVELOPMENT**

- a) Ensure that HIV is mainstreamed into national development plans.
- b) Assist with providing advice on possible international and regional funding streams to supplement budgetary allocations to HIV and AIDS.
- c) CSO will partner with NACC and MOH in the conduct of surveys, data management, improvement of data from vital registration, surveys, registers, etc. which impact on HIV and AIDS outcomes.

**MINISTRY OF EDUCATION**

- a) Update and Implement the Education Sector Policy on HIV and AIDS in all institutions and at all levels, including teacher training institutes, private schools, technical and vocational institutions.
- b) Lead and oversee the systematic implementation of the HFLE curriculum, in accordance with national policies and standards, and facilitate comprehensive and harmonized training in HFLE for teachers.
- c) Collaborate with health sector and other relevant agencies to ensure that other HIV-related services are accessible to workers and students.

**MINISTRY OF SOCIAL DEVELOPMENT AND FAMILY SERVICES**

- a) Mitigate the impact of HIV on PLHIV, Key and Vulnerable Populations
- b) Ensure that welfare and social services are accessible and meets the needs of people living with HIV and KPs.
- c) Ensure that services are provided in an inclusive and non-discriminatory manner for participants, and without tolerance for discrimination, regardless of HIV status, sexual orientation, gender, age, disability, religious beliefs, socio-economic status, immigration status, geographic location, level of literacy or vulnerability to exposure.

**MINISTRY OF SPORT AND YOUTH AFFAIRS**

- a) Ensure that information and education is provided to young people, and particularly youth from vulnerable and KPs, in youth friendly spaces.
- b) Design and implement risk reduction programmes for young people to reduce the potential for HIV infection.
- c) Promote greater societal understanding and acceptance of gender diversity and gender dimensions of HIV, including the intersection with gender-based violence and culturally-specific manifestations of gender discrimination.

**MINISTRY OF NATIONAL SECURITY**

- a) Increase Programs to educate all uniformed services personnel including police, prisons, defence force about the risks, transmission and prevention of HIV.
- b) Make Condoms available to uniformed services personnel as needed.
- c) Integrate HIV issues (prevention, treatment and care, stigma and discrimination) into statutory training for uniformed service officers.
- d) Build the capacity of all uniformed service offers especially police men to address gender based violence in general populations and key population groups.
- e) Ensure that the Ministry has the required human, technical and financial resources to implement HIV and wellness programmes for the sector.

**MINISTRY OF THE ATTORNEY GENERAL AND LEGAL AFFAIRS**

- a) Provide formal support for efforts of the NACC and other stakeholders to strengthen an enabling legislative and policy environment for the national HIV response, strengthen protection for the human rights of people living with HIV and other key populations.
- b) Support the establishment of mechanisms for reporting and provision of redress to people who experience human rights violations, including access to provision of legal aid.

- c) Develop, enact and disseminate legislation to strengthen human rights protections, including in employment, education, access to care, housing, transportation, and against discrimination on the basis of sexual orientation, gender, HIV status, age, disability, and socioeconomic status.

### **MINISTRY OF COMMUNITY DEVELOPMENT, CULTURE AND THE ARTS**

- a) Collaborate with the NACC to ensure that HIV prevention, treatment and care services are accessed by hard-to-reach communities throughout Trinidad and Tobago, including through integration of HIV interventions in community development programming.

### **MINISTRY OF TOURISM**

- a) The Ministry will promote HIV workplace policies related to prevention and treatment, care and support for workers in the tourism sector.
- b) The Ministry will collaborate with other actors in the sector to address the links between tourism and the spread of HIV.
- c) The tourism sector has a key role to play as a catalyst for driving prevention and promoting health messages, raising awareness and stigma reduction campaigns to reach the myriad networks with which they interact. Information on the modes of transmission and how to reduce risk behaviours should be disseminated among all sectors in the tourism industry.
- d) In collaboration with MOLSED and NACC develop strategies and interventions to assess the different HIV vulnerabilities of the various stakeholders and actors in the tourism industry e.g. workers in hospitality, tourists, the local community and enterprises to HIV risk and infection.

### **REVIEW AND PROMOTE THE IMPLEMENTATION OF THE GUIDELINES FOR MANAGING HIV IN THE PUBLIC SECTOR.**

- a) Provide and maintain a safe, healthy and welcoming work environment for all government employees regardless of HIV status.
- b) Provide equal opportunity to all employees, including employees who are HIV positive and identify as a key population.
- c) Provide information on HIV prevention and treatment services, and facilitate access to these for employees.

### **HIV COORDINATORS**

There shall be HIV Coordinators in each Ministry mentioned in this policy which play a critical role in implementing strategies to achieve the 90-90-90 targets and Vision 2030. A health and wellness approach which integrates HIV into a holistic health and wellness approach and includes

STIs, SRH, chronic diseases, mental and emotional health will be used. HIV Co-ordinators will be employed in all of the larger Ministries i.e. with at least 1000 employees

Specific roles and functions of the HIV Co-ordinator include:

- i. Coordinating HIV activities in their ministry and sector.
- ii. Advising on policies and strategies including development of sector plans and budgets.
- iii. Developing and promoting a multi-sectoral approach to the execution of the NSP.
- iv. Profile issues related to HIV and AIDS to a wide cross section of the society.
- v. Mobilize resources.
- vi. Ensuring that activities are aligned to Vision 2030 and the achievement of the 90-90-90 targets and end of AIDS by 2030.

### **OFFICE OF THE PARLIAMENT**

- a) Engage in high level advocacy to address the challenges in achieving the 90-90-90 targets and contributing toward the end of AIDS.
- b) Advocate for legislative changes, national plans, policies and budgetary allocations to create an enabling environment for the achievement of the objectives of the national response to HIV and for the elimination of stigma and discrimination.
- c) Work towards ending ignorance and fear by educating and informing constituencies, peers, and the public about HIV transmission, social and cultural drivers, risk factors, where to access help etc.
- d) Engage in policy dialogue aimed at laws to strengthen HIV prevention, promote protection for those most at risk and vulnerable to HIV and for improved care for those living with HIV.

### **B. PRIVATE SECTOR**

- a) The private sector includes and refers to both the private commercial sector and other private health providers, all of which have important roles to play in the multi-sectoral national response to HIV.
- b) Private sector engagement and activities are to be guided by the principles and objectives of the National HIV and AIDS Policy, to comply with national standards and protocols established by the NACC and MOH, and to contribute to achievement of national goals and targets articulated in the NSP and other relevant national policies.
- c) In line with this, private sector organisations and enterprises should:
  - i. Develop and implement policies and programmes for their workers, including health providers, to promote health and wellness and the human rights of PLHIV and other KPs.



- ii. Mobilise private sector resources, skills and capacities for HIV programming, including education, voluntary testing, linkage to and retention in care for clients and workers, their families and communities.
- iii. Integrate HIV training, including specific reference to rights of PLHIV and other KPs, into staff development activities at all levels.
- iv. Collaborate with employers and workers' organisation, government agencies, civil society and communities in the design, planning, implementation and monitoring of HIV-related activities that are accessible to all people, including KPs.

### **C. CIVIL SOCIETY**

- a) Civil society engagement and activities are to be guided by the principles and objectives of the National HIV and AIDS Policy, and are expected to contribute to achievement of national goals and targets articulated in the NSP and other relevant national policies.
- b) CSOs have important roles to play in:
  - i. Developing and implementing high-quality prevention and care strategies and interventions that are accessible and appropriate, and can reach KPs unable or unwilling to access public sector services, delivered in compliance with relevant national standards and protocols.
  - ii. Mobilising communities to provide and access prevention, treatment and care activities that are relevant, affordable and sustainable.
  - iii. Advocating for more effective and sustainable national programming that include and engage communities and meet the needs of key populations.
  - iv. Participating in national coordination activities to minimise duplication, and enhance the establishment of complementary programmes and interventions.
  - v. Participating in awareness raising and stigma reduction activities and engagements with public and private HIV service providers.
- c) The national response promotes and relies on community systems, particularly those of PLHIV and other KPs, that contribute to the longer-term sustainability of health and other interventions.
- d) Community networks should provide health services that include treatment, community health interventions, reduction of stigma and discrimination and health promotion, as well as activities that improve the enabling environment for health.
- e) Creation and sustaining of an NGO Forum.
- f) The Media has a critical role to play. The NACC will work with the Media to ensure accurate and sensitive reporting of HIV issues and the Media will partner with the NACC in implementing national communications campaigns.
- g) All NGOs involved in HIV and AIDS response must comply with all laws of Trinidad and Tobago and must ensure that they are duly registered with the Registrar General Department

under the Non-Profit Organisation Act and comply with regulations under the Financial Intelligence Unit where applicable

#### **D. TRADE UNIONS**

- a) Ensure that all members are provided with accurate information on modes of HIV transmission, risks, vulnerability, and protective mechanisms.
- b) Be champions for the rights based approach advocating for no mandatory HIV testing in the workplace, promoting prevention strategies such as condom use, knowing one's status, behavioural change, and confidentiality.
- c) Promote and advocate for strategies to eliminate stigma and discrimination against PLHIV and KPs and for legislative changes to address the rights of workers in these categories.
- d) Support uptake of and retention in treatment and care and support and protection of the rights of workers who are infected and affected by HIV and AIDS.
- e) Ensure that all agreements negotiated by the union have a clause inserted against discrimination against PLWHA.

#### **E. REGIONAL, BILATERAL AND INTERNATIONAL ORGANISATIONS**

These organisations have a key role to play in this policy and will assist by advising, providing resources- technical, financial, capacity building to the implementers of this Policy and ensuring that all HIV policies and strategies are aligned to international best practices.

#### **F. COORDINATION OF THE HIV RESPONSE IN TOBAGO**

- a) The National HIV and AIDS Policy recognizes that policy approaches and national guidelines may need to be adapted to fit the unique context of Tobago.<sup>46</sup>
- b) Greater impact of the response in Tobago requires supporting research efforts to build an evidence-base on better understanding of the needs of KP communities, and to support these communities
- c) The TACC will lead efforts to mobilize and strengthen community systems to fully engage in the HIV response, including effectively meeting the needs of KPs.
- d) The TACC will advocate for and ensure that the response in Tobago is adequately resourced to ensure that the goals of this Policy which provides the framework for Tobago response are achieved.
- e) The NACC and TACC will collaborate closely to ensure that the goals and objectives of the Policy are realised.

---

<sup>46</sup> Tobago consultation, November 2017

### 9.3 LEADERSHIP AND KNOWLEDGE MANAGEMENT

- a) The NACC will be responsible for providing effective leadership and management in all components of the national response. To this end, the NACC is responsible for upholding and championing the values and objectives of the National HIV and AIDS Policy; embracing and nurturing a team approach to collaborative decision-making, planning and implementation of the national HIV response; and promoting the continuous development and improvement of stakeholders and services.
- b) Knowledge management activities and processes of the above-listed stakeholders specific to and including their roles in the national HIV response shall comply with relevant national laws and regulations, and will comply with and support the principles and objectives of the National HIV and AIDS Policy.
- c) The NACC will be responsible for designing, implementing and coordinating knowledge management activities, practices and processes that foster a culture of sharing and innovation across the organizations and stakeholders engaged in the national HIV response.
- d) In collaboration with the CARPHA, HACU and other stakeholders, the NACC will establish a knowledge management framework and platform that can ensure the preservation and sharing of critical information.

### 9.4 RESOURCING THE NATIONAL RESPONSE

Adequate and sustainable financing is critical for sustaining an effective national response.

1. The Government commits to ensuring that the national HIV and AIDS response is adequately resourced with financial, human, capacity building, infrastructure, drugs and other commodities.
2. The Government commits to ensuring that the NACC is adequately resourced with financial resources and with a full-time competently staffed Secretariat to follow up and implement the Committee's decisions.
3. The NACC, MOH and Ministry of Finance shall lead multi-stakeholder efforts to develop sustainability plans to detail how the HIV response will be resourced in the long-term, including the scale-up of the treatment programme as implementation of Treat All progresses.
4. Resource mobilization efforts and funding mechanisms should lead to predictable financial resources and accountability for the resources mobilized. In this regard, the NACC should develop a resource mobilization strategy including an investment case which would identify.
5. Efforts to rationalize and reduce the costs of ARV procurement are key strategies for sustainability, alongside diversifying and increasing sources of domestic financing, including through new partnerships between the public and private sector.

9.5 MONITORING AND EVALUATION OF THE POLICY

The NACC in the Office of the Prime Minister is the state agency which is charged with the responsibility of co-ordinating the activities associated with the implementation of the National HIV and AIDS Policy. Accordingly the NACC shall develop and monitor the Implementation Plan of priority actions items, identifying responsible or lead organisations and establishing time frames for implementation.

An annual report containing an evaluation of the extent to which the goals and objectives of the National HIV and AIDS Policy are being achieved and recommendations for adjustments to the Policy if required will be compiled and submitted to the Cabinet.

APPENDICES

APPENDIX I-NATIONAL POLICIES AND PLANS RELEVANT TO HIV AND AIDS

Policy	Policy Description
<i>National Development Strategy 2016-2030</i>	The <i>National Development Strategy</i> is the country's sustainable development strategy which establishes the vision and broad framework for Trinidad and Tobago's development to 2030 and defines the key priorities for the first planning period 2016-2020. It incorporates the principles and objectives of the Sustainable Development Goals.
<i>National Child Policy (2018)</i>	The <i>National Child Policy</i> provides a comprehensive framework to guide all stakeholders towards achieving the optimal well-being of children and recognizes that all children are integral to the well-being and sustainable development of our country.
<i>National Policy on Gender and Development (A Green Paper) (2018)</i>	The <i>National Policy on Gender and Development</i> recognizes HIV as a critical development problem with gender dimensions and drivers that must be addressed. The policy provides a framework for a gender responsive approach to the implementation of sexual and reproductive health strategies.
<i>National Mental Health Policy (2019-2029)</i>	The <i>National Mental Health Policy</i> seeks to promote the mental wellbeing of all people of Trinidad and Tobago encouraging people to thrive and make meaningful contributions to their communities and places emphasis on prevention of mental disorders through the promotion of a culture of self-care, resilience and mutual support.
<i>National Policy on Sustainable Community Development (2018-2030)</i>	The <i>National Policy on Sustainable Community Development</i> asserts that community development cannot be pursued apart from the human and social development of residents and seeks to empower communities by paying careful attention to social factors such as health and wellness.
<i>National Workplace Policy on HIV and AIDS (2017)</i>	The <i>National Workplace Policy on HIV and AIDS</i> provides the framework for an effective workplace response to HIV. Developed by the Ministry of Labour and Small Enterprise Development, the policy provides a platform to enable people living with HIV to continue to be productive in their places of employment.

Policy	Policy Description
<b><i>Draft National Parenting Policy (2017)</i></b>	The <b><i>Draft National Parenting Policy</i></b> seeks to support parental empowerment in the performance of their parenting duties in order to promote the optimal holistic development of children at all stages of growth. It calls for the strengthening of age appropriate sex and sexuality education. It recognizes that age appropriate awareness of sex and sexuality is an essential step in pregnancy reduction which can start in schools.
<b><i>National Policy on Persons with Disability (2018)</i></b>	The <b><i>National Policy on Persons with Disability</i></b> provides a comprehensive framework for achieving social inclusion and equality of opportunity for all persons with disabilities in the Republic of Trinidad and Tobago. The scope of the Policy covers a wide range of areas that are to be improved for the benefit of persons with disabilities and recognizes that Persons with disabilities require the same general health care as everyone else and in some cases may require additional health care in order to prevent occurrences of secondary disabilities.
<b><i>National Population and Development Policy (2015-2021)</i></b>	The National Population and Development Policy seeks to effectively co-ordinate the State’s management of national population size and distribution. The Population and Development Policy has as one of its priorities the Quality of Life and Health Care within which there are recommendations for improving strategies to educate the public on the transmission of STIs including HIV and AIDS and fostering health seeking behaviours among populations at greatest risk.
<b><i>Draft Sexual and Reproductive Health Policy</i></b>	The <b><i>Draft Sexual and Reproductive Health Policy</i></b> encompasses the provision and delivery of services to underserved priority populations including males, adolescents and youth, and post-fertility adults. The policy explicitly addresses HIV-related issues.
<b><i>Education Sector Policy on HIV and AIDS (2009)</i></b>	The <b><i>Education Sector Policy on HIV and AIDS</i></b> is designed to promote HIV and AIDS awareness among the student and employee population.
<b><i>National Youth Policy (2012-2017)</i></b>	The <b><i>National Youth Policy</i></b> is designed to develop empowered young people who are able to make informed choices. The policy addresses HIV within the context of creating an enabling environment to meet the needs of at-risk youth.
<b><i>Draft National Policy on the Development and Implementation of a National Life Skills Curriculum for Personal Development and Employment Enhancement (A Green Paper)</i></b>	The <b><i>Draft National Policy on the Development and Implementation of a National Life Skills Curriculum for Personal Development and Employment Enhancement</i></b> sets guidelines for the delivery of standardised, quality life skills education and training throughout Trinidad and Tobago to

**NATIONAL HIV AND AIDS POLICY, 2020-2030**

Policy	Policy Description
	impact major social issues facing the country such as poverty, illiteracy, HIV, unemployment and crime.
<b><i>Guidelines for Managing HIV and AIDS in the Public Service (2009)</i></b>	The <b><i>Guidelines for Managing HIV and AIDS in the Public Service</i></b> was developed by the Office of the Chief Personnel Officer, Personnel Department, to support the national HIV response and people living with HIV who work in the public service.
<b><i>National Occupational Safety and Health Policy (Amended 2006)</i></b>	The <b><i>National Occupational Safety and Health Policy</i></b> which describes the conditions for health and safety in the workplace including accidents and protective measures to be adopted.
<b><i>National Tourism Policy (2010)</i></b>	The <b><i>National Tourism Policy</i></b> calls for suitable actions to prevent and minimize the spread of communicable and other diseases which impact the tourism sector.
<b><i>National HIV Testing and Counselling Policy (2012)</i></b>	The <b><i>National HIV Testing and Counselling Policy</i></b> establishes universal access to HIV testing and aims to ensure that HIV testing facilities and information about testing is accessible to all citizens.
<b><i>Prevention of Mother to Child Transmission of HIV (PMTCT) Policy (2010)</i></b>	The <b><i>Prevention of Mother to Child Transmission of HIV (PMTCT) Policy</i></b> provides a framework for the implementation of strategies for primary prevention of HIV infection among women, especially young women, and for reducing the transmission of the HIV from infected women to their babies during and after pregnancy.
<b><i>National Post Exposure Prophylaxis (PEP) Policy (2010)</i></b>	The <b><i>National Post Exposure Prophylaxis (PEP) Policy</i></b> addresses the issues associated with the treatment of those who have been exposed to occupational and non-occupational risk of HIV infection.
<b><i>Social Mitigation Plan (2017-2022)</i></b>	The overarching goal of the <b><i>Social Mitigation Plan</i></b> (SMP) is to mitigate the negative social impacts of the economic downturn in the Trinidad and Tobago economy and to improve access to social protection programmes in order to improve persons' capacities to better manage risks and shocks. It will also seek to enhance co-ordination and integration of existing social protection programmes, thereby creating an evidenced-based response package for persons requiring assistance.



**APPENDIX II- LISTING OF LEGISLATION RELEVANT TO HIV AND AIDS**

---

1. Adoption of Children Act 2000 Chapter 46:03
2. Administration of Estates Act 1913 Chapter 9:01
3. Age of Majority Act 1973 Chapter 46:06
4. Basic Conditions of Work and Minimum Wages Bill 2000
5. Children Act 2012 Chapter 46:01
6. Children's Authority Act 2000 Chapter 46:10
7. Children's Community Residences, Foster Care and Nurseries Act 2000 Chapter 46:04
8. Children's Life Fund 2010 Chapter 29:01
9. Criminal Offences Act 1844 Chapter 11:01
10. Cohabital Relationships Act 1998 Chapter 45:55
11. Dangerous Drugs Act 1991 Chapter 11:25
12. Data Protection Act 2011 Chapter 22:04
13. Defence Act 1962 Chapter 14:01
14. Distribution of Estates Act 2000
15. Domestic Violence Act 1999 Chapter 45:56
16. Education Act 1966 Chapter 39:01
17. Equal Opportunity Act 2000 Chapter 22:03
18. Family and Children Division Act 2016
19. Hindu Marriage Act 1945
20. Immigration Act 1969 Chapter 18:01
21. Industrial Relations Act 1972 Chapter 88:01
22. Insurance Act 2018
23. Judicial Review Act 2000 Chapter 7:08
24. Legal Aid and Advice Act 1976 Chapter 7:07
25. Marriage Act 1923
26. Matrimonial Proceedings and Property Act 1972
27. Medical Board Act 1960 Chapter 29:50
28. Mental Health Act 1975 Chapter 28:02
29. Miscellaneous Provisions (Marriage) Act 2017
30. Muslim Marriage and Divorce Act 1961
31. Occupational Safety and Health Act 2004 Chapter 88:08
32. Offences Against the Person Act 1925 Chapter 11:08
33. Orisa Marriage Act 1999 Chapter 45:04
34. Police Complaints Authority Act 2006 Chapter 15:05
35. Police Service Act 2006 Chapter 15:01
36. Prisons Act 1900 Chapter 13:01
37. Professions Related to Medicine Act 1985 Chapter 90:04
38. Schools (Medical Inspection) Act 1928 Chapter 28:04
39. Sexual Offences Act 1986 Chapter 11:28
40. Succession Act 1981 Chapter 9:02
41. Summary Offences Act 1921 Chapter 11:02



42. Trafficking in Persons Act 2011 Chapter 12:10
43. Widow's and Orphan's Pensions Act 1934 Chapter 23:54
44. Wills and Probate Act 1945 Chapter 9:03
45. Young Offenders Detention Act 1926 Chapter 13:05
46. Patient Charter of Rights and Obligations

### APPENDIX III – GLOSSARY

**Acquired immunodeficiency syndrome (AIDS):** AIDS (Acquired Immune Deficiency Syndrome) is the final and most serious stage of HIV disease, which causes severe damage to the immune system.

**Adherence:** Taking medications exactly as prescribed. Poor adherence to an HIV treatment regimen increases the risk for developing drug-resistant HIV and virologic failure.

**Advocacy:** Public support for or recommendation of a particular cause or policy.

**Affected person:** A person whose life is changed in any way by HIV and AIDS, due to the broad impact of the epidemic.

**Antiretroviral drugs (ARV) -** A drug that is the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease or replicating. Huge reductions have been seen in rates of death and suffering when use is made of a potent ARV regimen, particularly in early stages of the disease. Antiretroviral Therapy (ART) is sometimes used in place of ARV.

**Antiretroviral therapy (ART):** The recommended treatment for HIV infection. Antiretroviral therapy (ART) involves using a combination of three or more antiretroviral (ARV) drugs from at least two different HIV drug classes to prevent HIV from replicating.

**Behaviour change:** Behaviour change is usually defined as the adoption and maintenance of healthy behaviours.

**Behaviour Change Communication (BCC) -** Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. BCC makes use of information, education and communication materials where communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviours.

**Civil Society Organisation (CSO):** CSOs can be defined to include all non-market and non-state organizations outside of the family in which people organize themselves to pursue shared interests in the public domain. Examples include community-based organizations and village associations, environmental groups, women's rights groups, farmers' associations, faith-based organizations, labour unions, co-operatives, professional associations, chambers of commerce, independent research institutes and the not-for-profit media.

**Client-centred:**

Honoring the desires, interests, priorities, and motivations of a client and/or client's family/significant others in conducting evaluations and designing interventions

**Confidentiality:** A substantive rule in [bioethics](#) saying that the information a patient reveals to a health care provider is private and has limits on how and when it can be disclosed to a third party; usually the provider must obtain permission from the patient to make such a disclosure.

**Disclosure:** Disclosure means telling someone that you are living with HIV (HIV+). Sharing your HIV status can help with the stresses of living with HIV.

**Discrimination:** In this context of the policy, any distinction, exclusion, or preference made on the basis of HIV status, perceived HIV status, sexual orientation, age and gender. Discrimination consists of actions or omissions that are derived from stigma and directed towards those

individuals who are stigmatised. Discrimination is action, which has the effect of nullifying or impairing equality of opportunity or treatment, in employment or occupation, in accordance with the definition and principles of the ILO Discrimination (Employment and Occupation) Convention, 1958 (no. 111).

**Enabling environment:** There are different kinds of enabling environments in the context of HIV. An enabling legal environment is one in which laws and policies against discrimination on the basis of HIV status, risk behaviour, occupation, and gender are in place and are monitored and enforced. An enabling social environment is one in which social norms support healthy behaviour choices.

**Faith-Based Organisation (FBO):** Faith-based organisation' is the term is used to refer to church, synagogue, mosque, or religious organisation.

**Gender:** All attributes associated with women and men, boys and girls, that are socially and culturally ascribed and that vary from one society to another and over time.

**Gender-based violence:** Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships.

**Gender equality:** Gender equality, or equality between men and women, entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.

**Gender equity:** Gender equity is fairness and justice in the distribution of resources, benefits, and responsibilities between men and women, girls and boys in all spheres of life.

**Gender roles:** These are the socially constructed and defined responsibilities assigned to males and females for example, child rearing is considered a female gender role. Gender roles are not universal and differ in different places and from time to time. They are also changeable and interchangeable.

**Gender sensitive:** Gender sensitivity, is being conscious of the different situations and needs of women and men, throughout the decision-making process. It entails the ability to recognize the differences in perception and interests between males and females arising from their different social position and different gender roles.

**Gillick Competence:**

A UK term referring to the competence of a child under the age of 16 to consent to his/her own medical care, without the need for parental permission.

**Health and family life education (HFLE):** Health and Family Life Education is a comprehensive, life skills-based programme, which focuses on the development of the whole person and which refers to an interactive process of teaching and learning which enables learners to acquire knowledge and to develop attitudes and skills which support the adoption of healthy behaviours.

**HIV infection-** HIV is a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells. Over time, HIV can destroy many of these cells that the body can't fight off infections and disease. These special cells help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body. This damage to the immune system makes it harder and harder for the body to fight off infections and some other diseases.

**HIV testing and counselling:** A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of tests results, HIV prevention counselling to reduce their risk for transmitting or acquiring HIV, and is provided testing to detect the presence of HIV antibodies. This is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. Testing without counselling has little impact on behaviour and is a significant lost opportunity to assist people to avoid acquiring or transmitting infection.

**Homophobia:** Homophobia is a strong and unreasonable dislike of gay people, especially gay men.

**Human rights:** Human rights are rights inherent to all human beings, whatever the nationality and place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. All are equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible.

**Key population (KP):** The term refers to those who are most likely to be exposed to HIV or to transmit it. Their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In Trinidad and Tobago key populations comprise men who have sex with men, substance users, sex workers, youth, infants born to HIV positive mothers, prisoners and migrant workers. These groups are at higher risk of contracting and transmitting HIV.

**LGBTQI:** an acronym for Lesbian, gay, bisexual, transgender, questioning and intersex used to describe a person's sexual orientation

**Millennium Development Goals (MDGs):** Eight goals were agreed at the Millennium Summit in September 2000. Goal 6 refers specifically to halting and reversing HIV. Lack of progress across other MDGs may seriously curtail progress in tackling HIV and, conversely, success in attaining other MDGs is being hampered by the HIV epidemic. The concept of AIDS and MDGs implies sharing lessons and building stronger links between the global HIV response and broader health and development agendas.

**Men who have sex with men (MSM):** The term describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

**Modes of transmission (MoT):** MoT refers to an epidemiological model developed by UNAIDS to help countries calculate HIV incidence by mode of transmission in the short term. The model incorporates biological and behavioural inputs, such as HIV and sexually transmitted infection prevalence, risk behaviours, and transmission probabilities. This process is sometimes referred to as 'Know your Epidemic' and 'Know your Response' or 'Tailor your Response'.

**Multiple sexual partnerships:** A relationships between men and women who have more than one sexual relationships at the same time. These relationship can be long or short term. Some persons have multiple sex partners for pleasure while others do this to increase social status. When people engage in unprotected sex with many different partners they increase their chances of becoming infected with HIV.

**Non-governmental organisation (NGO) -** Nongovernmental organizations (NGOs) are typically mission-driven advocacy or service organizations in the non-profit sector.

**Opportunistic infection-** Opportunistic infections are illnesses caused by various organisms, many of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes, and other organs. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.

**Pre exposure prophylaxis (PrEP):** Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day.

**People living with HIV (PLHIV):** The term encompasses family members and dependents who may be involved in caregiving or otherwise affected by the HIV-positive status of a person living with HIV.

**Prevalence:** The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

**Prevention of mother to child transmission (PMTCT):** This refers to a 4-prong strategy for stopping new HIV infections in children and keeping mothers alive and families healthy. The four prongs are: halving HIV incidence in women (Prong 1), reducing unmet need for family planning (Prong 2), providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (Prong 3), and providing care, treatment and support for mothers and their families (Prong 4). PMTCT is often mistakenly used to refer to only Prong 3—the provision of antiretroviral prophylaxis.

**Post exposure prophylaxis (PEP) -** Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection.

**Psychosocial support:** The non-physical care meant to address challenges of isolation, depression, anxiety, other psychiatric impairment, and serious interpersonal problems as a result of HIV and AIDS. The purpose of psychosocial support is to ensure that quality of life and motivation to live are effectively optimised.

**Referral:** A process by which immediate client needs for prevention, care, and supportive services are assessed and prioritized and clients are provided with assistance in identifying and accessing services (such as, setting up appointments and providing transportation). Referral does not include ongoing support or case management. There should be a strong working relationship (preferably

a written agreement) with other providers and agencies that might be able to provide needed services.

**Risk factors:** Risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance (increase) and perpetuate risk which are known as factors. Some examples include unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; injecting drug use with contaminated needles and syringes.

**Sex workers (SW):** Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Acceptable alternative formulations for the term ‘sex worker’ are ‘women/men/people who sell sex’. Clients of sex workers may be called ‘men/ women/people who buy sex’. The term ‘commercial sex worker’ is not used because it says the same thing twice in different words. Children selling sex under the age of 18 are considered to be victims of commercial sexual exploitation (see under ‘prostitution’), unless otherwise determined.

**Sexual abuse:** Abuse of a person targeting his or her sexual organs, e.g., rape, touching the person’s private parts, or inserting objects into the person’s private parts.

**Sexual and reproductive health (SRH):** Sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health. services for family planning; infertility services; maternal and new-born health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.

**Sexually transmitted infections (STIs)-** Diseases transmitted through sexual intercourse and which include, among others, syphilis, chancroid, chlamydia, and gonorrhoea.

**Stigma:** A dynamic process of devaluation that significantly discredits an individual in the eyes of others.

**Sustainable Development goals (SDGs):** These are a new, universal set of goals, targets and indicators that UN member states will be expected to use to frame their agendas and political policies over the next 15 years.

**Tuberculosis (TB):** TB is a disease caused by bacteria that are spread through the air from person to person. If not treated properly, TB disease can be fatal. People infected with TB bacteria who are not sick may still need treatment to prevent TB disease from developing in the future.

**Transgender (TG):** Denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex.

**Transphobia:** Dislike of or prejudice against transsexual or transgender people.

**Universal access:** Universal access implies maximal coverage of HIV prevention, treatment, care, and support services for those who require them. Basic principles for scaling up towards universal access are that services must be equitable, accessible, affordable, comprehensive, and sustainable over the long term. Because different settings often have distinctly different needs, targets for universal access are set nationally.

**Viral load:** The amount of HIV in a sample of blood. Viral load (VL) is reported as the number of HIV RNA copies per millilitre of blood. An important goal of antiretroviral therapy (ART) is to suppress a person's VL to an undetectable level—a level too low for the virus to be detected by a VL test.

**Voluntary counselling and testing (VCT):** VCT is voluntary HIV testing that involves a process of pre- and post-test counselling, which helps people to know their sero-status and make informed decisions.

**Vulnerable populations:** Vulnerable populations are defined as those at greater risk for poor health status and health care access. This include the elderly, the homeless, those PLHIV, and those with other chronic health conditions, including severe mental illness. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care.



## REFERENCES

---

Adams, Stuart. *CVC/COIN Vulnerabilized Groups Project: Phase One (January 2011 - March 2013)*. An Independent Evaluation. 2013

Andrews, Beverly. *Draft Situational Analysis of HIV and AIDS in Trinidad and Tobago*, 2019.

Arreola et al. "Substance Abuse and HIV/AIDS in the Caribbean: Current Challenges and the Ongoing Response." *Journal of the International Association of Providers of AIDS Care*, vol. 16, no. 1, 2017, pp. 56–74

Community Action Resource. *Drug Users Community-based participatory Action Research Project*, 2017.

Gilbert, Godfrey. *World Poverty- A Reference Handbook*, 2004

*Global School Health Survey 2017*, Ministry of Health, Trinidad and Tobago, 2017

Hasbún, Julia et al. *Diversity and Commonality: A Look at Female and Transgender Sex Workers in Three Caribbean Countries*, Caribbean Vulnerable Communities Coalition/The Center for Integrated Training and Research and the Pan Caribbean Partnership on HIV and AIDS. Dominican Republic. 2012.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *90-90-90 An ambitious treatment target to help end the AIDS epidemic*. 2014.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *Fact sheet – Gender and HIV and AIDS*.

Joint United Nations Program on HIV/AIDS (UNAIDS). *Global AIDS Response Progress Report (GARPR) Country Narrative Report*. 2016.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *Trinidad and Tobago, UNAIDS Country Fact Sheet*, 2016.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *When Women Lead Change Happens*, 2017.

Maharaj, R et al. "Sexual Practices among 15-49 year olds in Trinidad and Tobago 2006-2007," *Caribbean Medical Journal*, vol. 76 no. 2, 2014, pp. 10-14.

McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) "The Social Ecology of Health Promotion Interventions." *Health Education Quarterly*, vol. 15, no. 4, 1988, pp. 351-377.

Ministry of Health. *2017 Annual Data Management Report*, 2017.



- Ministry of Health. *Female Sex Worker Study*, unpublished.
- Ministry of Health. *Global AIDS Monitoring Indicators*, unpublished, 2018
- Ministry of Health, HACU. *HIV Surveillance Annual Reports*, 2013-2017.
- Ministry of Health. *Men's Bio-Behavioural Survey*, unpublished, 2014.
- Ministry of Health. *National Surveillance Report 2005-2012*, unpublished.
- Ministry of Health. *2017 Spectrum Estimates for Trinidad and Tobago*, unpublished.
- Ministry of Social Development and Family Services, Central Statistical Office and UNICEF. "Key Findings & Tables." *Trinidad and Tobago Multiple Indicator Cluster Survey 2011*. Port of Spain, Trinidad and Tobago, 2017.
- Myrie, T. *Legal Environment Assessment for the HIV and AIDS Response in Trinidad and Tobago, Final Report*. 2018.
- Office of the Prime Minister, Trinidad and Tobago. *National HIV and AIDS Strategic Plan, 2013-2018*.
- Pemberton, C. and Joseph, J. *National Women's Health Survey for Trinidad and Tobago: Final Report*, 2018.
- Reid, Sandra. HIV Seroprevalence and risk factors in female substance abusers seeking rehabilitation in Trinidad and Tobago. *West Indian Medical Journal*, vol. 53, no. 3, June 2004, pp. 155-8
- Scott et al 2011. Poverty, Employment and HIV/AIDS in Trinidad and Tobago. *International Journal of Business and Social Science*, vol. 2, no. 15, August 2011.
- Texas HIV/STD Prevention Community Planning Group. *Texas HIV/STD Prevention Plan*, 2011. [http://www.rwpchouston.org/Publications/2012\\_Comp\\_Plan/Documents/2011%20Texas%20HIV%20Prevention%20Plan.pdf](http://www.rwpchouston.org/Publications/2012_Comp_Plan/Documents/2011%20Texas%20HIV%20Prevention%20Plan.pdf).
- World Health Organization. *Addressing violence against women in HIV testing and counselling: a meeting report*. Geneva, January 2006. [https://www.who.int/gender/documents/VCT\\_addressing\\_violence.pdf](https://www.who.int/gender/documents/VCT_addressing_violence.pdf). Accessed 8 April 2019
- World Health Organization. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update*. Geneva, 2016.
- World Health Organization. *Guidelines on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. September, 2015. [www.who.int](http://www.who.int). Accessed, 18 April 2018.

World Health Organization. *Provider-initiated HIV testing and counselling in health facilities*. <http://www.who.int/hiv/topics/vct/PITC/en/>. Accessed, 1 December 2017.

**National AIDS Co-ordinating Committee**  
**Office of the Prime Minister**  
**Level 21 Tower D**  
**International Waterfront, 1A Wrightson Road**  
**Port-of-Spain**